

## **PLANNING COMMISSION (COHAH) GENERAL BODY MEETING AGENDA**

**THURSDAY, JUNE 29, 2023 – 6:00PM TO 8:00PM**

**ZOOM CONFERENCE AND VIDEO CALL**

**Note: all times are approximate**

6:05 pm	1. Call To Order and Moment of Silence		
6:10 pm	2. Review and Adoption of the Meeting Agenda for June 29, 2023 3. Review and Approval of the Meeting Minutes for May 25, 2023		
6:15 pm	4. Ryan White HIV/AIDS Program (RWHAP) Recipient Report/ Updates		
6:25 pm	5. Understanding the Fee-for-Value Model – Ebony Fortune, Ryan White Program Manager, HAHSTA		
6:45 pm	6. <b>Standing Committee Updates</b> <ul style="list-style-type: none"> <li>• <i>Research &amp; Evaluation Committee (REC)</i> {Next mtg.: Tue. Jul 18<sup>th</sup> @ 3pm}</li> <li>• <i>Community Engagement &amp; Education Committee (CEEC)</i> {Next mtg.: Thur. July 20<sup>th</sup> @ 5pm}</li> <li>• <i>Comprehensive Planning Committee (CPC)</i> {Next mtg.: Wed. July 26<sup>th</sup> @ 11am}</li> <li>• <i>Integrated Strategies Committee (ISC)</i> {Next mtg.: Wed. July 26<sup>th</sup> @ 1pm}</li> </ul>		
7:05 pm	7. <b>Other Business</b> <ul style="list-style-type: none"> <li>• <i>Vote to approve Health Equity Position Paper</i></li> <li>• <i>Virginia Updates</i></li> <li>• <i>Maryland Updates</i></li> </ul>		
7:30 pm	8. Announcements/Adjournment		
<table border="1" style="width: 100%; background-color: yellow;"> <tr> <td style="width: 50%; text-align: center;"><b><u>NEXT PLANNING COMMISSION (COHAH) MEETING:</u></b></td> <td style="width: 50%; text-align: center;"><b>THURSDAY JULY 27, 2023 6PM-8PM ZOOM</b></td> </tr> </table>		<b><u>NEXT PLANNING COMMISSION (COHAH) MEETING:</u></b>	<b>THURSDAY JULY 27, 2023 6PM-8PM ZOOM</b>
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# PLANNING COMMISSION (COHAH) GENERAL BODY MEETING MINUTES

**THURSDAY, MAY 27, 2023 - 6:00PM**

**ZOOM CONFERENCE AND VIDEO CALL**

**ELECTRONIC – ONLINE MEETING**

## ATTENDEES/ROLL CALL

COMMISSIONERS	PRESENT	ABSENT	COMMISSIONERS	PRESENT	ABSENT
Barnes, Clover (Ex-Officio)		X	Hutton, Kenya		X
Barton, Jedidiah	X		Keita, Ramatoulaye		X
Blocker, Lakisa		X	Massie, Jenné	X	
Brown, Charles		X	Mekonnen, Betelhem ( <i>Comm. Co-Chair</i> )	X	
Camara, Farima	X		Murdaugh, Henry		X
Carney, Misty	X		Olinger, Joshua	X	
Cauthen, Melvin	X		Padmore, Gerald	X	
Clark, Lamont (Gov. Co-Chair)	X		Palmer, Kentrell		X
Coker, Sharon		X	Penner, Murray	X	
Cooper-Smith, Marjorie	X		Pettigrew, Kenneth		X
Copley, Mackenzie	X	X	Rakhmanina, Natella	X	
Corbett, Wallace		X	Ramos, Claudia		X
Cox, Derrick		X	Rhodes, Stefanie		X
Dean, Traci		X	Sain, Philip	X	
DeMartino, Peter		X	Shaw-Richardson, Re'ginald	X	
Fogal, Doug	X		Wallis, Jane ( <i>Comm. Vice-Chair</i> )		X
Ford, Jasmine		X	Washington, Antonio	X	
Forman, Lynn		X	Yocum, Ashley	X	
Gomez, Ana		X			
Gutierrez, Anthony		X			
Hickson, DeMarc		X			
RECIPIENT STAFF	PRESENT	ABSENT	CONSULTANTS	PRESENT	ABSENT
Smith, Avemaria	X		Washington, Mehki	X	
HAHSTA STAFF	PRESENT	ABSENT	COMMISSION STAFF	PRESENT	ABSENT
Jefferson, Regina	X		Bailey, Patrice	X	
Orban, Julie	X		Johnson, Alan	X	

## HIGHLIGHTS

*This is a draft version of the May 25, 2023, COHAH General Body Meeting Minutes which is subject to change. The final version will be approved on June 29, 2023.*

## **AGENDA**

<b>Item</b>	<b>Discussion</b>
<b>Call to Order</b>	The meeting was called to order by Lamont C. at 6:09 pm. gave the welcome, followed by a moment of silence. Attendance was taken via Zoom chat. With 18 of 36 voting commissioners present, a quorum was established.
<b>Review and Adoption of the Agenda</b>	Lamont asked for a motion to adopt the agenda for May 25, 2023. Melvin C. made the motion. Reginald S. seconded. The agenda was adopted unanimously via poll vote.
<b>Review and Approval of the Minutes</b>	Lamont asked for a motion to approve the meeting minutes from April 27, 2023. Antonio W. made the motion. Melvin seconded. The minutes were approved unanimously via poll vote.
<b>Ryan White HIV/AIDS Program (RWHAP) Recipient Report/Updates</b>	<p><b>Avemaria (Ave) S. presented the Recipient Report</b>            This Part A and Part A MAI report is being presented for the month of March, the beginning of Grant Year 33. The full award is in the amount of \$32,652,189.00.</p> <p><b><u>FISCAL STATUS</u></b>            For Part A and Part A MAI, 21 of 26 subrecipients submitted payment requests that were processed. Five (5) providers have not submitted their March invoices.</p> <p>There are no service delivery challenges in DC, Maryland or Virginia.</p> <p><b><u>PART A FISCAL SUMMARY</u></b>            Expenditures were at 7% and should have been at 8%.</p> <p>Service areas affected by unprocessed invoices were Outpatient/Ambulatory Health Services (OAHS), Early Intervention Services (EIS), Oral Health Care (OH), Home and Community-Based Health Services (HCBS), Medical Nutrition Therapy (MNT), Medical Case Management (MCM), Non-Medical Case Management Services (NMCM), Substance Abuse Services - Outpatient (SASO), Medical Transportation (MT), Outreach Services (OS), Medical Transportation (MT), Psychosocial Support Services (PSS), Oral Health Care (OH), and Psychosocial Support Services.</p> <p>Services spending 30% below expected were Early Intervention Services (EIS), Health Insurance Premium and Cost Sharing Assistance (HIPCSA), Home and Community-Based Health Services (HCBS), and Medical Transportation (MT).</p> <p>Services spending 30% above expected were Mental Health Services (MHS) and Other Professional Services (OPS).</p>



	<p><b><u>PART A MAI FISCAL SUMMARY</u></b>          Expenditures were at 5% and should have been at 8%.</p> <p>Services areas affected by unprocessed invoices were outpatient/Ambulatory Health Services (OAHS), Early Intervention Services (EIS), Mental Health Services (MHS), Medical Case Management (MCM), Substance Abuse Services – Outpatient (SASO), and Psychosocial Support Services (PSS).</p> <p>Services spending 30% below expected were Early Intervention Services (EIS), Medical Case Management (MCM), and Psychosocial Support Services (PSS).</p> <p><b>RECIPIENT REPORT</b>          All Part A GY33 continuations have been fully executed.</p> <p>Most of the challenges with invoicing in the new Electronic Grants Management System 2.0 (EGMS 2.0), have been resolved. There are only a few subrecipients still impacted. A workaround has been implemented for those unable to invoice through the system. Service delivery remains unaffected.</p> <p>Recipient staff are preparing all required programmatic and fiscal documentation to close out GY32 with HRSA by May 26, 2023. The new DIFS accounting system continues to pose challenges that are leading to delays in closing the books.</p> <p>HAHSTA is hiring. Ave shared a link to the vacancies in the chat. Please review the link and share with your networks.</p>
<p><b>Standing          Committee          Updates</b></p>	<p><b>Research and Evaluation Committee (REC) reported by Lamont.</b>          The REC had further discussions about the Consumer Needs Assessment. There are students located at various sites collecting surveys. However, there continue to be challenges with the Salesforce platform that’s being used. The deadline is still set for June.</p> <p>Julie indicated that an additional subsite has been added to place interns in Maryland that will begin in June. Another student has been added to help with the effort in increasing the Maryland numbers. The goal is to increase the numbers in survey completion. Currently, there have been 432 surveys submitted, 334 useable. There needs to be an increase of 50% (60 or more) in Maryland, 25% (15 or more) in Virginia and 2 in West Virginia to meet the goal.</p> <p>Additionally, Julie has received a response from HRSA and CDC regarding the Integrated Plan. Julie will reconvene the workgroup in June to discuss the feedback received,</p> <p><b>Community Education and Engagement committee (CEEC) reported by Jenné M.</b>          CEEC spent most of the meeting discussing the t D-Seeing Project. More approvals are needed to move forward with the institutional ethnography. Fortunately, an extension was granted to complete the project</p>

	<p>by the fall, giving more time to finish the groups and prepare for the exhibit. Jenné also met with potential partners to help with curating the exhibit.</p> <p>There was no one available to give an update on the PrEP Protocol Summit. Jenné hopes to have an update at the next meeting.</p> <p><b>Comprehensive Planning Committee (CPC) reported by Gerald P.</b>          The Recipient gave the financial report for March 2023.</p> <p>The data request has been submitted to the Recipient Office. The Recipient has disseminated the request to the Care and Treatment team, the HAHSTA Surveillance Department, and the jurisdictional partners. It is anticipated to be completed and submitted by July.</p> <p>Gerald announced his resignation from the COHAH. He has reached out to his network to encourage involvement in his absence.</p> <p><b>Integrated Strategies Committee (ISC) reported by Lamont.</b>          The ISC finalized and presented the Health Equity Paper. The Paper was divided into three (3) parts; the full 30-page paper, the ten (10) page Executive Summary, and one (1) page Action Steps/Work Plan for next steps. The Paper will be housed on the COHAH website for review, comment, and dissemination. Representatives from GW focused on the Action Steps as a living document and welcomes any feedback from subject matter experts in any of the following specified areas, (Employment, Housing, Transportation, Food, Medical Care, Medical Mistrust and HIV Stigma, and Education).</p>
<p><b>Other Business</b></p>	<p><b><u>Maryland Department of Health (MDH) by Misty C.</u></b>          Charles County had their first Price Event.</p> <p>The Medicaid Unwinding first cohort disenrollment will begin on May 31, 2023. Those customers who received the extended eligibility can expect some changes if they have not re-enrolled. The Maryland Medicaid team would like to present to the COHAH what the unwinding process will look like.</p> <p>The Community Operational Response Engagement meetings continue every other Tuesday from 10:00am -11:30am.</p> <p><b><u>Virginia Department of Health (VDH) by Ashley Y.</u></b>          VDH has revised the Ryan White (RW) Part B Service Standard and Quality Management Plan and will post it on the website soon.</p> <p>VDH released the Care Services Needs Assessment which focuses on access to transportation and Internet services in May. The survey is available</p>



	<p>in English and in Spanish. Clients can contact their RW Part B provider for paper copies of the survey.</p> <p>VDH received feedback on the Virginia Integrated Plan. VDH look forward to collaborating the DC COHAH on both plans.</p>		
<b>New Business</b>	<p>Lamont has asked each committee’s opinion about in-person meetings. Initially, the thought was to hold committee meeting in the 4th floor conference rooms at 899 North Capital St. However, the conference rooms are no longer feasible because they are currently overrun with boxes, in addition to the upcoming office move scheduled to take place in February 2024 to Shannon Place SE. The ISC indicated that they would like to meet in person once a quarter and push the time back a couple of hours so that they can end their workday from that meeting. The consensus was to have hybrid meetings. Lamont will continue to have discussions about having the General Body Meetings in-person. The previous location at 441 4th St. must be scheduled months in advance and is currently occupied by the Metropolitan Police since the pandemic. Reginald S. suggested the ANC space for Ward 5D residents at Union Market. Lamont will look further into that venue.</p>		
<b>Old Business</b>	None noted.		
<b>ANNOUNCEMENTS/OTHER DISCUSSION</b>			
<p>Rama K. announced that there will be a health and wellness pavilion at the Pride by the River in Anacostia June 28, 2023, from 11:00am – 4:00pm.</p> <p>Melvin announced that Montgomery County is having their 3<sup>rd</sup> Annual Pride in the Plaza on June 24, 2023. Melvin will send the flyer to Lamont.</p> <p>Mackenzie C. announced the 2<sup>nd</sup> Annual Happy Hour at Union Market tentatively for July 13, 2023, at 6:00pm.</p> <p>Lamont announced the resignations of Gerald P. and Antonio W. Lamont acknowledged their contribution to the planning body and thanked them for their service.</p>			
<b>HANDOUTS</b>			
<ul style="list-style-type: none"> <li>• Planning Commission (COHAH) Meeting Agenda May 25, 2023</li> <li>• Meeting Minutes April 27, 2023</li> <li>• Recipient Reports for 2023 March</li> </ul>			
<b>MEETING ADJOURNED</b>	<b>6:42 pm</b>	<b>NEXT MEETING</b>	<b>THURSDAY, JUNE 29, 2023 6:00pm to 8:00pm ZOOM CONFERENCE AND VIDEO CALL</b>

**Date: June 21, 2023**

**To: Comprehensive Planning Committee (CPC)**

**From: Ryan White HIV/AIDS Program (RWHAP) Recipient Staff**

**Re: Monthly Fiscal and Recipient Report (Part A and Part A MAI Funding)  
Year 33 - Reporting Period: April 1 – 30, 2023**

**Part A and Part A MAI.** The Ryan White HIV/AIDS Program (RWHAP) Part A Grant Year 33 includes two components: Part A and Part A Minority AIDS Initiative (MAI). These reports are designed to report distinctly on the associated program activities. **For GY 33, the recipient received the full award in the amount \$32,652,189.00.**

**Notes on Overview.** The fiscal spreadsheets list the service categories by Part and jurisdiction and identifies the reported expenditure as a proportion of expected-to-date. The COHAH has requested an explanation of those service categories with a 30% variance from the target percentage.

### **FISCAL STATUS**

For Part A and Part A MAI in **April 2023**, of the twenty-six (**26**) providers, twenty-one (**23**) submitted payment request that were processed, and five (**3**) providers have not yet submitted April 2023 invoices.

### **SERVICE DELIVERY CHALLENGES**

**DC:** No challenges.

**MD:** No challenges.

**VA:** No challenges.

### **PART A FISCAL SUMMARY**

**Part A expenditures are 15% and should be 17%.** (Overall Expenditure rates by funding source for the reporting period)

**Service areas affected by unprocessed invoices:**

Early Intervention Services (EIS)
Medical Nutrition Therapy (MNT)

Medical Case Management (MCM)
Non-Medical Case Management Services (NMCM)
Medical Transportation (MT)
Outreach Services (OS)
Psychosocial Support Services (PSS)

**Services 30% below expected:**

Early Intervention Services (EIS)
Health Insurance Premium and Cost Sharing Assistance (HIPCSA)
Home and Community-Based Health Services (HCBS)

**Services 30% above expected:**

Mental Health Services (MHS)
Other Professional Services (OPS)

**PART A MAI FISCAL SUMMARY**

**Part A MAI expenditures are 10% and should be 17%.** (Overall Expenditure rates by funding source for the reporting period)

**Service areas affected by unprocessed invoices:**

Outpatient/Ambulatory Health Services (OAHS)
Early Intervention Services (EIS)
Mental Health Services (MHS)
Medical Case Management (MCM)
Substance Abuse Services – Outpatient (SASO)
Psychosocial Support Services (PSS)

**Services 30% below expected:**

Early Intervention Services (EIS)
Medical Case Management (MCM)
Psychosocial Support Services (PSS)
Outpatient/Ambulatory Health Services (OAHS)
Substance Abuse Services – Outpatient (SASO)



Services 30% above expected:

N/A

## RECIPIENT REPORT

1. **Part A Conditions of Award:** Recipient staff are preparing all required programmatic and fiscal documentation for the GY32 Annual Progress Report, GY33 Program Submission Report, and GY33 Program Terms Report.
2. **GY 33 Core Medical Services Waiver:** The Recipient submitted the Core Medical Services Waiver for GY 33 with the Non-competing Continuation (NCC) progress report and are awaiting review and approval from HRSA.
3. **Integrated Plan:** The Recipient received feedback on the Integrated Plan joint review by the CDC & HRSA and will incorporate feedback as needed.
4. **Reprogramming Request:** After reconciling the accepted subawards for GY33, the Recipient will make a reprogramming request to reduce the lapse rate of the Part A award for GY33.

# FEE-FOR-VALUE

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An overview of the Washington, DC EMA Fee-for-Value funding model

Ebony Fortune | June 2023

# FEE-FOR-VALUE

- ▶ Transition from Fee-for-Service to Fee-for-Value
- ▶ What is Fee-for-Value?
  - Model
  - Assessment Tools
  - Value Enhancement awards

# Fee-For-Value

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# Transition from Fee-For-Service to Fee-For-Value

- Fee - For – Service, was a unit-based cost payment reimbursement model utilized by the Washington, DC EMA from GY 27 until the end of GY 31.
- The services reimbursed under this model were O/AHS, OHS, NMCM, FB/HDM, MH, SA and HCM.
- In GY 30, the CARE and treatment division conducted a lean sigma project entitled the Ryan White Redesign.
- The Ryan White Redesign project was conducted over an 18-month period.

# Transition from Fee-For-Service to Fee-For-Value

- During this process, a survey of Prevention and CARE FFS HCA providers was conducted, and a review of the program data from the fee-for-service model illustrated that many of the providers in the network were providing units of service to get maximum reimbursement, the quality of services provided decreased, and less health outcome and eligibility data was being reported.
- The Redesign project team reviewed the prior reimbursement model and determined that customers of the WDC, EMA RWHAP would be better served by programs that demonstrated improved health outcomes and had a positive impact.
- This resulted in the development and implementation of the fee-for-value model currently in use.



# What is Fee-For-Value (FFV)?



- Program model which rewards sub-recipients with value-based payments for the quality of care provided in delivering Ryan White HIV/AIDS Program(RWHAP) services.

## What does Fee-For-Value support?



- Better care for customers



- Better health outcomes for customers



- An improved sustainable system of care

# Why Fee-For-Value?

- Rewards sub-recipients for providing services in a matter that is consistent with the programmatic goals and objectives of HAHSTA's RWHAP.
- Allocates funds with more transparency and accuracy than previous funding models.
- Improves overall spending of grant.
- Rewards quality over quantity, with defined and standardized targets based on outcomes, process, and capacity.

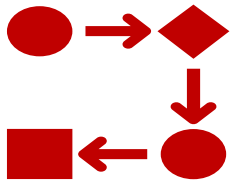
# The FFV Model

- A grant-funded model, with standard inputs that help determine organization's grant awards.
- Ties funding to performance and varies year to year.
- Employs a fair comparison to similar sub-recipients.
- Rewards strong processes and program models.
- Scales emerging best practices across provider network.
- Includes the voice of sub-recipients.

# The FFV Model



Pays for the percentage of Ryan White network customers the sub-recipient serves.



Pays for the quality of service and program the sub-recipient provides, *relative to the network*.



Includes an opportunity for additional value enhancement funds for sub-recipients with the highest health outcomes.

# Fee-For-Value Service Categories

Outpatient Ambulatory Health Services

Medical Case Management

Non-Medical Case Management

Medical Nutrition Therapy

Food Bank/Home Delivered Meals

# Value Enhancements

- Consist of process assessment and outcome measure awards.
- Are funds awarded to sub-recipients based on their performance as a Ryan White sub-recipient and for providing funded services commensurate with service size and scope of their program.
- Are determined by HAHSTA staff who conduct an annual review of the processes and outcomes of each FFV sub-recipient.
- Are determined through annual reviews that occur in the fourth quarter (December) of the current grant, in preparation for future funding decisions.



# Process Assessment Award

- Evaluates current best practices based on deliverables.
- Is administered by HAHSTA monitoring staff.
- Will be conducted for all FFV sub-recipients to determine award amounts.
- Measures sub-recipients based on their performance commensurate to the size and scope of their program.

# Process Assessment Tool

- Measures each FFV service category based on their unique protocols and standards as they relate to:
  - Patient Care
  - Performance Measures
  - Infrastructure
  - Chart Audits
- Measures the elements determined by HAHSTA to be most valuable.
- Consists of measures that review each FFV sub-recipient's overall quality management, fiscal and program reporting activities.

# Outcome Measure Award

- Sub-recipients are grouped and assessed commensurate to the size and scope of the program.
- Only awarded to the top performers – Max 2 sub-recipients.
- The top performing sub-recipient is eligible to receive 65% of available funds.
- The second highest sub-recipient is eligible to receive 35% of available funds.
- Outcome metrics will be shared with sub-recipients in advance of the measurement period.
- Data for these metrics will be retrieved from data submitted into CAREWare.

# Fee-For-Value Value Enhancement Awards Schedule

- In the first year of this new funding model the value enhancement awards were made available to sub-recipients in October of the grant year.
- December 2022, process and outcome assessments were conducted to determine funding for the next grant year.
- January 2023, sub-recipients were notified of planned GY 33 award amounts for grants that started March 1, 2023.

# Fee-For-Value Grant Award Breakdown – GY32

- Capacity (80%)
  - Baseline: Amount that will be split equally split amongst total sub-recipient network.
  - Service Size: Award amount split amongst similar sized sub-recipients. Based on the number of customers proposed in the applicant’s scope of service (Table A).
- Value Enhancement (20%)
  - Comprised of two elements:
    - Process assessment award: Performance award-based process assessment measures amongst similar sized sub-recipients.
    - Outcome measure award – not applicable in GY32

# Fee-For-Value Grant Award Breakdown – GY33

- Capacity (70%)
  - Baseline: Amount that will be split equally split amongst total sub-recipient network.
  - Service Size: Award amount split amongst similar sized sub-recipients. Based on service utilization data documented in CAREWare.
- Value Enhancement (30%)
  - Comprised of two elements:
    - Process assessment award: Performance award-based process assessment measures amongst similar sized sub-recipients.
    - Outcome measure award



# Fee-For-Value Grant Award Breakdown – GY34

- Capacity (60%)
  - Baseline: Amount that will be split equally split amongst total sub-recipient network.
  - Service Size: Award amount split amongst similar sized sub-recipients. Based on service utilization data documented in CAREWare.
- Value Enhancement (40%)
  - Comprised of two elements:
    - Process assessment award: Performance award-based process assessment measures amongst similar sized sub-recipients.
    - Outcome measure award

# Contact Information

Ebony Fortune

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*POSITION STATEMENT(S) OF THE DC REGIONAL PLANNING  
COMMISSION ON HEALTH AND HIV:*

**ADVANCING HIV HEALTH EQUITY BY  
ADDRESSING SOCIAL DETERMINANTS OF  
HEALTH IN THE DC EMA**

*EXECUTIVE SUMMARY*

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## Introduction

The Washington DC Commission on Health and HIV (COHAH) supports action to address the significant disparities in the impact of HIV across racial and ethnic lines. This executive summary provides an overview of HIV disparities in the DC region and outlines policies, principles, and activities that the Commission supports to promote health equity. COHAH has focused on the specific role of key social determinants of health driving HIV inequities: employment, housing, transportation, food, medical care, medical mistrust, HIV stigma, and education. COHAH's full report provides further detail on these issues, as well as descriptions of local programs and providers already working to address these gaps.

## Health and HIV Inequities Nationally and in the DC Region

Among the estimated 1.2 million people living with HIV (PLWH) in the United States in 2019,<sup>1</sup> prevalence of HIV was highest among Black, Multiracial, and Hispanic people, with rates three to seven times higher than white people.\* Nationally, Black men who have sex with men (MSM) experience the highest number of HIV diagnoses of all subgroups, despite making up a small proportion of the total population.

These same inequities are observed across the DC region. For example, between 2017 and 2021, 63.9% of people newly diagnosed with HIV in DC were Black<sup>2</sup> as were 83% of people newly diagnosed in Prince George's County.<sup>3</sup> People of Hispanic/Latinx descent also made up a significant portion of the newly diagnosed in Maryland, accounting for 21.5% of new diagnoses in Montgomery County, Maryland.<sup>4</sup> In Northern Virginia, people who are Black made up 45% of new HIV diagnoses, while people who are Hispanic/Latinx or white made up 26% and 21% of new HIV diagnoses, respectively.<sup>5,6</sup>

## Social Determinants Driving Health Inequity

### Employment

Research suggests that PLWH experience unemployment at three times the national rate,<sup>7</sup> due to factors including stigma, restrictive policies, and disease progression.<sup>8</sup> Unemployment is associated with lack of testing for HIV, delayed HIV diagnosis, and delayed access to active anti-retroviral therapy (ART). Furthermore, the most significant delays in ART initiation are found in low-income areas.<sup>9</sup> In the DC EMA, lower-income communities experience the highest rates of unemployment, putting them at an increased risk for HIV complications, low medication adherence, homelessness, depression, and poverty.<sup>10</sup>

COHAH supports the following principles, positions, and activities regarding employment for people living with or at risk of HIV in the DC EMA:

### Federal, State, and Local Policies.

COHAH supports:

- Efforts to improve coordination between Departments of Health and Departments of Employment Services
- Mandatory paid family and medical leave to improve access to medical care and recovery from illness for PLWH and those at risk of HIV infection

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\* In this executive summary and the full report, COHAH may use different terms to describe specific populations of people, depending on the terms used in source materials such as state surveillance reports or peer-reviewed articles.

- Enforcement of anti-discrimination protections in the workplace, including protection from discrimination related to actual or perceived HIV status, substance use disorder, and other types of workplace discrimination that impact PLWH and those at risk of HIV infection

### Service Delivery and Programming

COHAH supports:

- Efforts to ensure that health care and social service providers have information on employment assistance services, including whether these services are accepting new clients
- Targeted efforts to link people who are undocumented, people who are chronically unhoused, young Black and Latino gay men, and transgender women with employment services
- The development of procedures (such as warm handoffs) and allocation of resources to ensure that social service providers are successful in enrolling clients in employment assistance services
- The provision of employment assistance in multiple languages
- Evaluations of the effectiveness of general employment services for PLWH and people at risk of HIV and identification of employment services that overlap with programs administered by health departments and Housing Opportunities for Persons with AIDS (HOPWA)
- Further research on the use of HIV testing services to facilitate linkage to employment services and efforts to expand testing to people who are unemployed

### Housing

For PLWH, a lack of safe and stable housing can be a significant barrier to accessing HIV care and is associated with poorer access and adherence to antiretroviral therapy, incomplete viral suppression, and greater risk of HIV transmission.<sup>11,12,13,14</sup> Conversely, stable housing can improve health outcomes, reduce overall healthcare costs, and is positively associated with keeping up with medical treatments and appointments and with viral suppression.<sup>15,16</sup>

Unfortunately, PLWH experience homelessness at a rate three times higher than the general population,<sup>17</sup> due in part to the costs of HIV care and higher rates of unemployment.<sup>18</sup>

DC has one of the highest rates of homelessness in the country, and more than half of DC-area renters spend more than 30% of their income on housing.<sup>19,20</sup> In Northern Virginia, 67% of low-income families spend more than half of their income on housing, with Black families, Hispanic families, and immigrant families most likely to be severely burdened by housing costs.<sup>21</sup> In Maryland's EMA counties, and particularly in Prince George's County, both renters and homeowners experience a high housing cost burden, felt most acutely by people of color.<sup>22</sup>

COHAH supports the following principles, positions, and activities regarding housing for people living with or at risk of HIV in the DC EMA:

### Federal, State, and Local Policies

COHAH supports:

- Efforts to increase the rent ceiling for Ryan White-funded direct housing assistance from 50% Fair Market Rent (FMR) to 80% FMR

- Federal, state, and local efforts to fund housing and enact protected classes in jurisdictions beyond DC for aging people (especially ages 40-60), people with accessibility needs, transgender people, and undocumented people
- Removing federal, state, or local policy barriers to transitional and short-term housing (e.g. employment or sobriety requirements, instead implementing a “housing first” approach)
- The enactment of tenant protections, including requiring a court hearing before foreclosure, mandated right to counsel, and sealing or expunging eviction cases after two years, in jurisdictions throughout the EMA.

### Service delivery and programming

COHAH supports:

- Sharing information about tenants’ legal protections to PLWH and people at risk of HIV
- Improved coordination between state and local health departments and HOPWA
- Providing government agencies with more latitude to service undocumented people
- Education for Ryan White-funded housing program staff to ensure they understand that HUD’s housing programs do not condition receipt of HOPWA services on immigration status or screen applicants for immigration status

### Transportation

Transportation issues can also present significant obstacles to service utilization for PLWH. HIV-positive individuals without reliable transportation are less likely to receive HIV-related medical and ancillary care.<sup>23, 24</sup> Increasing access to public transportation and expanding medical service provision in underserved areas can better help PLWH access and maintain care.

In the District, transit issues are most prevalent among residents from Southeast DC, particularly those who live east of the Anacostia River in Wards 7 and 8, which has the highest prevalence of HIV in DC. Approximately 91% of people who live in Wards 7 and 8 are Black (compared to 42% citywide),<sup>25</sup> and residents of these wards face longer travel times, fewer metro stops, higher bus ridership and overcrowding, and lower bus reliability.

COHAH supports the following principles, positions, and activities regarding transportation for people living with or at risk of HIV in the DC EMA:

### Federal, State, and Local Policies

COHAH supports:

- Free or subsidized public transportation, as well as selected rideshare services for low-income individuals to access medical and supportive care
- Policies that facilitate telehealth, mobile clinics, and self-HIV and STI testing
- Access to free or subsidized Wi-Fi access for low-income individuals to access telehealth when in-person services are challenging to reach

### Service Delivery and Programming

COHAH supports:

- Efforts to improve the availability and ease of use of non-emergency medical transportation
- Efforts to establish one-stop shops for health care and social services

- COHAH supports further research into the impact of telehealth services in facilitating access to HIV prevention and care

## Food

Food insecurity affects about 11% of all Americans<sup>26</sup> and between a quarter to a half of all PLWH.<sup>27</sup> Food insecurity can lead to adverse HIV clinical outcomes, including non-adherence to ART increased risk of transmission, and incomplete viral load suppression. LGBTQ+ individuals also experience food insecurity at higher rates; during the COVID-19 pandemic, LGBTQ+ households were nearly twice as likely as non-LGBTQ+ households to experience food insecurity, and transgender people were three times as likely as cisgender people to experience food insecurity.<sup>28,29</sup>

DC's 2017 consumer needs assessment found that more than one in three respondents reported lacking enough money for food or other necessities at some point during the year.<sup>30</sup> Wards 7 and 8 have the highest levels of food insecurity and some of the highest concentrations of HIV-positive individuals in the DC area.

COHAH supports the following principles, positions, and activities regarding food insecurity for people living with or at risk of HIV in the DC EMA:

### Federal, State, and Local Policies

COHAH supports:

- Advocacy for policies that address the needs of LGBTQ+ individuals, youth, and unhoused individuals
- Expanded access to medically tailored meals through Medicare and Medicaid
- Additional funding for programs that address food insecurity among PLWH and people at risk of HIV
- Flexible timelines and documentation standards to decrease administrative burden experienced by individuals attempting to access federal and local food access programs

### Service Delivery and Programming

COHAH supports:

- Efforts by hospitals and health centers to screen PLWH and people at risk of HIV for food insecurity and other health-related social needs
- Efforts by hospitals and health centers to create a standardized, closed-loop referral procedure to refer clients to food access organizations
- Targeted outreach to populations vulnerable to food insecurity, including Latinx households who may have limited their utilization of SNAP and WIC due to the prior Administration's public charge rule

## Access to Medical Care

The ability or inability to access medical care is a major factor in determining the health of PLWH or at risk of HIV. In multiple studies, PLWH have reported barriers to accessing health care including insufficient insurance coverage, substance use, mental health issues, cognitive or physical impairments, and distance to HIV care providers.<sup>31,32,33,34</sup> Conversely, the presence of insurance, case management, and a positive relationship with healthcare providers are associated with improved engagement in HIV care and care retention.<sup>35,36</sup>

Racial disparities in insurance coverage in the DC EMA largely mirror national trends. Despite high rates of overall insurance, there are stark disparities in coverage based on race, ethnicity, and income, with Hispanic/Latinx people and people earning below 138% of the federal poverty level most likely to be uninsured.

Accessing mental and behavioral health services is a particular challenge for PLWH, who experience mental illness and substance use disorder at significantly higher rates than the general population.<sup>37,38</sup>

Within HIV service organizations, insufficient funding, suboptimal training, reliance on passive outreach strategies, lack of patient navigation, and difficulty collaborating between medical providers and community-based organizations (CBOs) can hinder access to care for underserved populations.<sup>39</sup>

COHAH supports the following principles, positions, and activities regarding access to medical care for people living with or at risk of HIV in the DC EMA:

#### Federal, State, and Local Policies

COHAH supports:

- State and local public insurance programs for uninsured individuals who are not eligible for Medicare or Medicaid, such as undocumented immigrants
- Telehealth reimbursement parity to improve access to services
- Policies and models of care that remove administrative barriers to accessing health care and decriminalize and/or destigmatize sexual health and behavioral health

#### Service Delivery and Programming

COHAH supports:

- Efforts to reduce barriers to mental health/SUD provider participation in Ryan White and Prevention funded programming
- Models of care that assure cultural competence and language access among health care and social service providers for multilingual populations
- Research into approaches adopted by other jurisdictions to increase or support the behavioral health/SUD workforce

#### Medical Mistrust and HIV Stigma

Medical mistrust refers to mistrust or suspicion of health care, medical providers, medical treatments, and/or the public health establishment.<sup>40</sup> Rates of medical mistrust are higher among Black and Latinx communities,<sup>41,42,43</sup> reflecting personal and generational experiences of mistreatment and racism.<sup>44</sup> Medical mistrust may be informed by a number of factors, including systemic racism, which may manifest as a lack of funding or attention toward the health of people of color or other groups.<sup>45</sup> It may also be informed by historical trauma, such as the enslavement of African Americans, the genocide of Native Americans, and other forms of oppression, cultural destruction, and displacement.<sup>46</sup>

HIV stigma refers to negative attitudes and beliefs about PLWH<sup>47</sup> and is an important barrier to HIV care. Stigma may be internalized (HIV stigma felt by PLWH) or experienced on interpersonal, institutional, and structural levels. Homophobia, transphobia, racism, classism, and negative views of people who inject drugs can feed into HIV stigma.<sup>48</sup> For example, some



healthcare providers report associating people who seek HIV prevention and care services with negative characteristics such as poverty and promiscuity.<sup>49</sup> Providers' fears of acquiring HIV through occupational exposure can lead to reduced quality of care, refusal of care, and anxiety when providing services to PLWH.<sup>50</sup>

Furthermore, laws that criminalize HIV transmission contribute to HIV stigma and discrimination and are ineffective in preventing HIV transmission.<sup>51</sup> Many states – including Maryland and Virginia – have laws that criminalize the behavior of people living with HIV and/or have used non-HIV-specific laws to prosecute behaviors of people living with HIV.<sup>52,53</sup>

COHAH supports the following principles, positions, and activities regarding medical mistrust and HIV stigma for PLWH or at risk of HIV in the DC EMA:

#### Federal, State, and Local Policies

COHAH supports:

- The development of a plan, which may overlap with jurisdictions' Ending the Epidemic goals, to identify and promote evidence-based policies to reduce HIV stigma
- The creation of accountability measures (including funding implications) to promote the adoption of best practices for stigma reduction and trust building
- Replication of Virginia's CAP advisory board across EMA jurisdictions

#### Service Delivery and Programming

COHAH supports:

- Expanding provider networks to ensure that people who feel stigmatized by or mistrustful of their provider can seek care elsewhere
- Integration of community health workers into client care teams to address mistrust and assess social needs
- Efforts to promote transparent, patient-centered care, including spaces where people feel comfortable accessing testing and prevention services
- The creation and dissemination of a self-assessment tool for HAHSTA subgrantees to determine how they evaluate and address stigma, paired with a patient assessment to identify best practices and areas of improvement for stigma reduction and trust building
- Initiatives to hire healthcare providers and staff who reflect the communities being served, including people who can provide translation services
- Diverse leadership of Ryan White and Prevention-funded health care providers and community-based organizations
- Further research into existing cultural competence/humility practices and hiring practices in the DC EMA, how providers are held accountable, what assessments are performed, and whether these practices are effective
- Efforts to examine the origins of medical mistrust and ensure that understanding of medical mistrust is community-led
- Further research on stigma and mistrust surrounding HIV testing, substance use, and behavioral health

## Education

Research shows that greater educational attainment is associated with higher rates of HIV testing, increased rates of viral suppression, and improved adherence to ART in some individuals.<sup>54,55</sup>

Aside from broader associations with educational attainment, specific education about sex and HIV in school and community settings can also improve health among youth and adults. Comprehensive sex education has been shown to reduce sexual risk behaviors, such as unprotected sex and having sex with multiple partners.<sup>56</sup> However, not all states require comprehensive sex education in schools.<sup>57</sup> Even where offered, sex education may not be inclusive to all minority groups and sexual orientations.<sup>58</sup> In some studies, students of color, including Hispanic and Black students, were less likely to report having received HIV education than white students.<sup>59</sup>

COHAH supports the following principles, positions, and activities regarding HIV and sexual health education for people living with or at risk of HIV in the DC EMA:

### Federal, State, and Local Policies

COHAH supports:

- Education departments holding Local Education Agencies (LEAs) and schools accountable for meeting sexual health education requirements and nationwide standards
- The use of health department funding for upstream patient outreach and education for youth on how to access HIV services and testing
- The inclusion of health education in jurisdictions' Ending the Epidemic Plans

### Service Delivery and Programming

COHAH supports:

- The Whole School, Whole Community, Whole Child (WSCC) model for education and efforts to provide sexual health education using culturally and linguistically appropriate approaches
- Sexual health education in schools, particularly CDC-funded education, based on the National Sexuality Education Standards
- Better integration of health department and education department policies and goals
- A greater emphasis on education about HIV testing, including in school-based health education.
- Initiatives to increase the emphasis on education about sexual health for all Ryan White and Prevention-funded providers in the EMA
- Research into how authority and reporting for sexual health education initiatives from school agencies (such as Office of the State Superintendent of Education (OSSE)) and health agencies (such as DC Health) overlap
- Research into other promising programs in the EMA that are helping to educate youth about sexual health and HIV prevention, including current CDC-funded school-based education projects

## Conclusion: COHAH's Intended Path

In addition to the positions outlined above, COHAH intends to redouble its efforts to promote health equity in the DC region by focusing on the key social drivers of health underlying disparities in HIV acquisition and access to services. Specifically, COHAH will work to ensure that our needs assessment process and Priority Setting and Resource Allocation processes gather information on and steer resources to, gaps in these areas. We will also work to identify innovative programs in the DC Eligible Metropolitan Area (EMA) that serve people in ways that promote health equity. Finally, COHAH will reach out to service providers and agency officials working across these issue areas to identify needs and opportunities to promote access to care, treatment, and prevention services.

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<sup>4</sup> <https://health.maryland.gov/phpa/OIDEOR/CHSE/SiteAssets/Pages/County-Data-Sheets/Montgomery-County-Fact-Sheet--2021.pdf>

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*POSITION STATEMENT(S) OF THE DC REGIONAL PLANNING  
COMMISSION ON HEALTH AND HIV:*

**ADVANCING HIV HEALTH EQUITY BY  
ADDRESSING SOCIAL DETERMINANTS OF  
HEALTH IN THE DC EMA**

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## Introduction

The Washington DC Commission on Health and HIV (COHAH) supports action to address the significant disparities in the impact of HIV across racial and ethnic lines. This set of position statements outlines key disparities in the impact of HIV nationally and in the DC region. It then outlines the specific role of seven key social determinants of health driving HIV inequities: employment, housing, transportation, food, medical care, medical mistrust and HIV stigma, and education. While a range of other factors, such as environmental conditions or community safety, impact health, the seven determinants addressed in this paper were identified by COHAH as those with the closest relationship to the regions' HIV services and COHAH's goal. For each, COHAH identifies current policies and programs underway in the EMA and recommends further programmatic and policy actions.

## Health Disparities and HIV

In 2020, there were an estimated 30,635 new HIV diagnoses nationally, a 17% decrease since 2019.<sup>1</sup> This national decrease in diagnoses due in large part to the COVID-19 epidemic, which disrupted clinical care services and created shortages in HIV testing materials. Despite the pandemic's disruption of medical care, racial and ethnic differences in HIV diagnoses remained the same. Black and Hispanic people experience a disproportionate share of new HIV diagnoses and represent the highest shares, 42% and 27%, respectively, of new HIV diagnoses. White individuals account for 26%<sup>2</sup> of new diagnoses while Asian, American Indian/Alaska native, and Native Hawaiians/other Pacific Islanders account for lower percentages of new HIV diagnoses, 2%, 1%, and <1%, respectively.<sup>3,4</sup>

Similar disparities exist in HIV prevalence and survivorship. Among the estimated 1.2 million people living with HIV (PLWH) in the United States in 2019,<sup>5</sup> Black, Multiracial, and Hispanic people are disproportionately represented, with HIV rates three to seven times higher than in white people. Black, Hispanic, and Multiracial people also had disproportionately high rates of deaths caused by HIV as compared to white people (see Appendix A).

## Key Definitions

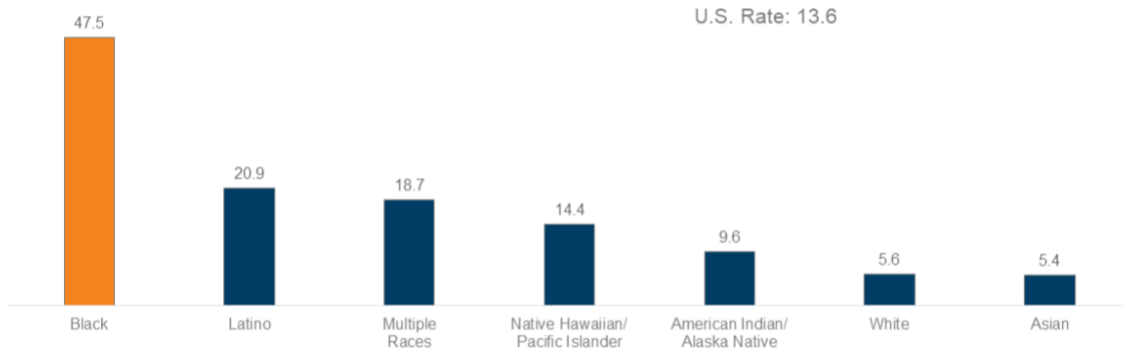
**Equity:** A condition wherein all people have access to the resources and opportunities they need regardless of socially defined circumstances, like race, gender, or class. Equity is different from equality: an “equality approach” involves providing the same resources and opportunities to all people, but an “equity approach” provides variable resources to people based on their needs in recognition that some many need more/different assistance than others because of systemic injustices.

**Intersectionality:** The way in which the effects of multiple forms of discrimination (such as racism, sexism, and classism) overlap to create distinct experiences, especially among marginalized individuals or groups.

**Stigma:** Negative beliefs or attitudes about a person or group based on a distinguishing trait. HIV stigma refers to negative beliefs or attitudes about people with HIV and can be external (coming from the outside) or internalized (experienced by a person about themselves).



## Rates of New HIV Diagnoses per 100,000, by Race/Ethnicity, 2018



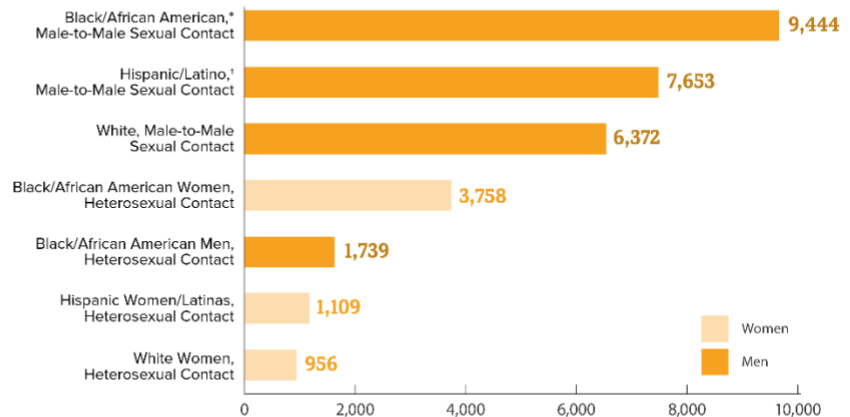
NOTES: HIV diagnosis data are preliminary estimates and based on 6 months reporting delay.  
SOURCE: CDC, NCHHSTP Atlas Plus. Accessed February 2020



Overlaying race and ethnicity with sexual orientation and gender identity reveals how some populations experience a particularly high burden of HIV. Nationally, Black men who have sex with men (MSM) experience the highest number of HIV diagnoses of all subgroups, despite making up a small proportion of the total population:

## New HIV Diagnoses in the US and Dependent Areas for the Most-Affected Subpopulations, 2018

**Gay and bisexual men are the population most affected by HIV.**



Subpopulations representing 2% or less of all people who received an HIV diagnosis in 2018 are not represented in this chart.

\* Black refers to people having origins in any of the black racial groups of Africa. African American is a term often used for Americans of African descent with ancestry in North America.  
<sup>†</sup> Hispanics/Latinos can be of any race.

Source: CDC. Diagnoses of HIV infection in the United States and dependent areas, 2018 (updated). *HIV Surveillance Report* 2020;31.

Meanwhile, a recent study found that 4 in 10 transgender women interviewed in seven cities across the U.S. were living with HIV; among Black transgender women in the study, nearly two thirds were living with HIV.<sup>6</sup>

## HIV Inequity in the DC Region

Racial and ethnic disparities in the incidence of HIV are on stark display in new diagnoses numbers in the DC region:

- 63.9% of people newly diagnosed with HIV in DC in 2021 were Black,<sup>7</sup> as were 83% of those newly diagnosed in Prince George's County in 2019.<sup>8</sup>
- People of Hispanic/Latinx descent also make up a significant portion of the newly diagnosed in Maryland, accounting for 21.5% of new diagnoses in Montgomery County, Maryland,<sup>9</sup> and 46.2% of diagnoses in Frederick County, Maryland.<sup>10</sup>
- In Northern Virginia, people who are Black made up 45% of new HIV diagnoses, while people who are Hispanic/Latinx or white made up 26% and 21% of new HIV diagnoses, respectively.<sup>11,12</sup>

The same disparities are seen in prevalence: of the more than 34,000 PLWH in the DC EMA, nearly two-thirds are Black. See Appendix B for more information on PLWH in the DC metropolitan area by race/ethnicity. In addition, see COHAH's 2021 position paper on Immigration for further discussion of some of the disparities in HIV experienced by specific communities based on immigration status and related factors.

At the programmatic level, these disparities reveal a need for increased HIV prevention and treatment services for Black and Hispanic/Latinx individuals throughout the DC EMA. However, truly addressing these inequities requires asking fundamental questions about how these HIV disparities came to be and why they persist. The next sections of this paper aim to shed light on these questions by investigating the relationship between specific social determinants of health and HIV.

### **Overall Health Inequities in the DC Region**

DC's most recent Community Health Needs Assessment reported "direct correlations between the concentration of poverty in segments of the city, particularly in Wards 7 and 8 [where a majority of residents are Black], and patterns of poor health outcomes concentrated in the same areas" (See Figure 1).<sup>13</sup> Similarly, in Northern Virginia, neighborhoods with more residents of color and low-income residents have markedly lower life expectancies than those with more white, wealthy residents.<sup>14</sup> In DC, Maryland, and Virginia, Black and Hispanic residents were also more likely to contract COVID-19 and experience death or severe symptoms because Black and Hispanic individuals are more likely to be essential workers, live in crowded areas or housing, and have more limited access to health care.<sup>15,16,17</sup>

Notable health disparities also persist among the LGBTQ+ community; a 2017 report found that LGBTQ+ adults in DC were more likely to report poor mental health, substance use, and engaging in HIV risk behaviors compared to non-LGBTQ+ counterparts.<sup>18</sup>

**Figure 1. Extreme Differences Between the Wealthiest (Ward 3) and Least Wealthy (Ward 8) Areas of DC**

Measure	Ward 3	Ward 8
Attended College <sup>1</sup>	94.1%	45.5%
Median Household Income <sup>1</sup>	\$136,832	\$34,824
Child Poverty <sup>1</sup>	2.9%	48.5%
Families Below Poverty with Children <sup>1</sup>	1.3%	25.4%
%Black <sup>1</sup>	5.4%	92.1%
%Latino <sup>1</sup>	9.5%	2.8%
%Unemployed <sup>1</sup>	2.9%	18.5%
Public Health Insurance <sup>2</sup>	18.7%	64.6%
Gross Rent as Percentage of Household Income (35% or more) <sup>2</sup>	33.8%	53.9%
Grandparents Responsible for Grandchildren <sup>2</sup>	16.0%	47.3%
Civilian Population with Disability <sup>2</sup>	5.9%	17.8%
Adult Asthma Prevalence <sup>3</sup>	11.6%	13.1%
Adults with Hypertension <sup>4</sup>	19.7%	42.2%
Adults with Depression <sup>3</sup>	14.7%	16.3%
Adults with Diabetes <sup>3</sup>	4.8%	14.5%
Adults who are Overweight or Obese <sup>3</sup>	44.9%	70.0%
Adults with Difficulty Remembering or Concentrating <sup>3</sup>	2.8%	19.3%

Source: DC Health Matters Collaborative. Community Health Needs Assessment, District of Columbia, 2019. [https://www.dchealthmatters.org/content/sites/washingtondc/2019\\_DC\\_CHNA\\_FINAL.pdf](https://www.dchealthmatters.org/content/sites/washingtondc/2019_DC_CHNA_FINAL.pdf). Published June 28, 2019. Accessed July 2021.

## Social Determinants Driving Health Inequity

### Employment

Employment provides individuals with financial support, stability, and health benefits. Among PLWH, employment is associated with significantly higher overall quality of life; higher social, cognitive and mental functioning; and higher perceived self-worth.<sup>19</sup> Employment is also positively associated with access to HIV testing, linkage to HIV care, retention in HIV care, and medication adherence,<sup>20</sup> which is an important factor in maintaining optimal health for both PLWH and people at risk of HIV infection.<sup>21,22</sup> Additionally, working full time can provide access to benefits such as health insurance and paid sick leave.<sup>23,24</sup> Employer-sponsored insurance can provide a safety net for PLWH because health costs can be a source of stress for individuals.<sup>25,26</sup> Inversely, PLWH who are employed part-time are less likely to have access to these benefits which puts them at higher risk for financial difficulties.<sup>27</sup>

HIV-related employment challenges may be compounded by other barriers to employment like a lack of legal status. Although it is illegal to employ undocumented immigrants, there are approximately eight million undocumented workers in the U.S.<sup>28</sup> These workers often experience hazardous job conditions,<sup>29</sup> threats of immigration enforcement actions,<sup>30</sup> low wages,<sup>31</sup> and wage theft.<sup>32</sup>

### Employment and HIV

Research suggests that PLWH experience unemployment at three times the national rate.<sup>33</sup> Reasons for unemployment can include stigma, restrictive hiring policies, and the physical and neurological effects of disease progression.<sup>34</sup> With higher rates of unemployment, PLWH experience higher rates of depression, anxiety, social isolation, and low self-esteem.<sup>35</sup> Unemployment is also associated with lack of testing for HIV, delayed HIV diagnosis, and delayed access to active anti-retroviral therapy (ART), with the most significant delays in ART initiation found in poverty-stricken areas.<sup>36</sup> HIV-related barriers to employment include physical symptoms of HIV, HIV-related illness, side effects of medication, the burden of HIV regimens, and frequent medical visits.<sup>37</sup>

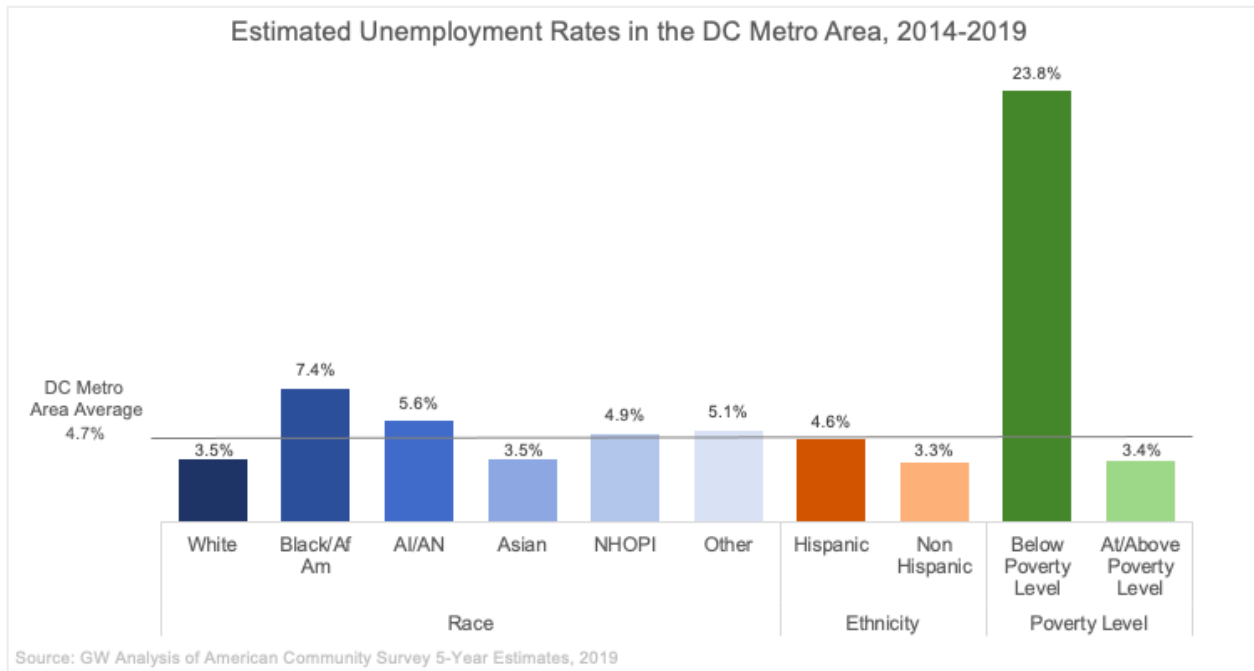
People living with HIV also report difficulty finding employment due to outdated job skills (e.g. because of long absences from employment), the perception that some jobs are no longer suitable for them (e.g. because of fears of potential HIV transmission), and a dearth of jobs that could accommodate HIV-related needs (e.g. frequent medical visits). Concerns about workplace discrimination and losing access to public assistance, including health insurance, may also serve as barriers to employment. Among PLWH who do work, occupational functioning may be reduced by episodic illness, fatigue, physical and cognitive limitations, medication schedules, and frequent medical appointments.<sup>38</sup>

Conversely, supportive work environments, flexible work schedules, and social support from clinicians, friends, and family can serve as facilitators of employment for PLWH. People living with HIV also report a need for job-seeking skills and job training. Specific needs for employment services likely vary among different populations, but, in general, research suggests that PLWH would particularly benefit from guidance on explaining employment gaps on a resume and requesting workplace accommodations. Further research is needed to identify ways

to increase PLWHs’ engagement in employment assistance programs and to expand Ryan White case management or peer navigation programs to address employment-related needs.<sup>39</sup>

In the DC EMA, lower-income communities and communities of color experience disproportionate rates of HIV (See Appendix B) and the highest rates of unemployment (see Figure 2 below), which puts them at an increased risk for HIV complications, lower rates of medication adherence, and an increased risk of homelessness, depression, and poverty.<sup>40</sup>

**Figure 2: Employment Status in the DC Metropolitan Area by Race/Ethnicity and Poverty Status, 2015-2019 Estimates**



**Figure 2 Definitions and Acronyms**

- Black/Af Am: Black/African American
- AI/AN: American Indian/Alaska Native
- NHOPI: Native Hawaiian or Other Pacific Islander
- Hispanic: Hispanic/Latinx, any race
- Non-Hispanic: Non-Hispanic White

**Current Programs in the EMA**

The Housing Opportunities for Persons with AIDS (HOPWA) program allocates funding for job training and transportation as a supportive service for DC EMA residents.<sup>41</sup> Additionally, many local organizations offer job training, employment assistance, and resume development services that are not specific to PLWH but can provide additional support to those living with, or experiencing higher vulnerability to, HIV.<sup>42</sup>

**COHAH Principles and Positions on Employment**

COHAH supports the following principles, positions, and activities regarding employment for people living with or at risk of HIV in the DC EMA:

### Federal, State, and Local Policies.

#### COHAH supports:

- Efforts to improve coordination between Departments of Health and Departments of Employment Services
- Mandatory paid family and medical leave to improve access to medical care and recovery from illness for PLWH and those at risk of HIV infection
- Enforcement of anti-discrimination protections in the workplace, including protection from discrimination related to actual or perceived HIV status, substance use disorder, and other types of workplace discrimination that impact PLWH and those at risk of HIV infection

### Service Delivery and Programming

#### COHAH supports:

- Efforts to ensure that health care and social service providers have information on employment assistance services, including whether these services are accepting new clients
- Targeted efforts to link people who are undocumented, people who are chronically unhoused, young Black and Latino gay men, and transgender women with employment services
- The development of procedures (such as warm handoffs) and allocation of resources to ensure that social service providers are successful in enrolling clients in employment assistance services
- The provision of employment assistance in multiple languages
- Evaluations of the effectiveness of general employment services for PLWH and people at risk of HIV and identification of employment services overlap with programs administered by health departments and HOPWA
- Further research on the use of HIV testing services to facilitate linkage to employment services and efforts to expand testing to people who are unemployed

## Housing

Housing stability greatly impacts mental and physical health.<sup>43</sup> Research suggests that people who face housing instability are more likely to experience poor health outcomes such as depression, drug and alcohol use, and anxiety.<sup>44</sup> Additionally, unstable housing can result in employment or education disruptions, higher medical costs, and decreased medication adherence.<sup>45</sup>

### **Housing and HIV**

The availability of adequate and affordable housing for PLWH has been a concern since the onset of the HIV epidemic.<sup>46</sup> For PLWH, a lack of safe and stable housing can be a significant barrier to accessing HIV care and has been associated with poorer access and adherence to antiretroviral therapy, incomplete viral suppression, and greater risk of HIV transmission.<sup>47,48,49,50</sup> Conversely, stable housing can improve health outcomes, reduce overall healthcare costs, and is positively associated with keeping up with medical treatments and appointments and with viral suppression.<sup>51,52</sup> Unfortunately, PLWH experience homelessness at a rate three times higher than the general population,<sup>53</sup> due in part to the costs of HIV care and higher rates of unemployment.<sup>54</sup> Among HIV-negative people who inject drugs, homelessness and housing insecurity are associated with higher risk of HIV infection.<sup>55</sup>

DC has one of the highest rates of homelessness in the country, and more than half of DC-area renters spend more than 30% of their income on housing.<sup>56,57</sup> In Northern Virginia, 67% of low-income families and 19% of moderate-income families spend more than half of their income on housing; within Northern Virginia, Black families, Hispanic families, and immigrant families are most likely to be severely burdened by housing costs.<sup>58</sup> In Maryland's EMA counties, particularly in Prince George's County, both renters and homeowners experience a high housing cost burden, felt most acutely by people of color.<sup>59</sup> Rising rent costs have pushed thousands of disproportionately Black DC residents out of their homes within the last decade, making them vulnerable to homelessness and unstable housing.<sup>60</sup>

### **Current Programs in the EMA**

In 1990, the Department of Housing and Urban Development (HUD) developed the Housing Opportunities for Persons with AIDS (HOPWA) program, which remains the only federal program dedicated to providing housing support to individuals living with HIV/AIDS and their families.<sup>61</sup> The program tackles the need for affordable housing for many low-income individuals who are living with HIV. Funds for HOPWA are appropriated to the largest cities in a metropolitan area that meet certain HIV case requirements.<sup>62</sup>

DC awarded a total of \$5,688,851 in HOPWA sub-awards to providers across the region in FY20 (the award area for HOPWA is similar, though not identical to, the EMA). PLWH who reside in Washington, DC; Prince George's County, MD; and Charles County, MD are eligible for assistance through DC HOPWA, regardless of their immigration status.<sup>63</sup> DC also receives funding from the HOPWA/Violence Against Women Act (VAWA) program, which addresses the needs of PLWH who are homeless or need assistance due to intimate partner violence. In Montgomery County, the HOPWA program is managed by the HIV/STI program and follows the same eligibility and immigration criteria as DC HOPWA.

In the DC region, HOPWA funding supports:

- Short-Term Rent, Mortgage, and Utility Assistance (STRMU) - Can be used for up to 21 weeks within a 52-week period. The CAP for utilization is up to \$3000. This service is offered in DC, Maryland (Prince George's, Charles and Calvert Counties only) and Northern Virginia.
- Transition Housing - A program to temporarily house PLWH for up to twenty-four (24) months
- Supportive Services - There are up to 11 supportive services categories that HUD allows grantees to fund. HAHSTA's funding for supportive services in the region is focused on Housing Case management, food and transportation assistance only
- Housing Information and Referral Services (HIRS) - To provide housing information and referral services to PLWH seeking housing and case management
- Tenant-Based Rental Assistance (TBRA) (in development) - HAHSTA is working on developing a short-term TBRA program to assist newly diagnosed PLWH. This program will be designed to assist persons with housing for up to 3 years and the focus will be to help participants achieve viral suppression.

In addition to HOPWA, the Ryan White program also enables localities to offer housing assistance for PLWH, including short-term supportive housing, short-term rental assistance, and housing placement assistance.<sup>64, 65</sup> However, due to funding constraints, the DC EMA Ryan White program has been unable to offer short-term supportive housing (i.e. identifying, securing, and paying for housing) since 2016. When short-term supportive housing vouchers have been available, they have only covered housing that is 50% of the Fair Market Rent (FMR) for a given area, and it has been difficult to find housing priced under this limit. The Ryan White program also offers PLWH housing referral services through support and case management services.

In Montgomery County, in addition to the HOPWA program, short-term, transitional, and emergency assistance is available to for housing support for HIV positive Maryland residents through Ryan White part B funding. Ryan White part B funding is not limited to Montgomery County and can be used, when available, throughout the state of Maryland. Montgomery County provides medical and non-medical case management for 60-65 housing voucher holders. Assistance with security deposit and/or first month's rent is available for county residents through the Montgomery County Department of Social Services.

COHAH members with expertise in housing programs in the DC EMA have noted several barriers to housing and housing assistance programs specific to PLWH and people at risk of acquiring HIV. For example, some HOPWA-funded programs in the DC EMA require individuals to be employed or sober in order to receive assistance, despite evidence that rapid housing that is not conditional on abstinence from substance use effectively reduces homelessness without increasing substance use.<sup>66</sup> Low-income PLWH and people at risk of developing HIV may also face discrimination from housing providers because of their credit history, rental history, or use of housing vouchers. Low-income people who qualify for affordable housing may also be hesitant or unwilling to accept the housing offered because of safety or quality issues; poor location (e.g. if the housing is located in a food desert or far from their kids' schools); or stigma associated with public housing. COHAH members also noted that there is insufficient support to meet the housing needs of people ages 40-55, who do not yet qualify for senior housing, as well as transgender people, undocumented people, and Social Security Disability Insurance (SSDI) recipients. Finally, COHAH members note a lack of



coordination of resources across DC EMA housing authorities and a lack of information about area-specific housing resources.

The federal Department of Housing and Urban Development administers several housing programs that are not HIV-specific, such as the Section 8 voucher program and the housing choice voucher program in Maryland (formerly Section 8). PLWH may be able to get support for these programs if they meet eligibility criteria.<sup>67</sup>

### **COHAH Principles and Positions on Housing**

COHAH supports the following principles, positions, and activities regarding housing for people living with or at risk of HIV in the DC EMA:

#### Federal, State, and Local Policies

COHAH supports:

- Efforts to increase the rent ceiling for Ryan White-funded direct housing assistance from 50% FMR to 80% FMR
- Federal, state, and local efforts to fund housing and enact protected classes in jurisdictions beyond DC for aging people (especially ages 40-60), people with accessibility needs, transgender people, and undocumented people
- Removing federal, state, or local policy barriers to transitional and short-term housing (e.g. employment or sobriety requirements, instead implementing a “housing first” approach)
- The enactment and enforcement of tenant protections, including requiring a court hearing before foreclosure, mandated right to counsel, and sealing or expunging eviction cases after two years, in jurisdictions throughout the EMA.

#### Service delivery and programming

COHAH supports:

- Sharing information about tenants’ legal protections to PLWH and people at risk of HIV
- Improved coordination between state and local health departments and HOPWA
- Providing government agencies with more latitude to service undocumented people
- Education for Ryan White-funded housing program staff to ensure they understand that HUD’s housing programs do not condition receipt of HOPWA services on immigration status or screen applicants for immigration status.

## Transportation

Safe and reliable transportation services are an important social determinant of health. Individuals are less likely to access necessary health services when they experience transportation barriers, such as a lack of vehicle access, long distances and lengthy travel times to reach services, costs of travel, traffic and congestion, unsafe public transportation, and inadequate railways and roads. Transportation barriers to health care are more likely to affect older adults, people of color, and people with lower incomes and educational attainment.<sup>68</sup>

### **Transportation and HIV**

Transportation issues can also present significant obstacles to service utilization for PLWH. HIV-positive individuals who experience transportation vulnerability are less likely to receive HIV-related medical and ancillary care. Research shows that patients who had fewer barriers to transportation had greater medical compliance and fewer missed doses of anti-retroviral medications.<sup>69</sup> The distance an individual must travel to receive HIV care can also affect outcomes; one study found that PLWH who had to travel more than five miles had worse outcomes for retention in care and viral suppression.<sup>70</sup> Increasing access to public transportation and expanding medical service provision in underserved areas can help PLWH access and maintain care.

In the EMA, many people are employed in a different city than where they live, making the need for reliable transit systems even more critical. Despite the region's numerous public transit options, traffic, congestion, parking costs and unavailability, and unreliable public transit are common challenges.<sup>71</sup> Such transportation difficulties can lead to patients being late to or missing medical appointments.

Transit issues are most prevalent among residents of Southeast DC, particularly those who live east of the Anacostia River in Wards 7 and 8, the wards with the highest prevalence of HIV in DC. Approximately 91% of people who live in Wards 7 and 8 are Black (compared to 42% citywide),<sup>72</sup> and residents of these wards face longer travel times, fewer metro stops, higher bus ridership and overcrowding, and lower bus reliability. Exacerbating this problem, less than 25% of publicly insured people in the Southeast corridor receive primary care from a provider located in their ZIP code, which makes them more reliant on public transportation and subject to the issues associated with it (e.g., unpredictable delays and longer commutes).<sup>73</sup>

### **Current Programs in the EMA**

The DC EMA receives federal funding through the Ryan White HIV/AIDS Program to provide core medical and support services for people living with HIV, including medical transportation and transportation to Ryan White-funded supportive services. Providing non-emergency medical transportation can enable PLWH to access or stay retained in health services. Under the program, medical transportation can be provided through contracts with providers of transportation services, mileage reimbursement, purchase or lease of organizational vehicles for client transportation programs, volunteer drivers, selected rideshare services, and voucher or token systems.<sup>74</sup> Healthcare and social service providers are responsible for coordinating rides to appointments on behalf of Ryan White clients. In 2022, Montgomery County, Maryland, ruled out the use of ridesharing apps for non-emergency medical transportation. Ryan White also provides funding through Emergency Financial Assistance, which includes limited one-time or short-term payments to assist clients with emergent needs for housing, food, medical

transportation, and medication.<sup>75</sup> DC, Maryland, and Virginia also offer free, self HIV testing kits<sup>76, 77</sup> to improve access to testing for people who commonly experience transportation-based or other barriers to in-person testing.

In its 2017-2021 DC EMA Integrated HIV/AIDS Prevention and Care Plan, the DC Department of Health reported that medical transportation was the fifth most utilized Ryan White service in the EMA and the most utilized service in Northern Virginia in 2015. Furthermore, assistance with transportation to medical and laboratory appointments was commonly cited as one of the most needed support services, with 16% of survey respondents reporting needing but not receiving transportation support.<sup>78</sup> One goal from the 2022-2026 DC EMA Integrated HIV/AIDS Prevention and Care Plan is to conduct community engagement and develop programs to address structural and individual barriers to care. In addition, telehealth in combination with transportation rideshare support, has been shown to be effective in maintaining viral suppression rates among pediatric and adolescent patients living with HIV in our region during the COVID-19 pandemic.<sup>79</sup>

### **COHAH Principles and Positions on Transportation**

COHAH supports the following principles, positions, and activities regarding transportation for people living with or at risk of HIV in the DC EMA:

#### Federal, State, and Local Policies

COHAH supports:

- Free or subsidized public transportation, as well as selected rideshare services for low-income individuals to access medical and supportive care
- Policies that facilitate telehealth, mobile clinics, and self HIV and STI testing
- Access to free or subsidized Wi-Fi access for low-income individuals to access telehealth when in-person services are challenging to reach

#### Service Delivery and Programming

COHAH supports:

- Efforts to improve the availability and ease of use of non-emergency medical transportation
- Efforts to establish one-stop shops for health care and social services
- COHAH supports further research into the impact of telehealth services in facilitating access to HIV prevention and care

## Food

Access to food, specifically nutritious food, is considered a key social determinant of health that has a direct impact on a person's well-being. Food insecurity refers to the lack of access to and affordability of nutritious foods needed to live a healthy life. It can include insufficient quantities of food, excess consumption of highly processed non-nutritious foods, contaminated foods, and inadequate range, cost, and quality of foods available in a person's local community.

Food-insecure adults have higher average healthcare costs and can experience more health issues compared to food-secure individuals. Undernutrition can lead to impairments in immunity, growth, cognitive functioning, reproductive outcomes, blood cortisol levels, and autonomic nervous system functioning.<sup>80</sup> Overconsumption of foods low in nutrient density, but high in saturated fat, sugar, and calories can increase a person's risk of heart disease, diabetes, stroke, atherosclerosis, osteoporosis, and some cancers.<sup>81</sup>

Disparities in food insecurity rates exist across socioeconomic status, race, and ethnicity. Individuals with low incomes, unstable living conditions, less education, and poor working conditions are more likely to experience food insecurity. Immigrants of Hispanic origin are also vulnerable to food insecurity, which was exacerbated by federal policy. In March 2019, Former President Trump's Public Charge Rule restricted people on public benefits for more than 12 months within any 36-month period from becoming a Lawful Permanent Resident (LPR). As a result, many Hispanic residents became hesitant to apply for both SNAP and WIC benefits; many remain hesitant despite the rule's repeal in March 2021.<sup>82</sup> In addition, women, seniors, children, and Black and Latinx individuals report higher levels of food insecurity.<sup>83</sup>

### **Food Insecurity and HIV**

Food insecurity affects about 11% of all Americans,<sup>84</sup> but between a quarter to a half of all PLWH.<sup>85</sup> The relationship between HIV and food insecurity is interdependent.<sup>86</sup> Food insecurity can lead to adverse HIV clinical outcomes, including non-adherence to antiretroviral treatment (ART), increased risk of transmission, and incomplete viral load suppression. Food insecurity is also associated with lower CD4+ counts, limited use of health services, and worse physical health. Conversely, HIV can increase an individual's metabolic rate and nutrient requirements, while simultaneously disrupting nutrient absorption and reducing appetite.<sup>87</sup> A study found that women living with HIV who reported having food insecurity had a two times higher viral load than those who were food secure.<sup>88</sup> LGBTQ+ individuals also experience food insecurity at higher rates; during the COVID-19 pandemic, LGBTQ+ households were nearly twice as likely as non-LGBTQ+ households to experience food insecurity, and transgender people were three times as likely as cisgender people to experience food insecurity.<sup>89,90</sup>

In 2020, approximately 10.5% of households (13.8 million households) were food insecure.<sup>91</sup> One study found that more than one in three DC residents living with HIV did not have enough money for food or other necessities.<sup>92</sup> Wards 7 and 8 have the highest levels of food insecurity and some of the highest concentrations of HIV-positive individuals in the DC area. In addition, seniors in DC had the highest rate of food insecurity (14.3%) in the country in 2018.<sup>93</sup> The COVID-19 pandemic has only worsened these problems: in 2020, the percentage of DC residents experiencing food insecurity increased from 10% before COVID-19 to at least 16%.<sup>94</sup>

COHAH members report that as food assistance program participation increased during the COVID-19 pandemic, many LGBTQ+ clients dropped out of food assistance programs due to burdensome documentation requirements, such as proof of income, diagnosis, and residency.

These barriers to care will likely be exacerbated for LGBTQ+ individuals by the impending end of SNAP emergency allotments and the return to in-person certification when the Public Health Emergency (PHE) ends.<sup>95,96, 97,98,99,100</sup>

### **Current Programs in the EMA**

The Ryan White program offers a range of food and nutrition services to residents of the EMA. Medical Nutrition Therapy (MNT), considered a core medical service, provides individuals with nutritional assessments and screenings, dietary evaluations, nutrition education, and food and/or nutrition supplements. All services are provided by a licensed, registered dietician nutritionist who develops a nutritional plan for each client. MNT has been shown to improve health outcomes for PLWH and increase the effectiveness of and adherence to HIV medications.<sup>101</sup> Ryan White also provides funding for food pantries, food voucher programs, and home-delivered meals and groceries. Finally, the program offers Emergency Financial Assistance which includes limited one-time or short-term payments to assist clients with emergent needs for housing, food, transportation, and medication.<sup>102</sup>

In its 2017-2021 DC EMA Integrated HIV/AIDS Prevention and Care Plan, the DC Department of Health reported that MNT and food banks/home-delivered meals were the ninth and tenth most utilized service categories among EMA residents in 2015.<sup>103</sup> Food and nutrition services were also commonly cited as among the most needed services for residents, with substantial service gaps recorded among survey respondents. Almost 21% reported needing but not receiving emergency food vouchers and over 12% lacked needed MNT and access to food banks/home-delivered meals.<sup>104</sup>

### **COHAH Principles and Positions on Food**

COHAH supports the following principles, positions, and activities regarding food insecurity for people living with or at risk of HIV in the DC EMA:

#### Federal, State, and Local Policies

COHAH supports:

- Advocacy for policies that address the needs of LGBTQ+ individuals, youth, and unhoused individuals
- Expanded access to medically tailored meals through Medicare and Medicaid
- Additional funding for programs that address food insecurity among PLWH and people at risk of HIV
- Flexible timelines and documentation standards to decrease administrative burden experienced by individuals attempting to access federal and local food access programs

#### Service Delivery and Programming

COHAH supports:

- Efforts by hospitals and health centers to screen PLWH and people at risk of HIV for food insecurity and other health-related social needs
- Efforts by hospitals and health centers to create a standardized, closed-loop referral procedure to refer clients to food access organizations

- Targeted outreach to populations vulnerable to food insecurity, including Latinx households who may have limited their utilization of SNAP and WIC due to the prior Administration's public charge rule.

## Access to Medical Care

Access to medical care is influenced by several factors, including insurance status; care affordability; provider location; provider language and cultural competence; facility accessibility (for example, the presence of ramps or braille signage); and whether the person seeking care has other significant factors that compromise their overall health. Nationally, people of color typically face greater barriers to accessing health care and receiving high-quality health care.<sup>105,106,107,108,109,110</sup>

### Access to Medical Care and HIV

PLWH reported barriers to accessing health care include substance use, mental health issues, cognitive or physical impairments, insufficient insurance coverage, and distance to HIV care providers.<sup>111,112,113,114</sup> Conversely, the presence of insurance, case management, and a positive relationship with healthcare providers have been associated with improved engagement in HIV care and care retention.<sup>115,116</sup> Within HIV service organizations, insufficient funding, suboptimal training, reliance on passive outreach strategies, lack of patient navigation, and difficulty collaborating between medical providers and community-based organizations (CBOs) can hinder access to care for underserved populations.<sup>117</sup>

Accessing mental and behavioral health services is a particular challenge for people living with HIV. People with HIV and people at risk of HIV infection experience mental illness at significantly higher rates than the general population.<sup>118</sup> People with HIV also experience high rates of substance use disorder (SUD) and are more likely to have a history of trauma.<sup>119</sup> Unfortunately, many people face significant barriers to mental health services, which include the high cost of treatment; insufficient insurance coverage; excessive waiting lists or administrative barriers (such as need for written referrals); and structural factors such as scheduling inconvenience, lack of transportation, or limited ability to locate service providers.<sup>120,121</sup> In addition, during the first stages of the COVID-19 pandemic, many clients were not able or willing to attend medical appointments, and some health care providers serving LGBTQ+ patients were not yet capable of providing telehealth services.

Barriers to care may be compounded by HIV stigma and inequities experienced by people of color, such as provider bias and stereotyping, greater likelihood of living in areas with low-quality health care, inequities in social determinants of health, and lack of access to culturally appropriate care. As a result, people of color have limited access to mental health services and are more likely to receive poor-quality care for behavioral and mental health conditions.<sup>122</sup> Likewise, formerly incarcerated individuals,<sup>123,124</sup> people experiencing homelessness,<sup>125,126,127</sup> immigrants,<sup>128</sup> veterans,<sup>129</sup> and youth<sup>130,131</sup> face multiple additional challenges in accessing mental health and substance abuse services.

Having health insurance has been shown to improve people's access to health care, leading to better health outcomes.<sup>132</sup> Furthermore, having health insurance is associated with increased awareness of one's HIV status;<sup>133</sup> a better chance of sustained viral suppression;<sup>134</sup> less frequent and shorter hospital stays;<sup>135</sup> and lower death rates.<sup>136</sup> Among people vulnerable to HIV infection, having health insurance is associated with increased pre-exposure prophylaxis (PrEP) use.<sup>137</sup> During the COVID-19 pandemic, the Centers for Medicare and Medicaid Services (CMS) expanded its coverage for telehealth care and the U.S. Department of Health and Human Services (HHS) released guides on how to test, treat, and prevent HIV using telehealth. These flexibilities increased access to services for many patients. Since the national quarantine period

ended, there is debate about sustaining telehealth coverage. Several state bills have been introduced at the federal and state levels to maintain payment for telehealth services at the same rates as in-person care visits to promote equitable access to care.<sup>138</sup>

However, people of color—specifically, Native Americans, Black people, and Hispanic/Latinx people—remain more likely to be uninsured.<sup>139</sup> Nationally, these disparities are largely attributable to three main factors. First, many people of color are ineligible for Medicaid or Affordable Care Act (ACA) Marketplace coverage because of their immigration status.<sup>140</sup> Second, people of color and undocumented immigrants are overrepresented in low-wage jobs and industries, such as retail, that are less likely to offer health insurance to employees.<sup>141,142</sup> Finally, people of color are more likely to be among the uninsured population in states that have not expanded Medicaid.<sup>143</sup>

Racial disparities in insurance coverage in the DC EMA largely mirror national trends. In 2019, DC had the second-highest health insurance rate in the country, with 96.5% of DC residents covered by some form of insurance.<sup>144</sup> This feat was likely achieved thanks to the District's generous Medicaid eligibility standards<sup>145,146</sup> and insurance programs for undocumented residents.<sup>147,148</sup> However, in Maryland, Virginia, and West Virginia, the income eligibility level for Medicaid is lower<sup>149</sup> and statewide public insurance programs for undocumented immigrants do not exist. As a result, insurance rates were slightly lower across the entire DC metropolitan area, at 92.5%.

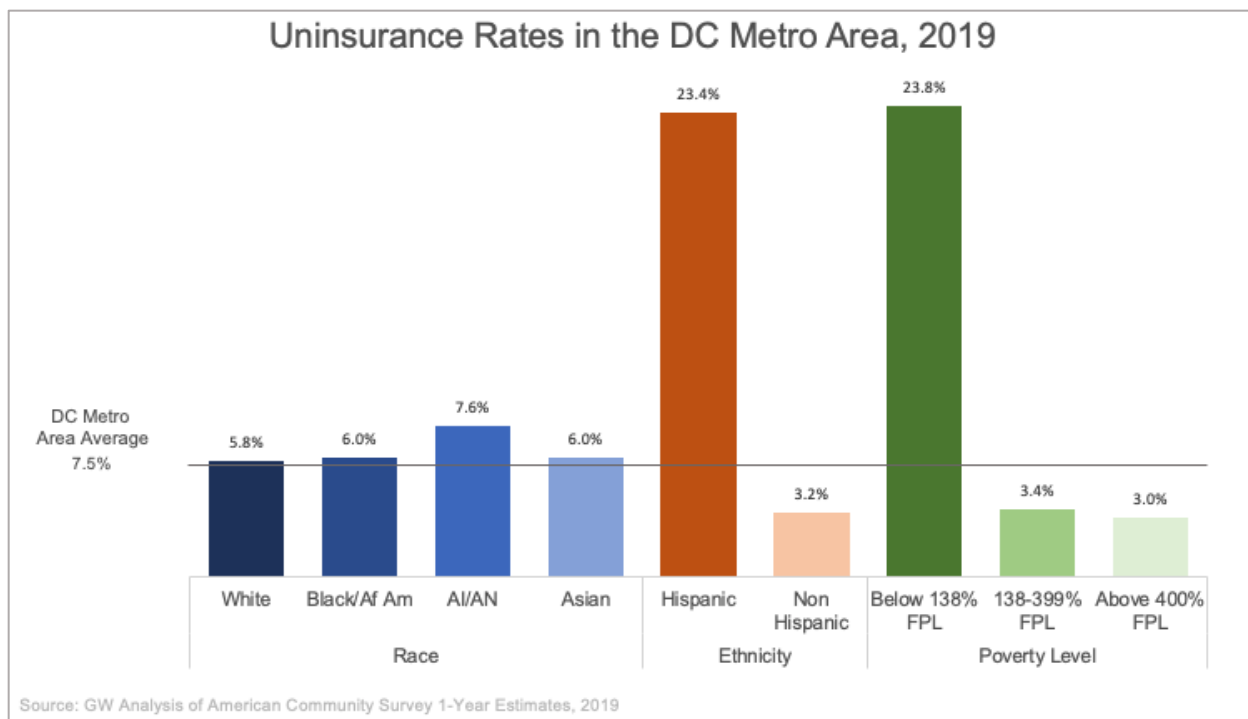
Despite high rates of overall insurance, there are stark disparities in coverage based on race, ethnicity, and income, with Hispanic/Latinx people and people earning below 138% of the federal poverty level most likely to be uninsured (see Figure 3). A 2018 DC Health analysis also found variations in insurance status by neighborhood, with the highest rates of uninsured people in Northeast DC neighborhoods with large immigrant populations.<sup>150</sup>

While immigrants in DC have a high rate of insurance coverage compared to immigrants in other parts of the country, the uninsured rate among immigrants in DC is twice as high as US-born DC residents.<sup>151</sup> In Virginia, green card holders must reside and work in the US for 10 years in order to become eligible for Medicaid (federal law only requires five years).<sup>152</sup> Twenty-nine states waive this waiting period for pregnant women, per CMS allowance, and 21 states, including DC, Maryland, Virginia, and West Virginia, also cover lawfully-residing children or pregnant women without a waiting period under CHIP.<sup>153,154</sup>

As of 2021, 971 foreign-born individuals are living with HIV in DC and immigrant populations represented approximately 12% of HIV cases in Maryland.<sup>155,156</sup> Virginia and West Virginia do not report information on foreign-born individuals living with HIV. Late-stage HIV diagnosis is a concerning trend in some DC EMA jurisdictions; for example, nearly one in four new HIV diagnoses in Montgomery County in Maryland was a late-stage diagnosis.<sup>157</sup> COHAH members have expressed that these delayed diagnoses are likely related to the high rates of uninsurance due to an inability to afford the cost of health care.

### **Figure 3. Uninsurance Rates in the DC Statistical Metropolitan Area, 2019**





**Figure 3 Definitions and Acronyms**

Black/Af Am: Black/African American

AI/AN: American Indian/Alaska Native

Hispanic: Hispanic/Latinx, any race

Non-Hispanic: Non-Hispanic White

FPL: Federal Poverty Level

Data on the insurance status of Native Hawaiians or Other Pacific Islanders were not available

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As discussed earlier in this report, there are significant overall health inequities related to race, ethnicity, and income across the EMA. These racial inequities are exacerbated by differences in access to medical providers, including a shortage of pharmacies in Wards 7 and 8 and recent closures of hospitals and birthing facilities that predominantly served low-income Black patients.<sup>158,159</sup> Residents of Wards 7 and 8 also reported numerous barriers to utilizing mental health services, including fear and distrust of the medical system.<sup>160</sup>

**Current Programs in the EMA**

The Ryan White HIV/AIDS Program plays an integral role in facilitating access to health care for people with HIV. The program supports primary medical care, access to antiretroviral treatment, medical case management, mental health services, oral health care, outpatient care for substance abuse, and support services (e.g., non-emergency medical transportation) for PLWH. The Ryan White program, including the AIDS Drug Assistance Programs (ADAPs), does not have a citizenship requirement. In 2015, four core medical service categories represented the four categories with the highest levels of spending in the DC EMA: outpatient medical services ranked first, followed by medical case management, mental health services, and oral health services; outpatient substance use treatment ranked eighth.<sup>161</sup> Ryan White funds can also be used to provide health insurance premium and cost-sharing assistance for low-income individuals who have health insurance but have difficulty affording their coverage.<sup>162</sup>

In addition to funding health care for people diagnosed with HIV, COHAH has adopted a status-neutral approach to ensure that people at risk of HIV also receive assistance to access comprehensive health care.<sup>163</sup> In order to improve access to health care among people of color who are living with or at risk of HIV, COHAH and its partners have conducted robust community engagement to inform program planning and implementation; translated public awareness campaigns into Spanish; and maintained a number of initiatives aimed at improving viral suppression and access to care for priority populations, such as Black women, people experiencing homelessness, men of color who have sex with men, and transgender women of color.<sup>164</sup> COHAH and its partners have also supported the growth of lay health professionals, such as health impact specialists and rapid peer responders, to support clients from priority communities in achieving their health goals.<sup>165</sup>

In DC, residents who are low-income and uninsured and who are not eligible for Medicare or Medicaid may be eligible for the DC Healthcare Alliance (“The Alliance”) and the Immigrant Children’s Program (ICP), regardless of their immigration status.<sup>166</sup> These insurance plans cover preventive care, office visits, prescription drugs, and lab services without cost-sharing.<sup>167,168</sup> However, no such programs are available in Maryland, Virginia, or West Virginia.<sup>169</sup> In Maryland, Virginia, and West Virginia,<sup>170</sup> undocumented immigrants may be able to apply for comprehensive insurance coverage outside of the ACA Marketplace (known as “off-exchange” plans) if issuers do not require social security numbers, but without eligibility for ACA premium subsidies, such policies may be unaffordable.

Several other health assistance programs are also available to help individuals who are uninsured or underinsured afford medications for HIV treatment and prevention, regardless of immigration status. All four EMA states use the AIDS Drug Assistance Program (ADAP) to cover drugs as well as insurance premiums and cost-sharing.<sup>171,172,173,174</sup> DC<sup>175</sup> and Virginia<sup>176</sup> have also used local funds for PrEP drug access programs (DAPs).

## **COHAH Principles and Positions on Medical Care**

### Federal, State, and Local Policies

COHAH supports:

- State and local public insurance programs for uninsured individuals who are not eligible for Medicare or Medicaid, such as people who are undocumented immigrants
- Telehealth reimbursement parity to improve access to services
- Policies and models of care that remove administrative barriers to accessing health care and decriminalize and/or destigmatize sexual health and behavioral health

### Service Delivery and Programming

COHAH supports:

- Efforts to reduce barriers to mental health/SUD provider participation in Ryan White and Prevention funded programming
- Models of care that assure cultural competence and language access among health care and social service providers for multilingual populations
- Research into approaches adopted by other jurisdictions to increase or support the behavioral health/SUD workforce

## Medical Mistrust and HIV Stigma

Medical mistrust and HIV stigma are prominent barriers to health care, particularly for people of color.

### **Medical Mistrust and HIV**

Medical mistrust refers to mistrust or suspicion of health care, medical providers, medical treatments, and/or the public health establishment.<sup>177</sup> A long history of discrimination and exploitation in our healthcare and health research systems, combined with ongoing discriminatory practices and systemic racism, have fueled to this mistrust.<sup>178</sup>

Rates of medical mistrust are higher among Black and Latinx communities,<sup>179,180,181</sup> reflecting personal and generational experiences of mistreatment and racism.<sup>182</sup> Medical mistrust may be informed by a number of factors, including systemic racism, which may manifest as a lack of funding or attention toward the health of people of color or other groups.<sup>183</sup> It may also be informed by historical trauma, such as the enslavement of African Americans, the genocide of Native Americans, and other forms of oppression, cultural destruction, displacement, and land loss. On an institutional level, unethical medical experimentation on people of color and contemporary discrimination by healthcare providers and institutions has caused justified mistrust of the health care system among people of color.<sup>184</sup>

As a result of these abuses, people of color may view the medical establishment as a historically white institution that does not understand their needs (benign neglect theory) or as an agent of white supremacy that intentionally aims to harm them (malicious intent theory).<sup>185,186</sup> Medical mistrust can also stem from non-racialized experiences. For example, some patients distrust healthcare providers because they believe that clinicians value their financial interests above patients' health, particularly if patients are unable to afford care.<sup>187</sup> Poor communication from health care providers, inadequate consent practices, and interactions that leave patients feeling ignored, dismissed, judged, and disrespected further inhibit trust in the medical system.<sup>188,189,190,191</sup>

The COVID-19 pandemic has highlighted the impacts of medical mistrust on public health. Mistrust in the medical and public health establishments hindered the adoption of protective behaviors and contributed to racial and ethnic disparities in COVID-19 vaccination.<sup>192,193</sup> Of note, one study of Black HIV-positive people found that 97% of participants endorsed at least one general COVID-19 mistrust belief, and more than half endorsed at least one COVID-19 vaccine or treatment hesitancy belief.<sup>194</sup>

### **Impacts of Medical Mistrust**

Both medical mistrust and HIV stigma have been linked to negative health and healthcare outcomes. Medical mistrust is associated with lower healthcare utilization and satisfaction<sup>195</sup> and can lead to skepticism toward medical advice.<sup>196</sup> In the context of HIV prevention and care, medical mistrust has been associated with a range of worse outcomes for Black people, including:

- decreased condom use among Black men and women,<sup>197,198</sup>
- decreased comfort talking to a health care provider about PrEP among Black women,<sup>199</sup>

- gaps in routine health care among Black MSM,<sup>200</sup> and
- poorer ART adherence among Black men and women.<sup>201,202,203</sup>

Among Latino sexual minority men, medical mistrust has been associated with decreased PrEP awareness, willingness, use, and adherence.<sup>204</sup>

### **HIV Stigma**

HIV stigma refers to negative attitudes and beliefs about PLWH<sup>205</sup> and is another important barrier to HIV care. Stigma may occur or be reinforced on multiple levels: it may be internalized (HIV stigma felt by people living with HIV) or experienced on interpersonal, institutional, and structural levels. Homophobia, transphobia, racism, classism, and negative views of people who inject drugs can feed into HIV stigma. For example, some healthcare providers report associating people who seek HIV prevention and care services with negative characteristics such as poverty and promiscuity.<sup>206</sup> Language can also be key in reinforcing or combatting HIV stigma; for example, statements identifying at-risk populations can be perceived as blaming individuals in those groups for broader public health issues or associating individuals in those groups with illness, promiscuity, homosexuality, or drug use.<sup>207,208</sup>

Within health care settings, providers' fears of acquiring HIV through occupational exposure can lead to reduced quality of care, refusal of care, and anxiety when providing services to PLWH.<sup>209</sup> Outside of health care settings, laws that criminalize HIV transmission contribute to HIV stigma and discrimination and are ineffective in preventing HIV transmission.<sup>210</sup> Many states – including Maryland and Virginia – have laws that criminalize the behavior of people living with HIV and/or have used non-HIV-specific laws to prosecute behaviors of people living with HIV.<sup>211,212</sup>

### **Impacts of HIV Stigma**

HIV stigma is similarly associated with a range of negative health behaviors and outcomes. Among people living with HIV, these include:

- depression,
- lower levels of social support,
- non-disclosure of a positive HIV status to sexual partners,
- reduced ART adherence,
- reduced access to and usage of health and social services,
- poorer quality of care, and
- mistrust of health care providers.<sup>213,214,215,216</sup>

Among HIV-negative individuals, impacts of HIV stigma include reduced HIV preventive behaviors and reluctance to seek HIV testing.<sup>217,218</sup>

### **Current Programs in the EMA**

There are few statistics on the impact of HIV stigma and medical mistrust in the DC EMA, specifically. However, community engagement initiatives in DC, Maryland, and Virginia highlighted HIV stigma and racism as key barriers to HIV care.<sup>219,220,221,222</sup> Notably, in Virginia,

half of the respondents to the state’s 2016 consumer needs assessment cited “fear and/or stigma” as their main barrier to receiving HIV services.<sup>223</sup> Furthermore, Virginia’s 2020 HIV Stigma Summary Score was 36.6, compared to the national average score of 27.6, indicating a greater prevalence of stigma in the state.<sup>224</sup> Each jurisdiction has taken a tailored approach to address stigma and discrimination. DC plans to address HIV stigma by integrating Undetectable Equals Untransmittable (U=U) messaging into clinical and support services; promoting harm reduction approaches among people who use drugs; and launching a status-neutral wellness program.<sup>225</sup> In Montgomery County, HIV capacity-building training and technical assistance to social services programs will emphasize HIV stigma and intersectional cultural humility.<sup>226</sup> Virginia’s Community Advancement Project (CAP) – an advisory board of HIV-positive and HIV-negative MSM and transgender women of color – advises the Virginia Department of Health Division of Disease Prevention on issues including stigma and racial disparities in access to care.<sup>227</sup>

### **COHAH Principles and Positions on Medical Mistrust and HIV Stigma**

COHAH supports the following principles, positions, and activities regarding medical mistrust and HIV stigma for people living with or at risk of HIV in the DC EMA:

#### Federal, State, and Local Policies

COHAH supports:

- The development of a plan, which may overlap with jurisdictions’ Ending the Epidemic goals, to identify and promote evidence-based policies to reduce HIV stigma
- The creation of accountability measures (including funding implications) to promote the adoption of best practices for stigma reduction and trust building
- Replication of Virginia’s CAP advisory board across EMA jurisdictions

#### Service Delivery and Programming

COHAH supports:

- Expanding provider networks to ensure that people who feel stigmatized by or mistrustful of their provider can seek care elsewhere
- Integration of community health workers into client care teams to address mistrust and assess social needs
- Efforts to promote transparent, patient-centered care, including spaces where people feel comfortable accessing testing and prevention services
- The creation and dissemination of a self-assessment tool for all HAHSTA subgrantees to determine how they evaluate and address stigma, paired with a patient assessment to identify best practices and areas of improvement for stigma reduction and trust building
- Initiatives to hire healthcare providers and staff who reflect the communities being served, including people who can provide translation services
- Diverse leadership of Ryan White and Prevention-funded health care providers and community-based organizations
- Further research into existing cultural competence/humility and hiring practices in the DC EMA, how providers are held accountable, what assessments are performed, and whether these practices are effective

- Efforts to examine the origins of the medical mistrust and ensure that understanding of medical mistrust is community-led
- Further research on stigma and mistrust surrounding HIV testing, substance use, and behavioral health

## Education

Education serves as a key social determinant of HIV risk and health in two ways: through the general association between overall educational attainment and health, including HIV; and through the specific impact of sex education for youth.

### **Educational Attainment and HIV**

Education can improve health by providing economic and social benefits and encouraging healthy behaviors.<sup>228</sup> In general, individuals with higher levels of education live longer and healthier lives than those with fewer years of education, for several reasons. First, education can provide a variety of economic benefits that can improve health. More educated individuals are more likely to be employed, have higher wages, and have jobs that provide benefits, such as health insurance and paid leave.<sup>229</sup> Educated adults are also more likely to have larger social networks that provide financial and psychological benefits which may reduce hardships and stress. In addition, those with higher educational attainment are, on average, less likely to engage in certain activities that negatively impact health, such as cigarette and alcohol use. Finally, good health is a prerequisite for learning and education. Poor health can interfere with learning and lead to adverse educational outcomes, such as reduced attendance and concentration in school.<sup>230</sup>

Research shows that greater educational attainment is associated with higher rates of HIV testing, increased rates of viral suppression, and improved adherence to ART in some individuals. One study found that African Americans with higher educational attainment are more likely to report having been tested for HIV than those with lower educational attainment. The higher the level of educational attainment (high school, college, professional degree, etc.), the more likely participants were to report being tested for HIV.<sup>231</sup> In another study of women living with or at risk of HIV, education was also shown to influence health outcomes. Women with less than a high school level of education were less likely to be virally suppressed than those with higher educational attainment. Also, adherence to ART improved with increased levels of education in women.<sup>232</sup>

Educational performance and quality vary considerably in the EMA depending on neighborhood and race. In Ward 3, which has very low rates of HIV compared to the rest of DC,<sup>233</sup> only 2% of residents lack a high school diploma.<sup>234</sup> In contrast, in Ward 8, which has high rates of HIV,<sup>235</sup> about 17% of residents lack a high school diploma.<sup>236</sup> There is also a gap in educational achievement between White and Black students throughout schools in the EMA. In DC Public Schools (DCPS), Black students are, on average, almost five grade levels behind their white peers. In Arlington and Montgomery County schools, Black students are, on average, three grade levels behind their white peers.<sup>237</sup> Finally, in DCPS, Black and Hispanic students are more likely to be disciplined and less likely to be enrolled in advanced placement courses than White students.<sup>238</sup> These gaps in education across Wards and race likely reflect and contribute to health inequities.

### **Sex Education and HIV**

Sex and HIV education in schools can also improve health among students. Since more than 56 million students spend their day in school, schools are an ideal setting to provide sexual health education to reach most adolescents.<sup>239</sup> Comprehensive sex education has been shown to reduce sexual risk behaviors, such as unprotected sex and having sex with multiple partners.<sup>240</sup> However, not all states require comprehensive sex education in schools.<sup>241</sup> Even where offered, sex education may not be inclusive to all minority groups and sexual orientations. For example,

young men who have sex with men (YMSM) are at increased risk of HIV infection but are less likely to report learning about HIV in schools compared to young men who have sex with women only.<sup>242</sup> Students of color, including Hispanic and Black students, are also less likely to report having received HIV education but are more likely to report high-risk sexual behaviors, such as having sex with more than one partner.<sup>243</sup>

The District of Columbia mandates that public schools provide sex and HIV education to their students. DC schools are also required to provide information on contraception and abstinence, and, overall, sex education must be inclusive of all sexual orientations. Though this mandate could improve health and reduce high-risk sex behavior, sex education is not uniformly implemented across DC public and charter schools.<sup>244,245</sup> One analysis found that in 2017, only some charter schoolteachers reported abiding by DC’s standards, leading to varying levels of sex and HIV education across schools.<sup>246</sup> Between 2016-2020, young people ages 13-24 accounted almost 19% of new HIV diagnoses in DC,<sup>247</sup> underscoring the need to ensure that every school provides thorough sex and HIV education to its students.

### **Current Programs in the EMA**

The Ryan White program offers Health Education and Risk Reduction (HERR) services to people living with HIV (PLWH) in the EMA. The service provides education to PLWH on HIV transmission and how to reduce risk of transmission. It also links PLWH to medical and psychosocial support services and provides counseling to individuals to improve their health status. For example, clients may receive education on healthcare coverage options, treatment adherence, and health literacy.<sup>248, 249</sup>

Aside from Ryan White services and school-based sex education, other organizations and programs exist in the District to increase education about sexual health and HIV. One Tent Health is a youth-led organization that provides sex education, HIV testing, and PrEP services to residents in DC’s underserved neighborhoods.<sup>250</sup> DC Health also launched its “Sex Is…” campaign in 2017 to combat stigma surrounding sex education and spread sex positivity.<sup>251</sup> The campaign works with high school students, teachers, and community organizations to provide contraception and start honest conversations about safe and healthy sexual relationships. Finally, the DC DOH partners with DCPS to provide HIV testing and PrEP linkage referrals.<sup>252</sup>

### **COHAH Principles and Positions on Education**

COHAH supports the following principles, positions, and activities regarding HIV and sexual health education for people living with or at risk of HIV in the DC EMA:

#### Federal, State, and Local Policies

COHAH supports:

- Education departments holding LEAs and schools accountable for meeting sexual health education requirements and nationwide standards
- The use of health department funding for upstream patient outreach and education for youth on how to access services and testing
- The inclusion of health education in jurisdictions’ Ending the Epidemic Plans

#### Service Delivery and Programming



COHAH supports:

- The Whole School, Whole Community, Whole Child (WSCC) model for education and efforts to provide sexual health education using culturally and linguistically appropriate approaches
- Sexual health education in schools, particularly CDC-funded education, based on the National Sexuality Education Standards
- Better integration of health department and education department policies and goals
- A greater emphasis on education about HIV testing, including in school-based health education.
- Initiatives to increase the emphasis on education about sexual health for all Ryan White and Prevention-funded providers in the EMA
- Research into how authority and reporting for sexual health education initiatives from school agencies (such as OSSE) and health agencies (such as DC Health) overlap
- Research into other promising programs in the EMA that are helping to educate youth about sexual health and HIV prevention, including current CDC-funded school-based education projects

## Conclusion: COHAH's Commitment to Promoting Equity

The Washington DC EMA Commission on Health and HIV (COHAH) supports concerted action by government, providers, community members, and other partners to promote health equity and reduce racial and ethnic disparities in HIV throughout our region.

As detailed in this position statement on HIV Health Equity, disease vulnerability, acquisition, and health outcomes are heavily impacted by a number of social determinants of health, including employment, housing, transportation, food, medical care, medical mistrust and HIV stigma, and education. Together, these social determinants create health inequities, including in HIV.

Addressing the underlying factors creating health inequities requires collaboration across sectors, with policymakers, government officials and advocates working in each of these areas. The “upstream” nature of these determinants means that, in many cases, improving access and addressing unmet social needs has the potential to address disparities across multiple health issues. In our full position statement, we outline the range of policy changes, programming steps, research needs, and other measures that we encourage various entities to undertake to advance health equity.

While COHAH's own role is largely an advisory one, we are uniquely situated to contribute to the promotion of health equity in the region. Our general body comprises members from across the Washington D.C. region, including government officials, providers, and community members, with expertise in HIV prevention, treatment, and care. To promote the goals of our position statement over the next year, we commit to:

- Inviting experts on the policy areas listed above to COHAH full body or workgroup meetings, to better understand the intersections of their work with COHAH's jurisdiction, and to identify opportunities for collaboration with the HIV field;
- Further exploring the intersectionality of racial and ethnic disparities with sexism, homophobia, transphobia, and other axes of discrimination and health;
- Continuing to work with HAHSTA and other agencies in the EMA to include measures relevant to equity in consumer needs assessments and other instruments in the region;
- Centering equity in the Priority Setting and Resource Allocation (PSRA) process, including by reviewing all available data on equity and unmet social needs;
- Engaging with people living with HIV and communities disproportionately impacted by HIV on further opportunities to address underlying causes of health inequities

## Appendix A: National HIV Disparities

### HIV in the United States, 2020

<b>Race/ Ethnicity</b>	<b>Population</b>	<b>New HIV Diagnoses</b>	<b>Rate of New HIV Diagnoses<sup>†</sup></b>	<b>PLWH</b>	<b>PLWH Rate<sup>†</sup></b>	<b>Deaths</b>	<b>Death Rate<sup>†</sup></b>
American Indian/ Alaska Native	1.3%	201	8.3	3,248	133.5	78	3.2
Asian	6.1%	637	3.3	16,198	83.6	97	0.5
Black/African American	13.6%	12,856	31.0	430,015	1,038.0	7,930	19.1
Hispanic/ Latinx	18.9%	8,008	13.1	246,097	401.4	3,245	5.3
Native Hawaiian/ other Pacific Islander	0.3%	66	10.8	936	152.6	10	1.6
White*	75.8%	7,843	4.0	305,956	155.5	5,514	2.8
Multiracial	2.9%	792	10.5	52,423	693.7	1,290	17.1

<sup>†</sup> Rate per 100,000 population

\*Not Hispanic/Latinx

Sources: <https://www.census.gov/quickfacts/fact/table/US/POP010220>, Centers for Disease Control and Prevention. HIV Surveillance Report, 2020; vol.33. <https://www.cdc.gov/hiv/library/reports/hiv-surveillance/vol-33/index.html>. Published May 2022

## Appendix B: HIV Disparities in the DC Metropolitan Area

### HIV Incidence in the DC Metropolitan Area, 2020-2021

Locality	New HIV Diagnoses				
	Black/African American	Hispanic/Latinx	White*	Other**	Total
<b>Washington, DC</b>	<b>147</b>	<b>32</b>	<b>24</b>	<b>27</b>	<b>230</b>
<b>Suburban Maryland</b>	<b>≥353</b>	<b>≥67</b>	<b>≥6</b>	—	<b>475</b>
Calvert County	—	—	—	—	20
Charles County	24	—	6	—	25
Frederick County	5	6	—	—	11
Montgomery County	84	29	—	—	101
Prince George's County	240	32	—	—	244
<b>Northern Virginia</b>	<b>99</b>	<b>36</b>	<b>36</b>	<b>1</b>	<b>172</b>
Northern†	74	33	16	1	124
Northwest‡	25	3	20	0	48

\*Not Hispanic/Latinx

\*\* Other includes American Indian/Alaska Native, Asian, Native Hawaiian/ other Pacific Islander, and Multiracial

† Northern Virginia includes Alexandria (city), Arlington (city), Fairfax (city), Fairfax County, Falls Church (city), Loudoun County, Manassas (city), Manassas Park (city), Prince William County, all of which are part of the DC EMA

‡ Northwest Virginia includes Clarke County, Culpeper County, Fauquier County, Fredericksburg (city), King George County, Loudon County, Spotsylvania County, Stafford County, and Warren County, all of which are part of the DC EMA. However, Northwest Virginia also includes 23 additional cities/counties, and publicly available data do not include city or county-level totals by race/ethnicity. Accordingly, there are 40 more newly diagnosed cases of HIV in Northern and Northwest Virginia than in the parts of Northern Virginia included in the DC EMA.

Sources: <https://dchealth.dc.gov/sites/default/files/dc/sites/doh/publication/attachments/2022-HAHSTA-Annual-Surveillance-Report-Appendix-11.pdf>,

[https://www.vdh.virginia.gov/content/uploads/sites/10/2021/10/Annual\\_Report\\_2020.pdf](https://www.vdh.virginia.gov/content/uploads/sites/10/2021/10/Annual_Report_2020.pdf),

<https://phpa.health.maryland.gov/OIDEOR/CHSE/Pages/County-Data-Sheets.aspx>

### HIV Prevalence in the DC Metropolitan Area, 2020-2021

Locality	PLWH				
	Black/African American	Hispanic/Latinx	White*	Other**	Total
<b>Washington, DC</b>	<b>8,448</b>	<b>1,000</b>	<b>1,767</b>	<b>689</b>	<b>11,904</b>
<b>Suburban Maryland</b>	<b>9,854</b>	<b>1,352</b>	<b>1,136</b>	<b>752</b>	<b>13,094</b>
Calvert County	71	10	49	6	136
Charles County	540	25	84	30	679
Frederick County	217	62	185	34	498
Montgomery County	2,325	583	496	270	3,674
Prince George's County	6,701	672	322	412	8,107
<b>Northern Virginia</b>	<b>4,470</b>	<b>1,573</b>	<b>3,102</b>	<b>216</b>	<b>9,361</b>
Northern†	3,480	1,377	2,072	142	7,071
Northwest‡	990	196	1,030	74	4,475

\*Not Hispanic/Latinx

\*\* Other includes American Indian/Alaska Native, Asian, Native Hawaiian/ other Pacific Islander, and Multiracial  
† Northern Virginia includes Alexandria (city), Arlington (city), Fairfax (city), Fairfax County, Falls Church (city), Loudoun County, Manassas (city), Manassas Park (city), Prince William County, all of which are part of the DC EMA

‡ Northwest Virginia includes Clarke County, Culpeper County, Fauquier County, Fredericksburg (city), King George County, Loudon County, Spotsylvania County, Stafford County, and Warren County, all of which are part of the DC EMA. However, Northwest Virginia also includes 23 additional cities/counties and publicly available data do not include city or county-level totals by race/ethnicity. Accordingly, there are 1,274 more PLWH in Northern and Northwest Virginia than in the parts of Northern Virginia included in the DC EMA.

Sources: <https://dchealth.dc.gov/sites/default/files/dc/sites/doh/publication/attachments/2022-HAHSTA-Annual-Surveillance-Report-Appendix-11.pdf>,

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