Washington, DC Regional PLANNING COMMISSION on HEALTH and HIV

*The **Washington, D.C. Regional Planning Commission on Health and HIV** (COHAH) will invigorate planning for HIV prevention and care programs that will demonstrate effectiveness, innovation, accountability, and responsiveness to our community.*

INTEGRATED STRATEGIES COMMITTEE (ISC) MEETING AGENDA

WEDNESDAY MARCH 22, 2023 – 1:00PM TO 3:00PM

ONLINE MEETING VIA ZOOM

Note: all times are approximate	
1:05 pm	**1. Call To Order and Moment of Silence** **2. Welcome and Introductions**
1:10 pm	**3. Review and Approve the Agenda for March 22, 2023** **4. Review and Approve the Minutes from Feb 22, 2023**
1:15 pm	**5. Check-In – How are YOU!?**
1:20 pm	**6. EHE Updates** - **Washington DC EHE – Ashlee Wimberly, EHE Coordinator, HAHSTA** - **Montgomery County – Emily Halden Brown, EHE Program Manager, MCPHS**
2:30 pm	**7. Health Equity Position Paper Discussion**
2:45 pm	**8. Other Business** - **Child Care Standard Update**
2:55 pm	**9. Future Agenda Items**
2:30 pm	**10. Announcements & Adjournment**
NEXT INTEGRATED STRATEGIES COMMITTEE (ISC) MEETING:	**APRIL MARCH 26, 2023** **1PM – 3PM** **ELECTRONIC MEETING VIA ZOOM**

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INTEGRATED STRATEGIES COMMITTEE (ISC)
MEETING MINUTES

WEDNESDAY, FEBRUARY 22, 2023 - 1:00PM

ZOOM CONFERENCE AND VIDEO CALL

ELECTRONIC – ONLINE MEETING

ATTENDEES/ROLL CALL					
COMMISSIONERS	**PRESENT**	**ABSENT**	**COMMITTEE MEMBERS**	**PRESENT**	**ABSENT**
Camara, Farima		X	Givens, Phyllis	X	
Cauthen, Melvin	X		Mitchell, NaToya		X
Clark, Lamont (Govt. Co-chair)	X				
Gomez, Ana		X			
Gutierrez, Anthony		X			
Hutton, Kenya		X			
Keita, Rama	X		**COMMUNITY PARTNERS/GUESTS**	**PRESENT**	**ABSENT**
Ollinger, Joshua		X	Jordan, Alexandra		X
Pettigrew, Ken		X	Taliaferro, Tiffany		X
Wallis, Jane	X		**CONSULTANTS**	**PRESENT**	**ABSENT**
			Osei, Alexis		X
			Seiler, Naomi	X	
			Turner, Taylor	X	
			Washington, Mekhi	X	
RYAN WHITE RECIPIENT STAFF	**PRESENT**	**ABSENT**	**COMMISSION SUPPORT STAFF**	**PRESENT**	**ABSENT**
Coleman, Ashley		X	Bailey, Patrice	X	
Delao Hernandez, Jose		X	Johnson, Alan	X	
Olejemeh, Christie	X				
Orban, Julie	X				
HAHSTA STAFF	**PRESENT**	**ABSENT**			
Cooper, Stacey		X			
Wimberly, Ashlee	X				

NOTE: This is a draft version of the February 22, 2023, Integrated Strategies Committee (ISC) Meeting Minutes which is subject to change. The final version will be approved on March 22, 2023.

AGENDA

ITEM	DISCUSSION
Call to Order	Jane W. called the meeting to order at 1:08 pm followed by a moment of silence and introductions.
Review and Approval of the Agenda	Jane assumed the motion to adopt the meeting agenda for February 22, 2023. The agenda was adopted as is.
Review and Approval of the Minutes	Jane assumed the motion to approve the meeting minutes for the January 25, 2023, meeting. There were no corrections to the minutes. The meeting minutes were approved as presented.
Check – In	Melvin C. shared that his team is preparing their submission for Ryan White Part B through Maryland's State Health Department. Montgomery County has vacant positions including the nurse practitioner and the supervisory social worker. Both positions close on March 10th. Phyllis G. noted that the numbers are higher at Food and Friends and the organization is working for a solution as they are beyond capacity. The good news is that Food and Friends is currently fully staffed.
Position Papers Discussion	***Health Equity Position Paper*** Naomi S. and Mekhi W. provided updates on the Health Equity Position Paper. Naomi noted that the surveillance data points have been updated using the 2022 DC Health Surveillance Report and citations. Mekhi walked through revised Executive Summary that has been condensed even more for clarity. Medical mistrust and HIV stigma were separated out as two different issues and will be focused on individually in the paper. Julie O. suggested adding a glossary, or a description of acronyms used in the paper. The paper should be ready for final review in March.
Service Standards Review	None noted.
Service Standards Discussion	***Child Care Service Standards*** Dr. Christie O. noted that the Ryan White Program is planning some in-person community engagement with Ryan White Providers to do a survey to gauge interest and client need for Child Care Services. The plan is to host the event before May 2023.
Other Business	None noted.

Future Agenda Items	Equity Paper Child Care Service Standards Update (if applicable) EHE Update (March) – Invite other Jurisdictions to meetings.
ANNOUNCEMENTS/OTHER DISCUSSION	None noted.

HANDOUTS

- February 22, 2023, Integrated Strategies Committee Meeting Agenda
- January 25, 2023, Integrated Strategies Committee Meeting Minutes

MEETING ADJOURNED	**1:40 PM**	**NEXT MEETING**	**WEDNESDAY, MARCH 22, 2023 1:00pm to 3:00pm ZOOM CONFERENCE AND VIDEO CALL**

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

Table of Contents

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 **[INSERT LINK]** 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,[1] 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[2] as were 83% of people newly diagnosed in Prince George's County.[3] 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.[4] 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.[5,6]

Social Determinants Driving Health Inequity

Employment

Research suggests that PLWH experience unemployment at three times the national rate,[7] due to factors including stigma, restrictive policies, and disease progression.[8] 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.[9] 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.[10]

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

<u>Federal, State, and Local Policies.</u>
COHAH supports:

[*] 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.

- 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 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.[11,12,13,14] 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.[15,16] Unfortunately, PLWH experience homelessness at a rate three times higher than the general population,[17] due in part to the costs of HIV care and higher rates of unemployment.[18]

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.[19,20] 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.[21] 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.[22]

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.[23, 24] 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),[25] 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 home-based 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[26] and between a quarter to a half of all PLWH.[27] 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.[28,29]

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.[30] 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 report barriers to accessing health

care including insufficient insurance coverage, substance use, mental health issues, cognitive or physical impairments, and distance to HIV care providers.[31,32,33,34] 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.[35,36]

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.[37,38]

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.[39]

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:

<u>Federal, State, and Local Policies</u>
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

<u>Service Delivery and Programming</u>
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. [40] Rates of medical mistrust are higher among Black and Latinx communities,[41,42,43] reflecting personal and generational experiences of mistreatment and racism.[44] 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.[45] 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.[46]
HIV stigma refers to negative attitudes and beliefs about PLWH [47] 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.[48] For example, some healthcare providers report associating people who seek HIV prevention and care services with negative characteristics such as poverty and promiscuity.[49] 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.[50]

Furthermore, laws that criminalize HIV transmission contribute to HIV stigma and discrimination and are ineffective in preventing HIV transmission.[51] 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.[52,53]

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:

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e.g. "Diverse leadership of Ryan White and Prevention-funded health care providers and community-based organizations"

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 subgranteesto 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.[54,55]

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.[56] However, not all states require comprehensive sex education in schools.[57] Even where offered, sex education may not be inclusive to all minority groups and sexual orientations.[58] In some studies, students of color, including Hispanic and Black students, were less likely to report having received HIV education than white students.[59]

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

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- 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 bove, 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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[1] https://www.hiv.gov/hiv-basics/overview/data-and-trends/statistics
[2] District of Columbia Department of Health, HIV/AIDS, Hepatitis, STD, and TB Administration (HAHSTA). Annual Epidemiology & Surveillance Report: Data Through December 2021. https://dchealth.dc.gov/sites/default/files/dc/sites/doh/publication/attachments/2022-Annual-Surveillance-Report_0.pdf
[3] https://health.maryland.gov/phpa/OIDEOR/CHSE/SiteAssets/Pages/County-Data-Sheets/Prince-George%27s-County-Fact-Sheet--2021.pdf
[4] https://health.maryland.gov/phpa/OIDEOR/CHSE/SiteAssets/Pages/County-Data-Sheets/Montgomery-County-Fact-Sheet--2021.pdf
[5] Virginia HIV Epidemiology Profile. *Persons Living With HIV.* Data Reported from 2018. 2021. https://www.vdh.virginia.gov/content/uploads/sites/10/2020/10/Persons-Living-with-HIV-2018.pdf
[6] Virginia HIV Surveillance Annual Report. Data Reported 2020-2021. 2022. https://www.vdh.virginia.gov/content/uploads/sites/10/2022/05/HIV-Annual_Report_Update_2021.pdf
[7] People Living With HIV. The GAP Report 2014. https://www.unaids.org/sites/default/files/media_asset/01_PeoplelivingwithHIV.pdf.
[8] People Living With HIV. The GAP Report 2014. https://www.unaids.org/sites/default/files/media_asset/01_PeoplelivingwithHIV.pdf.
[9] Maulsby CH, Ratnayake A, Hesson D, Mugavero MJ, Latkin CA. A Scoping Review of Employment and HIV. *AIDS Behav*. 2020;24(10):2942-2955. doi:10.1007/s10461-020-02845-x
[10] Benson C, Wang X, Dunn KJ, et al. Antiretroviral Adherence, Drug Resistance, and the Impact of Social Determinants of Health in HIV-1 Patients in the US. *AIDS Behav*. 2020;24(12):3562-3573. doi:10.1007/s10461-020-02937-8
[11] Aidala AA, Wilson MG, Shubert V, et al. Housing Status, Medical Care, and Health Outcomes Among People Living With HIV/AIDS: A Systematic Review. *Am J Public Health*. 2016;106(1):e1-e23. doi:10.2105/AJPH.2015.302905.
[12] Aquino G, Byrne M, Dorsey K, et al. Examining Retention in HIV Care and HIV Suppression on Housing Services Intake at a Washington, DC Community Based Organization. *J Community Health*. 2021. https://doi.org/10.1007/s10900-020-00959-w
[13] Thakarar K, Morgan JR, Gaeta JM, Hohl C, Drainoni ML. Homelessness, HIV, and Incomplete Viral Suppression. *J Health Care Poor Underserved*. 2016;27(1):145-156. doi:10.1353/hpu.2016.0020
[14] Milloy MJ, Marshall BD, Montaner J, Wood E. Housing status and the health of people living with HIV/AIDS. *Curr HIV/AIDS Rep*. 2012;9(4):364-374. doi:10.1007/s11904-012-0137-5

[15] Milloy MJ, Marshall BD, Montaner J, Wood E. Housing status and the health of people living with HIV/AIDS. *Curr HIV/AIDS Rep*. 2012;9(4):364-374. doi:10.1007/s11904-012-0137-5
[16] Hawk M, Davis D. The effects of a harm reduction housing program on the viral loads of homeless individuals living with HIV/AIDS. *AIDS Care*. 2012;24(5):577-582. doi:10.1080/09540121.2011.630352.
[17] National Alliance to End Homelessness. Health. https://endhomelessness.org/homelessness-in-america/what-causes-homelessness/health/. Accessed July 2021.
[18] Lennon CA, Pellowski JA, White AC, et al. Service priorities and unmet service needs among people living with HIV/AIDS: Results from a nationwide interview of HIV/AIDS housing organizations. *AIDS Care*. 2013;25(9), 1083–1091. doi:10.1080/09540121.2012.749337.
[19] Brink-Johnson A, Lupin J. Structural Racism in Washington, DC Facts Figures and Opportunities for Advancing Racial Equity. https://urbanandracialequity.org/wp-content/uploads/2020/08/Structural-Racism-in-Washington-DC-1.pdf. Published August 19, 2020. Accessed July 2021.
[20] Aquino G, Byrne M, Dorsey K, et al. Examining Retention in HIV Care and HIV Suppression on Housing Services Intake at a Washington, DC Community Based Organization. *J Community Health*. 2021. https://doi.org/10.1007/s10900-020-00959-w.
[21] Hughes E. Unequal Burden Low-Income Northern Virginians face the country's most severe housing cost burden. The Center for Community Research at the Community Foundation for Northern Virginia. January 2021. Accessed September 27, 2021. https://www.cfnova.org/images/communityreports/InsightRegion_UnequalBurden_Copyright2021.pdf.
[22] Maryland Department of Housing and Community Development. Maryland Housing Needs Assessment & 10-Year Strategic Plan. December 2020. Accessed September 27, 2021. https://dhcd.maryland.gov/Documents/Other%20Publications/Report.pdf.
[23] [3] Lynda M. Sagrestano, Joy Clay, Ruthbeth Finerman, Jennifer Gooch & Melanie Rapino (2014) Transportation vulnerability as a barrier to service utilization for HIV-positive individuals, AIDS Care, 26:3, 314-319, DOI: 10.1080/09540121.2013.819403
[24] Terzian, A. S., Younes, N., Greenberg, A. E., Opoku, J., Hubbard, J., Happ, L. P., Kumar, P., Jones, R. R., Castel, A. D., & DC Cohort Executive Committee (2018). Identifying Spatial Variation Along the HIV Care Continuum: The Role of Distance to Care on Retention and Viral Suppression. *AIDS and behavior*, *22*(9), 3009–3023. https://doi.org/10.1007/s10461-018-2103-8
[25] Summary Data for Ward: Ward 7. DC Health Matters. https://www.dchealthmatters.org/demographicdata?id=131494
[26] Coleman-Jensen, Alisha, Matthew P. Rabbitt, Christian A. Gregory, and Anita Singh. 2019. *Household Food Security in the United States in 2018*, ERR-270, U.S. Department of Agriculture, Economic Research Service.
[27] Spinelli, M. A., Frongillo, E. A., Sheira, L. A., Palar, K., Tien, P. C., Wilson, T., Merenstein, D., Cohen, M., Adedimeji, A., Wentz, E., Adimora, A. A., Metsch, L. R., Turan, J. M., Kushel, M. B., & Weiser, S. D. (2017). Food Insecurity is Associated with Poor HIV Outcomes Among Women in the United States. *AIDS and behavior*, 21(12), 3473–3477. https://doi.org/10.1007/s10461-017-1968-2
[28] File T, Marshall J. Household Pulse Survey Shows LGBT Adults More Likely to Report Living in Households With Food and Economic Insecurity Than Non-LGBT Respondents. U.S. Census Bureau. August 11, 2021. Accessed May 23, 2022. https://www.census.gov/library/stories/2021/08/lgbt-community-harder-hit-by-economic-impact-of-pandemic.html.
[29] Conron KJ, O'Neill KK. Food Insufficiency Among Transgender Adults During the COVID-19 Pandemic. UCLA School of Law, Williams Institute. December 2021. https://williamsinstitute.law.ucla.edu/wp-content/uploads/Trans-Food-Insufficiency-Dec-2021.pdf.
[30] Unpublished data, 2017 Metropolitan Washington Regional Ryan White Planning Council Unmet Needs Assessment: Consumer Survey and Provider Consultation Results; DC DOH HIV/AIDS, Hepatitis, STD and TB Administration
[31] Yehia BR, Stewart L, Momplaisir F, et al. Barriers and facilitators to patient retention in HIV care. *BMC Infect Dis.* 2015;15(246). doi:10.1186/s12879-015-0990-0.
[32] Smith LR, Fisher JD, Cunningham CO, Amico KR. Understanding the behavioral determinants of retention in HIV care: a qualitative evaluation of a situated information, motivation, behavioral skills model of care initiation and maintenance. *AIDS Patient Care STDS*. 2012;26(6):344-355. doi:10.1089/apc.2011.0388.
[33] Rajabiun S, Mallinson RK, McCoy K, et al. "Getting me back on track": the role of outreach interventions in engaging and retaining people living with HIV/AIDS in medical care. *AIDS Patient Care* STDS. 2007;21 Suppl 1:S20-S29. doi:10.1089/apc.2007.9990.

[34] Kimmel AD, Masiano SP, Bono RS, et al. Structural barriers to comprehensive, coordinated HIV care: geographic accessibility in the US South. *AIDS Care*. 2018;30(11):1459-1468. doi:10.1080/09540121.2018.1476656.
[35] Cunningham CO, Sohler NL, Wong MD, et al. Utilization of health care services in hard-to-reach marginalized HIV-infected individuals. *AIDS Patient Care STDS*. 2007;21(3):177-186. doi:10.1089/apc.2006.103.
[36] Rajabiun S, Mallinson RK, McCoy K, et al. "Getting me back on track": the role of outreach interventions in engaging and retaining people living with HIV/AIDS in medical care. *AIDS Patient Care* STDS. 2007;21 Suppl 1:S20-S29. doi:10.1089/apc.2007.9990.
[37] Remien RH, Stirratt MJ, Nguyen N, Robbins RN, Pala AN, Mellins CA. Mental health and HIV/AIDS: the need for an integrated response. *AIDS*. 2019;33(9):1411-1420. doi:10.1097/QAD.0000000000002227.
[38] SAMHSA-HRSA Center for Integrated Health Solutions. The Case for Behavioral Health Screening in HIV Care Settings. https://store.samhsa.gov/sites/default/files/d7/priv/sma16-4999.pdf. Published 2016. Accessed August 2021.
[39] National Center for Innovation in HIV Care. Addressing Organizational Barriers to HIV Care: Lessons Learned from AIDS United's Positive Charge Initiative. https://targethiv.org/sites/default/files/supporting-files/Barriers%20to%20Care%20Fact%20Sheet.pdf. Accessed July 2021.
[40] Centers for Disease Control and Prevention. HIV Stigma and Discrimination. June 1, 2021. Accessed October 15, 2021. https://www.cdc.gov/hiv/basics/hiv-stigma/index.html.
[41] Bazargan M, Cobb S, Assari S. Discrimination and Medical Mistrust in a Racially and Ethnically Diverse Sample of California Adults. *Ann Fam Med*. 2021;19(1):4-15. doi:10.1370/afm.2632.
[42] Saha S, Jacobs EA, Moore RD, Beach MC. Trust in physicians and racial disparities in HIV care. *AIDS Patient Care STDS*. 2010;24(7):415-420. doi:10.1089/apc.2009.0288.
[43] Armstrong K, Ravenell KL, McMurphy S, Putt M. Racial/ethnic differences in physician distrust in the United States. *Am J Public Health*. 2007;97(7):1283-1289. doi:10.2105/AJPH.2005.080762.
[44] Bogart LM, Takada S, Cunningham WE. Medical Mistrust, Discrimination, and the Domestic HIV Epidemic. In: Ojikutu B, Stone V (eds). *HIV in US Communities of Color*. Springer, Cham; 2021:207-231. doi:10.1007/978-3-030-48744-7_12.
[45] Heller J. Rumors and Realities: Making Sense of HIV/AIDS Conspiracy Narratives and Contemporary Legends. *Am J Public Health*. 2015;105(1):e43-e50. doi:10.2105/AJPH.2014.302284.
[46] Earnshaw VA, Bogart LM, Dovidio JF, Williams DR. Stigma and racial/ethnic HIV disparities: moving toward resilience. *Am Psychol*. 2013;68(4):225-236. doi:10.1037/a0032705.
[47] Centers for Disease Control and Prevention. HIV Stigma and Discrimination. June 1, 2021. Accessed October 15, 2021. https://www.cdc.gov/hiv/basics/hiv-stigma/index.html.
[48] Geter A, Herron AR, Sutton MY. HIV-Related Stigma by Healthcare Providers in the United States: A Systematic Review. *AIDS Patient Care STDS*. 2018;32(10):418-424. doi:10.1089/apc.2018.0114.
[49] Geter A, Herron AR, Sutton MY. HIV-Related Stigma by Healthcare Providers in the United States: A Systematic Review. *AIDS Patient Care STDS*. 2018;32(10):418-424. doi:10.1089/apc.2018.0114.
[50] Davtyan M, Olshansky EF, Brown B, Lakon C. A Grounded Theory Study of HIV-Related Stigma in U.S.-Based Health Care Settings. *J Assoc Nurses AIDS Care*. 2017;28(6):907-922. doi:10.1016/j.jana.2017.07.007
[51] Yang YT, Underhill K. Rethinking Criminalization of HIV Exposure — Lessons from California's New Legislation. *NEJM. 2*018;378:1174-1175. https://doi.org/10.1056/NEJMp1716981.
[52] The Center for HIV Law and Policy. HIV Criminalization in the United States: A Sourcebook on State and Federal HIV Criminal Law and Practice. August 2021. Accessed October 14, 2021. https://www.hivlawandpolicy.org/sourcebook.
[53] The Center for HIV Law and Policy. Map: HIV Criminalization in the United States. July 2020. Accessed October 14, 2021. https://www.hivlawandpolicy.org/resources/map-hiv-criminalization-united-states-center-hiv-law-and-policy-updated-july-2020.
[54] Onyeabor OS, Iriemenam N, Adekeye OA, Rachel SA. The effect of educational attainment on HIV testing among African Americans. *J Health Care Poor Underserved*. 2013;24(3):1247-1256. doi:10.1353/hpu.2013.0113
[55] Chandran A, Edmonds A, Benning L, et al. Longitudinal Associations Between Neighborhood Factors and HIV Care Outcomes in the WIHS. *AIDS Behav*. 2020;24(10):2811-2818. doi:10.1007/s10461-020-02830-4
[56] Ma Z-qiang, Fisher MA, Kuller LH. School-based HIV/AIDS Education is Associated with Reduced Risky Sexual Behaviors and Better Grades with Gender and Race/Ethnicity Differences. *Health Education Research*. 2014;29(2):330-339. doi:10.1093/her/cyt110
[57] HIV and AIDS in the United States of America (USA). Avert. https://www.avert.org/professionals/hiv-around-world/western-central-europe-north-america/usa. Published July 2019. Accessed October 15, 2021.

[58] Raifman J, Beyrer C, Arrington-Sanders R. HIV Education and Sexual Risk Behaviors Among Young Men Who Have Sex with Men. *LGBT Health*. 2018;5(2):131-138. doi:10.1089/lgbt.2017.0076

[59] Raifman J, Beyrer C, Arrington-Sanders R. HIV Education and Sexual Risk Behaviors Among Young Men Who Have Sex with Men. *LGBT Health*. 2018;5(2):131-138. doi:10.1089/lgbt.2017.0076

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

Table of Contents

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.[1] This national decrease in diagnoses isis due in large part to the COVID-19 epidemic, which disrupted clinical care services andcreated 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%[2] 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.[3,4]

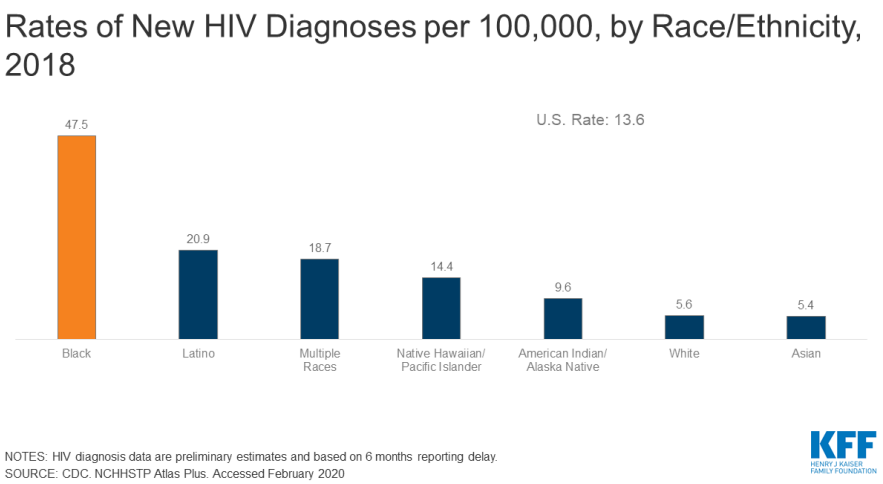
Similar disparities exist in HIV prevalence and survivorship. Among the estimated 1.2 million people living with HIV (PLWH) in the United States in 2019,[5] Black, Multiracial, and Hispanic people are disproportionately represented, with HIV rates three to seven times higher than in white people. Black,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

Key Definitions

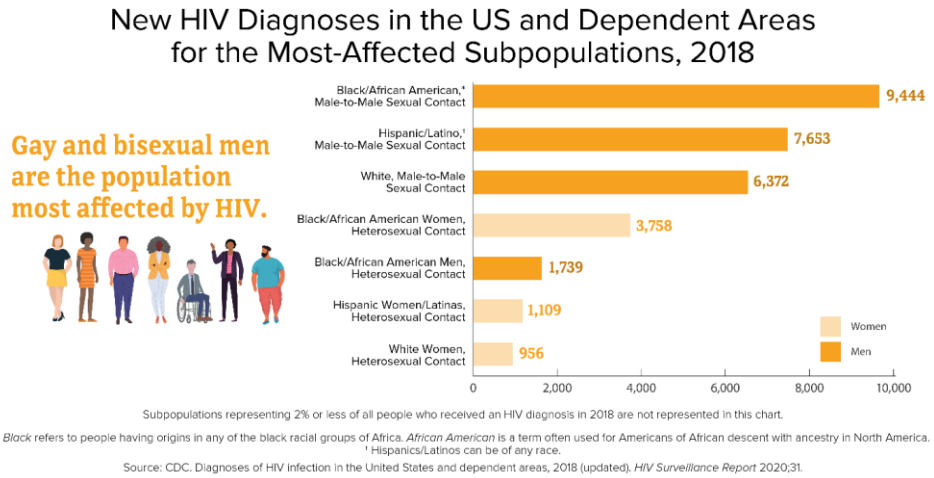
Equity: A condition wherein all people have access to the resources and opportunities they need regardless of socially defined circumstances, like race, gender, or class. Equity is different from equality: an "equality approach" involves providing the same resources and opportunities to all people, but 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).



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:



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.[6]

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 in2021 were Black,[7] as were 83% of those newly diagnosed in Prince George's County in 2019.[8]
- 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,[9] and 46.2% of diagnoses in Frederick County, Maryland.[10]
- 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.[11,12]

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).[13] 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.[14] 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.[15,16,17]

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.[18]

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

Measure	Ward 3	Ward 8
Attended College[1]	94.1%	45.5%
Median Household Income[1]	$136,832	$34,824
Child Poverty[1]	2.9%	48.5%
Families Below Poverty with Children[1]	1.3%	25.4%
%Black[1]	5.4%	92.1%
%Latino[1]	9.5%	2.8%
%Unemployed[1]	2.9%	18.5%
Public Health Insurance[2]	18.7%	64.6%
Gross Rent as Percentage of Household Income (35% or more)[2]	33.8%	53.9%
Grandparents Responsible for Grandchildren[2]	16.0%	47.3%
Civilian Population with Disability[2]	5.9%	17.8%
Adult Asthma Prevalence[3]	11.6%	13.1%
Adults with Hypertension[4]	19.7%	42.2%
Adults with Depression[3]	14.7%	16.3%
Adults with Diabetes[3]	4.8%	14.5%
Adults who are Overweight or Obese[3]	44.9%	70.0%
Adults with Difficulty Remembering or Concentrating[3]	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. 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.[19] Employment is also positively associated with access to HIV testing, linkage to HIV care, retention in HIV care, and medication adherence,[20] which is an important factor in maintaining optimal health for both PLWH and people at risk of HIV infection.[21,22] Additionally, working full time can provide access to benefits such as health insurance and paid sick leave.[23,24] Employer-sponsored insurance can provide a safety net for PLWH because health costs can be a source of stress for individuals.[25,26] 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.[27]

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.[28] These workers often experience hazardous job conditions,[29] threats of immigration enforcementactions,[30] low wages,[31] and wage theft.[32]

Employment and HIV

Research suggests that PLWH experience unemployment at three times the national rate.[33] Reasons for unemployment can include stigma, restrictive hiring policies, and the physical and neurological effects of disease progression.[34] With higher rates of unemployment, PLWH experience higher rates of depression, anxiety, social isolation, and low self-esteem.[35] 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.[36] HIV-related barriers to employment include physical symptoms of HIV, HIV-related illness, side effects of medication, the burden of HIV regimes, and frequent medical visits.[37]

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.[38]

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.[39]

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.[40]

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

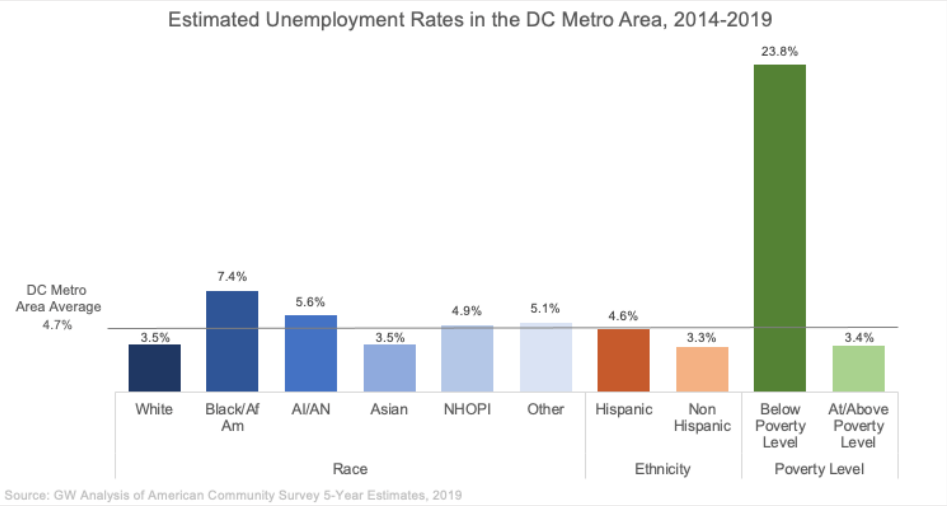


Figure 2 Definitions and Acronyms
Black/Af Am: Black/African American
AI/AN: American Indian/Alaska Native
NHOPI: Native Hawaiian or Other Pacific Islander
Hispanic: Hispanic/Latinx, any race
Non-Hispanic: Non-Hispanic White

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.[41] 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.[42]

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.[43] 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.[44] Additionally, unstable housing can result in employment or education disruptions, higher medical costs, and decreased medication adherence.[45]

Housing and HIV

The availability of adequate and affordable housing for PLWH has been a concern since the onset of the HIV epidemic.[46] 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.[47,48,49,50] 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.[51,52] Unfortunately, PLWH experience homelessness at a rate three times higher than the general population,[53] due in part to the costs of HIV care and higher rates of unemployment.[54] Among HIV-negative people who inject drugs, homelessness and housing insecurity are associated with higher risk of HIV infection.[55]

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.[56,57] 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.[58] 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.[59] 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.[60]

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.[61] 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.[62] HOPWA provides three tiers of services for those seeking housing assistance including permanent supportive housing, long-term rental assistance, and housing placement assistance.[63]

The DC EMA 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.[64] 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.

The Ryan White program also enables localities to offer short-term, transitional, and emergency housing assistance for PLWH, including short-term supportive housing, short-term rental assistance, and housing placement assistance.[65] Ryan White-funded housing assistance in the DC EMA is available to people living with HIV, regardless of their immigration status. 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. Currently, the program provides case management for 300 voucher holders in Washington, DC, and Prince George's County, Maryland. 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.

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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.[66] 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.[67]

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.[68]

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.[69] 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.[70] 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.[71] 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),[72] 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).[73]

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.[74] 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 nonemergency 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.[75] DC, Maryland, and Virginia also offer free, at-home HIV testing kits[76, 77] 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. [78] 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.[79]

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:

<u>Federal, State, and Local Policies</u>
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 home-based 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

<u>Service Delivery and Programming</u>
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.[80] 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.[81]

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.[82] In addition, women, seniors, children, and Black and Latinx individuals report higher levels of food insecurity.[83]

Food Insecurity and HIV

Food insecurity affects about 11% of all Americans,[84] but between a quarter to a half of all PLWH.[85] The relationship between HIV and food insecurity is interdependent.[86] 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.[87] 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.[88] 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.[89,90]

In 2020, approximately 10.5% of households (13.8 million households) were food insecure.[91] One study found that more than one in three DC residents living with HIV did not have enough money for food or other necessities.[92] 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.[93] 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%.[94]

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.[95,96, 97,98,99,100]

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.[101] 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.[102]

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.[103] 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.[104]

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:

<u>Federal, State, and Local Policies</u>
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

<u>Service Delivery and Programming</u>
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.[105,106,107,108,109,110]

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.[111,112,113,114] 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.[115,116] 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.[117]

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.[118] People with HIV also experience high rates of substance use disorder (SUD) and are more likely to have a history of trauma.[119] 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.[120,121] 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.[122] Likewise, formerly incarcerated individuals,[123,124] people experiencing homelessness,[125,126,127] immigrants,[128] veterans,[129] and youth[130,131] 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.[132] Furthermore, having health insurance is associated with increased awareness of one's HIV status;[133] a better chance of sustained viral suppression;[134] less frequent and shorter hospital stays;[135] and lower death rates.[136] Among people vulnerable to HIV infection, having health insurance is associated with increased pre-exposure prophylaxis (PrEP) use.[137] 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.[138]

However, people of color–specifically, Native Americans, Black people, and Hispanic/Latinx people– remain more likely to be uninsured.[139] 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.[140] 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.[141,142] Finally, people of color are more likely to be among the uninsured population in states that have not expanded Medicaid.[143]

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.[144] This feat was likely achieved thanks to the District's generous Medicaid eligibility standards[145,146] and insurance programs for undocumented residents.[147,148] However, in Maryland, Virginia, and West Virginia, the income eligibility level for Medicaid is lower[149] 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.[150]

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.[151] 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).[152] 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.[153,154]

As of 2021, 971 foreign-born individuals are living with HIV in DC and immigrant populations represented approximately 12% of HIV cases in Maryland.[155,156] 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.[157] 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

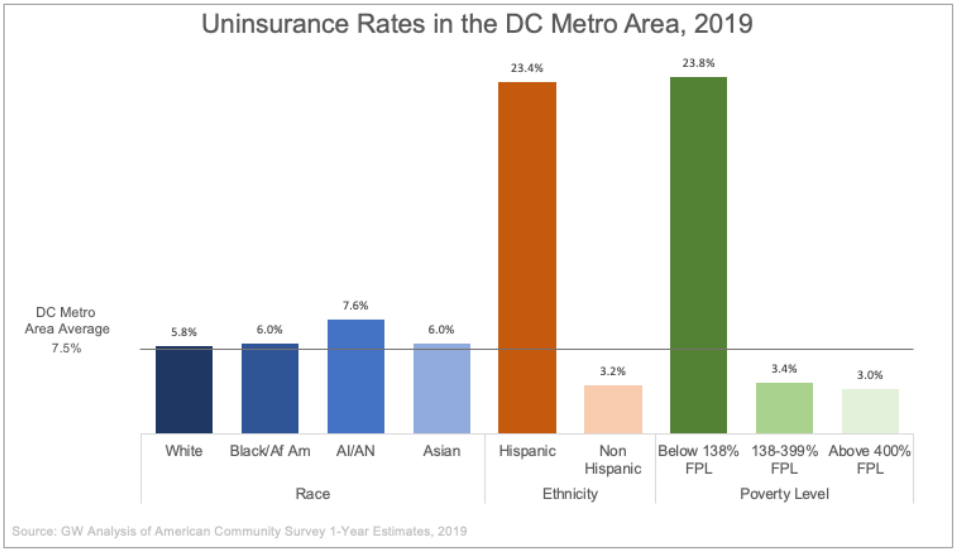

Figure 3 Definitions and Acronyms
Black/Af Am: Black/African American
AI/AN: American Indian/Alaska Native
Hispanic: Hispanic/Latinx, any race
Non-Hispanic: Non-Hispanic White
FPL: Federal Poverty Level
Data on the insurance status of Native Hawaiians or Other Pacific Islanders were not available
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As 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.[158,159] Residents of Wards 7 and 8 also reported numerous barriers to utilizing mental health services, including fear and distrust of the medical system.[160]

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.[161] 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.[162]

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.[163] 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.[164] 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.[165]

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.[166] These insurance plans cover preventive care, office visits, prescription drugs, and lab services without cost-sharing.[167,168] However, no such programs are available in Maryland, Virginia, or West Virginia.[169] In Maryland, Virginia, and West Virginia,[170] 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.[171,172,173,174] DC[175] and Virginia[176] have also used local funds for PrEP drug access programs (DAPs).

COHAH Principles and Positions on Medical Care

<u>Federal, State, and Local Policies</u>
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

<u>Service Delivery and Programming</u>
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.[177] 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.[178]

Rates of medical mistrust are higher among Black and Latinx communities,[179,180,181] reflecting personal and generational experiences of mistreatment and racism.[182] 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.[183] 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.[184]

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).[185,186] 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.[187] 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.[188,189,190,191]

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.[192,193] 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.[194]

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[195] and can lead to skepticism toward medical advice.[196] 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,[197,198]
- decreased comfort talking to a health care provider about PrEP among Black women,[199]

- gaps in routine health care among Black MSM,[200] and
- poorer ART adherence among Black men and women.[201,202,203]

Among Latino sexual minority men, medical mistrust has been associated with decreased PrEP awareness, willingness, use, and adherence.[204]

HIV Stigma

HIV stigma refers to negative attitudes and beliefs about PLWH [205] 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.[206] 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.[207,208]

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.[209] Outside of health care settings, laws that criminalize HIV transmission contribute to HIV stigma and discrimination and are ineffective in preventing HIV transmission.[210] 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.[211,212]

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.[213,214,215,216]

Among HIV-negative individuals, impacts of HIV stigma include reduced HIV preventive behaviors and reluctance to seek HIV testing.[217,218]

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

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highlighted HIV stigma and racism as key barriers to HIV care.[219,220,221,222] 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.[223] 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.[224] 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.[225] In Montgomery County, HIV capacity-building training and technical assistance to social services programs will emphasize HIV stigma and intersectional cultural humility.[226] 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.[227]

COHAH Principles and Positions on Medical Mistrust and HIV

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.[228] 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.[229] 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.[230]

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.[231] 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.[232]

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 ofiDC,[233] only 2% of residents lack a high school diploma.[234] In contrast, in Ward 8, whichhas high rates of HIV,[235] about 17% of residents lack a high school diploma.[236] 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.[237] 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.[238] 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.[239] Comprehensive sex education has been shown to reduce sexual risk behaviors, such as unprotected sex and having sex with multiple partners.[240]

However, not all states require comprehensive sex education in schools.[241] 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.[242] 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.[243]

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.[244,245] 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.[246] Between 2016-2020, young people ages 13-24 accounted almost 19% of new HIV diagnoses in DC,[247] 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.[248, 249]

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.[250] DC Health also launched its "Sex Is…" campaign in 2017 to combat stigma surrounding sex education and spread sex positivity.[251] 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.[252]

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:

<u>Federal, State, and Local Policies</u>
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 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.

Appendix A: National HIV Disparities

HIV in the United States, 2020

Race/ Ethnicity	Population	New HIV Diagnoses	Rate of New HIV Diagnoses†	PLWH	PLWH Rate†	Deaths	Death Rate†
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

† 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**
Washington, DC	**147**	**32**	**24**	**27**	**230**
Suburban Maryland	**≥353**	**≥67**	**≥6**	—	**475**
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
Northern Virginia	**99**	**36**	**36**	**1**	**172**
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://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**
Washington, DC	**8,448**	**1000**	**1,767**	**689**	**11,904**
Suburban Maryland	**9,854**	**1,352**	**1,136**	**752**	**13,094**
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
Northern Virginia	**4,470**	**1,573**	**3,102**	**216**	**9,361**
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, 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

[1] Bosh KA, Hall HI, Eastham L, Daskalakis DC, Mermin JH. Estimated Annual Number of HIV Infections — United States, 1981–2019. MMWR Morb Mortal Wkly Rep 2021;70:801–806. DOI: http://dx.doi.org/10.15585/mmwr.mm7022a1.
[2] Centers for Disease Control and Prevention. HIV Surveillance Report, 2020; vol.33. http://www.cdc.gov/hiv/library/reports/hiv-surveillance.html. Published May 2022. Accessed December 22, 2022
[3] Centers for Disease Control and Prevention. HIV Surveillance Report, 2020; vol.33. http://www.cdc.gov/hiv/library/reports/hiv-surveillance.html. Published May 2021. Accessed December 22, 2022
[4] https://www.cdc.gov/nchhstp/healthdisparities/asians.html
[5] https://www.hiv.gov/hiv-basics/overview/data-and-trends/statistics
[6] Centers for Disease Control and Prevention. HIV Infection, Risk, Prevention, and Testing Behaviors Among Transgender Women—National HIV Behavioral Surveillance, 7 U.S. Cities, 2019–2020. HIV Surveillance Special Report 27. http://www.cdc.gov/hiv/library/reports/hiv-surveillance.html. Published April 2021. Accessed June 15, 2021.
[7] District of Columbia Department of Health, HIV/AIDS, Hepatitis, STD, and TB Administration (HAHSTA). Annual Epidemiology & Surveillance Report: Data Through December 2021. https://dchealth.dc.gov/sites/default/files/dc/sites/doh/publication/attachments/2022-Annual-Surveillance-Report_0.pdf
[8] https://phpa.health.maryland.gov/OIDEOR/CHSE/SiteAssets/Pages/County-Data-Sheets/Prince-George%27s-County-Fact-Sheet99.pdf
[9] https://phpa.health.maryland.gov/OIDEOR/CHSE/SiteAssets/Pages/County-Data-Sheets/Montgomery-County-Fact-Sheet2.pdf
[10] https://phpa.health.maryland.gov/OIDEOR/CHSE/SiteAssets/Pages/County-Data-Sheets/Frederick-County-Fact-Sheet2.pdf
[11] Virginia HIV Epidemiology Profile. *Persons Living With HIV.* Data Reported from 2018. 2021. https://www.vdh.virginia.gov/content/uploads/sites/10/2020/10/Persons-Living-with-HIV-2018.pdf
[12] Virginia HIV Surveillance Annual Report. Data Reported 2020-2021. 2022. https://www.vdh.virginia.gov/content/uploads/sites/10/2022/05/HIV-Annual_Report_Update_2021.pdf
[13] DC Health Matters Collaborative. Community Health Needs Assessment, District of Columbia, 2019. https://www.dchealthmatters.org/content/sites/washingtondc/2019_DC_CHNA_FINAL.pdf. Published June 28, 2019. Accessed July 2021.
[14] Woolf SH, Chapman DA, Lee, JH, Kelley L, Cohen SA. A Study in Contrasts: Why Life Expectancy Varies In Northern Virginia. Virginia Commonwealth University, Center on Society and Health. June 2016. Accessed September 21, 2021. https://novahealthfdn.org/wp-content/uploads/csh-nova-report-v10.pdf.
[15] Brink-Johnson A, Lubin J. Structural Racism in Washington, DC: Facts, Figures & Opportunities for Advancing Racial Equity. Center for Urban and Racial Equity. https://urbanandracialequity.org/wp-content/uploads/2020/08/Structural-Racism-in-Washington-DC-1.pdf. Published August 19, 2020. Accessed July 2021.
[16] Virginia Department of Health. COVID-19 Disparities by Race and Ethnicity in Virginia. https://www.vdh.virginia.gov/coronavirus/2021/03/08/covid-19-disparities-by-race-and-ethnicity-in-virginia. Published March 8, 2021. Accessed July 2021.
[17] The COVID Tracking Project. Maryland: All Race & Ethnicity Data. https://covidtracking.com/data/state/maryland/race-ethnicity. Updated March 7, 2021. Accessed July 2021.
[18] DC Health. Report on the Health of the Lesbian, Gay, Bisexual and Transgender (LGBT) Community in the District of Columbia. https://dchealth.dc.gov/sites/default/files/dc/sites/doh/publication/attachments/LGBT%20Health%20in%20the%20District%20of%20Columbia.pdf. Accessed July 2021.
[19] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7716244/
[20] https://archpublichealth.biomedcentral.com/articles/10.1186/2049-3258-72-37
[21]Schaecher KL. The importance of treatment adherence in HIV. *Am J Manag Care*. 2013;19(12 Suppl):s231-s237
[22] Pre-exposure Prophylaxis (PrEP). Centers for Disease Control and Prevention. https://www.cdc.gov/hiv/effective-interventions/prevent/prep/index.html. Published September 10, 2020. Accessed July 15, 2021.
[23] Published: Dec 14 2020. Paid Family and Sick Leave in the U.S. KFF. https://www.kff.org/womens-health-policy/fact-sheet/paid-family-leave-and-sick-days-in-the-u-s/. Published December 22, 2020. Accessed July 2021.

[24] Paid Sick Leave to Protect Income, Health and Jobs through the COVID-19 Crisis. *OECD Policy Responses to Coronavirus (COVID-19)*. 2020. doi:10.1787/a9e1a154-en
[25] Paid Sick Leave to Protect Income, Health and Jobs through the COVID-19 Crisis. *OECD Policy Responses to Coronavirus (COVID-19)*. 2020. doi:10.1787/a9e1a154-en
[26] Published: Dec 14 2020. Paid Family and Sick Leave in the U.S. KFF. https://www.kff.org/womens-health-policy/fact-sheet/paid-family-leave-and-sick-days-in-the-u-s/. Published December 22, 2020. Accessed July 2021.
[27] Reif S, Mugavero M, Raper J, et al. Highly stressed: stressful and traumatic experiences among individuals with HIV/AIDS in the Deep South. *AIDS Care*. 2011;23(2):152-162. doi:10.1080/09540121.2010.498872
[28] Budiman A. Key findings about U.S. immigrants. Pew Research Center. August 20, 2020. https://www.pewresearch.org/fact-tank/2020/08/20/key-findings-about-u-s-immigrants/.
[29] Hall M, Greenman E. The Occupational Cost of Being Illegal in the United States: Legal Status, Job Hazards, and Compensating Differentials. Int Migr Rev. 2015;49(2):406-442. doi:10.1111/imre.12090.
[30] Khouri A. More Workers Are Saying Their Bosses Are Threatening to Have Them Deported. *Los Angeles Times.* January 2, 2018. https://www.latimes.com/business/la-fi-immigration-retaliation-20180102-story.html.
[31] Ortega F, Hsin A. Discussion Paper: Occupational Barriers and the Labor Market Penalty from Lack of Legal Status. IZA Institute of Labor Economics. July 2018. https://docs.iza.org/dp11680.pdf.
[32] Ferriss S, Yerardi J. Wage theft hits immigrants — hard. The Center for Public Integrity. October 14, 2021. https://publicintegrity.org/inequality-poverty-opportunity/workers-rights/cheated-at-work/garment-immigrant-workers-wage-theft/.
[33] People Living With HIV. The GAP Report 2014. https://www.unaids.org/sites/default/files/media_asset/01_PeoplelivingwithHIV.pdf.
[34] People Living With HIV. The GAP Report 2014. https://www.unaids.org/sites/default/files/media_asset/01_PeoplelivingwithHIV.pdf.
[35] Blalock AC, Stephen Mcdaniel J, Farber EW. Effect of Employment on Quality of Life and Psychological Functioning in Patients With HIV/AIDS. *Psychosomatics*. 2002;43(5):400-404. doi:10.1176/appi.psy.43.5.400
[36] Maulsby CH, Ratnayake A, Hesson D, Mugavero MJ, Latkin CA. A Scoping Review of Employment and HIV. *AIDS Behav*. 2020;24(10):2942-2955. doi:10.1007/s10461-020-02845-x
[37] Maulsby CH, Ratnayake A, Hesson D, Mugavero MJ, Latkin CA. A Scoping Review of Employment and HIV. AIDS Behav. 2020;24(10):2942-2955. doi:10.1007/s10461-020-02845-x
[38] Maulsby CH, Ratnayake A, Hesson D, Mugavero MJ, Latkin CA. A Scoping Review of Employment and HIV. *AIDS Behav*. 2020;24(10):2942-2955. doi:10.1007/s10461-020-02845-x
[39] Maulsby CH, Ratnayake A, Hesson D, Mugavero MJ, Latkin CA. A Scoping Review of Employment and HIV. *AIDS Behav*. 2020;24(10):2942-2955. doi:10.1007/s10461-020-02845-x
[40] Benson C, Wang X, Dunn KJ, et al. Antiretroviral Adherence, Drug Resistance, and the Impact of Social Determinants of Health in HIV-1 Patients in the US. *AIDS Behav*. 2020;24(12):3562-3573. doi:10.1007/s10461-020-02937-8
[41]https://doh.dc.gov/sites/default/files/dc/sites/doh/service_content/attachments/DC%20DOH%20INTEGRATED%20PLAN_FINAL.pdf.pdf
[42] https://linku.auntbertha.com/work/job-placement--washington-dc?cursor=0&postal=20009&filters=%7B%22attribute_tags%22%3A+%5B%22chronic+illness%22%5D%7D&claredfilter=1
[43] Taylor L. Housing And Health: An Overview Of The Literature: Health Affairs Brief. *Health Affairs.* https://www.healthaffairs.org/do/10.1377/hpb20180313.396577/full/. Published June 7, 2018.
[44] Taylor L. Housing And Health: An Overview Of The Literature: Health Affairs Brief. *Health Affairs*. https://www.healthaffairs.org/do/10.1377/hpb20180313.396577/full/. Published June 7, 2018.
[45] Taylor L. Housing And Health: An Overview Of The Literature: Health Affairs Brief. *Health Affairs*. https://www.healthaffairs.org/do/10.1377/hpb20180313.396577/full/. Published June 7, 2018.
[46] Perl L. Housing for persons living with HIV/AIDS. Congressional Research Service. https://www.everycrsreport.com/files/20120703_RL34318_f2e59db79b12ef41ef21981daec1b97ff7027f6a.pdf. Published July 3, 2012. Accessed July 2021.
[47] Aidala AA, Wilson MG, Shubert V, et al. Housing Status, Medical Care, and Health Outcomes Among People Living With HIV/AIDS: A Systematic Review. *Am J Public Health*. 2016;106(1):e1-e23. doi:10.2105/AJPH.2015.302905.
[48] Aquino G, Byrne M, Dorsey K, et al. Examining Retention in HIV Care and HIV Suppression on Housing Services Intake at a Washington, DC Community Based Organization. *J Community Health.* 2021. https://doi.org/10.1007/s10900-020-00959-w

[49] Thakarar K, Morgan JR, Gaeta JM, Hohl C, Drainoni ML. Homelessness, HIV, and Incomplete Viral Suppression. *J Health Care Poor Underserved*. 2016;27(1):145-156. doi:10.1353/hpu.2016.0020
[50] Milloy MJ, Marshall BD, Montaner J, Wood E. Housing status and the health of people living with HIV/AIDS. *Curr HIV/AIDS Rep*. 2012;9(4):364-374. doi:10.1007/s11904-012-0137-5
[51] Milloy MJ, Marshall BD, Montaner J, Wood E. Housing status and the health of people living with HIV/AIDS. *Curr HIV/AIDS Rep*. 2012;9(4):364-374. doi:10.1007/s11904-012-0137-5
[52] Hawk M, Davis D. The effects of a harm reduction housing program on the viral loads of homeless individuals living with HIV/AIDS. *AIDS Care*. 2012;24(5):577-582. doi:10.1080/09540121.2011.630352.
[53] National Alliance to End Homelessness. Health. https://endhomelessness.org/homelessness-in-america/what-causes-homelessness/health/. Accessed July 2021.
[54] Lennon CA, Pellowski JA, White AC, et al. Service priorities and unmet service needs among people living with HIV/AIDS: Results from a nationwide interview of HIV/AIDS housing organizations. *AIDS Care*. 2013;25(9), 1083–1091. doi:10.1080/09540121.2012.749337.
[55] Arum C, Fraser H, Artenie AA, et al. Homelessness, unstable housing, and risk of HIV and hepatitis C virus acquisition among people who inject drugs: a systematic review and meta-analysis. *The Lancet Public Health.* 2021;6(5):E309-E323. doi:10.1016/S2468-2667(21)00013-X.
[56] Brink-Johnson A, Lupin J. Structural Racism in Washington, DC Facts Figures and Opportunities for Advancing Racial Equity. https://urbanandracialequity.org/wp-content/uploads/2020/08/Structural-Racism-in-Washington-DC-1.pdf. Published August 19, 2020. Accessed July 2021.
[57] Aquino G, Byrne M, Dorsey K, et al. Examining Retention in HIV Care and HIV Suppression on Housing Services Intake at a Washington, DC Community Based Organization. *J Community Health.* 2021. https://doi.org/10.1007/s10900-020-00959-w.
[58] Hughes E. Unequal Burden Low-Income Northern Virginians face the country's most severe housing cost burden. The Center for Community Research at the Community Foundation for Northern Virginia. January 2021. Accessed September 27, 2021. https://www.cfnova.org/images/communityreports/InsightRegion_UnequalBurden_Copyright2021.pdf.
[59] Maryland Department of Housing and Community Development. Maryland Housing Needs Assessment & 10-Year Strategic Plan. December 2020. Accessed September 27, 2021. https://dhcd.maryland.gov/Documents/Other%20Publications/Report.pdf.
[60] Brink-Johnson A, Lupin J. Structural Racism in Washington, DC Facts Figures and Opportunities for Advancing Racial Equity. https://urbanandracialequity.org/wp-content/uploads/2020/08/Structural-Racism-in-Washington-DC-1.pdf. Published August 19, 2020. Accessed July 2021.
[61] Housing opportunities for persons with AIDS. U.S. Department of Housing and Urban Development Web site. https://www.hudexchange.info/programs/hopwa. Accessed Sep 27, 2021.
[62] HOPWA eligibility requirements. U.S. Department of Housing and Urban Development Web site. https://www.hudexchange.info/programs/hopwa/hopwa-eligibility-requirements. Accessed Sep 27, 2021.
[63] Housing opportunities for persons with AIDS. U.S. Department of Housing and Urban Development Web site. https://www.hudexchange.info/programs/hopwa. Accessed Sep 27, 2021.
[64] DC Health. HAHTSA/HOPWA Program. Accessed February 15, 2022. https://dchealth.dc.gov/HOPWA-HOUSING.
[65] Housing Opportunities for Persons With AIDS.U.S. Department of Housing and Urban Development. https://www.hudexchange.info/programs/hopwa/. Accessed February 15, 2022
[66] Baxter AJ, Tweed EJ, Katikireddi SV, Thomson H. Effects of Housing First approaches on health and well-being of adults who are homeless or at risk of homelessness: systematic review and meta-analysis of randomized controlled trials. *J Epidemiol Community Health*. 2019;73(5):379-387. doi:10.1136/jech-2018-210981.
[67] Housing and Health. HIV.gov website. https://www.hiv.gov/hiv-basics/living-well-with-hiv/taking-care-of-yourself/housing-and-health
[68] Health Research & Educational Trust. (2017, November). *Social determinants of health series: Transportation and the role of hospitals*. Chicago, IL: Health Research & Educational Trust. Accessed at www.aha.org/transportation
[69] [3] Lynda M. Sagrestano, Joy Clay, Ruthbeth Finerman, Jennifer Gooch & Melanie Rapino (2014) Transportation vulnerability as a barrier to service utilization for HIV-positive individuals, AIDS Care, 26:3, 314-319, DOI: 10.1080/09540121.2013.819403
[70] Terzian, A. S., Younes, N., Greenberg, A. E., Opoku, J., Hubbard, J., Happ, L. P., Kumar, P., Jones, R. R., Castel, A. D., & DC Cohort Executive Committee (2018). Identifying Spatial Variation Along the HIV Care Continuum:

The Role of Distance to Care on Retention and Viral Suppression. *AIDS and behavior*, *22*(9), 3009–3023. https://doi.org/10.1007/s10461-018-2103-8

[71] Lazo, L and Guskin, E. "The car is still king in the Washington region, poll finds" (2019). *The Washington Post*. https://www.washingtonpost.com/local/trafficandcommuting/the-car-is-still-king-in-the-washington-region-post-shar-school-poll-finds/2019/06/06/106ce1b4-86df-11e9-a491-25df61c78dc4_story.html

[72] Summary Data for Ward: Ward 7. DC Health Matters. https://www.dchealthmatters.org/demographicdata?id=131494

[73] Terzian, A. S., Younes, N., Greenberg, A. E., Opoku, J., Hubbard, J., Happ, L. P., Kumar, P., Jones, R. R., Castel, A. D., & DC Cohort Executive Committee (2018). Identifying Spatial Variation Along the HIV Care Continuum: The Role of Distance to Care on Retention and Viral Suppression. *AIDS and behavior*, *22*(9), 3009–3023. https://doi.org/10.1007/s10461-018-2103-8.

[74] Ryan White HIV/AIDS Program Services: Eligible Individuals & Allowable Uses of Funds (2018). Policy Clarification Notice (PCN) #16-02. https://ryanwhite.hrsa.gov/sites/default/files/ryanwhite/grants/service-category-pcn-16-02-final.pdf

[75] PRIORITY SETTING AND RESOURCE ALLOCATION (PSRA) PLAN (2018). Metropolitan Washington Regional Ryan White Planning Council. https://doh.dc.gov/sites/default/files/dc/sites/doh/service_content/attachments/GY27-FY17%20PSRA%20Plan.pdf

[76] GetCheckedDC. Get Your Test. Accessed April 20, 20222. https://www.getcheckeddc.org/

[77] Virginia Department of Health, Division of Disease Prevention, and Maryland Department of Health, Center for HIV Prevention and Health Services. Virginia & Maryland Home HIV Testing Program. Accessed April 20, 2022. https://redcap.vdh.virginia.gov/redcap/surveys/?s=77W7DKHHKJ.

[78] "District of Columbia Eligible Metropolitan Area (EMA) Integrated HIV/AIDS Prevention and Care Plan" (2017-2021). *DC Department of Health (DC DOH) HIV/AIDS, Hepatitis, STD, and TB Administration (HAHSTA)*. https://doh.dc.gov/sites/default/files/dc/sites/doh/service_content/attachments/DC%20DOH%20INTEGRATED%20PLAN_FINAL.pdf.pdf

[79] Koay WLA, Prabhakar S, Neilan A, Meyers J, Lee N, Rakhmanina N. Brief Report: Supporting Access to HIV Care for Children and Youth During the COVID-19 Pandemic With Telemedicine and Rideshare. J Acquir Immune Defic Syndr. 2021 Dec 1;88(4):384-388. doi: 10.1097/QAI.0000000000002792. PMID: 34710072; PMCID: PMC8547581.

[80] Friel, S., Ford, L. Systems, food security and human health. *Food Sec*. 7, 437–451 (2015). https://doi.org/10.1007/s12571-015-0433-1

[81] Friel, S., Ford, L. Systems, food security and human health. *Food Sec*. 7, 437–451 (2015). https://doi.org/10.1007/s12571-015-0433-1

[82] "Public Charge was Reversed— But Not Enough Immigrant Families Know (2021). Accessed May 23, 2022. https://www.nokidhungry.org/sites/default/files/2021-12/NKH_Public%20Charge_Micro-Report_English_0.pdf

[83] Friel, S., Ford, L. Systems, food security and human health. *Food Sec*. 7, 437–451 (2015). https://doi.org/10.1007/s12571-015-0433-1

[84] Coleman-Jensen, Alisha, Matthew P. Rabbitt, Christian A. Gregory, and Anita Singh. 2019. *Household Food Security in the United States in 2018*, ERR-270, U.S. Department of Agriculture, Economic Research Service.

[85] Spinelli, M. A., Frongillo, E. A., Sheira, L. A., Palar, K., Tien, P. C., Wilson, T., Merenstein, D., Cohen, M., Adedimeji, A., Wentz, E., Adimora, A. A., Metsch, L. R., Turan, J. M., Kushel, M. B., & Weiser, S. D. (2017). Food Insecurity is Associated with Poor HIV Outcomes Among Women in the United States. *AIDS and behavior*, 21(12), 3473–3477. https://doi.org/10.1007/s10461-017-1968-2

[86] Anema, A., Fielden, S.J., Castleman, T. *et al.* Food Security in the Context of HIV: Towards Harmonized Definitions and Indicators. *AIDS Behav* **18,** 476–489 (2014). https://doi.org/10.1007/s10461-013-0659-x

[87] Anema, A., Fielden, S.J., Castleman, T. *et al.* Food Security in the Context of HIV: Towards Harmonized Definitions and Indicators. *AIDS Behav* 18, 476–489 (2014). https://doi.org/10.1007/s10461-013-0659-x

[88] Spinelli, M. A., Frongillo, E. A., Sheira, L. A., Palar, K., Tien, P. C., Wilson, T., Merenstein, D., Cohen, M., Adedimeji, A., Wentz, E., Adimora, A. A., Metsch, L. R., Turan, J. M., Kushel, M. B., & Weiser, S. D. (2017). Food Insecurity is Associated with Poor HIV Outcomes Among Women in the United States. *AIDS and behavior*, 21(12), 3473–3477. https://doi.org/10.1007/s10461-017-1968-2

[89] File T, Marshall J. Household Pulse Survey Shows LGBT Adults More Likely to Report Living in Households With Food and Economic Insecurity Than Non-LGBT Respondents. U.S. Census Bureau. August 11, 2021. Accessed May 23, 2022. https://www.census.gov/library/stories/2021/08/lgbt-community-harder-hit-by-economic-impact-of-pandemic.html.

[90] Conron KJ, O'Neill KK. Food Insufficiency Among Transgender Adults During the COVID-19 Pandemic. UCLA School of Law, Williams Institute. December 2021. https://williamsinstitute.law.ucla.edu/wp-content/uploads/Trans-Food-Insufficiency-Dec-2021.pdf.
[91] Alisha Coleman-Jensen, Matthew P. Rabbitt, Christian A. Gregory, and Anita Singh. 2021. Household Food Security in the United States in 2020, ERR-298, U.S. Department of Agriculture, Economic Research Service.
[92] Kharfen, M., Barnes, C., Lago, L., Dwyer, G., Horton, K., & Seiler, N. (2020). New Reimbursement and Integrated Planning: Policy Approaches to Reduce the Morbidity, Mortality, and Incidence of HIV in Washington, DC. Public Health Reports, 135(1_suppl), 19S-24S. https://doi.org/10.1177/0033354920915446
[93] Food Access & Food Security in the District of Columbia: Responding to the COVID-19 Public Health Emergency. *DC Food Policy Council*. https://dcfoodpolicycouncilorg.files.wordpress.com/2020/09/food-food-security-report-executive-summary-final.pdf
[94] https://dcfoodpolicycouncilorg.files.wordpress.com/2020/09/food-food-security-report-executive-summary-final.pdf
[95] US Department of Agriculture, Food and Nutrition Service. SNAP: COVID-19 Waivers by State. September 8, 2021. Accessed September 27, 2021. https://www.fns.usda.gov/disaster/pandemic/covid-19/snap-waivers-flexibilities.
[96] US Department of Agriculture, Food and Nutrition Service. WIC: COVID-19 Waivers by State. September 8, 2021. Accessed September 27, 2021. https://www.fns.usda.gov/disaster/pandemic/covid-19/wic-waivers-flexibilities.
[97] Food Access & Food Security in the District of Columbia: Responding to the COVID-19 Public Health Emergency. *DC Food Policy Council*. https://dcfoodpolicycouncilorg.files.wordpress.com/2020/09/food-food-security-report-executive-summary-final.pdf
[98] ArlingtonVA.us. COVID-19 Food Assistance. Accessed September 27, 2021. https://www.arlingtonva.us/covid-19/food-assistance/.
[99] City of Alexandria, Virginia. Food Assistance. September 7, 2021. Accessed September 27, 2021. https://www.alexandriava.gov/dchs/economicsupport/default.aspx?id=115053.
[100] Montgomery County Government. COVID-19 Information Portal: Food Resources / Recursos Alimenticios. Accessed September 27, 2021. https://montgomerycountymd.gov/covid19/get-help/food.html.
[101] PRIORITY SETTING AND RESOURCE ALLOCATION (PSRA) PLAN (2018). Metropolitan Washington Regional Ryan White Planning Council. https://doh.dc.gov/sites/default/files/dc/sites/doh/service_content/attachments/GY27-FY17%20PSRA%20Plan.pdf
[102] PRIORITY SETTING AND RESOURCE ALLOCATION (PSRA) PLAN (2018). Metropolitan Washington Regional Ryan White Planning Council. https://doh.dc.gov/sites/default/files/dc/sites/doh/service_content/attachments/GY27-FY17%20PSRA%20Plan.pdf
[103]"District of Columbia Eligible Metropolitan Area (EMA) Integrated HIV/AIDS Prevention and Care Plan" (2017-2021). *DC Department of Health (DC DOH) HIV/AIDS, Hepatitis, STD, and TB Administration (HAHSTA)*. https://doh.dc.gov/sites/default/files/dc/sites/doh/service_content/attachments/DC%20DOH%20INTEGRATED%20PLAN_FINAL.pdf.pdf
[104]"District of Columbia Eligible Metropolitan Area (EMA) Integrated HIV/AIDS Prevention and Care Plan" (2017-2021). *DC Department of Health (DC DOH) HIV/AIDS, Hepatitis, STD, and TB Administration (HAHSTA)*. https://doh.dc.gov/sites/default/files/dc/sites/doh/service_content/attachments/DC%20DOH%20INTEGRATED%20PLAN_FINAL.pdf.pdf
[105] Healthy People 2020. Access to Health Services. https://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-health/interventions-resources/access-to-health. Accessed July 2021.
[106] Sohn H. Racial and Ethnic Disparities in Health Insurance Coverage: Dynamics of Gaining and Losing Coverage over the Life-Course. *Popul Res Policy Rev*. 2017;36(2):181-201. doi:10.1007/s11113-016-9416-y.
[107] Amin K, Claxton G, Ramirez G, Cox C. How does cost affect access to care? Peterson-KFF Health System Tracker. https://www.healthsystemtracker.org/chart-collection/cost-affect-access-care/#item-costaccesstocare_3. Posted January 5, 2021. Accessed July 2021.
[108] Georgetown University, McCourt School of Public Policy, Health Policy Institute. Cultural Competence in Health Care: Is it important for people with chronic conditions? https://hpi.georgetown.edu/cultural/. Accessed July 2021.
[109] Lagu T, Iezzoni LI, Lindenauer PK. The axes of access--improving care for patients with disabilities. *N Engl J Med.* 2014;370(19):1847-1851. doi:10.1056/NEJMsb1315940

[110] Johnson-Lawrence V, Zajacova A, Sneed R. Education, race/ethnicity, and multimorbidity among adults aged 30-64 in the National Health Interview Survey. *SSM Popul Health*. 2017;3:366-372. Published 2017 Mar 29. doi:10.1016/j.ssmph.2017.03.007.
[111] Yehia BR, Stewart L, Momplaisir F, et al. Barriers and facilitators to patient retention in HIV care. *BMC Infect Dis.* 2015;15(246). doi:10.1186/s12879-015-0990-0.
[112] Smith LR, Fisher JD, Cunningham CO, Amico KR. Understanding the behavioral determinants of retention in HIV care: a qualitative evaluation of a situated information, motivation, behavioral skills model of care initiation and maintenance. *AIDS Patient Care STDS*. 2012;26(6):344-355. doi:10.1089/apc.2011.0388.
[113] Rajabiun S, Mallinson RK, McCoy K, et al. "Getting me back on track": the role of outreach interventions in engaging and retaining people living with HIV/AIDS in medical care. *AIDS Patient Care* STDS. 2007;21 Suppl 1:S20-S29. doi:10.1089/apc.2007.9990.
[114] Kimmel AD, Masiano SP, Bono RS, et al. Structural barriers to comprehensive, coordinated HIV care: geographic accessibility in the US South. *AIDS Care*. 2018;30(11):1459-1468. doi:10.1080/09540121.2018.1476656.
[115] Cunningham CO, Sohler NL, Wong MD, et al. Utilization of health care services in hard-to-reach marginalized HIV-infected individuals. *AIDS Patient Care STDS*. 2007;21(3):177-186. doi:10.1089/apc.2006.103.
[116] Rajabiun S, Mallinson RK, McCoy K, et al. "Getting me back on track": the role of outreach interventions in engaging and retaining people living with HIV/AIDS in medical care. *AIDS Patient Care* STDS. 2007;21 Suppl 1:S20-S29. doi:10.1089/apc.2007.9990.
[117] National Center for Innovation in HIV Care. Addressing Organizational Barriers to HIV Care: Lessons Learned from AIDS United's Positive Charge Initiative. https://targethiv.org/sites/default/files/supporting-files/Barriers%20to%20Care%20Fact%20Sheet.pdf. Accessed July 2021.
[118] Remien RH, Stirratt MJ, Nguyen N, Robbins RN, Pala AN, Mellins CA. Mental health and HIV/AIDS: the need for an integrated response. *AIDS*. 2019;33(9):1411-1420. doi:10.1097/QAD.0000000000002227.
[119] SAMHSA-HRSA Center for Integrated Health Solutions. The Case for Behavioral Health Screening in HIV Care Settings. https://store.samhsa.gov/sites/default/files/d7/priv/sma16-4999.pdf. Published 2016. Accessed August 2021.
[120] Substance Abuse and Mental Health Services Administration (SAMHSA). Racial/Ethnic Differences in Mental Health Service Use among Adults. February 2015. Accessed September 20, 2021. https://www.samhsa.gov/data/sites/default/files/MHServicesUseAmongAdults/MHServicesUseAmongAdults.pdf.
[121] Priester MA, Browne T, Iachini A, Clone S, DeHart D, Seay KD. Treatment Access Barriers and Disparities Among Individuals with Co-Occurring Mental Health and Substance Use Disorders: An Integrative Literature Review. *J Subst Abuse Treat*. 2016;61:47-59. doi:10.1016/j.jsat.2015.09.006.
[122] McGuire TG, Miranda J. New evidence regarding racial and ethnic disparities in mental health: policy implications. *Health Aff (Millwood).* 2008;27(2):393-403. doi:10.1377/hlthaff.27.2.393.
[123] Begun AL, Early TJ, Hodge A. Mental Health and Substance Abuse Service Engagement by Men and Women During Community Reentry Following Incarceration. *Adm. Policy Ment. Health*. 2016;43:207-218. doi:10.1007/s10488-015-0632-2.
[124] Owens MD, Chen JA, Simpson TL, Timko C, Williams EC. Barriers to addiction treatment among formerly incarcerated adults with substance use disorders. *Addict. sci. amp; clin. pract*. 2018;13. doi:10.1186/s13722-018-0120-6.
[125] Doran KM, Rahai N, McCormack RP, et al. Substance use and homelessness among emergency department patients. *Drug Alcohol Depend*. 2018;188:328-333. doi:10.1016/j.drugalcdep.2018.04.021.
[126] Youn SJ, Sauer-Zavala S, Patrick KA, et al. Barriers and Facilitators to Implementing a Short-Term Transdiagnostic Mental Health Treatment for Homeless Persons. *J Nerv Ment Dis*. 2019;207(7):585-594. doi:10.1097/NMD.0000000000001010.
[127] Upshur CC, Jenkins D, Weinreb L, Gelberg L, Orvek EA. Homeless women's service use, barriers, and motivation for participating in substance use treatment. *Am J Drug Alcohol Abuse*. 2018;44(2):252-262. doi:10.1080/00952990.2017.1357183.
[128] Derr AS. Mental Health Service Use Among Immigrants in the United States: A Systematic Review. *Psychiatr Serv*. 2016;67(3):265-274. doi:10.1176/appi.ps.201500004.
[129] Bovin MJ, Miller CJ, Koenig CJ, et al. Veterans' experiences initiating VA-based mental health care. *Psychol Serv*. 2019;16(4):612-620. doi:10.1037/ser0000233.
[130] Harris TB, Udoetuk SC, Webb S, Tatem A, Nutile LM, Al-Mateen CS. Achieving Mental Health Equity: Children and Adolescents. *Psychiatr Clin North Am*. 2020;43(3):471-485. doi:10.1016/j.psc.2020.06.001.

[131] Skidmore CR, Kaufman EA, Crowell SE. Substance Use Among College Students. *Child Adolesc Psychiatr Clin N Am.* 2016;25(4):735-753. doi:10.1016/j.chc.2016.06.004
[132] Institute of Medicine. *Care Without Coverage: Too Little, Too Late.* The National Academies Press; 2002. doi:10.17226/10367.
[133] Farkhad BF, Holtgrave DR, Albarracin D. Effect of Medicaid Expansions on HIV Diagnoses and Pre-Exposure Prophylaxis Use. *Am J Prev Med*. 2021;60(3):335-42. doi:10.1016/j.amepre.2020.10.021.
[134] Yehia BR, Fleishman JA, Agwu AL, et al. Health insurance coverage for persons in HIV care, 2006-2012. *J Acquir Immune Defic Syndr.* 2014;67(1):102-106. doi:10.1097/QAI.0000000000000251.
[135] Yehia BR, Fleishman JA, Hicks PL, et al. Inpatient health services utilization among HIV-infected adult patients in care 2002-2007. *J Acquir Immune Defic Syndr.* 2010;53(3):397-404. doi:10.1097/QAI.0b013e3181bcdc16.
[136] Goldman DR, Bhattacharya J, McCaffrey DF, et al. Effects of insurance on mortality in an HIV-positive population in care. *J Am Stat Assoc*. 2001;96(455):883–94. doi:10.1198/016214501753208582.
[137] Farkhad BF, Holtgrave DR, Albarracin D. Effect of Medicaid Expansions on HIV Diagnoses and Pre-Exposure Prophylaxis Use. *Am J Prev Med*. 2021;60(3):335-42. doi:10.1016/j.amepre.2020.10.021.
[138] "Understanding The Case For Telehealth Payment Parity", Health Affairs Blog, May 10, 2021. DOI: 10.1377/hblog20210503.625394
[139] Finegold K, Conmy A, Chu RC, Bosworth A, Sommers BD. Trends in the U.S. Uninsured Population: 2010-2020. Department of Health and Human Services, Assistant Secretary for Planning and Evaluation, Office of Health Policy. February 11, 2021. Accessed December 1, 2021.
[140] Artiga S, Hill L, Orgera K, Damico A. Health Coverage by Race and Ethnicity, 2010-2019. Kaiser Family Foundation. July 16, 2021. Accessed September 1, 2021. https://www.kff.org/racial-equity-and-health-policy/issue-brief/health-coverage-by-race-and-ethnicity/.
[141] Kaiser Family Foundation. Employer Health Benefits: 2020 Annual Survey. 2020. Accessed September 3, 2021. https://files.kff.org/attachment/Report-Employer-Health-Benefits-2020-Annual-Survey.pdf.
[142] Artiga S, Diaz M. Health Coverage and Care of Undocumented Immigrants. Kaiser Family Foundation. July 15, 2019. Accessed March 21, 2022. https://www.kff.org/racial-equity-and-health-policy/issue-brief/health-coverage-and-care-of-undocumented-immigrants/.
[143] Garfield R, Damico A, Rudowitz R. Taking A Closer Look At Characteristics of People in the Coverage Gap. Kaiser Family Foundation. July 29, 2021. Accessed December 1, 2021. https://www.kff.org/policy-watch/taking-a-closer-look-at-characteristics-of-people-in-the-coverage-gap/.
[144] Keisler-Starkey K, Bunch LN. Health Insurance Coverage in the United States: 2019 Current Population Reports. US Census Bureau. https://www.census.gov/content/dam/Census/library/publications/2020/demo/p60-271.pdf. Published September 2020. Accessed July 2021.
[145] Kaiser Family Foundation. Medicaid Income Eligibility Limits for Adults as a Percent of the Federal Poverty Level. https://www.kff.org/health-reform/state-indicator/medicaid-income-eligibility-limits-for-adults-as-a-percent-of-the-federal-poverty-level/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Other%20Adults%20(for%20an%20individual)%22,%22sort%22:%22desc%22%7D. Updated January 1, 2021. Accessed July 2021.
[146] Kaiser Family Foundation. Medicaid and CHIP Income Eligibility Limits for Pregnant Women as a Percent of the Federal Poverty Level. https://www.kff.org/health-reform/state-indicator/medicaid-and-chip-income-eligibility-limits-for-pregnant-women-as-a-percent-of-the-federal-poverty-level/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Medicaid%22,%22sort%22:%22desc%22%7D. Updated January 1, 2021. Accessed July 2021.
[147] DC Health, Department of Health Care Finance. Health Care Alliance. https://dhcf.dc.gov/service/health-care-alliance. Accessed July 2021.
[148] DC Health, Department of Health Care Finance. Immigrant Children's Program. https://dhcf.dc.gov/service/immigrant-childrens-program. Accessed July 2021.
[149] Kaiser Family Foundation. Medicaid Income Eligibility Limits for Adults as a Percent of the Federal Poverty Level. January 1, 2021. Accessed February 16, 2022. https://www.kff.org/health-reform/state-indicator/medicaid-income-eligibility-limits-for-adults-as-a-percent-of-the-federal-poverty-level.
[150] DC Health, Office of Health Equity. Health Equity Report: District of Columbia 2018. https://app.box.com/s/yspij8v81cxqyebl7gj3uifjumb7ufsw. Published February 8, 2019. Accessed July 2021.
[151] Tatian PA, McTarnaghan S, Arena O, Su Y. State of Immigrants in the District of Columbia: Data Profiles of Immigrants from Latin America, Asia, Africa, and the Caribbean. The Urban Institute. December 2018. https://www.urban.org/sites/default/files/publication/99031/state_of_immigrants_in_dc_brief_2.pdf,

[152] *VPM*. Virginia Immigrants Have To Work 10 Years To Qualify For Medicaid. https://vpm.org/news/articles/6073/virginia-immigrants-have-to-work-10-years-to-qualify-for-medicaid. Published June 25, 2019. Accessed January 15, 2020.
[153] Medicaid.gov. Medicaid and CHIP Coverage of Lawfully Residing Children & Pregnant Women. December 11, 2019. https://www.medicaid.gov/medicaid/enrollment-strategies/medicaid-and-chip-coverage-lawfully-residing-children-pregnant-women.
[154] National Immigration Law Center. Medical Assistance Programs for Immigrants in Various States. July 2020. Accessed 8/7/20 at: https://www.nilc.org/wp-content/uploads/2015/11/med-services-for-imms-in-states.pdf
[155] District of Columbia Department of Health, HIV/AIDS, Hepatitis, STD, and TB Administration (HAHSTA). Annual Epidemiology & Surveillance Report: Data Through December 2021. https://dchealth.dc.gov/sites/default/files/dc/sites/doh/publication/attachments/2022-Annual-Surveillance-Report_0.pdf

[156] Maryland Department of Health, Prevention and Health Promotion Administration, Infectious Disease Prevention and Health Services Bureau, Center for HIV Surveillance, Epidemiology, and Evaluation. Maryland Annual HIV Epidemiological Profile 2020: Data Reported Through June 30, 2021. 2021. https://health.maryland.gov/phpa/OIDEOR/CHSE/SiteAssets/Pages/statistics/Maryland-Annual-HIV-Epidemiological-Profile--2020.pdf.
[157] Maryland Department of Health, Infectious Disease Prevention and Health Services Bureau, Prevention and Health Promotion Administration, Center for HIV Surveillance, Epidemiology and Evaluation. Montgomery County Annual HIV Epidemiological Profile. Table 2 – Reported HIV Diagnoses, among People Aged 13+ during 2020, Linked to Care, Late Diagnosis, First CD4 Test Result, and Mean Years from HIV Diagnosis by ZIP Code of Residence at Diagnosis, Reported through June 30, 2021. Accessed July 26, 2022. https://health.maryland.gov/phpa/OIDEOR/CHSE/SiteAssets/Pages/statistics/Montgomery-County-Annual-HIV-Epidemiological-Profile--2020.pdf.
[158] DC Health Matters Collaborative. Community Health Needs Assessment, District of Columbia, 2019. https://www.dchealthmatters.org/content/sites/washingtondc/2019_DC_CHNA_FINAL.pdf. Published June 28, 2019. Accessed July 2021.
[159] Brink-Johnson A, Lubin J. Structural Racism in Washington, DC: Facts, Figures & Opportunities for Advancing Racial Equity. Center for Urban and Racial Equity. https://urbanandracialequity.org/wp-content/uploads/2020/08/Structural-Racism-in-Washington-DC-1.pdf. Published August 19, 2020. Accessed July 2021.
[160] Ganz O, Curry LE, Jones P, Mead KH, Turner MM. Barriers to Mental Health Treatment Utilization in Wards 7 and 8 in Washington, DC: A Qualitative Pilot Study. Health Equity. 2018;2(1):216-222. Published 2018 Aug 1. doi:10.1089/heq.2017.0051.
[161] DC Health. 2017-2021 District of Columbia Eligible Metropolitan Area Integrated HIV/AIDS Prevention and Care Plan. Accessed September 21, 2021. https://doh.dc.gov/sites/default/files/dc/sites/doh/service_content/attachments/DC%20DOH%20INTEGRATED%20PLAN_FINAL.pdf.pdf.
[162] Health Resources and Services Administration (HRSA). About the Ryan White HIV/AIDS Program. December 2020. Accessed September 21, 2021. https://hab.hrsa.gov/about-ryan-white-hivaids-program/about-ryan-white-hivaids-program.
[163] DC Health. 2017-2021 District of Columbia Eligible Metropolitan Area Integrated HIV/AIDS Prevention and Care Plan. Accessed September 21, 2021. https://doh.dc.gov/sites/default/files/dc/sites/doh/service_content/attachments/DC%20DOH%20INTEGRATED%20PLAN_FINAL.pdf.pdf.
[164] DC Health. 2017-2021 District of Columbia Eligible Metropolitan Area Integrated HIV/AIDS Prevention and Care Plan. Accessed September 21, 2021. https://doh.dc.gov/sites/default/files/dc/sites/doh/service_content/attachments/DC%20DOH%20INTEGRATED%20PLAN_FINAL.pdf.pdf.
[165] Washington AIDS Partnership, DC Appleseed, DC Health, and Mayor Muriel Bowser. DC Ends HIV: Ending the HIV Epidemic in the District of Columbia for All Communities by 2030. Accessed September 21, 2021. https://assets.website-files.com/5faac3b49b484021bd3f9502/602ef507ad7091a06fa49299_DCH-101%20DC%20Ends%20HIV%20Report_508.pdf.
[166] DC Department of Health Care Finance (DCHCF). DC Healthy Families. [website]. Accessed 8/7/20 At: https://dhcf.dc.gov/service/dc-healthy-families

[167] DC DHCF. Health Care Alliance. https://dhcf.dc.gov/service/health-care-alliance. Accessed August 2020.
[168] DC Health Link. DC Healthcare Alliance and Cover All DC. https://dchealthlink.com/node/2478. Accessed August 2020.
[169] National Immigration Law Center. Medical Assistance Programs for Immigrants in Various States. July 2020. Accessed 8/7/20 at: https://www.nilc.org/wp-content/uploads/2015/11/med-services-for-imms-in-states.pdf
[170] Norris L. What are off-exchange health insurance plans and how are they regulated? HealthInsurance.org. October 21, 2020. https://www.healthinsurance.org/faqs/what-are-off-exchange-health-insurance-plans-and-how-are-they-regulated/.
[171] DC Health. Health Insurance Assistance Program. https://dchealth.dc.gov/node/137082.
[172] Maryland Department of Health. Maryland AIDS Drug Assistance Program (MADAP). https://phpa.health.maryland.gov/OIDPCS/CHCS/pages/madap.aspx.
[173] Virginia Department of Health. VA MAP Eligibility. https://www.vdh.virginia.gov/disease-prevention/eligibility/.
[174] West Virginia Department of Health and Human Resources, Office of Epidemiology and Prevention Services. Ryan White Program. https://oeps.wv.gov/rwp/Pages/default.aspx#icp.
[175] DC Health. Pre Exposure Prophylaxis Drug Assistance Program (PrEP DAP). https://dchealth.dc.gov/DCPrEPDAP.
[176] Virginia Department of Health. PrEP and NPEP Locator. https://www.vdh.virginia.gov/disease-prevention/prep-and-npep/.
[177] Centers for Disease Control and Prevention. HIV Stigma and Discrimination. June 1, 2021. Accessed October 15, 2021. https://www.cdc.gov/hiv/basics/hiv-stigma/index.html.
[178] Emily Bergeron, "The Historical Roots of Mistrust in Science" American Bar Association Human Rights Magazine, Vol. 47, No. 4 (2021). Available at https://www.americanbar.org/groups/crsj/publications/human_rights_magazine_home/the-truth-about-science/the-historical-roots-of-mistrust-in-science/
[179] Bazargan M, Cobb S, Assari S. Discrimination and Medical Mistrust in a Racially and Ethnically Diverse Sample of California Adults. *Ann Fam Med*. 2021;19(1):4-15. doi:10.1370/afm.2632.
[180] Saha S, Jacobs EA, Moore RD, Beach MC. Trust in physicians and racial disparities in HIV care. *AIDS Patient Care STDS*. 2010;24(7):415-420. doi:10.1089/apc.2009.0288.
[181] Armstrong K, Ravenell KL, McMurphy S, Putt M. Racial/ethnic differences in physician distrust in the United States. *Am J Public Health*. 2007;97(7):1283-1289. doi:10.2105/AJPH.2005.080762.
[182] Bogart LM, Takada S, Cunningham WE. Medical Mistrust, Discrimination, and the Domestic HIV Epidemic. In: Ojikutu B, Stone V (eds). *HIV in US Communities of Color*. Springer, Cham; 2021:207-231. doi:10.1007/978-3-030-48744-7_12.
[183] Heller J. Rumors and Realities: Making Sense of HIV/AIDS Conspiracy Narratives and Contemporary Legends. *Am J Public Health*. 2015;105(1):e43-e50. doi:10.2105/AJPH.2014.302284.
[184] Earnshaw VA, Bogart LM, Dovidio JF, Williams DR. Stigma and racial/ethnic HIV disparities: moving toward resilience. *Am Psychol*. 2013;68(4):225-236. doi:10.1037/a0032705.
[185] Bogart LM, Takada S, Cunningham WE. Medical Mistrust, Discrimination, and the Domestic HIV Epidemic. In: Ojikutu B, Stone V (eds). *HIV in US Communities of Color*. Springer, Cham; 2021:207-231. doi:10.1007/978-3-030-48744-7_12.
[186] Randolph SD, Golin C, Welgus H, Lightfoot AF, Harding CJ, Riggins LF. How Perceived Structural Racism and Discrimination and Medical Mistrust in the Health System Influences Participation in HIV Health Services for Black Women Living in the United States South: A Qualitative, Descriptive Study. *J Assoc Nurses AIDS Care*. 2020;31(5):598-605. doi:10.1097/JNC.0000000000000189.
[187] Duke CC, Stanik C. Overcoming Lower-Income Patients' Concerns About Trust And Respect From Providers. *Health Aff Blog (Milwood).* 2016. doi:10.1377/hblog20160811.056138.
[188] Randolph SD, Golin C, Welgus H, Lightfoot AF, Harding CJ, Riggins LF. How Perceived Structural Racism and Discrimination and Medical Mistrust in the Health System Influences Participation in HIV Health Services for Black Women Living in the United States South: A Qualitative, Descriptive Study. *J Assoc Nurses AIDS Care*. 2020;31(5):598-605. doi:10.1097/JNC.0000000000000189.
[189] Duke CC, Stanik C. Overcoming Lower-Income Patients' Concerns About Trust And Respect From Providers. *Health Aff Blog (Milwood).* 2016. doi:10.1377/hblog20160811.056138.
[190] Hostetter, M and Klein, S. Understanding and Ameliorating Medical Mistrust Among Black Americans (2021). *The Commonwealth Fund* https://www.commonwealthfund.org/publications/newsletter-article/2021/jan/medical-mistrust-among-black-americans.

[191] Cuevas AG, O'Brien K, Saha S. African American experiences in healthcare: "I always feel like I'm getting skipped over". *Health Psychol*. 2016;35(9):987-995. doi:10.1037/hea0000368
[192] Smith AC, Woerner J, Perera R, Haeny AM, Cox JM. An Investigation of Associations Between Race, Ethnicity, and Past Experiences of Discrimination with Medical Mistrust and COVID-19 Protective Strategies [published online ahead of print, 2021 Jun 11]. *J Racial Ethn Health Disparities*. 2021;1-13. doi:10.1007/s40615-021-01080-x.
[193] Thompson HS, Manning M, Mitchell J, et al. Factors Associated With Racial/Ethnic Group–Based Medical Mistrust and Perspectives on COVID-19 Vaccine Trial Participation and Vaccine Uptake in the US. *JAMA Netw Open*. 2021;4(5):e2111629. doi:10.1001/jamanetworkopen.2021.1162.
[194] Bogart LM, Ojikutu BO, Tyagi K, et al. COVID-19 Related Medical Mistrust, Health Impacts, and Potential Vaccine Hesitancy Among Black Americans Living With HIV. *J Acquir Immune Defic Syndr*. 2021;86(2):200-207. doi:10.1097/QAI.0000000000002570.
[195] Jaiswal J. Whose Responsibility Is It to Dismantle Medical Mistrust? Future Directions for Researchers and Health Care Providers. *Behav Med*. 2019;45(2):188-196. doi:10.1080/08964289.2019.1630357.
[196] Randolph SD, Golin C, Welgus H, Lightfoot AF, Harding CJ, Riggins LF. How Perceived Structural Racism and Discrimination and Medical Mistrust in the Health System Influences Participation in HIV Health Services for Black Women Living in the United States South: A Qualitative, Descriptive Study. *J Assoc Nurses AIDS Care*. 2020;31(5):598-605. doi:10.1097/JNC.0000000000000189.
[197] Ross MW, Essien EJ, Torres I. Conspiracy beliefs about the origin of HIV/AIDS in four racial/ethnic groups. *J Acquir Immune Defic Syndr*. 2006;41(3):342-344. doi:10.1097/01.qai.0000209897.59384.52.
[198] Quinn KG, Kelly JA, DiFranceisco WJ, et al. The Health and Sociocultural Correlates of AIDS Genocidal Beliefs and Medical Mistrust Among African American MSM. *AIDS Behav*. 2018;22(6):1814-1825. doi:10.1007/s10461-016-1657-6
[199] Tekeste M, Hull S, Dovidio JF, et al. Differences in Medical Mistrust Between Black and White Women: Implications for Patient-Provider Communication About PrEP. *AIDS Behav*. 2019;23(7):1737-1748. doi:10.1007/s10461-018-2283-2.
[200] Eaton LA, Driffin DD, Kegler C, et al. The role of stigma and medical mistrust in the routine health care engagement of black men who have sex with men. *Am J Public Health*. 2015;105(2):e75-e82. doi:10.2105/AJPH.2014.302322.
[201] Kalichman SC, Eaton L, Kalichman MO, Cherry C. Medication beliefs mediate the association between medical mistrust and antiretroviral adherence among African Americans living with HIV/AIDS. *J Health Psychol*. 2017;22(3):269-279. doi:10.1177/1359105315600239.
[202] Pellowski JA, Price DM, Allen AM, Eaton LA, Kalichman SC. The differences between medical trust and mistrust and their respective influences on medication beliefs and ART adherence among African-Americans living with HIV. *Psychol Health*. 2017;32(9):1127-1139. doi:10.1080/08870446.2017.1324969.
[203] Kalichman SC, Eaton L, Kalichman MO, Grebler T, Merely C, Welles B. Race-based medical mistrust, medication beliefs and HIV treatment adherence: test of a mediation model in people living with HIV/AIDS. *J Behav Med*. 2016;39(6):1056-1064. doi:10.1007/s10865-016-9767-1.
[204] Kimball D, Rivera D, Gonzales M 4th, Blashill AJ. Medical Mistrust and the PrEP Cascade Among Latino Sexual Minority Men. AIDS Behav. 2020;24(12):3456-3461. doi:10.1007/s10461-020-02916-z.
[205] Centers for Disease Control and Prevention. HIV Stigma and Discrimination. June 1, 2021. Accessed October 15, 2021. https://www.cdc.gov/hiv/basics/hiv-stigma/index.html.
[206] Geter A, Herron AR, Sutton MY. HIV-Related Stigma by Healthcare Providers in the United States: A Systematic Review. *AIDS Patient Care STDS*. 2018;32(10):418-424. doi:10.1089/apc.2018.0114.
[207] Heller J. Rumors and Realities: Making Sense of HIV/AIDS Conspiracy Narratives and Contemporary Legends. *Am J Public Health*. 2015;105(1):e43-e50. doi:10.2105/AJPH.2014.302284.
[208] Cahill S, Taylor SW, Elsesser SA, Mena L, Hickson D, Mayer KH. Stigma, medical mistrust, and perceived racism may affect PrEP awareness and uptake in black compared to white gay and bisexual men in Jackson, Mississippi and Boston, Massachusetts. *AIDS Care*. 2017;29(11):1351-1358. doi:10.1080/09540121.2017.1300633.
[209] Davtyan M, Olshansky EF, Brown B, Lakon C. A Grounded Theory Study of HIV-Related Stigma in U.S.-Based Health Care Settings. *J Assoc Nurses AIDS Care*. 2017;28(6):907-922. doi:10.1016/j.jana.2017.07.007
[210] Yang YT, Underhill K. Rethinking Criminalization of HIV Exposure — Lessons from California's New Legislation. *NEJM. 2*018;378:1174-1175. https://doi.org/10.1056/NEJMp1716981.
[211] The Center for HIV Law and Policy. HIV Criminalization in the United States: A Sourcebook on State and Federal HIV Criminal Law and Practice. August 2021. Accessed October 14, 2021. https://www.hivlawandpolicy.org/sourcebook.

[212] The Center for HIV Law and Policy. Map: HIV Criminalization in the United States. July 2020. Accessed October 14, 2021. https://www.hivlawandpolicy.org/resources/map-hiv-criminalization-united-states-center-hiv-law-and-policy-updated-july-2020.
[213] Arnold EA, Rebchook GM, Kegeles SM. 'Triply cursed': racism, homophobia and HIV-related stigma are barriers to regular HIV testing, treatment adherence and disclosure among young Black gay men. *Cult Health Sex*. 2014;16(6):710-722. doi:10.1080/13691058.2014.905706.
[214] Rueda S, Mitra S, Chen S, et al. Examining the associations between HIV-related stigma and health outcomes in people living with HIV/AIDS: a series of meta-analyses. *BMJ Open*. 2016;6(7):e011453. Published 2016 Jul 13. doi:10.1136/bmjopen-2016-011453.
[215] Katz IT, Ryu AE, Onuegbu AG, et al. Impact of HIV-related stigma on treatment adherence: systematic review and meta-synthesis. *J Int AIDS Soc*. 2013;16(3 Suppl 2):18640. Published 2013 Nov 13. doi:10.7448/IAS.16.3.18640.
[216] Turan B, Budhwani H, Fazeli PL, et al. How Does Stigma Affect People Living with HIV? The Mediating Roles of Internalized and Anticipated HIV Stigma in the Effects of Perceived Community Stigma on Health and Psychosocial Outcomes. *AIDS Behav*. 2017;21(1):283-291. doi:10.1007/s10461-016-1451-5.
[217] Arnold EA, Rebchook GM, Kegeles SM. 'Triply cursed': racism, homophobia and HIV-related stigma are barriers to regular HIV testing, treatment adherence and disclosure among young Black gay men. *Cult Health Sex*. 2014;16(6):710-722. doi:10.1080/13691058.2014.905706.
[218] Rueda S, Mitra S, Chen S, et al. Examining the associations between HIV-related stigma and health outcomes in people living with HIV/AIDS: a series of meta-analyses. *BMJ Open*. 2016;6(7):e011453. Published 2016 Jul 13. doi:10.1136/bmjopen-2016-011453.
[219] Washington AIDS Partnership, DC Appleseed, DC Health, and Mayor Muriel Bowser. DC Ends HIV: Ending the HIV Epidemic in the District of Columbia for All Communities by 2030. Accessed October 19, 2021. https://assets.website-files.com/5faac3b49b484021bd3f9502/602ef507ad7091a06fa49299_DCH-101%20DC%20Ends%20HIV%20Report_508.pdf.
[220] Montgomery County, MD, Department of Health and Human Services. A Plan to End HIV in Montgomery County. December 30, 2020. Accessed October 19, 2021. https://www.montgomerycountymd.gov/HHS-Program/Resources/Files/PHSDocs/HIV/Attachment_1_A_Plan_to_End_HIV_in_Montgomery_County.pdf.
[221] Prince George's County Health Department. The Prince George's County Ending the HIV Epidemic Plan. December 30, 2020. Accessed October 19, 2021. https://www.princegeorgescountymd.gov/DocumentCenter/View/34210/Prince-Georges-County-EtHE-HIV-Eliminaton-Plan-2021-PDF.
[222] Virginia Department of Health, Division of Disease Prevention. Virginia Integrated HIV Services Plan, 2017-2021. January 4, 2017. Accessed October 19, 2021. https://www.vdh.virginia.gov/content/uploads/sites/10/2016/11/IntegratedPlan2016.pdf.
[223] Virginia Department of Health, Division of Disease Prevention. Virginia Integrated HIV Services Plan, 2017-2021. January 4, 2017. Accessed October 19, 2021. https://www.vdh.virginia.gov/content/uploads/sites/10/2016/11/IntegratedPlan2016.pdf.
[224] Virginia Department of Health, Division of Disease Prevention. Virginia Integrated HIV Services Plan, 2022-2026. https://www.vdh.virginia.gov/content/uploads/sites/10/2023/01/Virginia-2022-2026-Integrated-Plan_Complete.pdf

[225] Washington AIDS Partnership, DC Appleseed, DC Health, and Mayor Muriel Bowser. DC Ends HIV: Ending the HIV Epidemic in the District of Columbia for All Communities by 2030. Accessed October 19, 2021. https://assets.website-files.com/5faac3b49b484021bd3f9502/602ef507ad7091a06fa49299_DCH-101%20DC%20Ends%20HIV%20Report_508.pdf.
[226] Montgomery County, MD, Department of Health and Human Services. A Plan to End HIV in Montgomery County. December 30, 2020. Accessed October 19, 2021. https://www.montgomerycountymd.gov/HHS-Program/Resources/Files/PHSDocs/HIV/Attachment_1_A_Plan_to_End_HIV_in_Montgomery_County.pdf.
[227] Virginia Department of Health, Division of Disease Prevention. Virginia Integrated HIV Services Plan, 2017-2021. January 4, 2017. Accessed October 19, 2021. https://www.vdh.virginia.gov/content/uploads/sites/10/2016/11/IntegratedPlan2016.pdf.
[228] Why education Matters to Health: Exploring the Causes. Virginia Commonwealth University. https://societyhealth.vcu.edu/work/the-projects/why-education-matters-to-health-exploring-the-causes.html. Published February 2015. Accessed October 15, 2021.

[229] Why education Matters to Health: Exploring the Causes. Virginia Commonwealth University. https://societyhealth.vcu.edu/work/the-projects/why-education-matters-to-health-exploring-the-causes.html. Published February 2015. Accessed October 15, 2021.
[230] Why education Matters to Health: Exploring the Causes. Virginia Commonwealth University. https://societyhealth.vcu.edu/work/the-projects/why-education-matters-to-health-exploring-the-causes.html. Published February 2015. Accessed October 15, 2021.
[231] Onyeabor OS, Iriemenam N, Adekeye OA, Rachel SA. The effect of educational attainment on HIV testing among African Americans. *J Health Care Poor Underserved*. 2013;24(3):1247-1256. doi:10.1353/hpu.2013.0113
[232] Chandran A, Edmonds A, Benning L, et al. Longitudinal Associations Between Neighborhood Factors and HIV Care Outcomes in the WIHS. *AIDS Behav*. 2020;24(10):2811-2818. doi:10.1007/s10461-020-02830-4
[233] Annual Epidemiology & Surveillance Report: Data Through December 2020. District of Columbia Department of Health, HIV/AIDS, Hepatitis, STD, & TB Administration 2020. Accessed December 22, 2022 at https://dchealth.dc.gov/sites/default/files/dc/sites/doh/publication/attachments/2021%20Annual%20Surveillance%20Report_final_3.29.pdf
[234] Cunha E. 62 Years Later: It's Time to Desegregate DC Schools. The DC Post. https://thedcpost.com/washington-dc-schools-desegregation/. Published July 2020. Accessed October 15, 2021.
[235] Annual Epidemiology & Surveillance Report: Data Through December 2020. District of Columbia Department of Health, HIV/AIDS, Hepatitis, STD, & TB Administration 2020. Accessed December 22, 2022 at https://dchealth.dc.gov/sites/default/files/dc/sites/doh/publication/attachments/2021%20Annual%20Surveillance%20Report_final_3.29.pdf
[236] Cunha E. 62 Years Later: It's Time to Desegregate DC Schools. The DC Post. https://thedcpost.com/washington-dc-schools-desegregation/. Published July 2020. Accessed October 15, 2021.
[237] Abamu J. What Data on the Racial Divide in Schools Says about the Washington Region. WAMU. https://wamu.org/story/18/10/18/data-racial-divide-schools-says-washington-region/. Published October 2018. Accessed October 15, 2021.
[238] Abamu J. What Data on the Racial Divide in Schools Says about the Washington Region. WAMU. https://wamu.org/story/18/10/18/data-racial-divide-schools-says-washington-region/. Published October 2018. Accessed October 15, 2021.
[239] Ethier K. Schools are Vital in the Fight Against Youth HIV Infection. HIV.gov. https://www.hiv.gov/blog/schools-are-vital-fight-against-youth-hiv-infection. Published April 2019. Accessed October 15, 2021.
[240] Ma Z-qiang, Fisher MA, Kuller LH. School-based HIV/AIDS Education is Associated with Reduced Risky Sexual Behaviors and Better Grades with Gender and Race/Ethnicity Differences. *Health Education Research*. 2014;29(2):330-339. doi:10.1093/her/cyt110
[241] HIV and AIDS in the United States of America (USA). Avert. https://www.avert.org/professionals/hiv-around-world/western-central-europe-north-america/usa. Published July 2019. Accessed October 15, 2021.
[242] Raifman J, Beyrer C, Arrington-Sanders R. HIV Education and Sexual Risk Behaviors Among Young Men Who Have Sex with Men. *LGBT Health*. 2018;5(2):131-138. doi:10.1089/lgbt.2017.0076
[243] Raifman J, Beyrer C, Arrington-Sanders R. HIV Education and Sexual Risk Behaviors Among Young Men Who Have Sex with Men. *LGBT Health*. 2018;5(2):131-138. doi:10.1089/lgbt.2017.0076
[244] DC Appleseed Center for Law and Justice. Ending the HIV Epidemic in DC 2018 Progress Report. http://www.dcappleseed.com/wp-content/uploads/2018/12/Ending-the-HIV-Epidemic-in-DC-2018-Progress-Report.pdf. Accessed October 15, 2021.
[245] Annual Epidemiology & Surveillance Report: Data Through December 2020. District of Columbia Department of Health, HIV/AIDS, Hepatitis, STD, & TB Administration 2020. Accessed December 22, 2022 at https://dchealth.dc.gov/sites/default/files/dc/sites/doh/publication/attachments/2021%20Annual%20Surveillance%20Report_final_3.29.pdf
[246] DC Appleseed Center for Law and Justice. Ending the HIV Epidemic in DC 2018 Progress Report. http://www.dcappleseed.com/wp-content/uploads/2018/12/Ending-the-HIV-Epidemic-in-DC-2018-Progress-Report.pdf. Accessed October 15, 2021.
[247] Annual Epidemiology & Surveillance Report: Data Through December 2020. District of Columbia Department of Health, HIV/AIDS, Hepatitis, STD, & TB Administration 2020. Accessed December 22, 2022 at https://dchealth.dc.gov/sites/default/files/dc/sites/doh/publication/attachments/2021%20Annual%20Surveillance%20Report_final_3.29.pdf

[248] Ryan White HIV/AIDS Program Services: Eligible Individuals & Allowable Uses of Funds. Health Resources & Services Administration. https://hab.hrsa.gov/sites/default/files/hab/Global/service_category_pcn_16-02_final.pdf. Accessed October 15, 2021.
[249]Health Education/Risk Reduction. District of Columbia Department of Health. https://dchealth.dc.gov/sites/default/files/dc/sites/doh/page_content/attachments/2021%20Standards%20for%20Health%20Education%20Risk%20Reduction%20Services_0.pdf. Accessed October 15, 2021.
[250] What We Do. One Tent Health. https://www.onetenthealth.org/#what-we-do. Accessed October 15, 2021.
[251] About Us. Sex Is... https://sexisdc.org/about-us/. Accessed October 15, 2021.
[252] Alston C. Washington, D.C. Youth Face Barriers to HIV Prevention and Sexual Health. The Body Pro. https://www.thebodypro.com/article/washington-d-c-youth-face-barriers-to-hiv-prevention-and-sexual-health. Published October 2019. Accessed October 15, 2021.