DC | HEALTH
GOVERNMENT OF THE DISTRICT OF COLUMBIA

District of Columbia
Eligible Metropolitan Area
Integrated HIV Prevention and Care Plan, 2022-2026

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Integrated HIV Prevention and Care Plan,
2022-2026

DC Department of Health (DC Health)
HIV/AIDS, Hepatitis, STD, and TB Administration (HAHSTA)

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SECTION I: EXECUTIVE SUMMARY OF INTEGRATED PLAN AND STATEWIDE COORDINATED STATEMENT OF NEED (SCSN)

I. Executive Summary of Integrated Plan and SCSN

The Integrated HIV Prevention and Care Plan (Integrated Plan) provides an additional opportunity to accelerate key strategies and promote innovative approaches for long term success in supporting holistic approaches to sexual health. The District of Columbia is grateful for the support from the US Centers for Disease Control and Prevention (CDC) and the Health Resources and Services Administration (HRSA) through HRSA Ryan White Emergency Care Act, HRSA-20-078 Ending the HIV Epidemic: A Plan for America and CDC PS20-2010, Integrated HIV Programs for Health Departments to Support Ending the HIV Epidemic in the US.

On December 4, 2020, DC Mayor Muriel Bowser announced the release of DC's updated ending the HIV epidemic (DC EHE) plan and new community platform DCEndsHIV.org. The DC EHE plan was informed by robust community engagement and developed as a public-private partnership among the DC Department of Health (DC Health), DC Appleseed Center, and the Washington AIDS Partnership.
In the DC EHE plan, the goals for Washington, DC aligned with the federal goals of 95%/95%/95% of people knowing their HIV status, people diagnosed being on treatment, and people on treatment reaching viral suppression. The plan follows the four pillars of the federal Ending the HIV Epidemic of Diagnose, Treat, Prevent, and Respond. The plan also values health equity and recognizes structural barriers, such as racism and stigma, to optimal health outcomes and individual success. Additionally, it considers people's life experiences by addressing the social determinants of health (SDoH) through an added fifth pillar: Engage.

For the Integrated Plan, the regional responsibility is more significant as we collaborate with our regional partners to develop and plan prevention and care goals for the Washington DC Eligible Metropolitan Area (DC EMA). The DC EMA spans a wide metropolitan region of 6,922 square miles, comprising five counties in suburban Maryland, 11 counties and six independent cities in Northern Virginia, two counties in West Virginia, and the District of Columbia. DC Health will be collecting and reporting data by priority populations where available including Black and Latino men who have sex with men (MSM), Black heterosexual men and women, transgender individuals, youth aged 13-24, and people who inject drugs (PWID).

DC Health will utilize a health equity approach to address the needs of our priority populations and everyone in our DC EMA who needs support. DC Health intends to be more purposeful in linkage to care for our populations. The DC EMA Integrated Plan aligns with the goals of the federal EHE plan and the National HIV/AIDS Strategy. As reflected in this plan, DC Health is moving in that direction with an updated regional plan to improve capacity and achieve several goals focused on prevention/diagnosis, linkage, retention, and viral suppression.

DC Health recognizes that the SDoH, policy changes, community engagement, education, stigma, and data capacity are crucial drivers and strategies to addressing inequities. In addition, DC was the second public health department in the nation to endorse the Undetectable equals Untransmittable (U=U) consensus statement and remains committed to expanding this message among our communities, including intentional efforts among providers and stakeholders.

Ia. Approach

The development of the DC EMA Integrated Plan started during the coronavirus (COVID-19) pandemic. As a result, some community engagement activities were impacted by COVID-19 and transitioned to virtual platforms. DC Health developed the Integrated Plan with significant input from many different community stakeholders, including people living with HIV (PLWH), and supported by the DC EMA jurisdictional partners (Maryland and Virginia) and planning body, and four DC Health divisions' whose programs, policies, services, or activities contribute to our regional response in support of the national Ending the HIV Epidemic initiative. DC Health has also integrated the needs of West Virginia in the planning process given DC Health's HIV/AIDS, Hepatitis, STD & TB Administration (HAHSTA) administrative responsibilities of two West Virginia counties (Berkeley County and Jefferson County) that account for small numbers of PLWH (<1%) compared with the other jurisdictions. The updated Integrated Plan builds on progress and lessons learned from the first DC EMA's Integrated Plan iteration, DC's 95/95/95 goals and the DC EHE plan. It also reflects activities described in other documents, including the Ryan White Part A Application, Ryan White Part B Application, CDC-RFA-PS18-1802, and the Washington, DC Regional Planning Commission on Health and HIV (COHAH; the DC region's integrated prevention and care planning body) membership roster file and structure and responsibilities.

The success of the DC EMA Integrated Plan will be dependent on meaningful and ongoing community engagement in the ownership and implementation of the strategies; strong data driven strategies; enhancing critical, multi-sector partnerships with community providers, academic/research institutions, federal grantors, adjoining jurisdictions, foundations, advocates, and stakeholders; and maintaining leadership support from public officials, community planning bodies, and opinion influencers. The DC EMA honors a commitment to an authentic and credible process of implementation and continued planning guided by community participation.

Ib. Documents Submitted to Meet Requirements

Existing and new materials helped shape the development of the updated five-year DC EMA Integrated Plan. These materials included community and stakeholder feedback, jurisdictional discussions, program and operational documents, data gathered from across the jurisdictions (Statewide Coordinate Statement of Need [SCSN]), and the previously submitted documents listed below.

- 2017-2021 DC EMA Integrated HIV/AIDS Prevention and Care Plan: The DC EMA roadmap to accelerate progress towards reaching the goals of the National HIV/AIDS Strategy.
- DC EHE Plan: The local DC EHE plan to meet the national Ending the HIV Epidemic initiative.
- Ryan White Part A Application: The annual DC EMA application to ensure core medical and support services are available to PLWH.
- Ryan White Part B Application: The annual DC application to supplement HIV prevention and care services for eligible DC residents.
- CDC-RFA-PS18-1802 Application: The DC integrated HIV surveillance and prevention application to prevent new HIV infections and achieve viral suppression among PLWH.
- COHAH Membership, Structure and Responsibilities: The COHAH's membership roster file and structure and responsibilities.

SECTION II: COMMUNITY ENGAGEMENT AND PLANNING PROCESS

II-1. Jurisdiction Planning Process

DC Health developed the Integrated Plan with significant input from many different community stakeholders, including people living with HIV (PLWH), and supported by the Washington, DC Eligible Metropolitan Area's (DC EMA) jurisdictional partners (Maryland and Virginia) and planning body, and four DC Health divisions' whose programs, policies, services, or activities contribute to our regional response in support of the national Ending the HIV Epidemic initiative. DC Health has also integrated the needs of West Virginia in the planning process given DC Health's HIV/AIDS, Hepatitis, STD & TB Administration (HAHSTA) administrative responsibilities of two West Virginia counties (Berkeley County and Jefferson County) that account for small numbers of PLWH (<1%) compared with the other jurisdictions. The plan builds on progress and lessons learned from the first DC EMA's Integrated Plan iteration, DC's 95/95/95 goals and the DC Ends HIV (DC EHE) plan.

In 2021, the stakeholders created a workplan to devise and prioritize the goals, priority populations, and key strategies across the DC EMA to be included in the plan, while utilizing the National HIV/AIDS Strategy (2022-2025) as a roadmap. A workgroup composed of representatives from DC Health's (HAHSTA)—Divisions of Care and Treatment, Prevention and Intervention Services, Capacity Building, Housing & Community Partnership, and Strategic Information—and the Washington, DC Regional Planning Commission on Health and HIV (COHAH; the DC region's integrated prevention and care planning body), with participation from HIV experts was established to inform the planning process and liaise between the planning team and each division. A key component of the planning development process was community engagement and input to ensure that concerns from the DC EMA's focus populations—Black and Latino men who have sex with men (MSM), Black heterosexual men and women, transgender individuals, youth aged 13-24, people who inject drugs (PWID)—as well as the needs of providers, and other stakeholders were incorporated in the development of the plan. Qualitative and quantitative data collected via questionnaires, focus groups, topic-focused community discussions, and key informant interviews informed the planning process. While DC Health had planned to utilize the needs assessment to inform the Integrated Plan, the COVID-19 pandemic created a mass disruption for DC Health in administering the needs assessment in 2020. Additionally, internal delays including a delay in IRB approval and survey platform malfunction exacerbated DC Health's inability to administer the needs assessments as planned. This data collection effort is currently being administered across the DC EMA through a partnership with the George Washington University and Morgan State University. DC Health will submit an amended Integrated Plan in September 2023 once the needs assessment data has been collected, analyzed, and evaluated. Regardless, feedback on important elements of the plan and priority populations was obtained and integrated into the plan as described below.

II-1a. Entities Involved in Process

As the DC EMA emerges from the COVID-19 public health emergency, DC Health, community providers, activists and stakeholders are tasked to get back on track to achieving the ambitious goals for tackling the HIV epidemic. Mayor Muriel Bowser builds and maintains momentum for ending the epidemic utilizing the same resourcefulness, dedication, and coordination that enabled the DC EMA to make tremendous progress in the fight against HIV over the past decades. Mayor Muriel Bowser's new DC Ends HIV by 2030 plan raised the targets from the prior 90/90/90/50 plan to 95 percent of people living with HIV knowing their HIV status, 95 percent of people diagnosed with HIV being in treatment, and 95 percent of people in treatment achieving viral suppression. In addition, the DC EHE aims to increase utilization of pre-exposure prophylaxis (PrEP) to reach 50% of all those eligible on

PrEP and 21 new HIV diagnoses by the year 2030.[1] In concert with the prior DC EMA's Integrated Plan iteration, the DC EHE plan and goals guided the development of the Integrated Plan and provided the framework for the DC EMA's objectives responding to the National HIV/AIDs Strategy (NHAS) goals. As health departments throughout the DC EMA create goals and plans to end the epidemic, the COHAH and DC Health will work collaboratively to incorporate strategies and ensure a regional approach.

DC Health is working to create a coordinated and concentrated effort to prevent HIV and ensure care is provided to people living with HIV. These partnerships cross programs and community sectors, including but not limited to DC government agencies for housing (Department of Housing and Community Development), health insurance (Department of Health Care Finance/Medicaid and Department of Insurance, Security and Banking), mental health and substance use (Department of Behavioral Health), equity (Department of Health, Office of Health Equity), workforce development (Department of Employment Services, Office of Disability Services), re-entry services (DC Department of Corrections), regional prevention services and planning groups, Ryan White Parts B and C, HOPWA programs, local community-based organizations, and academic partners (George Washington University (GW) and Johns Hopkins University (JHU)).

The DC EMA maintains an institutional collaboration with GW's Department of Health Policy and Management and JHU's STD Prevention Training Center. GW has conducted research and analysis on a wide range of policy topics for DC Health since 2012. In the past year, key components of this work have included ongoing research support for DC Health's payment reform plans; analysis of a set of issues related to DC's HIV reporting requirements; an assessment of coverage of HIV and hepatitis C drugs in plans sold in the DC Health Insurance Marketplace (DC Health Link); and a synthesis and summary of the current body of evidence on the effectiveness of linkage to care activities. For this Integrated Plan, GW was instrumental in coordinating and preparing the development of the extensive, DC EMA wide Financial and Human Resources Inventory (hereafter referred to as Resource Inventory). Johns Hopkins University contributed to the Integrated Plan through their participation on the Citywide Expansion of Rapid Antiretroviral Therapy Initiation for the District of Columbia, which helped inform the needs assessment noted below in Section III: Contributing Data Sets and Assessments. JHU also provides training for DC providers and technical assistance for those in Maryland.

Due to the unique geographical profile of the DC EMA, an effective regional plan requires a deep understanding of the coordinated response in the other jurisdictions, as well as a complementary working relationship with jurisdictional agents and health department counterparts. During the development of this Integrated Plan, DC Health representatives met with and attended planning body meetings at the Maryland Department of Health and Mental Hygiene and the Virginia Department of Health to collaborate on the planning approach, coinciding strategies, as well as exchange ideas and data during plan development.

II-1b. Role of RWAP Part A Planning Council/Planning Body

The Washington, DC Regional Planning Commission on Health and HIV (COHAH) serves as the regional planning body for HIV prevention and care services in the federally defined Washington, DC Eligible Metropolitan Area (DC EMA). The COHAH is an integration of the former Washington DC Ryan White Planning Council and the Washington DC HIV Prevention Planning Group. A roster file of the COHAH Commissioners is included in the Appendix.

[1]U.S. Department of Health & Human Services. America's HIV Epidemic Analysis Dashboard (AHEAD). https://ahead.hiv.gov/locations/district-of-columbia. Revised 2021. Accessed December 7, 2022.

In addition to participation in the Integrated Plan strategy meetings, the COHAH lead efforts to identify community members, key stakeholders, and other HIV service providers involved in HIV prevention, care, and treatment services to participate in a comprehensive engagement process. This process includes a comprehensive needs assessment as well as community listening sessions engaging communities in discussion around the five pillars of Ending the HIV Epidemic (four national pillars and one DC specific pillar)—Diagnose, Treat, Prevent, Respond and Engage. Discussion of the five pillars and their relative goals and objectives for this submission are in Section V: 2022-2026 Goals and Objectives.

II-1c. Role of Planning Bodies and Other Entities

To form the Integrated Plan workgroup, members from HAHSTA and COHAH were invited to participate in the integrated HAHSTA/COHAH workgroup (Integrated Plan Workgroup) and planning process. The Integrated Plan was informed by robust community engagement activities of DC Health and the jurisdictional partners (Maryland and Virginia) in support of the Centers for Disease Control and Prevention's (CDC) national HIV prevention goals to achieve and sustain viral suppression and reduce new infections (PS19-1906). The Integrated Plan Workgroup also had frequent conversations with jurisdictional partners and participated in broad state integrated planning meetings to inform the DC EMA Integrated Plan.

As part of the DC EHE development process, extensive community engagement activities occurred in two phases: Phase 1 (2019-2020) and Phase 2 (2020-2021). A list of focus populations who participated in the community engagement activities are included in the Appendix. Initially started in October 2019 as in-person engagements, COVID-19 abruptly paused activities until May 2020 when engagements were moved to virtual platforms through Phase 2. While virtual sessions worked for many groups, DC Health may have missed some engagement opportunities because virtual platforms were not appropriate for all communities. In-person engagement sessions included breakfasts, casual chat and conversation gatherings, focus groups, dinners, and large-scale events—all held in familiar spaces to encourage conversations. These sessions engaged a variety of stakeholders including health care providers, staff from community-based organizations (including faith-based organizations), health department staff, community members representing the demographics of the local epidemic, including those unaffiliated with agencies funded by DC Health. Some virtual sessions included gift cards to food places to recreate the "chat and chew" theme of the in-person sessions. Since 2020, over 740 community member voices have been heard, particularly from those who are not traditionally part of engagement activities, through intentional efforts.

DC Appleseed Center for Law & Justice (DC Appleseed) has also worked collaboratively with HAHSTA in various community engagement capacities including the revision of the DC's 95/95/95 goals, participation in internal HAHSTA work group discussions, and stakeholder engagement. In 2021, DC Appleseed conducted 15 interviews with community HIV advocates, researchers, and providers to understand the state of the HIV/AIDS epidemic in DC. Overall, while DC Appleseed found the DC community to be proud of the accomplishments made around HIV despite COVID-19 challenges, including getting affected populations into care, there are still areas for improvement to keep people in care and opportunities for STI prevention and treatment. DC Appleseed also conducted three community listening sessions in 2022 with community providers (MedStar Health, the National AIDS Housing Coalition, Washington AIDS Partnership, Whitman-Walker Health, Unity Health Care, and SMYAL) to assess HAHSTA's efforts in ending the HIV epidemic in the DC. Overall, participants from the community listening sessions were pleased with HAHSTA's efforts in addressing the Diagnose and Response pillars to end the HIV epidemic, advocated for additional health equity considerations across

programming within the Treatment and Prevention pillars to address systemic barriers (particularly for youth, the trans/non-binary community, Spanish-speaking populations, and unhoused communities), and expressed concerns about staff retention at HAHSTA.

While community engagement activities are interwoven across the five pillars for the DC EMA, it is important to note the regional collaboration efforts in support of cluster detection activities for the Respond pillar. The COHAH was instrumental in the cluster detection and response (CDR) community engagement efforts which began in 2018 and continue to be a core entity of ongoing CDR activities. Since 2019, HAHSTA and the DC Center for AIDS Research Community Partnership Council (DC CFAR CPC)—comprised of prominent DC HIV community members, including DC HIV community-based organizations (CBOs), HIV research participating academic institutions, and community clinics—work in collaboration to promote and support HIV research utilizing CDR data. HAHSTA staff have provided education on routine CDR activities in a variety of forums, including the Ryan White Grantee Forum for community providers funded by HAHSTA to provide prevention and care/treatment services; the National Ryan White Conference, which includes a diverse group of stakeholders such as Ryan White recipients, providers, subrecipients, stakeholders, and people living with HIV; the CDC HIV Surveillance Technical Assistance Meeting which includes health department staff from various jurisdictions; and as guest lecture on HIV surveillance at GW's Milken Institute School of Public Health. Information related to molecular HIV surveillance/CDR is also provided on the DC Ends HIV website.

In addition, as part of HAHSTA's National Institutes of Health CFAR Administrative Supplement from 2019, a community-based participatory framework has been utilized to develop partnerships between DC Health, researchers, and community stakeholders. This work informs the surveillance-based public health interventions (including CDR). Interviews with providers to describe knowledge, perceptions, and concerns related to HIV surveillance-based interventions are ongoing and surveys with community members living with or at risk for HIV (including Black and Latino men who have sex with men, Black cisgender women and transgender individuals of color) are forthcoming.

The goal of CDR community engagement efforts is to collaborate with providers, community members, and other stakeholders to improve transparency and trust. Community discussions cover three main topics: transparency and trust (i.e., whether patients and community members are aware of HIV/STD reporting requirements and how DC Health staff should discuss disease intervention activities with community members); communications modalities (i.e., whether and how people should be informed that they are part of a cluster and what that would mean to them); and collaborative relationships (i.e., the potential role of providers and community-based organizations in initiating interventions and educating community members and how case managers and providers can be engaged to facilitate a warm hand off to disease intervention specialists). These conversations have uncovered several concerns expressed by community members including autonomy, criminalization, stigmatization, discrimination, mistrust in government, and privacy. In 2020, DC Health HAHSTA drafted its HIV Cluster and Outbreak Detection and Response Plan. Since then, comments from CDC and HAHSTA Senior Leadership have been incorporated in the revised draft. Solicitation of comments from community members on the revised plan is forthcoming and will be used to finalize the plan.

As such, the COHAH was included in all levels of HIV planning with the COHAH's Engagement and Education Committee (CEEC) providing guidance and connecting community engagement efforts between DC Health staff and PLWH.

II-1d. Collaboration with RWHAP Parts (SCSN Requirement)

The DC EHE, Statewide Coordinated Statement of Need (SCSN), and continuous community engagement efforts helped inform the overall program of activities for the Integrated Plan, particularly from the RWHAP Parts A-D providers and Part F recipients across the jurisdiction into the planning process to avoid duplication of efforts and gaps in the service delivery system. Provider sessions were conducted virtually due to COVID-19 restrictions. DC Health engaged health department staff in four virtual sessions guided by staff who identified essential populations and providers of substance use, senior/aging, mental health, and PrEP. DC Health also engaged providers who work with the Latinx community, wellness providers, providers working with returning citizens, middle management direct service providers, and youth providers.

Community engagement is ongoing across the DC EMA with COHAH facilitating collaboration between the four jurisdictions and community stakeholders. In particular, the COHAH's Community Engagement and Education Committee (CEEC) meets monthly to share jurisdictional updates, exchange best practices, discuss challenges, and develop opportunities for improvement—all to avoid duplication of efforts and identify gaps in the service delivery system. While each jurisdiction may conduct separate community engagement sessions and develop individual jurisdictional EHE plans, the CEEC provides and encourages broad engagement across jurisdictions where working collaboratively allows for the unique planning and implementation of HIV prevention and care across the DC EMA. This exchange of information promotes dialogue and focus to engage hard to reach populations, such as foreign-born and Latino men who have sex with men.

II-1e. Engagement of People with HIV (SCSN Requirement)

Persons living with HIV, key stakeholders in prevention, care and related services, and representatives of organizations that can inform and support the development and implementation were included in the planning process of the Integrated Plan. As previously noted, COHAH was integral in the strategic sessions for the Integrated Plan, as well as leading efforts to identify community members, key stakeholders, and other HIV service providers involved in HIV prevention, care, and treatment services to participate in a comprehensive engagement process. This process includes the ongoing needs assessment and community listening sessions engaging communities in discussion around the five pillars of Ending the HIV Epidemic (Diagnose, Treat, Prevent, Respond and Engage). COHAH membership includes 15 Persons Living with HIV. In addition to the COHAH members, approximately seven other persons living with HIV are active participants on the COHAH sub-committees. They were all engaged in a variety of the Integrated Plan engagement activities.

Additionally, members of COHAH includes community partners who provide prevention, care, mental health and substance abuse services. These community partners also specialize in providing prevention services to special populations such as: MSM, heterosexual black women, people who inject drugs (PWIDs), sex workers, transgender women, and youth (ages 13-24). Members of COHAH who consistently attended and contributed to workgroup meetings represented:

- Community-based organizations serving affected populations and AIDS service organizations.
- Academic/research institutions.
- Affected communities, including people living with HIV, members of a Federally recognized Indian tribe as represented in the population, individuals co-infected with hepatitis B or C, and historically underserved groups and subpopulations.

The COHAH announced the formation of the Integrated Plan Workgroup and invited COHAH members to participate in the workgroup at three General Body meetings and several subcommittee meetings. Members of the COHAH who participated in the Integrated Plan Workgroup represented the following groups per HRSA guidelines:

- Community-based organizations serving affected populations and AIDS service organizations.
- Affected communities, including people living with HIV, members of a Federally recognized Indian tribe as represented in the population, individuals co-infected with hepatitis B or C, and communities that are underserved groups with limited access to HIV and prevention services.
- State government (including the State Medicaid agency and the agency administering the program under Part B).
- Representatives of individuals who formerly were Federal, State, or local prisoners, were released from the custody of the penal system during the preceding 3 years, and had HIV as of the date on which the individuals were so released.

This represents 28% of the 13 categories that HRSA requires for the COHAH. The Integrated Plan Workgroup obtained the commitment and support from all members to contribute to the development of Integrated Plan goals, objectives, strategies, and activities. The Integrated Plan Workgroup, which consisted of planning body chairs, coordinator, and other community participants, convened monthly throughout the year to develop work plans, timelines, goals, strategies, and activities. As a result of a successful team effort, the workgroup was able to create and present a robust and comprehensive integrated five-year plan for the DC EMA. The Integrated Plan Workgroup will continue to engage with PLWHA throughout the implementation, monitoring, evaluation, and improvement process of the Integrated Plan at monthly meetings and local community engagement activities to reach PLWHAs that are not traditionally part of the engagement efforts or meetings.

The COHAH coordinated three Community Listening Sessions (one in Phase I and two in Phase II) in order to: 1) get input on the state of service provisions in the DC EMA; 2) identify gaps and barriers to Ryan White service access and/or availability; 3) describe general challenges of living with HIV in the DC EMA; 4) list and prioritize service needs; and 5) discuss services that are successful at keeping people living with HIV linked to care, retained in care, and virally suppressed. The information gained from this discussion was shared with the planning bodies and included in the five-year integrated planning process. This input is reflected in the strategies and activities of the Integrated Plan, particularly regarding housing activities, support services, availability of community health workers, and efforts to improve the regional coordination of care for people living with HIV in the DC EMA.

II-1f. Priorities

Under COHAH's leadership, the DC EMA has identified the following key priorities from the planning and community engagement process in recognition of the four federal pillars (Diagnose, Treat, Prevent, Respond) and DC Health's fifth (Engage) for the next five years:

- *Harm reduction*. Harm reduction will remain an important strategy implemented across the DC EMA to serve people at high risk of acquiring HIV. Harm reduction programs provide a variety of services, including clean syringe distribution, used syringe collection, and community cleanups.

They also provide a wide array of HIV prevention services, including education, rapid HIV screenings, condoms, and access to treatment.

- *Wellness services*. Whole-person health is a key priority identified from community conversations. These include wellness, integrative health services, and mental health. Programming underway and developing include Wellness Support Services service standards, pilot wellness program using a status-neutral approach, and increased uptake of pre-exposure prophylaxis (PrEP) and post-exposure prophylaxis (PEP) and other prevention options, support treatment adherence protocols, and ultimately improve overall health.

- *Molecular surveillance.* Continued molecular surveillance to identify clusters or outbreaks of HIV transmission and response work with enhanced testing, prevention, and care services. Activities include improving timeliness of molecular cluster detection, enhance engagement with planning bodies and community stakeholders described above, and cross jurisdictional collaboration to enhance the DC EMA approach to HIV cluster detection and response.

- *HIV Testing*. Cornerstone to the DC EMA response for many years, the jurisdictional regions will continue to offer HIV testing and related services using innovative approaches such as offering testing in nontraditional settings and in hot spots around the DC EMA.

- *Rapid Antiretroviral Therapy (ART)*. The DC EMA believes that all who are newly diagnosed with HIV should have rapid access to care and start antiretroviral therapy (ART) as soon as medically possible. A collaborative research team composed of members of DC Health, The George Washington University, and the community is exploring knowledge and attitudes about rapid ART among local HIV clinicians, community-based organizations, and community members. DC EMA aims to address individual, social, and structural barriers to rapid ART initiation to reduce the time from HIV diagnosis to treatment and ultimately to viral suppression.

- *U=U*. Viral suppression is a common goal for the DC EMA. The jurisdictional region will continue to expand programming in education and acceptability of U=U among individuals and providers.

- *PrEP and PEP*. Biomedical prevention methods—pre-exposure prophylaxis (PrEP) and post-exposure prophylaxis (PEP)—are needed to accelerate progress toward ending the HIV epidemic in the DC EMA. Programming will continue to expand access through social marketing, financial assistance, peer-based networks, and capacity-building, while enhancing wellness services to address misinformation, stigma and the perception of risk.

- *Data-to-Prevention*. The DC EMA will continue its work to enhance the use of STD surveillance to deliver HIV prevention services. Activities include using data to identify individuals at high risk of acquiring HIV, utilizing motivational interviewing techniques to increase PrEP acceptance, and identifying reasons for hesitancy.

II-1g. Updates to Other Strategic Plans Used to Meet Requirements

The DC EMA Integrated Plan is a jurisdictional-wide effort involving various stakeholders as noted above. It draws heavily from progress and lessons learned from the first DC EMA's Integrated Plan iteration, DC's 95/95/95 goals and the DC Ends HIV (DC EHE) plan. The COHAH led much of this work from the SCSN and meetings with stakeholders involved in COHAH sub-committees (Integrated Strategies [ISC],

Research and Evaluation [REC], Community Engagement and Education [CEEC], and Comprehensive Planning [CPC]) to develop the plan. Priorities are adjusted based on the data detailing the focus populations most affected by HIV, ongoing discussion across jurisdictions, and inclusion of PLWH. The Integrated plan offers an opportunity to assess our progress with EHE plan implementation, make changes based upon the data (including community and stakeholder feedback), and apply those strategies and activities across the DC EMA.

SECTION III: CONTRIBUTING DATA SETS AND ASSESSMENTS

III-1. Data Sharing and Use

The DC EMA's Testing, Surveillance, and RW data systems include eHARS and CAREWare, and a web portal, Evaluationweb. The District of Columbia's HIV, hepatitis, STD and TB data system is the DC Public Health Information System (DC PHIS).

Evaluationweb is a CDC administered web portal system that is used to collect information surrounding HIV testing data activities across the United States. Regarding the HIV Care Continuum, this web portal collects information such as demographics, risk behavior, HIV testing history, information surrounding the type and manner of HIV test performed, as well as linkage to care in the event of a positive test outcome. This web portal, in compliance with HIPAA regulations, does not collect any identifying information for each test event. In addition, clinical providers are not required to report risk information to the DC Health and that information is often incomplete.

CAREWare is used to manage and monitor RW-funded HIV clinical and supportive care data. CAREWare is the secure, centralized software application that captures client-level data for the District of Columbia, as well as the DC EMA. CAREWare is the source of the RW Services Report (RSR), Programmable Statistical Reports, and the Minority AIDS Initiative Report. These are used to assess and track trends in client demographics, service utilization, and eligibility for linkage, retention, and viral suppression data. CAREWare is also the source of the Performance Measure Reports to evaluate the effectiveness of services that are most critical to the care and treatment of people living with HIV.

Data on HIV and AIDS cases are entered into the CDC enhanced HIV/AIDS Reporting System (**eHARS**). Only confirmed reports of HIV are accepted; anonymous test results are not reported. Reports are received from a variety of sources, including hospitals, private physicians' offices, community-based organizations, clinics, and laboratories. These data are used to track newly diagnosed HIV cases, newly diagnosed staging, HIV related deaths, and non-HIV related deaths. This system is also used to determine rates for linkage to care, retention in care, and viral suppression to evaluate the prevention and care systems, as well as the HIV Care Continuum, from linkage to viral load suppression. This data system also produces the Data-to- Care Reports that are critical to linkage efforts with those who have never linked or fallen out of care. This report from eHARS can identify: 1. HIV cases without reported laboratory results within a defined period; 2. HIV cases with suboptimal clinical indicators; 3. current address; and 4. current provider.

The District of Columbia Public Health Information System **(DC PHIS)** was designed to be a comprehensive and integrated monitoring and evaluation tool that combines program and surveillance data at the client-level for the diseases that DC Health has responsibility for providing public health services and activities. It was intended to enhance the ties between resources and performance, enabling a user to monitor and evaluate the quality of programs and services. DC PHIS is supported by the Maven Suite, a user configurable case management, workflow and rules assessment system. Maven is a modifiable-off-the-shelf (MOTS) web-based solution, which enables interactive, automated information gathering and decision support processes while complying with state and national IT standards such as the CDC Public Health Information Network (PHIN) published standards. The DC PHIS system continues to evolve through ongoing improvements, development, and implementation of specific programs and activities within the information system. Currently, DC Health is focusing on

developing the surveillance aspects before incorporating the data from RW and HIV prevention programs.

At present, DC is enhancing and expanding the systems in place to collect and utilize data. These data integration efforts would provide solutions to address the remaining data system needs and gaps. On-going collaborative engagements are in place to promote the integration of eHARS and CAREWare into DCPHIS. The system administrators include internal and external specialists. DC Health staff administers eHARS and DCPHIS internally and are housed on internal servers. While CAREWare is administered internally, it sits on an external server. The DC EMA's primary data system is CAREWare, which is implemented on a remote server and accessible by all Ryan White sub-recipients of the DC EMA. Sub-recipients previously using a CAREWare system, such as Part B grantees in Maryland and all subcontractors in Northern Virginia, are uploading their data via the CAREWare Provider Data Import (PDI) function. This function is also being used to eliminate double manual entry among those that have an existing EMR. Implementation thus far has been successful. There are over 300 active unique users among 40 agencies, who have user accounts and have been trained by the grantee to use the DC EMA CAREWare system. The number of users and the size of the database make the DC CAREWare system one of the largest CAREWare networks in the nation. CAREWare has already enabled the grantee to improve client-level data quality and monitor care and treatment data across the DC EMA. The system will facilitate data sharing and care coordination within the provider network. This consolidation/integration of data will allow the grantee to better support efforts to focus on linkages and improvement of health outcomes and assess efficiencies and service gaps in the DC EMA HIV Care Continuum.

Not only is it imperative to leverage existing data resources to identify and support client needs and efficiently coordinate health care delivery; new data partnerships, interconnectivity and sharing between DC Government agencies, as well as private-sector partners will help to identify care status, monitor health outcomes, and break down barriers along the HIV care and prevention continuum at the population-level. In recent years, DC Health has established data- sharing agreements with the DC Departments of Health Care Finance (2015) and Behavioral Health (2014) to support the routine data exchange for the purpose of:

- Monitoring and evaluating HIV service utilization
- Assessing and ensuring appropriate subrogation of claims, by payer
- Improving coordination and continuity of care for individuals jointly served

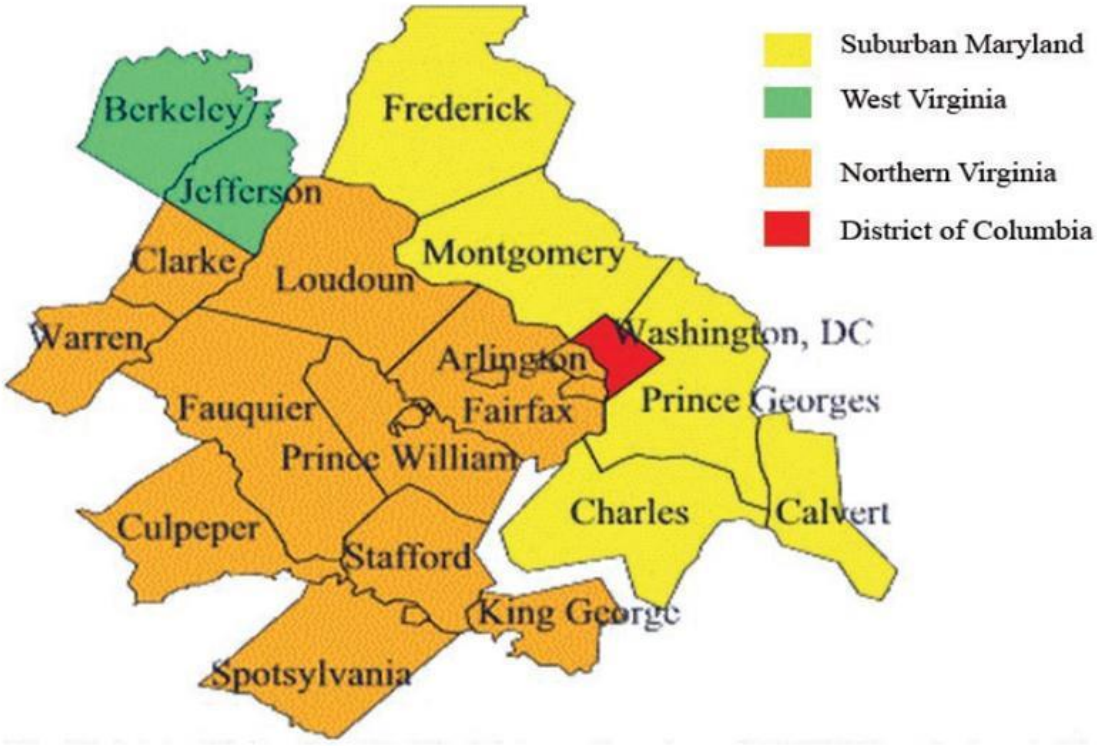
In addition, through facilitation by the DC Department of Insurance, Securities and Banking, DC Health has recently partnered with the health insurance carriers in DC. Though in the early stages of understanding data system parameters, opportunities for collaboration are being actively explored with Aetna, CareFirst BlueCross BlueShield, Kaiser Permanente, and United Healthcare. These partnerships are essential to success by filling in missing components of the continuum. The key data points include overall annual testing rates by DC residents, PrEP uptake and utilization, initiation of ART and medication adherence through prescription utilization data. These elements represent accountability and accomplishment of the plan's strategies.

Currently, Medicare data and data from private insurers are lacking and would be a useful part of capturing an epidemiologic profile and assessment of need in the DC EMA. The data sharing agreement DC Health now has with Medicaid has been essential towards efforts to represent resources and needs

for people living with HIV more accurately. Moving forward, DC Health is working to move testing data collection through DCPHIS to improve tracking of positive testing events and provide more comprehensive information for their testing behaviors, previous HIV test histories, and linkage to care information. Developing a data sharing agreement between jurisdictions for testing data would give DC Health a better understanding on who is truly a new positive as opposed to just a new positive in DC. This is a plan for the upcoming planning period.

III-2. Epidemiologic Snapshot

Figure 1. Map of the District of Columbia Eligible Metropolitan Area (DC EMA), 2022



The map above represents the District of Columbia Eligible Metropolitan Area (DC EMA) as designated by the United States Department of Health and Human Services, Health Resources and Services Administration (HRSA). It spans a wide metropolitan region of 6,922 square miles, comprising five counties in suburban Maryland, 11 counties and six independent cities in Northern Virginia, and two counties in West Virginia. The DC EMA is home to 6,226,242 people, according to 2020 estimates from the US Census Bureau. Ryan White (RW) funds are critical to maintaining a robust continuum of high-quality HIV care, treatment, and support services for persons across the region. Sub-recipients/providers throughout the DC EMA receive funding from the Ryan White HIV/AIDS Treatment Extension Act of 2009 through one or more of the RW Parts (A, B, C, D, and F) which support specific types of programs and target specific activities. Sub-recipients include health departments, hospitals, federally qualified health centers, community-based organizations, and training centers.

While RW funding covers the DC EMA, the Centers for Disease Control and Prevention (CDC) funds the region's jurisdictions separately. The DC Health receives CDC funding for HIV prevention efforts. Throughout the years of prevention efforts, there has been increased physiological understanding of the

virus, improved sensitivity and specificity in screenings, and advancements in effective treatment protocols that achieve virologic control, reducing the amount of the virus in a person to an undetectable level. In response, the CDC now promotes High Impact Prevention strategies to prevent new infections using evidence based behavioral interventions and expanded testing, but also facilitates efforts to keep people living with HIV engaged in care and virally suppressed. In addition, these strategies also address condom distribution, HIV prevention planning, capacity building, social marketing, and program marketing and evaluation.

Due to the way HIV prevention and care has evolved because of these advances, health departments and planning bodies are integrating prevention and care service planning to design a more coordinated, effective, regional response to the epidemic. Prevention and care planning bodies and providers will consult on decisions in areas of shared responsibility, work together to maximize testing, entry, and retention in care, and create a shared workgroup for combined planning. DC Health supports initiatives directly in line with the tenets of integration and has developed an Integrated Prevention and Care Plan to be implemented from 2022-2026.

The DC EMA is one of nine EMAs/TGAs that cross state boundaries and the only one that includes counties and independent municipalities spanning four jurisdictions. Its main city is Washington, DC, which has one of the highest rates of HIV in the country. Although all four jurisdictions comprising the DC EMA border each other, they each have unique and substantial variations in population characteristics and public policies that impact HIV service planning and delivery. Each also addresses health and social service needs of its residents in a different way. estimated prevalence rate in the Nation's Capital is approximately twice as high as the established guidelines of 1%**,** with 1.8% of residents in Washington, DC being diagnosed and reported with HIV.[2] A generalized epidemic requires a multilayered approach to alleviate its overall impact. The prevalence of people living with HIV (PLWH) for the DC EMA at the end of 2020 (0.6 %) is nearly twice the national estimated prevalence rate of 0.4% for diagnoses of HIV.[3] The epicenter of the EMA is the District of Columbia, which is 10.8% of the DC EMA population, but 45.5% of all DC EMA HIV cases. At the end of 2020 there were a total of 39,730 people living with HIV in the DC EMA.

[2]Government of the District of Columbia Department of Health, HIV/AIDS, Hepatitis, STI and TB Administration. Annual Epidemiology & Surveillance Report: Data Through December 2020. https://dchealth.dc.gov/publication/hahsta-annual-epidemiology-surveillance-report-2021. Published 2021. Accessed December 8, 2022.

[3]Centers for Disease Control and Prevention. Estimated HIV Incidence and Prevalence in the United States, 2015–2019. HIV Surveillance Supplemental Report 2021;26(No. 1). http://www.cdc.gov/hiv/library/reports/hiv-surveillance.html. Published May 2021. Accessed December 8, 2022.

Figure 2. Mosaic Plot of the Distribution of People Living with HIV in the DC EMA by Jurisdiction, 2020

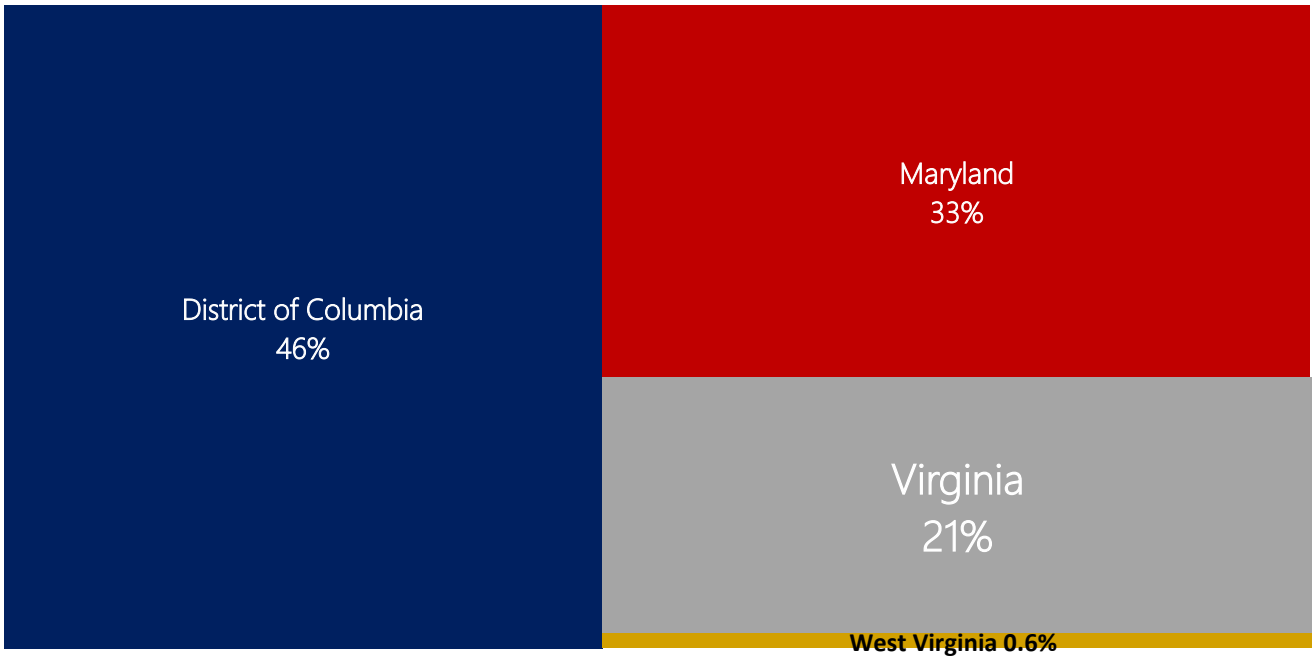
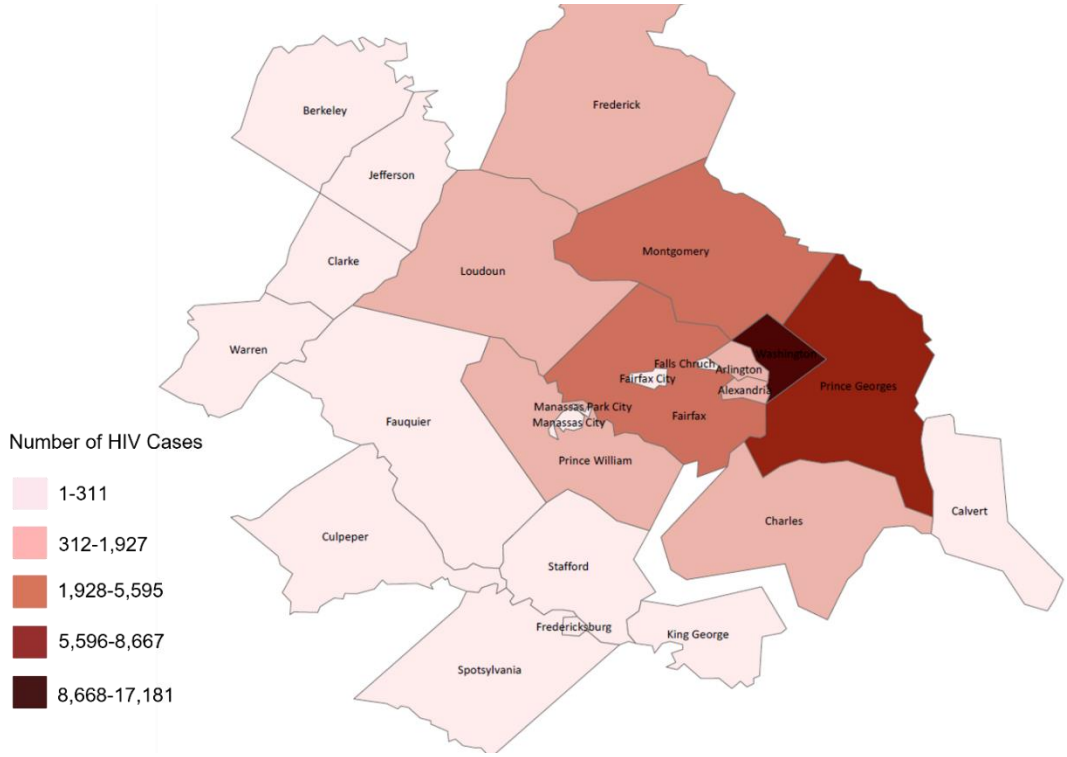


Figure 3. Geographic Distribution of the Number of People living with HIV in the DC EMA by County, 2020[a]

N= 39,730

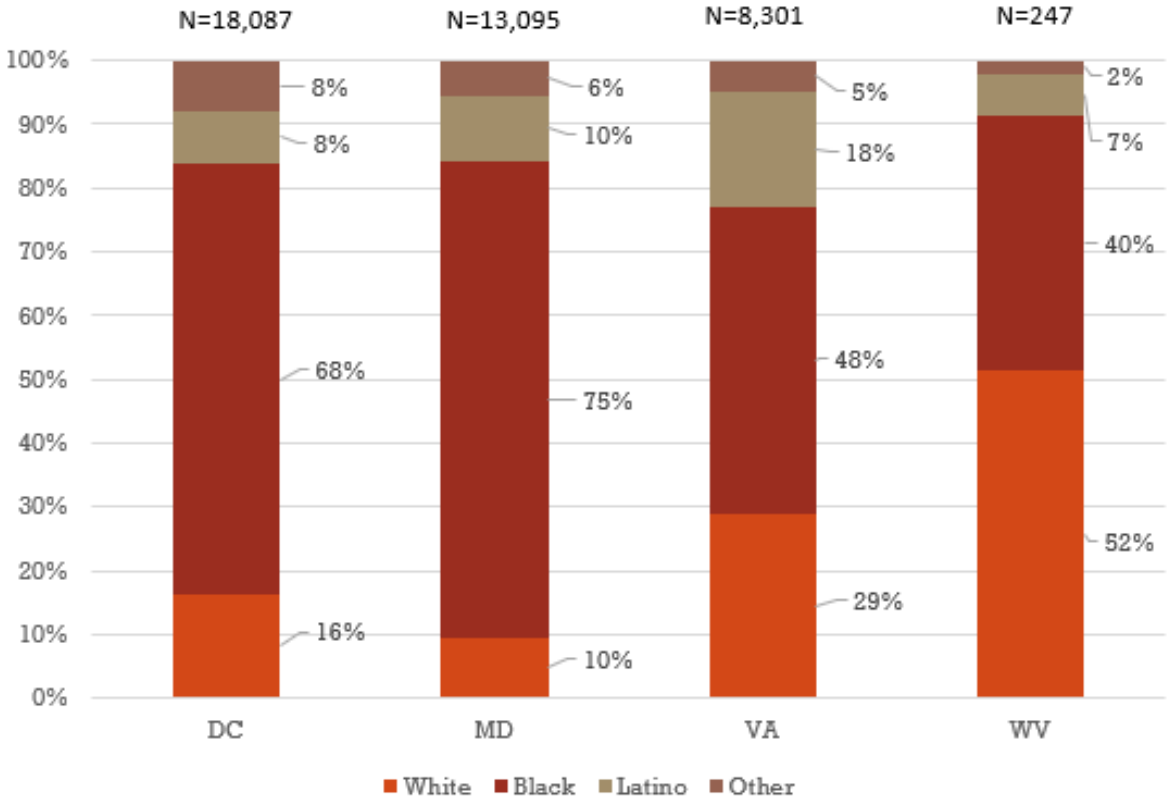


[a] Most up to date information from WV was for 2019

Most living HIV cases in the DC EMA were: Black (66%), male (71%), over 40 years old (75%) and had sexual contact as mode of transmission (80%). The graphs below display socio-demographic information of people living with HIV in the DC EMA by race/ethnicity, gender, age, and mode of transmission.

Living HIV/AIDS Cases by Race/Ethnicity. The HIV epidemic continues to impact communities of color in the DC EMA. People of color account for approximately half of the DC EMA population, but 83% of the estimated number of people living with HIV. Blacks account for most cases at 66%; whites, 17%; Latinos, 11%; Asian/Pacific Islanders, 1%; and Other*/ Unknown, 5%. Except for West Virginia, Blacks are the largest proportion of the estimated number of PLWH in all jurisdictions. In West Virginia, Blacks account for approximately 40% compared to 52% for whites. Virginia has the highest proportion of Latinos living with HIV (18%), almost double that of other jurisdictions.

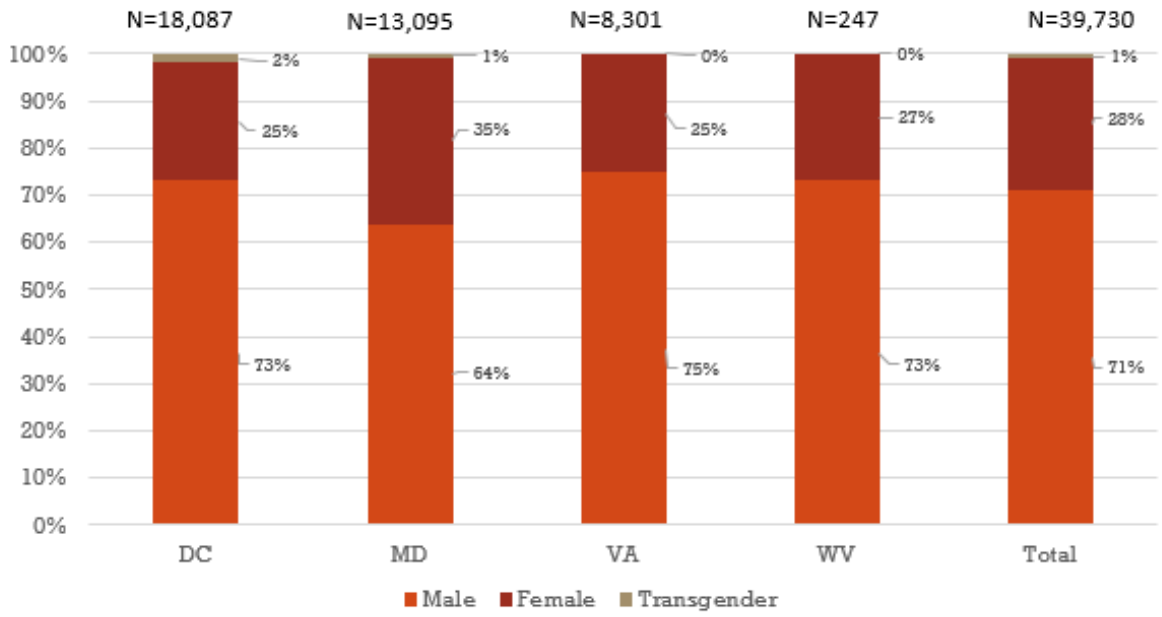
Figure 4. Proportion of People Living with HIV Disease by Race/Ethnicity and Jurisdiction, DC EMA 2020[a,b]



[a]Other race/ethnicity include Asian, Pacific Islander, Alaska Native, American Indian, Native Hawaiian and missing
[b]Most up to date information from WV was from 2019

Living HIV/AIDS Cases by Gender and Jurisdiction. In all jurisdictions, the majority of living HIV cases were men, with Maryland having the highest proportion of cases among women at 35%.

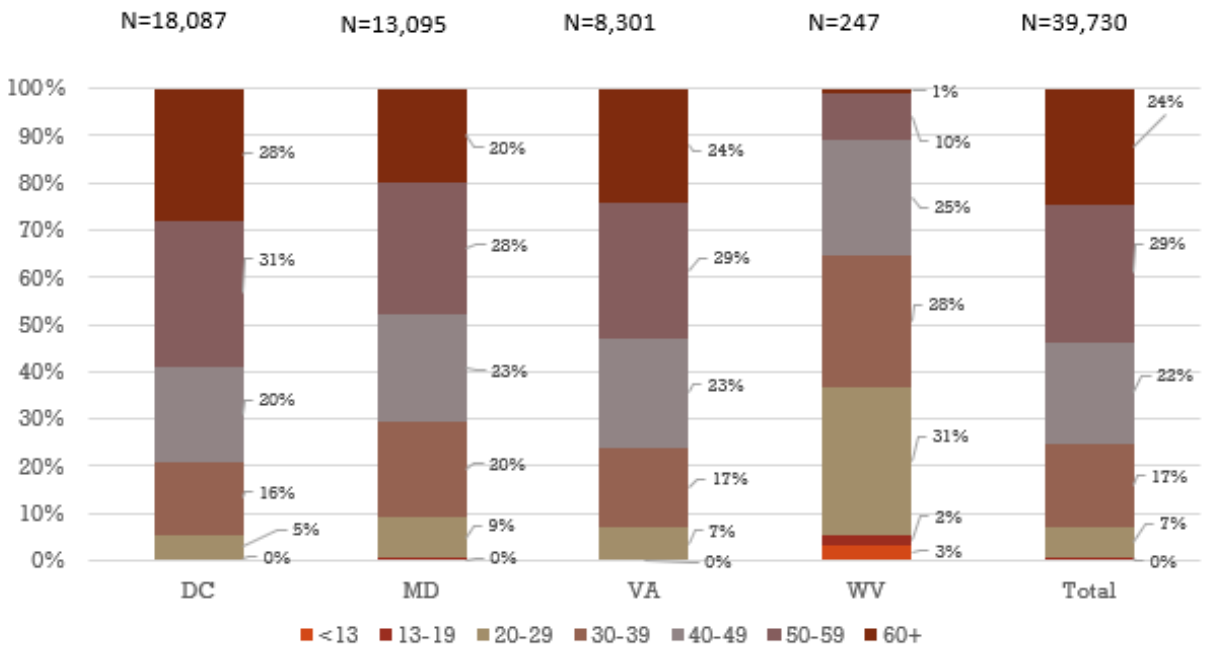
Figure 5. Proportion of People Living with HIV Disease by Gender Identity and Jurisdiction, DC EMA 2020[a,b]



[a]Not all jurisdictions collect data for transgender individuals
[b]Most up to date information for WV was from 2019

Living HIV/AIDS Cases by Age and Jurisdiction. Of the estimated cases living with HIV in the DC EMA, 24% were aged 20–39 years at diagnosis and 51% were between the ages of 40–59 years at the end of 2020. Advances in antiretroviral medications mean that individuals are living longer across the region.

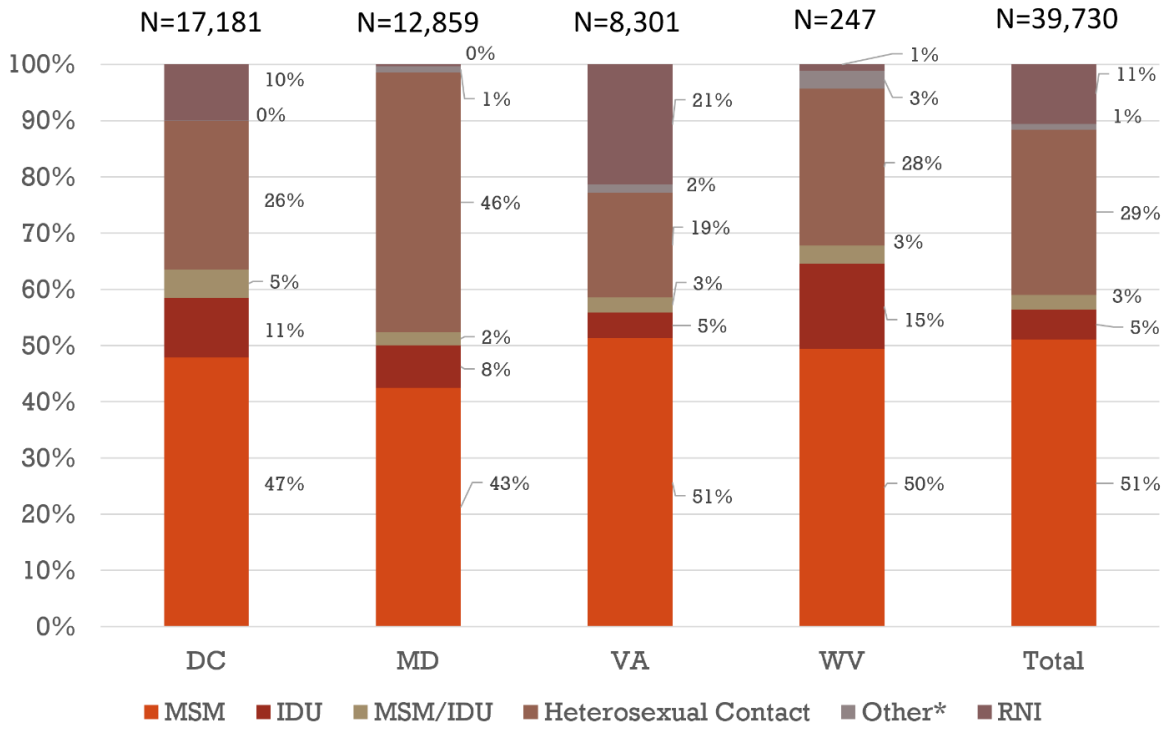
Figure 6. Proportion of Living HIV Cases by Current Age and Jurisdiction, DC EMA 2020[a]



[a]Most up to date information for WV was from 2019

Living HIV/AIDS Cases by Exposure Category and Jurisdiction. Overall, men who have sex with men accounted for the majority of people living with HIV in the DC EMA. This trend remained consistent by jurisdiction, ranging from 43% in MD to 51% in Virginia. Maryland had the highest proportion of people living with HIV transmitted through heterosexual contact (46%). West Virginia had the highest proportion of people living with HIV transmitted through injection drug use at 15%. A significant number of cases in the DC EMA (11%) are reported without any identifiable risk category.

Figure 7. Cases of Living with HIV by Mode of Transmission and Jurisdiction, DC EMA 2020[a]

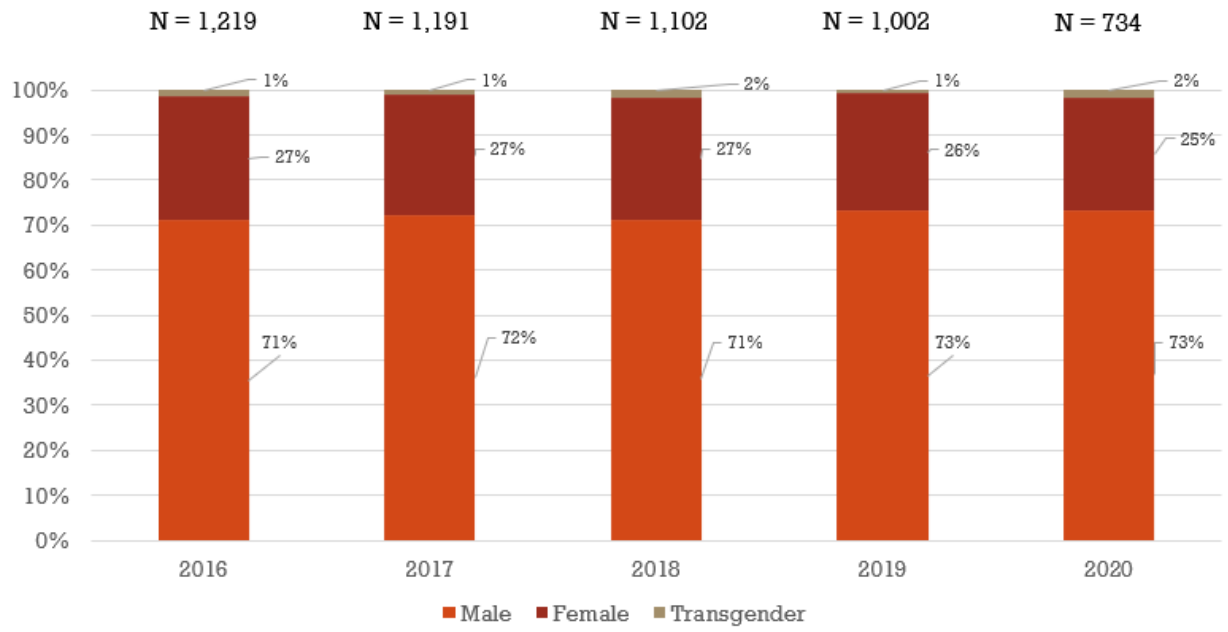


*Other mode of transmission includes hemophilia, blood transfusion, occupational exposure (healthcare workers), and perinatal exposure

[a]Most up to date information from WV was for 2019

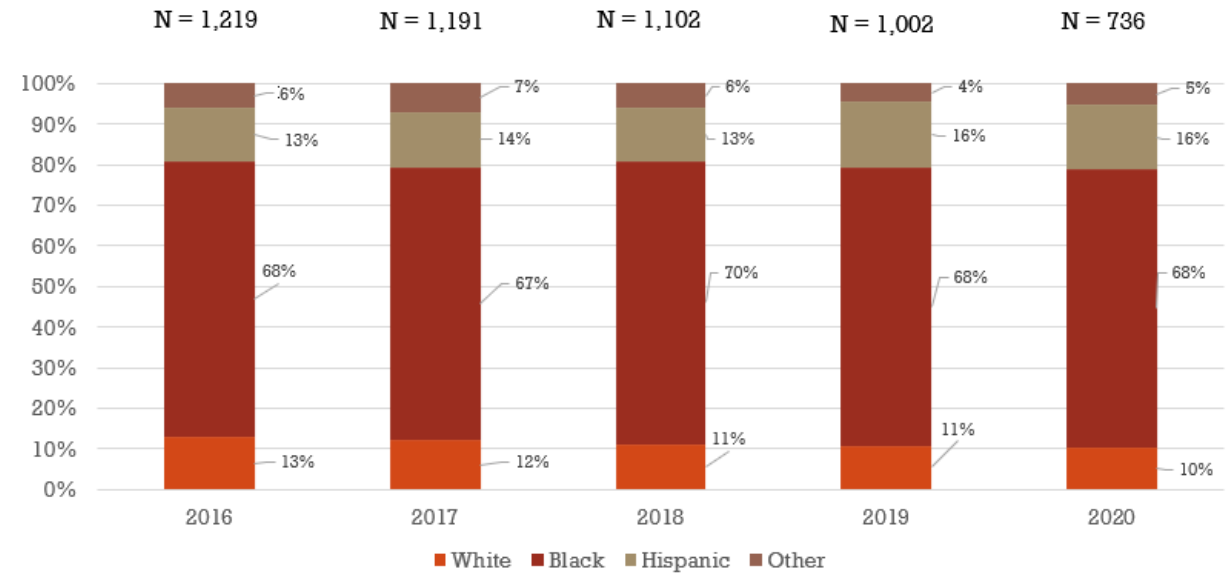
Newly Diagnosed HIV Cases. In 2020, Maryland had the highest number of newly diagnosed (343) and Virginia the lowest (162) (2020 West Virginia numbers unavailable, 2019 numbers used elsewhere in this report as an estimate). The highest new diagnosis rates were among Black non-Latino men between 20-39 years old and with sexual contact as the mode of transmission. Maryland had the highest amount of newly diagnosed women more than doubling the other jurisdictions. In 2020, Maryland also had the highest number of Latinos (51) newly diagnosed, and Virginia and Maryland had equal numbers of white non-Latinos (23) who were newly diagnosed in 2020. Sexual contact was the primary mode of transmission across jurisdictions, with 59% being MSM and 34% being heterosexual contact.

Figure 8. Newly Diagnosed HIV Cases by Gender Identity and Year, DC EMA 2016-2020[a]



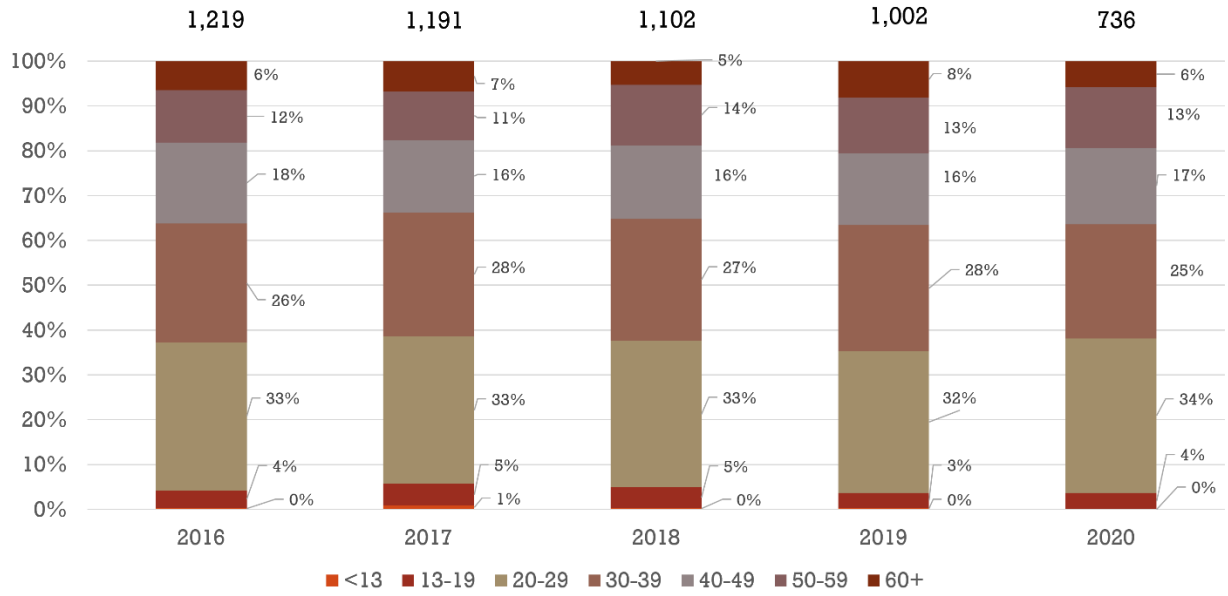
[a]Most up to date information from WV was for 2019

Figure 9. Newly Diagnosed HIV Cases by Race/Ethnicity and Year, DC EMA 2016-2020[a,b]



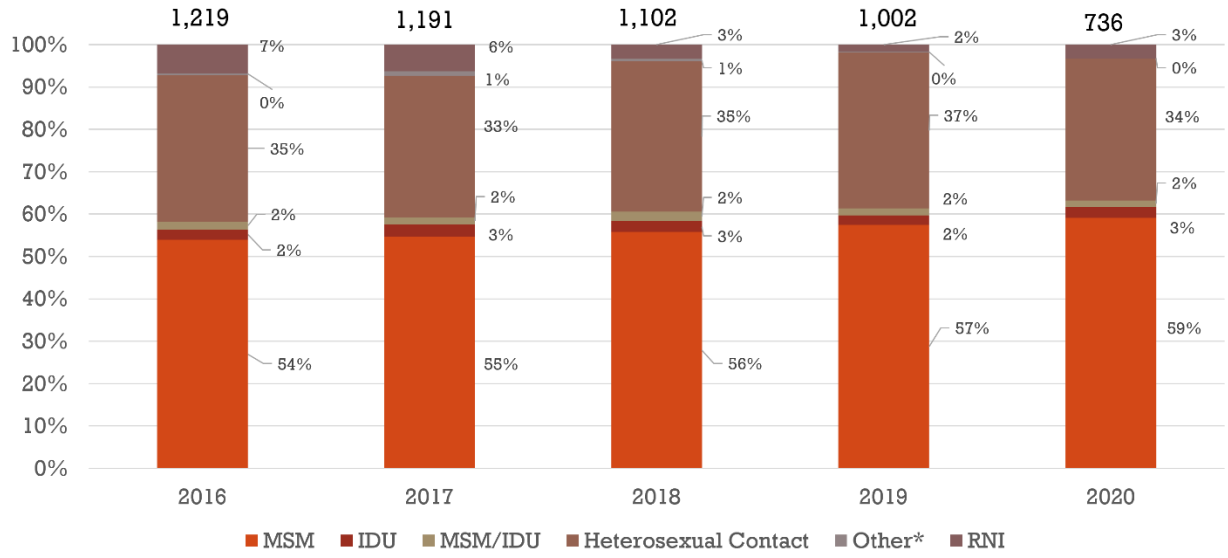
[a]Other race/ethnicity include Asian, Pacific Islander, Alaska Native, American Indian, Native Hawaiian and missing
[b]Most up to date information from WV was for 2019

Figure 10. Newly Diagnosed HIV Cases by Age at Diagnosis and Year, DC EMA 2016-2020[a]



[a]Most up to date information from WV was from 2019

Figure 11. Newly Diagnosed HIV Cases by Mode of Transmission and Year, DC EMA 2016-2020[a]

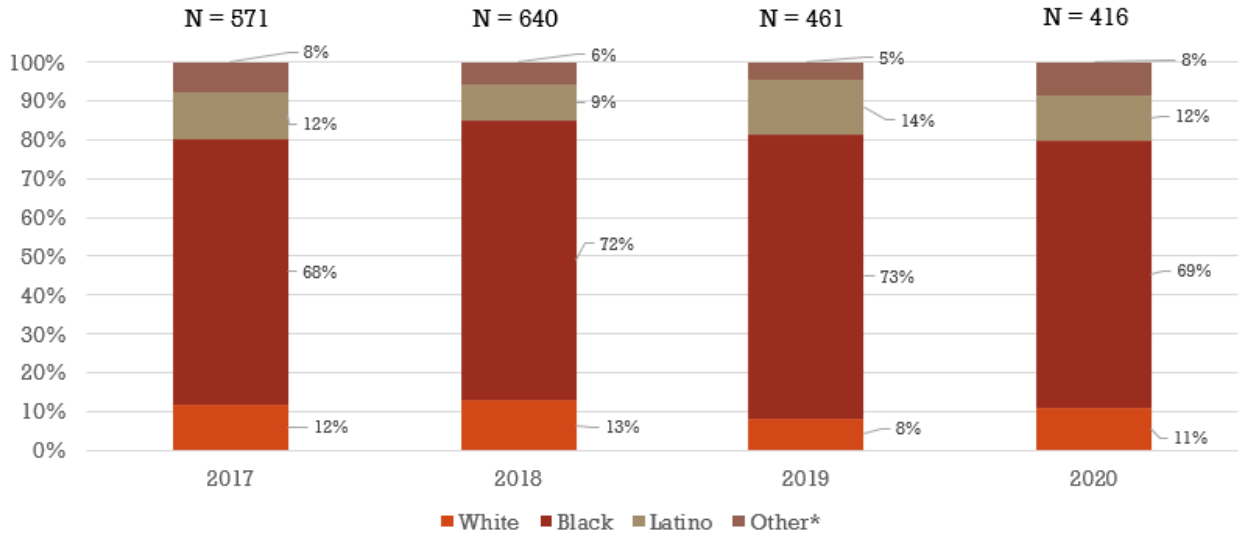


*Other mode of transmission includes hemophilia, blood transfusion, occupational exposure (healthcare workers), and perinatal exposure

[a]Most up to date from WV was for 2019

Newly Diagnosed Stage 3 (AIDS) Cases. For the four-year period of Jan. 1, 2017–Dec. 31, 2020, a total of 2,088 Stage 3 (AIDS) diagnoses were reported in the DC EMA. Overall, the number of new cases for each subsequent year has declined, but the proportion of new cases by race/ethnicity has remained relatively constant across the three years. Consistent with living HIV cases, newly diagnosed Stage 3 (AIDS) cases were predominantly among people of color, men, and those diagnosed between the ages of 20–49 and attributed to MSM transmission. The majority of newly diagnosed Stage 3 (AIDS) diagnoses were among Black non-Latinos in the DC EMA. Except for West Virginia, this is also true by jurisdiction. Half of all newly diagnosed AIDS cases in West Virginia were white non-Latino.

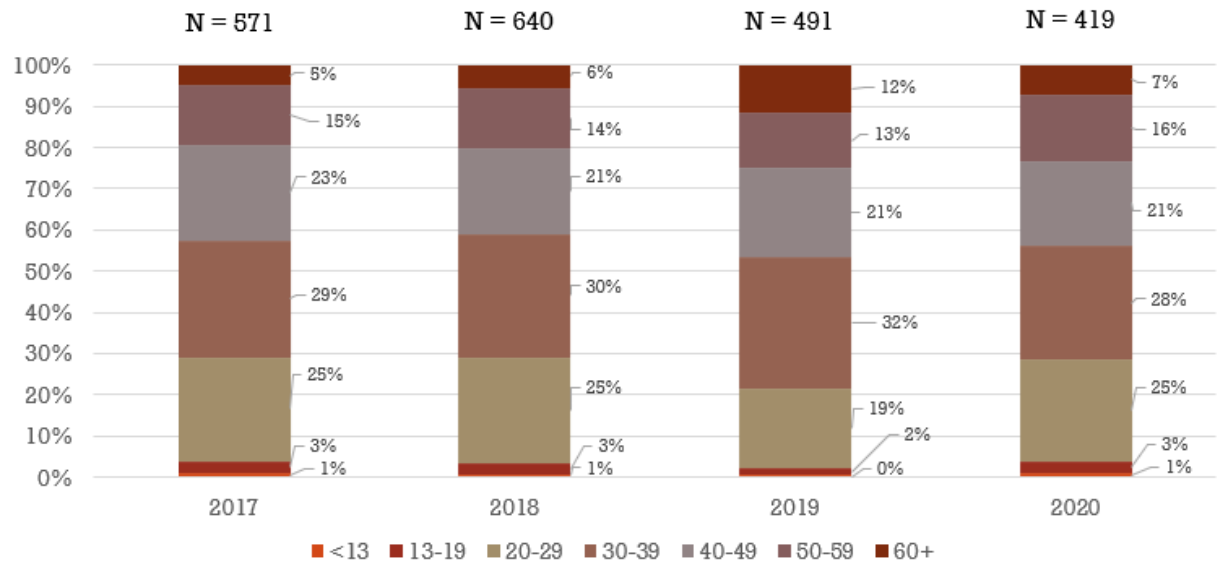
Figure 12. Newly Diagnosed Stage 3 (AIDS) by Race/Ethnicity and Year, DC EMA 2017-2020[a]



*Other race/ethnicity include Asian, Pacific Islander, Alaska Native, American Indian, Native Hawaiian and missing
[a]Most up to date information from WV was for 2019

Overall, the majority of newly diagnosed Stage 3 (AIDS) cases were among residents aged 40-49, 30-39 and 20-29 in the DC EMA. This is similar among all jurisdictions except for West Virginia, where the majority were aged 20-29 at diagnosis.

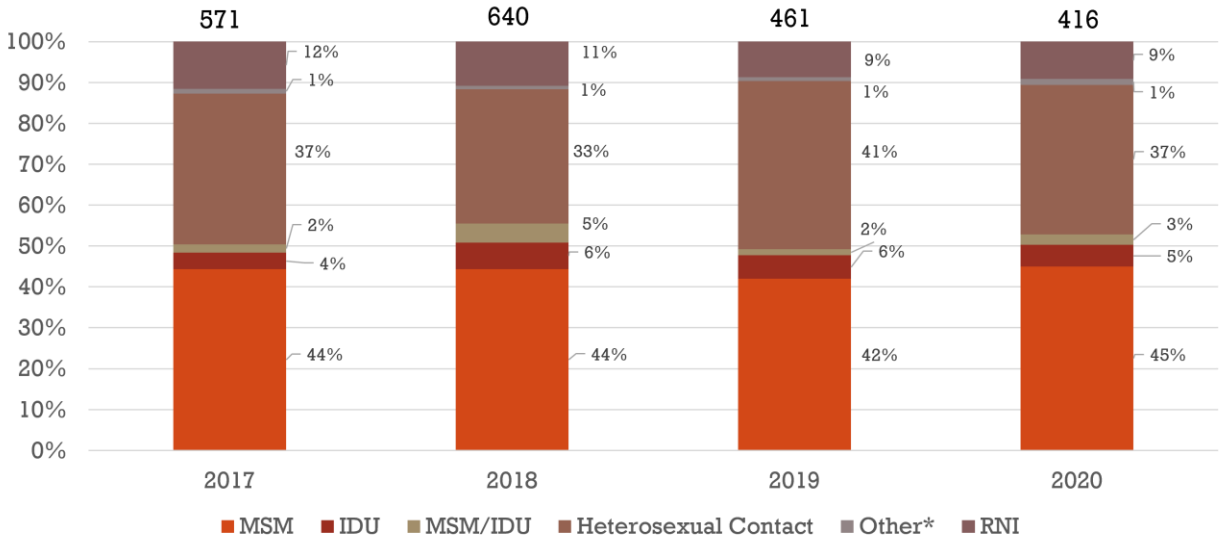
Figure 13. Newly Diagnosed Stage 3 (AIDS) by Age at Diagnosis and Year, DC EMA 2017-2020[a]



[a]Most up to date information from WV was for 2019

New diagnoses of Stage 3 (AIDS) cases by mode of HIV transmission varied by jurisdiction. Except for Maryland, the highest mode of transmission was MSM followed by heterosexual contact.

Figure 14. Newly Diagnosed Stage 3 (AIDS) by Mode of Transmission and Year, DC EMA 2017-2020[a]



*Other mode of transmission includes hemophilia, blood transfusion, occupational exposure (healthcare workers), and perinatal exposure

[a]Most up to date information from WV was for 2019

CDC HIV Testing Program Data. Most testing (70%) occurs in clinical settings (hospitals and other healthcare facilities) but other locations that provide testing include community-based organizations, faith-based organizations, mobile testing facilities, and organizations that serve populations at high risk,

including men who have sex with men, African American men, Latinos, commercial sex workers, and transgender persons. In 2020, through the CDC testing program in DC, 179 people tested positive for HIV out of 9,446 total tests. Half of those testing positive were between the ages of 25-44 years (49%). A large proportion of those who tested positive identified as Black (67.6%) or Latino (23.5%). Most were men (57.5%), 23.8% were women and 7.3% identified as transgender women. The most common identified mode of transmission was sexual contact among men who have sex with men (29.6%); however, a large percentage (45.3%) had no identified risk.

Early Identification of Individuals with HIV/AIDS (EIIHA). DC Health has an interdisciplinary work group guiding implementation of the FY2021 EIIHA plan. DC Health envisions a regional HIV health system in the DC EMA that is patient-centered and integrates the prevention to care continuum. As health departments throughout the DC EMA region create goals/plans to end the epidemic, the EIIHA team, regional integrated care and prevention planning commission and DC Health will work collaboratively to incorporate strategies and ensure a regional approach.

Socioeconomic Data for People living with HIV Receiving RW Services in the DC EMA. The socioeconomic data presented below is the poverty level and medical insurance status for Ryan White consumers in the DC EMA in 2020, with approximately 70% living below 100% of the federal poverty level (FPL).

Table 1. Washington, DC EMA PLWH by Federal Poverty Level, 2020

Poverty Level, Washington DC Eligible Metropolitan Area	PWH	
	Number	Percentage
<100% of FPL	8,015	70.48%
100 - 138% of FPL	880	7.74%
139 - 200% of FPL	1092	9.6%
201 - 250% of FPL	549	4.83%
251 - 400% of FPL	941	8.27%
401 - 500% of FPL	247	2.17%
>500% of FPL	80	.7%
Missing	0	0%
Total	**11,372**	**100%**
At or Below 138% FPL (Medicaid Eligibility)	8,895	78.21%
At or Below 400% FPL (Premium Asst Threshold)	11,045	97.12%
RW Income Eligibility (500%FPL) Threshold	11,292	99.29%

Source: 2020 Ryan White Services Report, Consolidated DC EMA Summary Data

Data on medical insurance status for the entire DC EMA shows that 75% of Ryan White customers have some type of medical insurance coverage. Approximately 36% were covered by Medicaid, 16% by Medicare, and 23% were covered through private insurance. Approximately 20% of people living in the DC EMA did not have insurance.

Table 2. Washington, DC EMA PLWH by Insurance Type, 2020

Insurance	DC	%	MD	%	VA	%	WV	%	EMA	%
Private - Employer	377	5.2	52	3.4	356	13.6	24	16	809	7
Private - Individual	740	10.2	292	18.9	402	15.4	8	5.3	1,442	12.5
Medicare	1,284	17.8	137	8.9	393	15.1	53	35.3	1,867	16.2
Medicaid, CHIP or other public	3,278	45.4	285	18.5	511	19.6	40	26.7	4,114	35.7
VA, Tricare & other military	6	0.1	4	0.3	5	0.2	14	9.3	29	0.2
Indian Health Srvc.	0	0	0	0	0	0	0	0	0	0
Other Plans	285	3.95	111	7.2	12	0.5	3	2	411	3.6
No ins./uninsured	1,251	17.3	361	23.4	747	28.6	5	3.3	2,364	20.5
Missing	0	0	301	19.5	183	7	3	2	487	4.2
Grand Total	**7,221**	**100**	**1,543**	**100**	**2609**	**100**	**150**	**100**	**11,523**	**100**

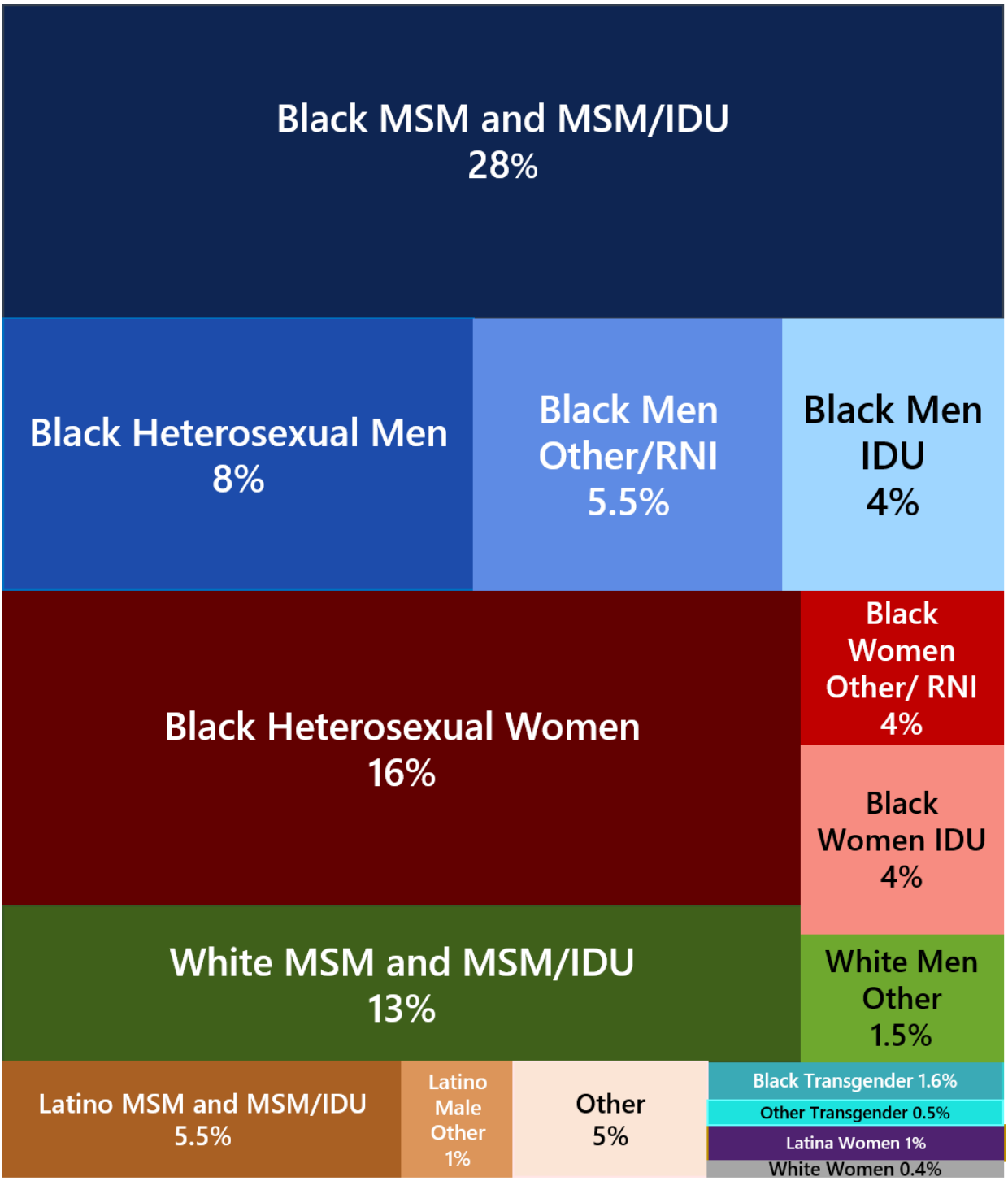
Source: 2020 Ryan White Services Report, Consolidated DC EMA Summary Data

Disproportionate Impact of HIV on Certain Populations. Surveillance and Ryan White data are monitored for patterns and emerging populations, as well as co-morbidities that impact the complexity and cost of care. The demographic characteristics reviewed include gender, age, race/ethnicity, and mode of transmission. While the number of newly diagnosed HIV cases continues to decline within the DC EMA, such declines are not consistent across all demographic populations, contributing to continuing health disparities.

Overall, people of color continue to be disproportionately impacted by HIV, representing 76.8% of HIV cases living in the DC EMA even though they comprise about half (50.3%) of its total population. Blacks accounted for over two-thirds (68%) of newly diagnosed HIV cases in 2020 and 66.1% of the people estimated to be diagnosed and living with HIV in the DC EMA yet only comprise nearly one-quarter (23.8%) of the population of the EMA. Over half (51.0%) of people diagnosed with HIV in the DC EMA were between the ages of 40 and 59 at the end of 2020 and over 75% of HIV diagnoses were transmitted through sexual contact. Analysis of the data also showed that those under the age of 30 years accounted for a growing percentage of newly diagnosed HIV cases with the 20-29 age group consistently being the largest ten-year age group with newly diagnosed HIV cases at about one third of total newly diagnosed HIV cases over the last five years. Women of color and those who list MSM behavior as their primary risk factor have also represented significant proportions of newly diagnosed HIV cases.

Proportion of Cases Living in DC by Race/Ethnicity, Gender Identity, and Mode of Transmission. The graph below displays the intersecting characteristics of people living with HIV in DC and the disproportionate impact on certain populations.

Figure 15. Characteristics of PLWH in Washington, DC, 2020



HIV Clusters. There are currently four steps in the cluster detection and response process: network identification, network prioritization, network investigation, and reporting of findings.

On a monthly basis, the CDC-provided and locally created SAS programs are executed to: 1) identify sequence data quality concerns; 2) properly format and prepare data for upload to Secure HIV-TRACE; 3) summarize the results generated from cluster detection in Secure HIV-TRACE; 4) determine which molecular clusters meet the local criteria of active, monitoring, and inactive investigation; and 5) generate a list of new cluster members needing follow-up. Data to identify time-space clusters is uploaded to Tableau monthly. In 2019, 55.6% of new HIV cases had a reported genotype test sequence within 3 months of diagnosis. In 2020, only 43.6% of new HIV cases had a reported genotype test sequence within 3 months of diagnosis, most likely due to the COVID-19 pandemic.

Clusters are prioritized in the following ways:

Molecular clusters

- Active: networks with 3+ members and at least 1 diagnosed in the previous 6 months
- Monitoring: networks with 3+ members and at least one member diagnosed 6-12 months prior, or all network outreach attempts have been completed
- Inactive: networks with 3+ members where no one was diagnosed in the previous 12 months

Epidemiologically linked clusters

- Active: networks with 5+ members and at least 2 members diagnosed in the previous 6 months
- Monitoring: networks with 5+ members and at least 2 members diagnosed 6-12 months prior, or all network outreach attempts have been completed
- Inactive: networks with 5+ members where <2 members diagnosed in the previous 12 months

Time-space clusters

- Active: zip codes where the number of new diagnoses is greater than two standard deviations (SD) above the mean number of new diagnoses for the prior 12 months
- Monitoring: zip codes where the number of new diagnoses is greater than one SD above the mean number new diagnoses for the prior 12 months
- Inactive: zip codes where the number of new diagnoses is less than one SD above the mean number new diagnoses for the prior 12 months

Networks are investigated by the Cluster Detection Response (CDR) Investigator, who starts with active molecular clusters as the highest priority. The CDR investigator attempts to gather as much information as possible by searching for cluster members with DC residence in our internal DC Public Health Information System (DCPHIS), searching for cluster members in the Chesapeake Regional Information System for Our Patients (CRISP), conducting CDC-based Soundex checks, conducting out of jurisdiction (OOJ) record searchers, and contacting the last known provider. If searches conducted by the CDR investigator do not yield any information, cases are tasked to Disease Intervention Specialists (DIS) for field investigation. Some of the interventions offered by DIS included risk education, risk reduction, care navigation and treatment adherence, linkage to care, and HIV/STI testing for partners. The CDR investigator meets with the CDR Coordinator weekly to provide updates on individual cluster members.

Findings are reported in a variety of meetings including:

- Weekly Case Conference between the CDR Investigator and CDR Coordinator to discuss cluster updates
- Monthly SID Cluster Meetings between the CDR Coordinator and the SID leadership team to review existing clusters and refine processes for identifying and responding to clusters
- Monthly Regional MHS Meetings between DC, Maryland, and Virginia Department of Health (DOH) staff to discuss generalized cluster information of regional concern
- Bimonthly Situational Update Meetings between the CDR Coordinator and the HAHSTA Leadership to provide situational awareness for local active clusters and/or clusters of national significance and to connect issues identified in the collection of CDR data to programmatic action

Between 2016 and 2020, two molecular clusters meeting national priority criteria were identified.

- Cluster 1: When first identified, the cluster contained a total of 12 members (9 molecular cases and 3 named partners). The cluster has not grown since it was first identified. Key characteristics of the cluster are described in the Table 3 below:

Table 3. Key Characteristics of Cluster 1, 2016-2020

Characteristic	HIV Positive Cases (n=9)	HIV Positive Partners (n=2)	Status-Unknown Partners (n=1)
Age at HIV Diagnosis			
13-19	0 (0.0%)	0 (0.0%)	0 (0.0%)
20-29	8 (88.9%)	1 (50.0%)	0 (0.0%)
30-39	1 (11.1%)	0 (0.0%)	0 (0.0%)
40-49	0 (0.0%)	1 (50.0%)	0 (0.0%)
50-59	0 (0.0%)	0 (0.0%)	0 (0.0%)
Current Age			
13-19	0 (0.0%)	0 (0.0%)	0 (0.0%)
20-29	3 (33.3%)	0 (0.0%)	1 (100.0%)
30-39	6 (66.7%)	1 (50.0%)	0 (0.0%)
40-49	0 (0.0%)	0 (0.0%)	0 (0.0%)
50-59	0 (0.0%)	1 (50.0%)	0 (0.0%)
Sex			
Male	9 (100.0%)	2 (100.0%)	1 (100.0%)
Female	0 (0.0%)	0 (0.0%)	0 (0.0%)
Unknown	0 (0.0%	0 (0.0%)	0 (0.0%)
Race/Ethnicity			
White	0 (0.0%)	0 (0.0%)	0 (0.0%)
Black/African American	8 (88.9%)	2 (100.0%)	0 (0.0%)
Latino/Latino	1 (11.1%)	0 (0.0%)	0 (0.0%)
Multiple Races	0 (0.0%)	0 (0.0%)	0 (0.0%)
Unknown	0 (0.0%)	0 (0.0%)	1 (100.0%)
Transmission Category			
MSM	9 (100.0%)	2 (100.0%)	N/A
MSM and Heterosexual Contact	0 (0.0%)	0 (0.0%)	N/A
MSM and IDU	0 (0.0%)	0 (0.0%)	N/A
Heterosexual Contact	0 (0.0%)	0 (0.0%)	N/A
Other	0 (0.0%)	0 (0.0%)	N/A
Unknown	0 (0.0%)	0 (0.0%)	N/A
Current Viral Load Suppression Status* (n=5)			
Suppressed (<200 c/mL)	3 (60.0%)	1 (50.0%)	N/A
Not Suppressed	2 (40.0%)	1 (50.0%)	N/A

*Limited to living DC Cases. Based on last available viral load result within 6 months of the most recent sequence analysis (July 2022).

One gap in care identified and addressed through cluster response activities was a temporary lapse in insurance coverage that resulted in visit and medication adherence issues.

- Cluster 2: When first identified in December 2020, the cluster contained a total of 11 members (9 molecular cases and 2 named partners). As of July 2022, the cluster contains a total of 14 members (11 molecular cases and 3 named partners). Key characteristics of the cluster are described in Table 4 below:

Table 4. Key Characteristics of Cluster 2, 2016-2020

Characteristic	HIV Positive Cases (n=11)	HIV Negative Partners (n=2)	Status-Unknown Partners (n=1)
Age at HIV Diagnosis			
13-19	0 (0.0%)	0 (0.0%)	0 (0.0%)
20-29	5 (45.4%)	0 (0.0%)	0 (0.0%)
30-39	3 (27.3%)	0 (0.0%)	0 (0.0%)
40-49	1 (9.1%)	0 (0.0%)	0 (0.0%)
50-59	2 (18.2%)	0 (0.0%)	0 (0.0%)
Current Age			
13-19	0 (0.0%)	0 (0.0%)	0 (0.0%)
20-29	4 (36.4%)	0 (0.0%)	0 (0.0%)
30-39	4 (36.4%)	2 (100.0%)	0 (0.0%)
40-49	1 (9.1%)	0 (0.0%)	0 (0.0%)
50-59	2 (18.2%)	0 (0.0%)	0 (0.0%)
Sex			
Male	11 (100.0%)	2 (100.0%)	1 (100.0%)
Female	0 (0.0%)	0 (0.0%)	0 (0.0%)
Unknown	0 (0.0%	0 (0.0%)	0 (0.0%)
Race/Ethnicity			
White	9 (81.8%)	0 (0.0%)	0 (0.0%)
Black/African American	1 (9.1%)	0 (0.0%)	0 (0.0%)
Latino/Latino	0 (0.0%)	0 (0.0%)	0 (0.0%)
Multiple Races	0 (0.0%)	0 (0.0%)	0 (0.0%)
Unknown	1 (9.1%)	2 (100.0%)	1 (100.0%)
Transmission Category			
MSM	8 (72.7%)	N/A	N/A
MSM and Heterosexual Contact	0 (0.0%)	N/A	N/A
MSM and IDU	2 (18.2%)	N/A	N/A
Heterosexual Contact	0 (0.0%)	N/A	N/A
Other	0 (0.0%)	N/A	N/A
Unknown	1 (9.1%)	N/A	N/A

Current Viral Load Suppression Status* (n=9)			
Suppressed (<200 c/mL)	5 (55.6%)	N/A	N/A
Not Suppressed	4 (44.4%)	N/A	N/A

*Limited to living DC Cases. Based on last available viral load result within 6 months of the most recent sequence analysis (July 2022).

Three gaps in HIV prevention were identified through cluster response activities: 1) limited knowledge of harm reduction methods and limited access to harm reduction materials; 2) limited knowledge of where to access PrEP; and 3) limited knowledge of the potential side effects of PrEP that eventually subside. As a result of investigating this cluster, an effort was made to revise data collection about risk behaviors across programs to be more sensitive and capture those who engage in certain behaviors infrequently.

Comorbidities Affecting People living with HIV in the DC EMA. Comorbidities among people living with HIV in the DC EMA are characterized as ever being diagnosed with HIV and a diagnosis of another disease. There were substantial comorbidities among people diagnosed and living with HIV in the DC EMA. Compared to the general population, people living with HIV have higher rates of sexually transmitted infections, tuberculosis, and Hepatitis B and C; rates more than three to over 10 times the general population.

Impact of COVID-19 on HIV surveillance data*.* Conducting re-engagement/linkage activities during the COVID-19 pandemic has been challenging. Most providers were forced to alter their operations in response to the pandemic either moving to telemedicine or closing entirely. As a result, DC Health was not able to conduct direct patient contact or re-engagement between March 2020 and May 2020. As DC moved into phases of reopening, infectious disease providers increased their availability and acceptance of re-engagement appointments, and the activities were able to resume. Reengagement/linkage activities have resumed via telephone, assisting with the confirmation of appointments and attendance.

COVID-19 challenges had an immense effect on data and capacity across the DC EMA. Detailing of health department and provider staff to pandemic response and the resulting data and capacity issues across the region forced jurisdictions to adjust to difficult circumstances without significant disruptions to care delivery. However, with continuing federal support, the DC EMA will advance progress on Ending the Epidemic initiatives, the National HIV/AIDS Strategy, HRSA HAB goals, and holistic outcomes for people living with HIV, while continuing to effectively recognize and respond to health inequities and needs in our communities.

Table 5. Comorbidities among the General Population and PLWHA, DC EMA, December 31, 2020[4]

		General Population					PLWHA				
Comorbidity		**DC**	**VA**	**MD**	**WV***	**Total**	**DC**	**VA**	**MD**	**WV***	**Total**
Chlamydia	N	5,956	9,278	12,841	-	28,075	342	175	412	-	929
	Rate	843.90	302.0	516.9	-	554.3	1890.9	2108.0	3146.2	-	2381.7
Gonorrhea	N	3,593	2,105	3,874	-	9,572	478	200	478	-	1,156
	Rate	509.1	68.0	156.0	-	244.4	2642.8	2409.0	3650.2	-	2900.7
Syphilis	N	234	166	275	-	675	73	123	90	-	286
	Rate	33.1	5.0	11.1	-	16.4	403.6	1482.0	687.3	-	857.6
Tuberculosis	N	19	88	101	-	208	3	2	20	-	25
	Rate	2.7	3.0	4.1	-	3.3	16.6	24.0	152.7	-	64.4
Hepatitis B	N	301	1,001	945	-	2,247	18	15	26	-	59
	Rate	42.8	33.0	38.2	-	38.0	101.2	222.2	202.2	-	175.2
Hepatitis C	N	1,099	2,322	1,460	-	4,881	41	19	32	-	92
	Rate	156.5	76.0	59.0	-	97.2	230.6	506.2	248.9	-	328.6

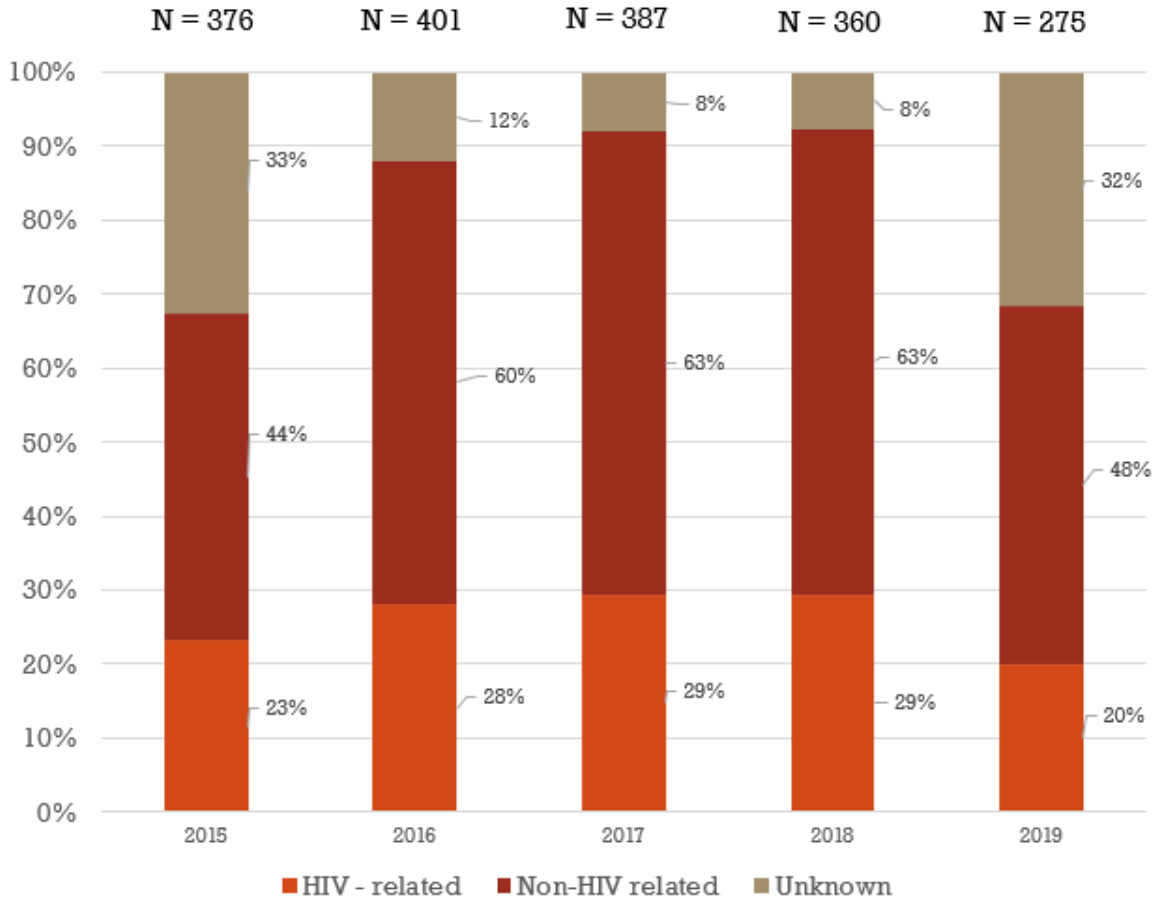
Table 6. Comorbidities among the General Population and PWH, 2020

Comorbidity	**General Population**		**PWH**	
	Number in 2020	**Rate per 100,000**	**Number in 2020**	**Rate per 100,000**
Chlamydia	28,075	554.3	929	1767.6
Gonorrhea	9,572	244.4	1,156	2042.3
P&S Syphilis	675	16.4	286	726.5
TB	208	3.3	25	93.9
	Number in 2019	**Rate per 100,000**	**Number in 2019**	**Rate per 100,000**
HBV	2,247	36.1	62	159.0
HCV	4,881	78.4	114	292.4

Trends in Deaths among People living with HIV. Examining five-year trends on the cause of death among people living with HIV across the DC EMA, deaths were non-HIV related. However, it is interesting to note the Virginia jurisdiction reported a large percentage of deaths with an unknown cause (47%).

[4]Sources: General population and PLWHA data were derived from epidemiologic data, with rates per 100,000. Ryan White-specific data were derived from the Ryan White Services Report. WV data were not available.

Figure 16. Cause of Death by Year, DC EMA, 2015-2019



Ryan White Services Report, GY 2020. While the data presented above represent 2020 surveillance data for the entire DC EMA, the following data describes those who received Ryan White services in the DC EMA for 2020. A total of 4,312 people living with HIV received Ryan White services in 2020. The majority of Ryan White consumers are men (60%) while women represent 38%, and transgender persons represent about 2% of the population. Clients aged less than 24 years made up about 6% of the total population of Ryan White consumers in the DC EMA. Consumers between 25 – 44 years old made up about 38% while those aged 45 and older represent the largest proportion (56%). Black or African Americans constitute the majority of the client population across the DC EMA. The highest proportions of consumers are Black or African Americans (84.8%). Heterosexual contact is the most common mode of transmission across all jurisdictions (46.3%), followed by men who have sex with men (33.4%).

Ryan White Service Utilization. Customers that utilize RWHAP services have favorable health outcomes because of early entry into and retention in care activities, as well as the treatment adherence and wraparound services. With healthcare payment reform and expanded Medicaid programs, most people living with HIV in the DC EMA have medical insurance

Due to generally higher rates of insurance coverage for PWH in the DC EMA, service utilization of Ryan White services has decreased overall, with a significant decrease in core service utilization and increase in support service utilization. This information assists in determining service priorities and resource

allocation and the decision-making process to seek a core services waiver for the DC EMA. The following tables outline core medical and support service usage across the DC EMA, from 2012-2020.

Table 7. Core Medical Services Utilization, DC EMA, 2020

DC EMA	2012	2013	2014	2015	2016	2017	2018	2019	2020	Change in Utilization[a]
Core Medical Service	**%**	**%**	**%**	**%**	**%**	%	%	%	%	
OAHS	59	71	71	77	73	74	51	58	62	↑
MCM	59	61	64	58	55	56	50	44	46	↑
Mental Health	18	29	22	24	24	19	7	8	9	↑
Oral Health	17	23	17	21	26	24	9	16	8	↓
Medical Nutrition	11	22	12	7	7	5	6	6	5	↓
Substance Use (Out.)	3	6	4	8	10	8	1	1	1	–[b]
Health Insurance Prog.	3	3	7	3	6	6	5	0	-	**N/A[c]**
EIS	1	3	2	3	3	4	9	9	17	↑
Home and Community Based Services	1	1	0	0	0	0	.5	.3	.4	↑

[a]Change in utilization from 2019 to 2020

[b]No change

[c]Not applicable

Table 8. Support Service Utilization, DC EMA, 2020

DC EMA	2012	2013	2014	2015	2016	2017	2018	2019	2020	Change in Utilization[a]
Support Service	**%**	**%**	**%**	**%**	**%**	%	%	%	%	
Food Bank	15	24	12	6	3	8	10	11	11	–
Medical Transport.	7	15	13	14	13	13	11	18	14	↓
EFA	13	10	15	12	20	17	16	19	18	↓
Linguistic	2		3	2	4	4	4	4	2	↓
Psycho-social	2	3	0	1	1	4	4	5	4	↓
Outreach	0	2	1	2	3	3	7	9	4	↓
NMCM	3	2	4	4	20	23	14	42	47	↑
Legal	10	1	1.4	2	2	-	1	-	-	–[b]
Referral to Healthcare	1	0.4	0.4	0	0	-	-	6	5	↓
Child Care	1	0.3	0.4	0	0	-	-	-		**N/A[c]**

[a]Change in utilization from 2019 to 2020

[b]No change

[c]Not applicable

Provision of care is complex and continues to develop in all four jurisdictions. Jurisdictions report a higher demand on case managers to perform insurance troubleshooting and advocacy to help Medicaid- and ACA-insured customers navigate these systems to receive needed care. This is clearly demonstrated in the overall increase in utilization of Non-Medical Case Management (NMCMS). Across the DC EMA, case managers help customers understand communications from insurance companies, intercede with

customers to address premium payment issues/cancellation notices, help customers understand and manage insurance bills, determine how customers will pay for out-of-pocket expenses, review plan's medication formularies for coverage of the customer current drug regimens, and educate customers how their insurance works, including how to use mail-order pharmacies. The DC EMA continues to make data driven decisions to create the best system of care to promote optimal health and wellness that leads to and maintains viral suppression.

AIDS Drug Assistance Program. The AIDS Drug Assistance Program (ADAP) in Washington DC served 1,295 clients in 2020 and responded to 9,383 Claims. Clients were a majority Black (64.8%) and male (75.6%) and overall, 21% were Latino. A third of clients (36%) were within 0-100% of the federal poverty level (FPL). The remaining 64% of clients earned between 100%-500% of the FPL. As the payer of last resort, this underscores the point that a significant number of HIV infected individuals rely on the ADAP program to provide their HIV medications and assist with paying their health care premiums. With the implementation of the Affordable Care Act (ACA), HIV positive persons were able to obtain quality healthcare coverage because insurance carriers could no longer deny a person with a pre-existing health condition from securing health insurance.

Behavioral Surveillance. Most of the behavioral survey data presented below pertains to DC only and not the entire EMA. In addition, behavior survey data are not collected every year. However, included below are data summaries from the most recent Youth Risk Behavior Surveillance System and the National HIV Behavioral Surveillance system.

Youth Risk Behavior Surveillance (YRBS). In the District of Columbia in 2020, youth ages 13 to 24 comprise 14% of the population. As the table below illustrates, DC youth disproportionately engage in sexual behaviors that increase the risk for sexually transmitted infections (STIs), including HIV, as well as unintended pregnancy, compared with youth nationally. Across DC, in 2019, 7.6% of male students and 1.4% of female students reported initiation of sexual intercourse by age 11, while 14.4% of male students and 2.1% of female students reported initiation by age 13. Additionally, 24.1% of high school students had a recent sexual partner who was three or more years older. At the end of 2019, HIV prevalence among youth ages 13–24 was 0.3%.

DC 2019 YRBS Report: Sexual Activity, STD, and HIV testing Among High School Aged Youth by Grade. The graph below displays that as youth get older, their sexual activity increases, but STD and HIV testing also increase at similar rates. However, by 12th grade, 62.5% of youth are sexually active, but only 40.7% have ever been tested for HIV. STD and HIV testing among sexually active youth remains particularly critical. However, DC high school-aged youth reported higher rates of condom use than the national average, and 66.8% of males, compared to 47.2% of females reported using condoms during their last sexual intercourse.

Figure 17. Youth Risk Behavior Surveillance Data Among High School Aged Youth by Grade, 2019

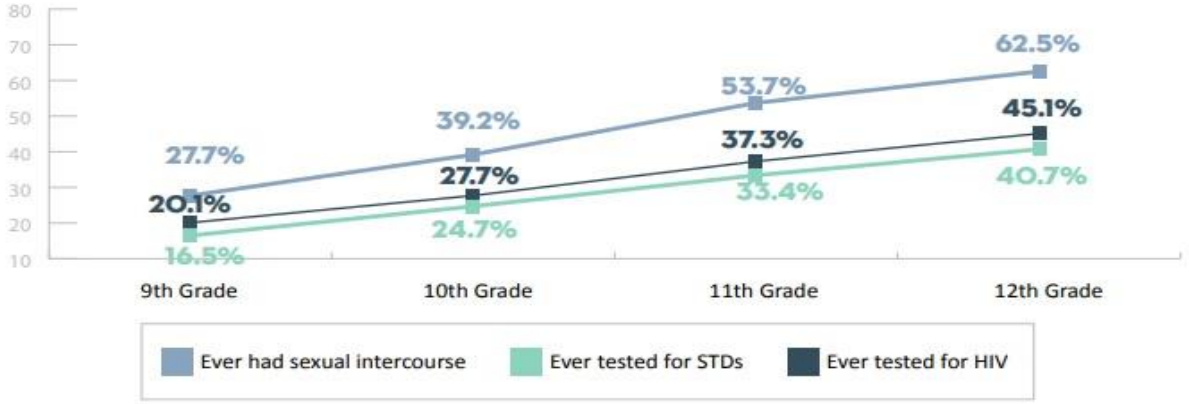


Table 9. Youth Risk Behavior Surveillance Sexual Activity Data - National & DC, 2019

Sexual Activity	DC	National
Ever had sexual intercourse	44.0% (CI: 42.9–45.1)) Total: 8,269	38.4% (CI: 35.4–41.6) Total: 11,040
Had sexual intercourse for the first time before age 13 years	7.9% (CI: 7.3–8.5) Total: 8,335	3.0% (CI: 2.5–3.6) Total: 11,962
Had sexual intercourse with four or more persons (during their life)	12.2% (CI: 11.5–13.0) Total: 8,256	8.6% (CI: 7.5–9.9) Total: 11,959
Were currently sexually active (had sexual intercourse with at least one person, during the 3 months before the survey)	30.9% (CI: 29.9–32.0) Total: 8,219	27.4% (CI: 25.2–29.8) Total: 11,959
Did not use a condom during last sexual intercourse (among students who were currently sexually active)	42.9% (CI: 40.8–45.0) Total: 2,309	45.7% (CI: 43.4–48.0) Total: 3,141
Did not use any method to prevent pregnancy during last sexual intercourse (among students who were currently sexually active)	20.8% (CI: 19.1–22.6) Total: 2,317	11.9% (CI: 10.3–13.9) Total: 3,048
Drank alcohol or used drugs before last sexual intercourse (among students who were currently sexually active)	16.5% (CI: 15.1–18.1) Total: 2,384	21.2% (CI: 18.8–23.9) Total: 3,136

National HIV Behavioral Surveillance (NHBS). For the National HIV Behavioral Surveillance system, the CDC identified three target populations with significant risk and behaviors associated with HIV infection: heterosexually active persons at increased risk of HIV infection (NHBS-HET), men who have sex with men (NHBS-MSM), and persons who inject drugs (NHBS-PWID). DC Health contracted with the George Washington University Milken Institute School of Public Health, Department of Epidemiology (GWU) to conduct the study for DC and named the local version the Washington Outreach Research Drive to Understand Prevention (WORD UP).

Heterosexually Active Persons 2016. Major findings from this sample of heterosexually active persons revealed that: 29% of HIV positive individuals were unaware of their status prior to the study and rates

of HIV were higher among women than men. All newly positive study participants had been to a health care provider in the previous 12 months, but only 8% were offered an HIV test at a provider visit.

Condom use was inconsistent, and only 40% reported condom use during their last sexual encounter. Most study participants (90%) perceived themselves to be at low risk of acquiring HIV through unprotected sex. One-third of participants reported having concurrent sexual partnerships and more than one third (38%) believed their last partner had sex with other partners as well. Only 8.5% of participants had previously heard of PrEP, less than half (41%) of participants expressed interest in using PrEP, and only 8% participants knew where to get PrEP in DC. More than half of the study participants (55%) reported non-injection drug use with marijuana having the highest utilization rate (51.5%), followed by crack cocaine (19%) and powdered cocaine (15%).

Men who have Sex with Men 2017. Major findings from this sample of men who have sex with men revealed that: 21% of HIV positive individuals were unaware of their status prior to the study and rates of HIV were higher among men of color compared to white men. Most men in the study had been to a health care provider in the previous 12 months (89%), and 71.5% were offered an HIV test at a provider visit.

Condom use was inconsistent, with 66% reporting condomless anal sex during their last sexual encounter. Black men were more likely than other men to exchange sex during their last sexual encounter. More than one-third of participants reported seven or more partners in the previous 12 months. More than half of the men (59%) reported having concurrent sexual partnerships and 64% believed their last partner had sex with other partners as well. Most participants (94%) had prior knowledge of PrEP and more than one-third (38%) had ever taken PrEP. Roughly two-thirds (68%) of HIV-negative participants who were not on PrEP had considered taking it. Among HIV-negative participants, 85% would be extremely likely/likely to take injectable PrEP and 66% would prefer an injection. Among those who were on PrEP, 76% would switch to an injectable form. Among HIV-positive participants, 72% had any partners who were on PrEP and over a third (35%) would be extremely unlikely/unlikely to use condoms if their partner was on PrEP. Half of the study participants (50.5%) reported marijuana use and 42% reported binge drinking in the past 30 days. Other non-injection drugs utilized by study participants include poppers (28%) and powdered cocaine (19%).

Persons who Inject Drugs 2018*.* The majority of the participants in the study were long-time injectors: the average time from start of injection drug use was 31.7 years. More than three-quarters of participants (77%) were 50 years old and older, but many participants started injection drug use at an average age of 23.9 years old. A higher proportion of participants reported sharing cookers, cotton or works (53.4%) than sharing needles (40.5%) or using drugs divided with a used syringe (40.7%) in the last 12 months. Women were more likely to use drugs divided with a used syringe than men. Only 13% of participants reported using condoms the last time they had vaginal sex. Less than one-fourth of participants (23%) were HIV positive with 13% of those reporting being unaware of their diagnosis prior to the study. Overall, 78% of participants had seen a medical provider in the last year with 56% being offered an HIV test.

Heterosexually Active Persons 2019*.* Major findings from this sample of heterosexually active persons revealed that: 37% of HIV positive individuals were unaware of their status prior to the study. Most participants (82%) had been to a health care provider in the previous 12 months, and 68% were offered an HIV test at a provider visit.

Condom use was inconsistent, with 64% of participants reporting condomless vaginal sex in the past 3 months. Less than one-third of participants (29%) reported having concurrent sexual partnerships and almost half of participants (45%) believed their last partner had sex with other partners as well. Almost half of participants (49%) had previously heard of PrEP (a significant increase from the previous cycle), yes less than 1% had taken PrEP in the past 12 months. Women were more likely to have heard of PrEP (53.5% versus 36.5%, p=0.0305), yet men were more likely to have had a discussion with a healthcare provider about PrEP in the last 12 months. More than half of participants (59%) of participants expressed interest in using PrEP, yet only 21% participants knew where to get PrEP in DC. More than half of the study participants (63%) reported marijuana use and 52% reported binge drinking in the past 30 days. Other non-injection drugs utilized by study participants include powdered cocaine (22%) and ecstasy (21%).

Transgender Women 2019-2020*.* While DC was not funded by CDC to participate in the National HIV Behavioral Surveillance among Transgender Women (NHBS-Trans) study conducted from 2019-2020, the GW team was able to secure local funding from DC Health to conduct a behavioral surveillance study (DC-Trans) among transgender women (n=151) in DC that was modeled after the NHBS-Trans study. Only 4% of participants were unaware of their HIV status prior to the study and Black women were more likely than Other or Latina women to test positive for HIV. Most participants (92%) had been to a health care provider in the previous 12 months, and 72% were offered an HIV test at a provider visit. Latina women were more likely than Black or Other women to be offered an HIV test within the past 12 months. Also, Latina women were more likely than Black or Other women to have lacked health care due to cost. Other women were more likely than Black or Latina women to report feeling comfortable with their provider.

Almost all participants (95%) had initiated medical gender transition and most (77%) were currently taking hormones. For almost all of participants (94%), their insurance covered their hormones and about half the participants (59%) began taking hormones before the age of 22.

Condom use was inconsistent, with 58.5% reporting condomless insertive anal sex in past 12 months and 56% reporting condomless receptive anal sex in past 12 months. More than half of participants (55%) reported having concurrent sexual partnerships. Most participants (statu) knew where to get PrEP and 88% of participants expressed interest in injectable PrEP. The most reported non-injection drugs used in past 12 months were marijuana (79.0%) and powdered cocaine (48.4%).

Men who have Sex with Men 2020*.* The COVID-19 pandemic resulted in major disruptions to the venue-based sampling strategy normally utilized to recruit men who have sex with men. Passive (e.g., flyers, social media ads) and active (e.g., reaching out to MSM via dating apps) recruitment strategies were utilized instead. However, this recruitment strategy was met with limited success in DC, as only 18 participants completed the core survey.

PrEP. Prep use has greatly increased between 2016 and 2020. However, barriers to PrEP uptake and maintenance persist including cost, clinic hours, and side effects. There are also disparities in PrEP use and the DC EMA has used marketing campaigns, surveys, and social media to promote PrEP use among people of color. Nationally in 2020, 301,033 people were prescribed PrEP, covering 24.8% of the

1,216,210 persons with indications for PrEP.[5] Of those receiving PrEP in 2020, 92% were men and 65% were White. Work remains in providing adequate PrEP services to people of color and both cis-women and transgender women. Across the DC EMA, the PrEP coverage for those with PrEP indications varies by state. DC has the highest coverage with 5,953 prescribed PrEP in 2020 (46% coverage), followed by Maryland prescribing to 4,809 individuals (17.6% coverage), Virginia to 5,164 individuals (16.4%) and West Virginia to 526 individuals (10% coverage).

PrEP is a top priority HIV prevention intervention at DC Health. In FY20, DC funded community organizations to provide PrEP services to individuals who may benefit and are not living with HIV. The program's focus is: (1) support an increase in the awareness of PrEP as a potential prevention strategy for persons who are HIV negative, (2) educate possible participants in the requirements of the intervention, (3) inform medical providers on the intervention as an option for their patients, and (4) provide support in the form of risk reduction counseling, medical appointments for relevant health screenings and access to appropriate resources for successful participation in the program. Providers focus on men who have sex with men, Black women, transgender persons, and the Latino population.

To combat barriers to PrEP and reduce disparities, the DC EMA is committed to conducting innovative community engagement activities that will focus on a range of key strategies, including responding to new diagnoses faster, increasing access and acceptability for PrEP and post-exposure prophylaxis (PEP), expanding rapid ART initiation, integrating U=U into all services, addressing distinctive needs of communities (particularly young people of color), and methods to sustain treatment and PrEP adherence for viral suppression and optimal prevention.

HIV in the DC EMA: Key Points. In the DC EMA, which incorporates Washington DC, Northern Virginia, suburban Maryland and two counties in West Virginia, DC has the highest proportion (46%) of people living with HIV in the region. A majority of people living with HIV are Black, men, 30-49 years old, and had sexual contact as a mode of transmission. Most new Stage 3 (AIDS) diagnoses were among African Americans, men, those between the ages of 30-49 and those with a mode of transmission of MSM or heterosexual contact. Those newly diagnosed with HIV in the DC EMA were black, men, between 20-29 years of age with sexual contact as the mode of transmission, although there is still a large amount of newly diagnosed people living with HIV who have no identified risk factor. Among RW consumers, most lived <100% below the federal poverty level, but rates and type of medical insurance varied based on state of residence.

Overall, living HIV cases in the DC EMA are experiencing co-infections, with higher rates of disease than the general public. What is noteworthy is that STD co-infections are being diagnosed after a person already received an HIV diagnosis, which indicates that PLWH are engaging in high-risk behaviors. The majority of deaths among people diagnosed with HIV in the DC EMA between 2016 and 2019 were non-HIV related, and much like surveillance data, the majority of deaths were among blacks, males, and those between the ages 50+. For death rates by mode of HIV transmission, proportions were almost evenly spread between MSM, heterosexual contact and IDU. Behavioral data reveal that condom use remains sporadic among the groups identified by the CDC for the NHBS system. Interestingly, according

[5]Centers for Disease Control and Prevention. Core indicators for monitoring the Ending the HIV Epidemic initiative (preliminary data): National HIV Surveillance System data reported through June 2021; and preexposure prophylaxis (PrEP) data reported through March 2021. HIV Surveillance Data Tables 2021;2(No. 4). https://www.cdc.gov/hiv/library/reports/surveillance-data-tables/. Published October 2021.

to the results from the YRBS report, sexual active youth may use condoms more often, although rates are still not very high.

HIV Care Continuum Graph with Five Main Stages of Diagnosis. Figure 18 below illustrates the distinct components of the continuum of HIV care for the DC EMA. Success in the care continuum relies on the synergy of the community system of planning, support, and accountability with the health care system of direct care, quality management, and data systems. The interdependence of these systems and the entities represented in them are essential to maintain persons through a dynamic career of HIV care to achieve consistent viral load suppression and health outcomes. The following two inputs are fundamental to support an ongoing process of system improvement:

• **Community Input –** Involving a wide array of entities, including local, state, and federal entities, professional groups, the school system, and unaffiliated HIV consumers that together provide guidance and influence how the continuum will be used to track progress of people living with HIV in the different stages of the treatment cascade.

• **Health Delivery System –** A set of health care institutions, professional practitioners, and public health systems, epidemiologic research bodies, disease surveillance units, and others that directly impact the continuum of care. These entities provide the components of HIV care and ensure that standards of care are executed to achieve viral suppression among clients.

An EMA-wide continuum was generated by using consolidated data sets from each of the jurisdictional regions. The total number of diagnosed cases in the DC EMA is 39,730. The caseload for each jurisdiction reflects the burden of HIV disease, with DC having almost 46 percent of total EMA cases. Maryland is second and has similar population characteristics to DC. Virginia, the largest in land area and demographically diverse, had about 21 percent of the cases in the DC EMA. Berkeley and Jefferson counties, West Virginia, have about 1 percent of the caseload. Regarding the continuum in all four jurisdictions, it is important to note the following:

• **Diagnosed:** The DC EMA has an estimated 44,895 cases living with HIV disease; of these 39,730 are reported and diagnosed. Approximately 13 percent are unaware that they are HIV-positive. In each of the jurisdictions, about 87 percent (total number of reported and diagnosed HIV, including Stage 3) of cases are reported and diagnosed with HIV disease[6].

• **Linked to Care:** Using the requisite definition of linked to care, 46 percent of the DC EMA's diagnosed cases are in RW care; DC has 48 percent of its cases linked to care, Maryland has 49 percent of its cases linked to care, Virginia has 31 percent of its case linked to care, and West Virginia has 1 percent of its cases linked to care.

• **Retained in Care:** Following the requisite definition of retained in care, 68 percent of the DC EMA's RW clients are retained in care. DC, Maryland, Virginia, and West Virginia jurisdictions indicate that 75 percent, 50 percent, 57 percent, 100 percent are retained in care, respectively.

[6]Centers for Disease Control and Prevention. Estimated HIV Incidence and Prevalence in the United States, 2015–2019. HIV Surveillance Supplemental Report 2021;26(No. 1). http://www.cdc.gov/ hiv/library/reports/hiv-surveillance.html. Published May 2021. Accessed December 8, 2022.

- **Prescribed ART:** As required, the proportion of DC EMA clients prescribed Anti-Retroviral Therapy is 94 percent, above the national average of 37 percent. The continuum indicates that West Virginia has the highest proportion (100 percent) of its HIV medical care clients prescribed ART; DC is at 96 percent, Virginia is at 95 percent, and Maryland is at 90 percent.

- **Viral Suppression:** The National Continuum indicates that of those people living with HIV in medical care, about 30 percent are virally suppressed. The DC EMA's Continuum indicates 82 percent are virally suppressed; West Virginia has the highest proportion (100 percent) of PLWHA who are virally suppressed; DC and Virginia have 85 and 87 percent respectively. Maryland reports 73 percent. The total number of clients linked to care in West Virginia is very low (only two) which affects the rate calculation. Hence, the interpretation of proportion of retained in care, prescription of ART, and viral suppression could be misleading.

The continuum shows the focus and direction of planning HIV prevention and care services. In each stage of the continuum, a set of prevention and care services, including counseling and testing and early intervention programs, are implemented to ensure that outcomes along each stage are realized. These services/programs are best described as the integration of HIV prevention and care of people living with HIV. Increased access and referral to medical care and other services are strategies that enable clients to progress from diagnosis to viral suppression.

In the next stage, HIV primary medical care and medical case management possess key intervention roles. Using Public Health Service guidelines for primary care, a person living with HIV will complete all required medical assessments and diagnostic screens for comorbid conditions like sexually transmitted infections, substance use, mental health, oral health, and other health conditions. A treatment plan is devised with components such as prescription of antiretroviral medications, risk-reduction counseling and education, and appropriate referrals to other services like oral health and nutrition therapy. Follow-up visits are also incorporated.

HIV Care Continuum: DC EMA and by Jurisdiction. Of the 4,312 RW clients with at least one medical visit in 2020, 68% of were considered retained in care, 94% were prescribed ART, and 82% were virally suppressed. Though the traditional continuum looks at all clients as the denominator, data from CAREWare for RW consumers uses clients who had at least one primary care visit as a denominator because not all clients used RW primary care services.

Figure 18. HIV Continuum of Care among Ryan White Clients in the DC EMA, 2020

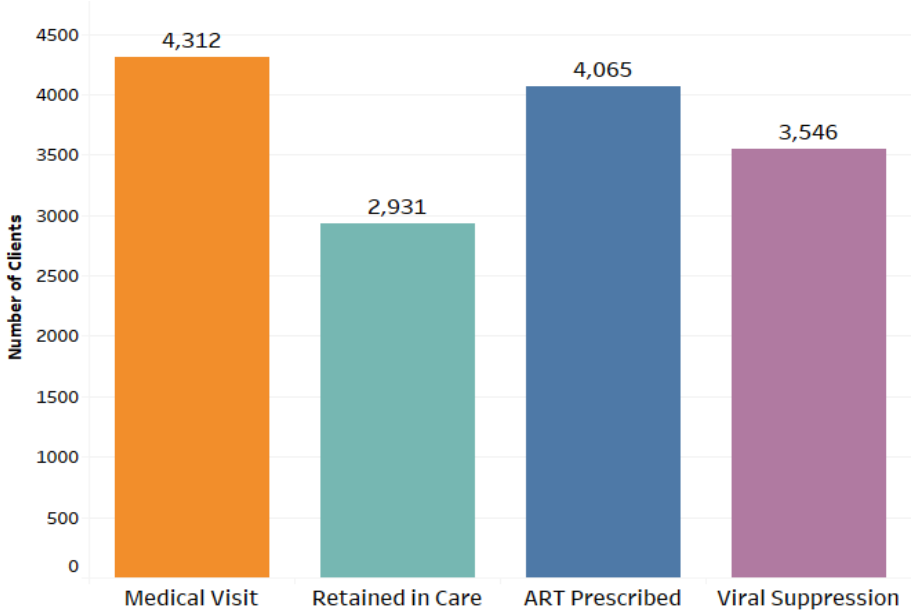


Figure 19. HIV Continuum of Care among Ryan White Clients in the DC EMA, 2020 (Proportion)

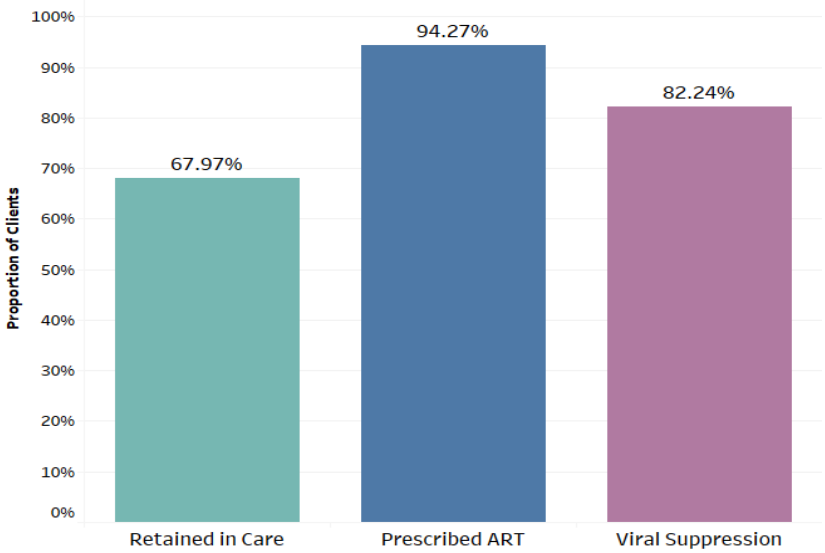
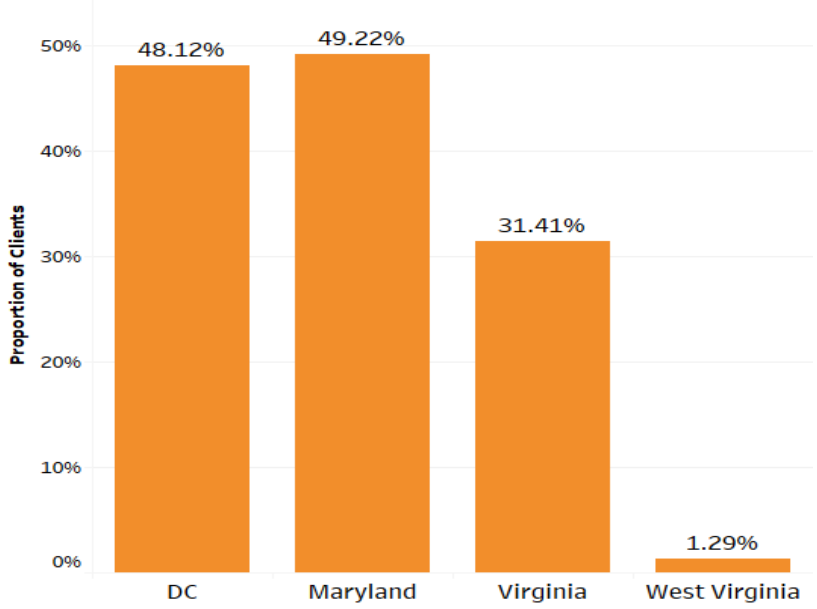
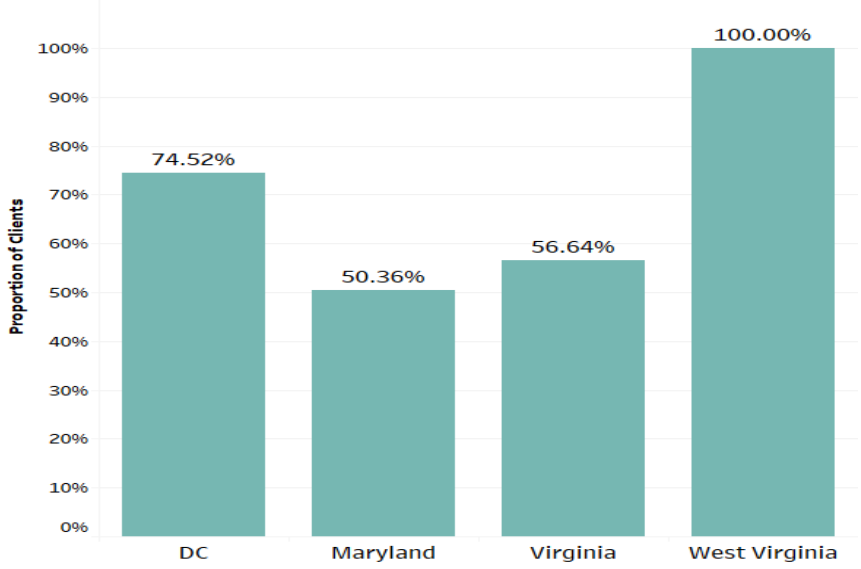


Figure 20. Proportion of RW Clients Receiving Services Who had 1 or More Primary Care Visits by Jurisdiction, 2020



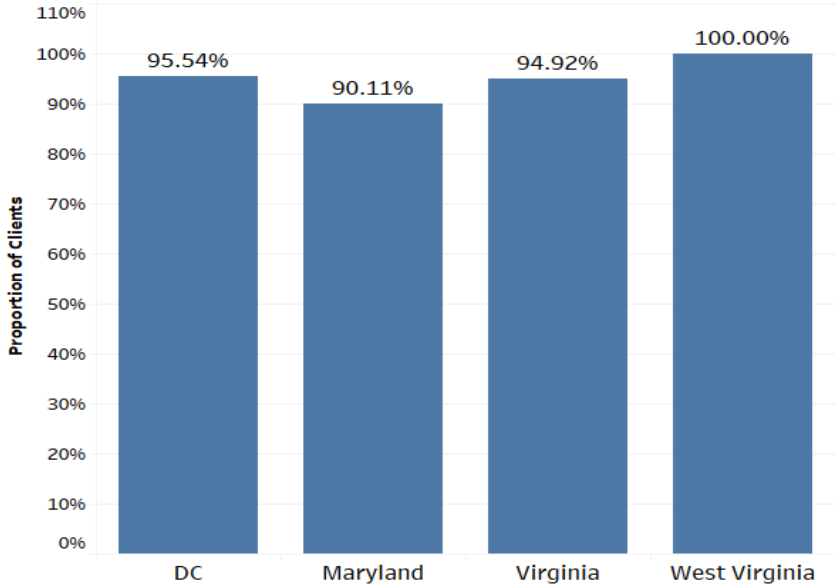
About half (46%) of Ryan White clients who were receiving any type of services had at least one primary care visit in 2020. The highest proportion of RW consumers receiving primary HIV care was in Maryland (49%) and the lowest proportion RW consumers receiving primary HIV care was in West Virginia (1%).

Figure 21. Proportion of RW Clients Receiving Services who had 2 or More Primary Care Visits at Least 90 Days Apart by Jurisdiction, 2020



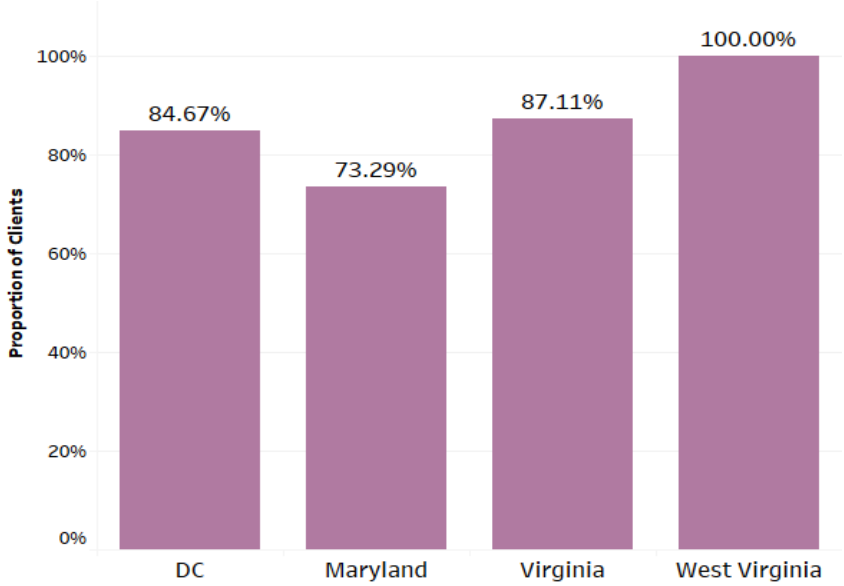
RW consumers who were retained in care varied by jurisdiction. The rate of retention in care ranged from 50% in Maryland to 100% in West Virginia.

Figure 22. Proportion of RW Clients Receiving Services Who were Prescribed ART by Jurisdiction, 2020



The rates of ART prescription among RW consumers were similar across jurisdictions. The rate of being prescribed ART ranged from 90% in Maryland to 100% in West Virginia.

Figure 23. Proportion of RW Clients Receiving Services Who were Virally Suppressed by Jurisdiction, 2020



Viral suppression varied slightly among RW consumers throughout the DC EMA. The rate of viral suppression ranged from 73% in Maryland to 100% in West Virginia.

HIV Care Continuum: Planning. The HIV Care continuum for the DC EMA is utilized in planning and prioritization through a process known as priority setting and resource allocation (PSRA). Led by the Ryan White Planning Council, this process is a participative and cooperative and aims to identify needs

at all levels; namely, providers, people living with HIV, stakeholders in the community, jurisdictional agencies, and nonaffiliated consumers.

No single set of services can effectively address the needs of a wide range of races, ethnicities, social identities, risk behaviors, clinical statuses, and service expectations throughout the DC EMA. The aim is for a service delivery system that establishes and maintains a continuum to ensure access, retention, and coordination of all required care and support services. This is characterized by:

- A full complement of client-focused, culturally competent, and multidirectional interventions.
- Coordination, collaboration, comprehensiveness, co-location, and competency-based care.
- Multiple points of entry and "reentry."
- Recognition that clients utilize services in very different proportions, sequences, and frequencies.
- A focus on the whole person.
- An extensive provider network that incorporates early intervention, prevention, counseling and testing, and care services.

The continuum is purposely not hierarchical to model the many varied and iterative ways in which clients experience the service delivery systems. This increases the likelihood that all eligible persons with HIV disease—newly diagnosed, historically underserved, disproportionately impacted and requiring non-standard settings—will be covered in care. A special focus is placed on the persons who are aware of their HIV status but are not in care and clients who are out of care for six months or more.

The HIV Care Continuum as illustrated is a guide to its focus and direction. Each stage has an accompanying set of services that may increase or augment the number of PLWHA moving along the continuum. Planning for services can be easily identified. It also aims to identify subpopulations that are underserved at the jurisdictional level. This information is used to effectively monitor service delivery in each local jurisdiction and redirect efforts in service planning and allocation of resources when appropriate.

HIV Care Continuum: Approaches to Address Health Disparities. The DC EMA contends with significant health disparities because of race, gender identity/expression, and sexual orientation. These difficulties are largely driven by unique service delivery gaps, including cultural, language, and stigmas that bar access to primary medical care. These focus populations experience social determinant factors (poverty, lack of employment opportunities, housing instability, behavioral health conditions, and transportation access, among others) that need specific, additional resources to access the care continuum. The table below presents the care continuum data by demographics and allows an analysis of which populations may need extra resources and at what point in their care experience. As part of the Integrated Plan, monitoring this data will reveal where to target efforts.

HIV Care Continuum among Ryan White Clients in the DC EMA, by Demographics, 2020. Table 10 shows the demographic breakdown at the different stages of the continuum of care for all RW clients in 2020. The continuums of care rates by gender are similar across all stages of the continuum. Similarly, the continuums of care rates by age are similar across all stages of the continuum. RW clients ages 0-12 had the lowest rates of being engaged in care. By race, Asian, Pacific Islander, Native Hawaiian, American Indian, and Native Alaskan had the lowest rates of being virally suppressed. However, the total number of persons is very low, which affects the rate calculation. Whites and African Americans living with HIV have similar rates across all stages of the continuum, though African Americans had slightly

higher rate across all stages of the continuum compared to White RW consumers. Non-Latino RW Consumers had higher rates of being retained in care, prescribed ART, and virally suppressed compared to Latinos.

Table 10. HIV Care Continuum Demographic Characteristics Among Ryan White Clients, 2020

	In Medical Care	Retained in care		Prescribed ART		Virally Suppressed	
GENDER	**N**	**N**	**%**	**N**	**%**	**N**	**%**
Male	2,586	1,698	66%	2,426	94%	2,126	82%
Female	1,662	1,186	71%	1,580	95%	1,370	82%
Transgender	64	47	73%	59	92%	50	78%
Grand Total	**4,312**	**2,931**	**68%**	**4,065**	**94%**	**3,546**	**82%**
AGE GROUPS	**N**	**N**	**%**	**N**	**%**	**N**	**%**
0 to 12	12	2	17%	12	100%	9	75%
13 - 24	246	147	60%	230	93%	189	77%
25 - 34	771	463	60%	688	89%	566	73%
35 - 44	865	586	68%	810	94%	688	80%
45 - 54	995	706	71%	934	94%	861	87%
55 - 64	1,025	762	74%	1,006	98%	935	91%
65 & >	398	265	67%	385	97%	298	75%
Grand Total	**4,312**	**2,931**	**68%**	**4,065**	**94%**	**3,546**	**82%**
RACE	**N**	**N**	**%**	**N**	**%**	**N**	**%**
White	441	263	60%	401	91%	348	79%
Black/African American	3,655	2,532	69%	3,468	95%	3,022	83%
Asian	27	21	78%	27	100%	25	93%
NH/PI/NA/AI	18	14	78%	18	100%	12	67%
More than one race/Other	121	78	64%	115	95%	97	80%
Missing	50	23	46%	36	72%	42	84%
Grand Total	**4,312**	**2,931**	**68%**	**4,065**	**94%**	**3,546**	**82%**
ETHNICITY	**N**	**N**	**%**	**N**	**%**	**N**	**%**
HISPANIC	491	292	59%	426	87%	376	77%
NON-HISPANIC	3,819	2,639	69%	3,637	95%	3,168	83%
Unknown	2	-	0%	2	100%	2	100%
Grand Total	**4,312**	**2,931**	**68%**	**4,065**	**94%**	**3,546**	**82%**
HIV/AIDS RISK FACTORS*	**N**	**N**	**%**	**N**	**%**	**N**	**%**
MSM	1,441	881	61%	1,345	93%	1,165	81%
IDU	350	281	80%	337	96%	314	90%
MSN & IDU	5	2	40%	4	80%	5	100%
HETEROSEXUAL	1,997	1,402	70%	1,903	95%	1,651	83%
Other	288	195	68%	282	98%	235	82%
Missing	231	170	74%	194	84%	176	76%
Grand Total	**4,312**	**2,931**	**68%**	**4,065**	**94%**	**3,546**	**82%**

*Other HIV risk exposures includes hemophilia, blood transfusion, and perinatal exposure

The care continuum is a vital tool that reveals the state of HIV care in a region using data from the first appointment with a primary medical service provider to, ideally, viral suppression. Though there are limitations in the data, the care continuum assists in the evaluation of cases through the course of care for effective planning purposes. Overall, RW consumers who had at least one medical visit in 2020 had

high rates of prescription of ART (94%), and viral load suppression (82%). In contrary, the rate of retained in care (67%) among RW consumers is low.

However, retained in care and viral suppression varied considerably and reveal that particularly racial minorities and young people living with HIV could benefit from focused strategic service efforts to improve engagement and retention in care leading to increased viral suppression among people living with HIV who are RW consumers.

III-3. HIV Prevention, Care and Treatment Resource Inventory

Within the DC EMA, a range of service providers, both inside and outside the RW system, offer prevention and care services to people living with HIV and those at risk of infection. Funding for the services and providers is offered through Ryan White and a range of other sources listed in the Resource Inventory of the Appendix.

Jurisdictional Coordination of Substance Use and Treatment Services Provision with HIV Prevention and Care Services. The DC EMA offers a compendium of services that includes the coordination of substance use and treatment services with HIV prevention and care services. Utilizing a holistic approach in coordination efforts, various HAHSTA workgroups like Ending the Epidemic and Early Identification of Individuals with HIV/AIDS (EIIHA) crosswalk epi data, service utilization, and identified customer needs to focus on the whole individual. Doing so enables program development to occur that takes into consideration social determinants, health equity factors, and other gaps in service that mitigate the optimization of health outcomes. Status neutral program planning, design, and implementation further supports the holistic approach by allowing the DC EMA's Ryan White program to support individuals with substance use disorder regardless of their HIV status. Braided funding from CDC and HRSA funds the medical and supportive needs of HIV positive and negative substance users in the forms of prevention, care, and treatment. Through a partnership with the DC Department of Behavioral Health, sub-recipients are able to offer a comprehensive continuum of services like syringe exchange, mobile Medication-Assisted Treatment (MAT) induction, mental and behavioral health services, substance use services, and outpatient/primary care health. Ultimately, focusing on the whole individual with a status neutral approach reduces the silos of HIV care and prevention services for individuals with substance use, regardless of where they are on the prevention to care spectrum and helps get them the wraparound supports that they need to increase their chances of optimizing their health outcomes.

The Intervention Services Program (ISP) is another example of the coordination between substance use and treatment services and HIV Prevention and care. According to the DC Health Annual Epidemiology and Surveillance Report, which reports data through 2020, 98% of people living with HIV were linked to care, 76% had at least 1 medical visit in 2020 and 66% achieved viral suppression in 2020. However, despite the encouraging data on linkage to care, people who inject drugs were among those with the lowest viral suppression rates. The ISP will provide more targeted patient care to improve the health outcomes of patients with uncontrolled viral loads—many of whom have additional medical or psychosocial problems like substance use which complicates their care. The expectation is that ISP model will result in a sustainable program that improves early HIV identification, early HIV intervention, treatment adherence, and viral load suppression of targeted populations. The use of best practices and innovative service models like Community Health Workers (CHW) and Peer Navigators will be key to the program's overall success.

Services And Activities Provided by Jurisdictional Organizations and Agency's Priority Population. Services and activities provided by organizations within the jurisdiction ensure: 1) access to care and

treatment, 2) continuity of care and treatment to achieve viral suppression, 3) outreach and referral for enrollment other health insurance programs, and 4) interdisciplinary and community collaboration. Prioritization and allocation of resources to these services and activities are anchored in data shared during the priority setting and resource allocation (PSRA) process and other information shared among stakeholders. Additionally, they coincide with the local demographic incidence of AIDS including the appropriate allocations for services to women, infants, children, and youth (WICY). Because of this, initiatives like the DC EMA MAI "Youth Reach" program focus on serving youth of color ages 13-30, particularly within these intersecting identities: Black women, Black/Latino/x men who have sex with men, Black heterosexual men, and Black/Latina/x transgender women. The individuals in these populations are shown to have low rates of linkage to care within 30-days of diagnosis and low rates of viral suppression. To address these low health outcomes, services provided must be consistent with on-going customer engagement, culturally and linguistically appropriate, and encompass a wide referral and linkage network that is readily able to address the varying needs of this population.

Entities funded under the Youth Reach program provide a cadre of services to youth in the identified subpopulations. The programs are designed to facilitate a seamless transition from prevention and testing programs into care, and from pediatric to adult care, through a coordinated cluster of services. The six service categories encompassed within the Youth Reach initiative are Early Intervention Services, Psychosocial Support Services, Outpatient Ambulatory Health Services, Medical Case Management, Mental Health Services, and Substance Use services.

The DC EMA has a comprehensive HIV care system that meets the needs of people living with HIV. Collectively, providers and activities outlined in the Resource Inventory of the Appendix, serve a variety of populations within the jurisdiction, including PWID, MSM, transgendered Individuals, people experiencing homelessness, and a host of other niche populations. Services are comprehensive and seek to address the whole individual and their preventive, medical and supportive needs.

How services will maximize the quality of health and support services available to people at-risk for or with HIV. HAHSTA's ongoing efforts seek to support a network of high quality, equitable care for consumers of HIV prevention, care, and treatment services within the DC EMA. Services are regularly evaluated for their responses to outcomes and emergent needs to maximize the quality of health and support services available to people at-risk for or with HIV. This results in data-driven decision making that impact program design and implementation.

Recently, HAHSTA's Ryan White model of reimbursement was transformed into a Quality Improvement project Fee-for-Value (FFV) Model that incentivizes subrecipients with additional funding for the delivery of services based on improved health outcomes. This value-based reimbursement model impacts clinical quality management (CQM), administrative, programmatic, and fiscal components of the Part A and Part B programs. Subrecipients are assessed on these component areas and provided with capacity building trainings to improve target areas considered to be less optimal based on the data. Trainings include, but are not limited to, service standards; using data for quality improvement; meaningful consumer engagement in quality improvement; and cultural competency/ implicit bias. Overall, HAHSTA aims to strengthen provider capacity to enhance the quality of services delivered across the DC EMA.

Data-driven decision making within various collaboratives and partnerships fortify HAHSTA's commitment to maximize the quality of health and support services available to people at-risk for or with HIV. For nearly ten years, HAHSTA continues to coordinate CQM activities as a participant in the Ryan White District of Columbia Cross-Part Collaborative with a focus to improve and demonstrate

measurable clinical outcomes. The data collected are used to identify and prioritize quality improvement activities, develop and disseminate best practices and service standards, and improve key service activities to minimize/eliminate barriers in communication between providers and consumers. Collaboration with intergovernmental agencies, disease surveillance, the Chesapeake Regional Information System Portal (CRISP health information exchange), and the Housing Opportunity for Persons with AIDS (HOPWA) allow for data match to enable opportunities for quality and health delivery systems improvement.

Most notably, as part of the DC EMA's regional ending the HIV epidemic efforts, enhanced dataset of HIV program and service data have supported linkages, retention, and bio-medical interventions. While incremental improvements are occurring across the DC EMA, HAHSTA recognizes the need to address service gaps identified by community stakeholders as important to maximizing the quality of health and support services available to people at-risk for or with HIV. A recent community engagement session revealed that patients experience barriers like transportation and housing when attempting to access PrEP services. Separating various HIV and healthcare services result in missed opportunities to engage individuals in HIV testing, prevention, and treatment. Fortunately, braided funding allows DC's Ryan White Program to leverage CDC funding and offer a status neutral program design. The status neutral program design embeds HIV care and prevention into routine care and allows for the provision of comprehensive clinical and support services, regardless of an individual's HIV status. This includes expanding access to traditionally funded Ryan White services like outpatient substance use services, non-medical and housing case management services, outpatient ambulatory services, and medical transportation services. Implementation of a status neutral program design will increase the efficiency of services delivered. Since the clinical and support services needed are nearly identical, efforts can be unified in a single service plan rather than different plans based on an individual's HIV status.

III-3a. Strengths and Gaps

DC Health consistently aims to be responsive to HIV prevention, care, and treatment needs within the jurisdiction. Data and stakeholder feedback is used to make informed decisions regarding funding allocations to support engagement and retention in care, and prevention of HIV transmission through viral suppression of persons with HIV. Funding allocations also support adherence to PrEP for those with behaviors that increase the risk of having HIV. The strength of DC Health's responsiveness is partially attributed to subrecipients who are carefully selected through competitive solicitations. Their activities and interventions help facilitate the link and retention of individuals in care which is critical to preventing HIV transmission. Funded services determined by data and stakeholder feedback are also strengths in DC Health's responsiveness. Service resources like non-medical case management, medical case management, health education/risk reduction, outpatient ambulatory health, mental health, transportation, and psychosocial services programs are available within DC's HIV prevention and care continuum that include intake, screening; linkage; engagement, retention, and drug therapy adherence.

Other strong services, program designs, initiatives, and implementations provided to respond to HIV prevention, care, and treatment needs within the jurisdiction include:

- A status neutral approach to support a continuum of care for emerging populations by funding outpatient ambulatory health services (OAHS), medical case management (MCM), mental health services, non-medical case management services, health education/risk reduction (HE/RR), transportation services, and psychosocial support (PS) with additional funding sources to support the status neutral stance;

- Promotion of cultural competency training for clinical and non-clinical providers to respond to service delivery needs of target populations;
- Provision of training opportunities to improve quality of services and patient outcomes, through various venues, like webinars;
- Enrollment of new and current customers in DC ADAP online by desktop or smartphone; and
- Provision of ADAP formulary medication dispensing services from HIV-trained pharmacy providers, drug adherence support for customers, and a digital application that monitors daily dosing and prescription refill reminders. Additionally, to make PrEP more available to HIV negative residents, DC implemented the PrEP Drug Assistance Program (DAP) using the ADAP platform.

The appropriate allocation of funds to services within the jurisdiction are made to address identified social needs and determinants that prevent individuals from accessing and remaining in care. Services within the jurisdiction are designed to reduce the unmet need of individuals who are out of care– including both PWH who were never connected to care after diagnosis, and those who dropped out of care. However, despite these efforts, HAHSTA still recognizes that its continuum must benefit more individuals.

Some residents within the jurisdiction have historically faced challenges accessing health care due to competing social needs such as diversity of culture, language, literacy and health literacy, and stigma. Oftentimes, these minority populations disproportionately experience negative forces of the social determinants of health (e.g., poverty, lack of employment opportunities, housing instability, behavioral health conditions, limited access to transportation), which require specific and additional resources to facilitate access along the HIV care continuum. Therefore, identified strategies to strengthen DC Health's capacity of service delivery based on health equity, geographic disparities, and other known causes of gaps in service include:

- Maintaining a multi-sector collaboration among governmental public health, community, academia/research, medical providers, and stakeholders to review HIV Care Continuum data, expanding innovative screening, treatment access, high impact prevention (including behavioral, condom distribution, syringe services, and Pre-Exposure Prophylaxis or PrEP), and social supports and services.
- Conducting innovative community engagement activities focused on key strategies such as rapid response to new diagnoses, increasing access and acceptability for PrEP and post-exposure prophylaxis (PEP), expanding rapid ART initiation and adherence, integrating U=U into all services, and addressing distinctive needs of communities (particularly young people of color);
- Expanding on the status neutral approach to deliver innovative and culturally appropriate HIV services to improve access to and use of quality, customer-centered services for individuals most affected by the HIV epidemic.
- Developing a supplemental analysis, as part of the *Annual Epidemiology & Surveillance Report*, to provide an in-depth profile of special populations (e.g., Black MSM, Black women, transgender women, foreign-born, returning citizens and Latina/o/x); disparities in HIV-related health outcomes; and factors potentially associated with the risk for HIV infection and/or suboptimal outcomes along the HIV care continuum.
- Standardizing the DC community health worker (CHW) network in collaboration with the DC EMA. The Recipient will work with DC Health's Health Regulations and Licensing Administration (HRLA) and DC Healthcare Finance (DCHF) on the DC CHW certification to facilitate CHWs

becoming a billable profession in DC. The EIIHA committee and the CHW workgroup, drafted legislation and regulations that include a CHW definition, scope of work, core competencies, and education- and experience- requirements. The EIIHA committee will collaborate with CHW associations to provide ongoing CHW trainings to; CHW networking opportunities; and CHW certification. DC Health will also utilize peer navigators to reach the most vulnerable and high-risk populations using the CHW model.

- Increasing linkages and referrals to early intervention services (both medical and social support) by connecting customers to DC Health's free online resource and referral platform called LinkU. LinkU is available for customers and community-based organizations (CBOs), for connecting people seeking help to verified social care providers.
- Increasing targeted testing through ongoing geospatial mapping activities. Past efforts included mapping of newly diagnosed cases, but now efforts to map repeat STI infections, retention rates, and viral suppression rates will be scaled up. By using these data to identify new testing opportunities, DC Health will: 1) maximize the use of testing resources, 2) allow partner agencies to focus their activities on higher risk populations, and 3) yield a higher positivity rate than routine or standard HIV testing.
- Providing self-testing (at-home) and walk-in STD and HIV testing services. During the COVID-19 pandemic, the recipient launched GetCheckedDC to expand access to HIV and STD testing services, with minimal or zero health care system touchpoints. Since June 2020, DC residents can request free HIV tests mailed directly to their homes from www.GetCheckedDC.org. DC residents can also walk into a LabCorp patient service center in the DMV area, with or without an appointment, and get tested for free. Within a week, residents receive an unmarked package that includes a third generation HIV antibody test kit, materials for DC-based resources for follow-up care, and PrEP and U=U information. In FY 2021, GetCheckedDC mailed over 2000 at-home HIV test kits to residents, and over 500 residents received walk-in HIV tests. The recipient is conducting an evaluation of the GetCheckedDC program to improve reach and use by priority populations.
- Monitoring its fee-for-value healthcare model to reimburse providers delivering Ryan White services and improve access to healthcare and increase linkage and retention rates throughout the DC EMA. This model is grants-based, and the award for each provider will vary year to year, as a function of a defined award process. DC Health used the Six-Sigma quality improvement tool to build this new model and develop a strategy for continuous improvement. Internal workgroups will meet regularly throughout the next three years to evaluate and monitor progress.
- Collaborating internally across the HAHSTA Divisions to improve existing data collection activities and database sharing systems, and developing a centralized database for providers to submit data and follow the patient as they access medical treatment, support services, and medication adherence.
- Addressing social determinants and health equity factors through housing services, substance use/needle exchange programs, re-entry, wellness support services, and non-medical case management to access benefits, employment services and outreach services.

There continues to be significant health disparities and inequities across the DC EMA impacting the ability of people to access and remain in care. HAHSTA will continue to selectively fund subrecipients to target underserved populations disproportionately challenged by these barriers, rely on data, and engage stakeholders; ultimately, optimizing resources and improving the health outcomes of individuals within the jurisdiction.

III-3b. Approaches and Partnerships

The HIV prevention, care and treatment financial and agency inventory was developed in partnership with the COHAH, GW, and informed by primary (three state departments of health and HAHSTA) and various secondary data sources. The inventory for the DC EMA includes a broad range of federal grant funds as well as an estimate of public insurance expenditures. Funding for each of the four jurisdictions (the District of Columbia, Maryland, Virginia, and West Virginia) is indicated for each funding line, along with lists of agencies in each jurisdiction providing services under each funding stream. Because the most recent year of funding data available varies by program and state, the inventory should be viewed as a general overview of resources available in the DC EMA, rather than a precise snapshot of funding at a moment in time; fiscal year information is provided in the notes column.

Data sources for the inventory include Part A allocations from HAHSTA, the HHS TAGGS Database, state appropriations documents, and direct communication with state officials, as well as funding reports from each of the jurisdictions' Part B programs that reflect allocations to providers within the DC EMA counties and cities. Where specific allocations by county were not available, statewide funding levels were prorated by the proportion of PLWH in each state who live within the EMA. All agencies' names were obtained from subgrantee lists provided by each jurisdiction as well as from the HHS TAGGS system for direct awards. Detailed information on services provided by each agency is available upon request from DC Health.

The inventory includes very rough estimates of insurance spending for HIV in the DC EMA, to provide a general sense of the likely scope of such expenditures. For Medicaid, the most recently available analysis for DC is included here. For Maryland Medicaid, capitated rate information from April 2017, the most recent available, was used instead of actual expenditures. For Virginia, we relied on Kaiser Family Foundation reports of 2013 CMS estimates of total Medicaid spending for HIV by state, and allocated a portion to the DC EMA based on prevalence. West Virginia was able to provide a prorated estimate of Medicaid spending for PLWH in the two EMA counties for 2017, the most recent available. For Medicare, the figure listed in the inventory is an estimate based on the number of PLWH in the DC area as a proportion of the national figure, multiplied by total Medicare spending for HIV based on Kaiser Family Foundation figures. Similarly, for VA spending, we used an estimate of the total number of utilizers of VA services in the DC region multiplied by a recent national spending estimate. Though many PLWH in the EMA have private insurance, no estimates of private insurance expenditures are available.

III-4. Needs Assessment

The Washington, DC Regional Planning Commission on Health and HIV (COHAH), which serves as the Ryan White Planning Council, regularly receives input on service needs, barriers, and priorities from COHAH members, committee participants and stakeholders, and the community of people living with HIV (PLWH). Although COVID-19 required an adjustment in meetings from in person to virtual, recent methodologies for gathering input included Community Engagement and Education Committee meetings (a subcommittee of COHAH) and listening sessions, jurisdictional consortia meetings, and Ending the Epidemic community engagement groups. The COHAH intended to conduct a comprehensive needs assessment collecting primary data in 2020/2021. Due to COVID-19 prevention public health strategies in 2020/2021, COHAH conducted a *modified* needs assessment combining secondary data sources to access service needs. During the summer of 2022, COHAH initiated a status neutral needs assessment to understand the needs of people with and vulnerable to HIV in the DC EMA. As mentioned in Section II: Community Engagement and Planning Process, this Integrated Plan will be amended once the needs assessment process has been completed and evaluated.

As such, additional needs assessment information was gathered from various other initiatives from within DC Health, other local Departments of Health (including but not limited to Virginia Department of Health, Montgomery Department of Health, and Maryland Department of Health) as well as academic partners such as the George Washington University and John Hopkins University. These additional sources include (but are not limited to) studies such as: Citywide Expansion of Rapid Antiretroviral Therapy Initiation in the District of Columbia, Virginia Ryan White Crossparts Collaborative Rapid Start Program Updates and HIV Surveillance Cluster Response (Community-Based Participatory Research). Collectively, these data gathered through the various community engagement and needs assessment processes inform the goals and objectives of this submission.

III-4a. Priorities

Despite the progress made in the DC EMA, there remains to be opportunities identified from the data, community engagement activities, and previous needs assessments where additional investments can advance the national initiative to ending HIV. These priorities include:

- Facilitating timely testing, diagnosis, and treatment of HIV;
- Providing training and education for health care professionals and service providers;
- Offering culturally inclusive education for people living with HIV and people with a high risk of HIV, their partners, and their loved ones;
- Combating HIV stigma and discrimination; and
- Addressing social determinants of health and health inequities.

Data from the COHAH shows that, overall, people living with HIV were engaged in care, received outpatient ambulatory health services on a timely basis, had high rates of antiretroviral medication use, and used those medications as prescribed. Regarding service needs, focus group and interview data identified the importance of mental health services, psychosocial support, and assistance with additional housing services in the DC EMA. Psychosocial and emotional factors were one of the most consistently reported barriers to linking with HIV care across communities. Additionally, the cost of housing, the availability of housing, and discrimination in housing were all identified as barriers to using and adhering to HIV care and treatment, particularly in DC and Maryland.

For the DC EMA, obstacles to service utilization for people-at risk for HIV and PWH include the myriad of challenges mentioned above where existing resources can be increased and new resources can be developed. With HIV disproportionally impacting people of color in the region, greater attention will be needed to address medical mistrust and stigma, and the social determinants of health (stable housing, reliable transportation, employment, education) to reduce barriers to access.

III-4b. Actions Taken

The COHAH evaluated the increased demand for services in high-risk populations and appropriately responded with increased allocations to Emergency Financial Assistance and Non-Medical Case Management, particularly for those who are unaware of their HIV status and for disproportionately impacted groups such as Black people and men who have sex with men. Pursuant to data findings, the following activities will continue to be supported to bolster linkage, outreach, adherence, and retention services: support for emergency financial assistance, housing navigator program and referral services; transitional, short-term, or emergency housing assistance; increase availability of support groups and counseling opportunities; counseling and education on medication and medication management; education on health care system navigation for newly diagnosed or those lost to care; immediate linkage

to treatment and/or psychosocial support at diagnosis or reengagement; and increase in the number of community health workers and peer navigators at every level of HIV care while ensuring proper representation of the populations served (by age, race/ethnicity, gender identity and sexual orientation).

Innovative strategies have been employed in local jurisdictions to address specific needs. The DC EMA is working towards formal certification for community health workers (CHW) and expanding the community health worker and peer navigator model throughout the DC EMA to reduce barriers to linkage and retention in care, particularly for minority populations. CHWs are trusted members of the communities they serve, making them an integral part of linkage and retention efforts, particularly for those who feel marginalized, have been lost to care, or are newly diagnosed. Housing is being addressed through a DC EMA-wide housing navigator program. The housing service category has been updated to include housing navigation and referral services, as well as transitional, short-term, or emergency housing assistance to enable PWH to gain or maintain outpatient/ambulatory health services and treatment. Under HRSA-20-078 (Ending the HIV Epidemic: A Plan for America: Ryan White HIV/AIDS Program Parts A and B), a wellness support service category is being developed to provide additional services to support holistic well-being that complements mental health and psychosocial support services. The Regional Early Intervention Services initiative is a status neutral approach towards prevention and care services and is described below in more detail in Section IV: Situational Analysis.

III-4c. Approach

The COHAH considered all available data to assess the needs of the DC EMA to identify key priorities in developing the goals and objectives. To understand and address service needs, data were reviewed from epidemiologic trends and surveillance, other jurisdictional assessments, community engagement sessions, cost analyses, continuum of care, service utilization, clinical quality management, and the DC Cohort Longitudinal HIV Study from George Washington University. Indicators of local need for services included the following factors: continuum of care across jurisdictions, cases among jurisdictions, cases in rural areas, cases of “unmet need,” cases unaware of HIV infection, low-income populations, emerging populations in need of services, and variations in Medicaid and in other health care system investments. COHAH also used information from other federally funded HIV programs—including all other CARE Act programs, CDC HIV Prevention Programs, SAMHSA, and HOPWA—to set priorities. As previously noted, people living with HIV were an integral part in the planning and implementation of the various needs assessment activities. One-third of COHAH membership is comprised of PLWHs. Additionally, other people living with HIV who are not members of the COHAH but play an active role on the various COHAH sub-committees, also participated in the various needs assessment activities. These roles included the participation in planning meetings, conducting qualitative, semi-structured interviews, recruitment for focus groups and surveys, and review of reports and presentations.

SECTION IV: SITUATIONAL ANALYSIS

IV-1. Situational Analysis

The DC EMA is well positioned to end the HIV epidemic in the next 8 years. There are multiple strengths to support this goal. The DC EMA contains an extensive network of clinical and non-clinical providers with well-developed partnerships among them. Individually, DC Health has a unique academic-government-community collaboration through its DC Center for AIDS Research to develop and study innovative approaches and promising practice supported and guided by the National Institutes of Health HIV research framework. DC Health compiles, analyzes, and disseminates data to drive policy and program directions. The COHAH collaborates with the Ryan White Program to develop relevant service standards and conduct comprehensive needs assessments. As previously mentioned, DC EMA has a comprehensive Integrated HIV Care and Prevention Plan, 95/95/95 goals, and a DC EHE plan to meet the 95/95/95 goals. There is a robust collaboration among regional health departments to coordinate program approaches and optimize resource allocations. An example of collaboration between health departments is the development of a regional early intervention services program initiative. The initiative defined a "status neutral" approach that supports early engagement with individuals across the metropolitan area in care or prevention services. This innovative design reduces the silos of HIV care and prevention services that often miss people in need of connection and a person-centered provider home. As a jurisdiction, Washington, DC values health equity and recognizes structural barriers, such as racism, as an impediment to optimal health outcomes and individual success. To that end, DC Health established the Office of Health Equity (OHE) in 2015 to address the root causes of health disparities beyond healthcare and health behaviors. Utilizing a Health-in-All-Policies (HiAP) approach, OHE achieves its mission to enable optimal health and well-being for residents by informing, educating, and empowering people about health issues and facilitating multi-sector collaborations to identify and solve community health problems related to the social determinants of health. HAHSTA partners with OHE to address health infrastructure components and social factors, as well as to accelerate the reduction of new HIV diagnoses and ensure successful health outcomes for people living with HIV.

While the described strengths provide the foundation to support ending the HIV epidemic goal, there are challenges which can detract or derail effective plans. First, there are fundamental social threats—structural racism, stigma, and inequity. The negative impact of racism on health is widely recognized, and ongoing systemic, structural change is needed to improve health outcomes in historically marginalized communities. Meaningful transformational change is possible and requires respect, cultural humility, and affinity while addressing ways to undo the systems that hold damaging policies in place. As part of this plan and all future functions, DC Health will address the impact of structural racism on sexual health and HIV outcomes with intentionality across its various programs. DC Health considers the social determinants of health that impact DC residents, and those who work in and visit the city across the DC EMA jurisdictions. Jurisdictional collaboration between OHE, other government agencies, community partners, and all DC Health Administrations is instrumental to ensuring a multi-pronged cohesive strategy in identifying and addressing the social determinants of health—which are the key drivers of inequities in health outcomes.

Along with acknowledging and addressing structural racism, it is also important to ensure equity in access to resources and opportunity to all people of racial, ethnic, gender and sexual identities and experiences. DC Health has developed programs on drug user health, sexual positivity, social and emotional well-being, and addressed issues such as employment, fellowship, and housing. It has also aimed to not define people by HIV risk group (such as young, gay, or black men), instead of naming risk

behaviors (e.g., not wearing condoms, not knowing status of a partner, etc.) to reduce stigma and misinformation around HIV. All efforts have been aimed to increase diversity, equity, and inclusion for several populations often left at the margins, as well as to reduce the stigma connected to some of these populations. Additional ongoing initiatives that help increase equity and reduce stigma are:

- *Undetectable = Untransmittable (U=U)*. DC Health was the second health department in the nation to endorse the Undetectable equals Untransmittable or U=U consensus statement as a significant message to emphasize treatment adherence, reduce stigma for persons living with HIV, and prevent new HIV transmissions. DC Health expects integration of U=U into clinical and support services. DC Health supports this integration by pairing U=U messaging with other sexual health education campaigns, translating messaging into Spanish (Indetectable=Intransmisible or I=I], and including it as a main strategy in planning efforts.

- *Health Impact Specialists*. Although the IMPACT DMV project (a prevention/care programs for MSM and transgender persons of color) ended, its impact is long lasting. It provided an opportunity for economic growth while simultaneously putting health resources into the same community. The workforce development program hired 73 people from the community with 98% reflecting the focus population of men who have sex with men of color and Transgender persons of color.

- *Peer Outreach Specialists*. The Peer Outreach Specialists program (formerly known as the Rapid Peer Responder program) was expanded to address the complex health needs of people who use drugs through a harm reduction approach. This program offers opportunities to individuals who are from the community they serve, and have identified employment challenges, such as recent incarceration experience, or limited work experience in the formal economy. The Peer Outreach Specialists assist with linkages to harm reduction, substance use disorder (SUD) treatment, and link individuals to primary care and other supportive services.

- *Status Neutral/Regional Early Intervention Services*. DC Health developed a status neutral approach, responding to individual sexual health needs wherever they are on the HIV prevention and treatment continuum. This status neutral approach is delivered using the “Hi-V (high five) model,” which consists of five (5) pillars (“find ‘em, teach ‘em, test ‘em, link ‘em, keep ‘em”) of client-centered services that promote equity, whole person health, and eliminate barriers (e.g., employment, housing, and behavioral health) to prevention and/or treatment services. This model is supported through Part A funding. As an update to the previous plan, this model was bundled with Psychosocial Support Services (PSS). Although Early Intervention Services (EIS) is status neutral, it is important to note that PSS services supported through this effort are for positives exclusively. Overall, however, the populations served through this approach are considerably vulnerable to HIV infection, have demonstrated high HIV prevalence, have inconsistent engagement in care and treatment, and/or are at increased risk of falling out of care and treatment. Additionally, with CDC funding, DC Health will also adopt a status neutral approach within Prevention programming. Regardless of HIV status, all people will be treated in the same way from the start. It begins with an HIV test—and, regardless of the results, the approach enters the individual into one of two paths: “HIV Prevention” and “HIV Treatment” to support an individual’s health regardless of status.

Additionally, there are local challenges that reflect geography and life priorities as expressed by residents during community engagement sessions. One challenge is how to end the HIV epidemic in the

DC when it is a small jurisdiction in an area within a large and complex metropolitan area inclusive of two other jurisdictions. People live, work, play, and access health services irrespective of jurisdictional lines. The eligible metropolitan area covers counties in Maryland, Virginia, and West Virginia, and DC. Two Ending the HIV Epidemic (EHE) jurisdictions—Montgomery County and Prince George's County—directly border DC. Baltimore City, another EHE jurisdiction, is 30 miles from Washington with well-connected social networks. Another challenge is how HIV factors in the lives of focus populations. In the first iteration of the plan, DC Health initiated community conversations to elicit in-depth responses to "What's going on in the lives of each population?" With a focus on equity and inclusion, subsequent questions were asked about resiliency and impacts on the population, the role of sexual health, and what needs would support overall health, among others. Among diverse community members, HIV health was not among their top concerns.

The COVID-19 pandemic interfered with the administration's capacity conduct a comprehensive needs assessment. Therefore, this Integrated Plan is informed by secondary data sources, a modified needs assessment, and other initiatives as mentioned in Section III: Contributing Data Sets and Assessments.

IV-1a. Priority Populations

As mentioned above, the DC EMA is home to 6,226,242 people, according to 2020 estimates from the US Census Bureau. As the lead entity on the development of the Integrated Plan, DC Health engaged in community engagement activities that included Black and Latino MSM, Black heterosexual men and women, transgender individuals, youth aged 13-24, and PWID. Based on the community engagement and planning process in Section II and the contributing data sets and assessments detailed in Section III, the needs of the DC EMA priority populations will be addressed through the goals and objectives activities as described below.

To meet the DC EMA priority population needs, DC Health is working towards formal certification for community health workers (CHW) and expanding the community health worker and peer navigator model to reduce barriers to linkage and retention in care, particularly for minority populations. CHWs are trusted members of the communities they serve, making them an integral part of linkage and retention efforts, particularly for those who feel marginalized, have been lost to care, or are newly diagnosed. Housing is being addressed through a housing navigator program. The Early Identification of Individuals with HIV/AIDS (EIIHA) committee, along with the CHW workgroup, drafted legislation and regulations that include the CHW definition, scope of work, core competencies, education requirements, and experience requirements. The EIIHA committee collaborates with the CHW associations in DC, MD, and VA to form standards, policies, and regulations to strengthen the CHW profession within the EMA. This includes regulated and ongoing CHW trainings to encourage best practices; CHW networking opportunities to stay informed on community resources for linkages and referrals; and CHW certification to standardize the profession of CHWs in the DC EMA.

Housing is being addressed through PrEP Housing—a housing navigator program under the CDC PS20-2010 funding. PrEP Housing provides temporary housing and case management services to address the social determinants of health needs of young men of color who have sex with men (YMCSM) who are using PrEP. The transitional, short-term housing support of 18-24 months includes medical case management services (i.e. quarterly PrEP lab visit and prescription, treatment-adherence services, and access to routine STI screening and treatment) and non-medical case management services (i.e. financial literacy, workforce development, transportation to and from all PrEP and STI clinical appointments, and groceries and toiletries resources) in collaboration with nonprofit organizations and the DC Health and Wellness Center.

A wellness support service category was developed to provide additional services to support holistic well-being that complements mental health and psychosocial support services. Three providers were identified to receive the funding. The overall outcome of the project is to improve health outcomes and adherence to prevention or HIV treatment strategies for those who could benefit from the non-traditional support. It is a status neutral approach towards prevention and care services.

The strengths, needs, and challenges with respect to HIV prevention and care service activities by priority populations are presented in Table 11. While each activity has been or will be implemented to address specific needs of the various populations, all are available to the prioritized populations, as well as the overall DC EMA. Some activities may cross pillars. Table 11 represents ongoing and future programming within the DC EMA and themes that emerged from the community engagement and planning process, epidemiologic snapshot, and resource inventory.

Table 11. Priority Populations

Priority Population	Strengths[a]	Needs[c]	Challenges
African-American MSM	PrEP Housing; Get Checked DC-HIV and STI screening (at-home, lab-based, CBO-based); Walk-in HIV and STI testing; LinkU; DC Adhere; Youth Reach; PrEPDap; nPEP Hotline	Trauma Informed Care	Lack of safe spaces; Lack of community; Transplant isolation (i.e., "where do I belong?"); Low perception of HIV risk
Latino MSM	PrEP Housing; Get Checked DC-HIV and STI screening (at-home, lab-based, CBO-based); Walk-in HIV and STI testing; LinkU; DC Health and Wellness Center; PrEPDap; nPEP Hotline	Need for more culturally and linguistically appropriate care; Need a guide or listing of where to find these services	Lack of welcoming spaces; Limited language access at providers; Difficulty navigating healthcare system; challenges related to immigration status; stigma
Transgender	Transgender Drop-In Center; Get Checked DC - HIV and STI screening (at-home, lab-based, CBO-based); Walk-in HIV and STI testing; Link U; DC Adhere; PrEPDap; nPEP Hotline	Mentoring and peer-based programming; PrEP/PEP programming	Domestic violence; Trauma; Socio-economic status; Housing
People who Inject Drugs (PWID)	Syringe Service Programs; HIV screening; Hepatitis screening; Medication Assisted Treatment (MAT)- housed at the DC Department of Behavioral Health; Link U; DC Adhere; PrEPDAP	Increased access to medical care (Pop-Up medical services)[b]; Increased focus on life and work balance (wellness activities, safe and confidential location for respite)[b]; Housing; HIV prevention integrated into syringe service programs[b]; PrEP/PEP progamming	Limited resources; Stigma; Focus on opioid use and not enough support for users of other drugs; Chaotic use-disruptive behavior; Population size estimate; Legal challenges
Youth (13-24)	School-Based Health Centers; DC Health and Wellness Center; Get Checked DC - HIV and STI screening (at-home, lab-based, CBO-based); Social Marketing campaign focused on youth (i.e., *Sex is*…); Youth Reach; Link U; DC Adhere; Clinical Care Coordinators; PrEPDap	Targeted and effective prevention messaging; Inclusion in planning activities; Trauma Informed Care	Low perception of risk; High STI rates; Trauma; Violence at home and in the community; Limited knowledge and understanding of the Minor Health Consent Law
Black Women	Women's Wellness Activities (focused on women with substance use concerns and experiencing homelessness); Get Checked DC - HIV and STI screening (at-home, lab-based, CBO-based); Link U; DC Adhere; Youth Reach; PrEPDAP; nPEP Hotline	Women-focused programming (i.e., "Sister Circle); Develop social marketing that displays Black women	Life and work balance; Generational trauma; "Super Woman Syndrome"; Violence
Heterosexual Black Men	Get Checked DC-HIV and STI screening (at-home, lab-based, CBO-based); Walk-in HIV and STI testing; LinkU;	Develop focused social marketing campaign around testing, condoms, and PrEP	Hesitant to seek healthcare services; Low Perception of risk

[a]Strengths are existing programming within the DC EMA
[b]Planned activity
[c]Needs as identified by community members

Snapshot by Federal Pillar

Using a health equity and trauma informed framework, current plan strategies are: testing, U=U, PrEP/PEP, Rapid ART, and accelerated responses to new diagnoses. These focus areas align with the four federal pillars, and the additional DC specific pillar Engage, and ongoing work at DC Health to assure programs are accessible and responsive to diverse communities, as well as the unique intersectional needs of this diversity. There are several initiatives at DC Health in these focus areas. The DC EMA continues to leverage and engage existing working partnerships across government, jurisdictions, academic/research, community providers, education, and consumer and stakeholder groups to inform and develop planning and programs. Funding through HRSA 20-078 and CDC PS20-2010 enables DC Health to expand access to programs, supporting the availability of innovative and effective medical, support services, and prevention services, to people living with HIV and people who are HIV negative. Under HRSA-20-078, the funding also engages people who previously were not eligible to receive Ryan White services. In addition, DC Health was awarded National Institutes of Health (NIH) supplements on ending the epidemic for planning new approaches on PrEP, molecular surveillance, and Rapid ART. DC Health adopted a status neutral approach through the Regional Early Intervention Services model to create innovative and culturally-appropriate services, either within specific stages, or along the full continuum of HIV prevention, testing, care and treatment. The goal is to improve access to and use of quality, client-centered services for individuals living in the DC EMA most affected by the HIV epidemic. DC Health continues its commitment to the regional DMV (District of Columbia, Maryland, and Virginia) Collaborative, innovative and expanded Data to Care, and the intersection of HIV and opioid use, while recognizing the impact of COVID-19 within systems of power and privilege, to address health inequities in communities.

Diagnose

DC Health maintained its contracting relationship with 19 clinical and non-clinical community-based organizations to provide HIV testing and linkage to care services. These partnerships have supported the sustainability of large and small organizations to provide either lab-based or point of care rapid HIV screenings. While COVID-19 interrupted services, an unexpected success was the development of new protocols and activities to safely continue offering HIV screening to clients throughout the pandemic. Increasing HIV screening access where DC Health achieves 95% of people living with HIV knowing their status is an ongoing goal. Programs developed various models tailored to their respective structures. DC Health facilitated meetings between HIV screening providers and community COVID-19 testing sites to learn specific approaches and workflows.

Providers within the DC EMA responded to COVID-19 pandemic-related closures and reductions in health care services by designing and implementing programming that served the community while allowing for social distancing. As such, virtual and telehealth modalities, including individual, group and community level interventions were offered. One such activity was the implementation of the HIV self-testing (HIVST) program, Get Checked DC. It allows for individuals to request, use, and receive HIV tests and results in their home. In June 2020, DC Health launched GetCheckedDC.org, a web site portal for requesting the OraQuick In-Home HIV Test and resources for potential follow-up. A post-test survey is sent two weeks after clients' requests, to gather test results and experiences with the program. Program data indicate success in terms of overall number of test kits distributed, reach of HAHSTA priority populations, satisfaction of residents who have received a test kit, and filling gaps which were created by pandemic-related closures and fears. In September 2020, DC Health added two new components of the program: 1) at-home STD test kits and walk-in testing for HIV, STD, and 2) hepatitis testing through a partnership with LabCorp.

To date, over 4,000 residents have ordered tests since 2020 due to the “effects of the COVID pandemic” and "convenience." Nearly 40% of participants last received an HIV test “more than 12 months ago” and over 10% indicated that they “had never been tested for HIV." All three components of the program continued to grow in popularity as COVID-related restrictions were loosened, with home test kits and walk-in testing providing new convenient and safe options for residents to receive diagnoses and follow-up care. This service is available to all DC residents and is not specific to one population.

Treat

DC Health’s 2021 Annual Surveillance Report cites that 12,161 current residents of the District of Columbia or 1.7% of the population are living with HIV. This is a slight decrease from the previous iteration of this document. Swift HIV diagnosis and treatment is a priority for DC Health. Among people newly diagnosed with HIV, 58% were linked to medical care within 7 days of diagnosis and 80% within 30 days. Viral suppression among all people living with HIV in DC decreased to 66% overall and 87% among people with an indication of engagement in care. Community providers continued their linkage to care approach under the DC Red Carpet Entry protocol of confirming a linkage to care appointment within 72 hours of diagnosis.

HAHSTA enhanced linkages to care with LinkU, an online resource and referral platform for internal/external partners and community members. LinkUDMV.org is a free online resource and referral platform available for consumers and community-based organizations (CBOs) to connect with verified medical and social support services. The website contains a full range of community providers in the DC metropolitan area with features that include online referrals directly to providers; the ability to evaluate referral outcomes related to linkages; needs assessment screening tools, appointment scheduling directly with providers and more. LinkU has an average of 1,500 searches per month. 54% of searches are related to connecting to HIV and other health resources.

The Part A funded Minority Aids Initiative (MAI) Youth Reach Program is focused on serving youth of color ages 13-30 in the following sub-populations: Black women, Black/ Latino men who have sex with men (MSM), Black heterosexual men and Black/Latino transgender women. The individuals in these populations are shown to have low rates of linkage to care within 30-days of diagnosis and low rates of viral suppression. To address these low health outcomes, services provided must be consistent with on-going consumer engagement, culturally and linguistically appropriate, and encompass a wide referral and linkage network that is readily able to address the varying needs of this population.

Entities funded under the Youth Reach Program provide a cadre of services to youths in the identified subpopulations. The programs are designed to facilitate a seamless transition from prevention and testing programs into care and from pediatric to adult care through a coordinated cluster of services. The service categories integral to the Youth Reach Program, which must be offered on site are early intervention services and medical case management. These two services are designed to engage consumers in care, facilitate linkage to medical care while ensuring that their non-medical needs such as housing, food, transportation, and other supportive services are addressed. Other services like mental health and psychosocial support, take nontraditional approaches to break service-related stigma, providing a greater likelihood of consumers’ interest and enrollment in services.

Youth often report exposure to multiple traumas and experience many barriers to stability. These barriers include housing instability, food instability, economic insecurity, transportation, domestic violence, and mental health challenges to name just a few. In response to this, the MAI program targets high-risk (youth) populations for HIV, provide education and prevention, encourage linkages into care,

and retain customers at risk for falling out of care. To do this, specific psychosocial barriers are addressed to mitigate negative impacts on adherence and retention in care.

The DC Adhere mobile application was rolled out to pharmacies, providers, and clients associated with the AIDS Drug Assistance Program (ADAP) administered by DC Health. This app is designed to track prescription pick up (point of sale); send alerts/reminders to clients concerning prescriptions and ADAP enrollment; track daily prescription utilization (voluntary); and generate client and population level reports. Trainings were conducted for pharmacy and physician providers as part of the roll out process, providing an overview of utilization requirements and end-user procedures. Marketing materials designed for the Adhere App were distributed to our case management providers. The Adhere App ad hoc data report development is currently being formulated.

Using HRSA 20-078 funding, which goes through 2025, DC Health has begun implementation of three program initiatives to expand services to more people living with HIV through innovative approaches to care and treatment: (1) integration of community health workers (CHWs) with community health providers; (2) integrated health and wellness; and (3) a community disease intervention specialist (DIS) project with enhanced data to action. First, CHWs will be hired as DC Health employees and deployed to community health providers to increase providers' capacity for early HIV intervention, care navigation and social support services. They will facilitate outreach and care coordination services to individuals who are diagnosed with HIV and not virally suppressed while ensuring timely, high quality and efficient navigation, health, and referral to support services. Second, DC Health funds three organizations (La Clínica del Pueblo, Washington Health Institute, and Whitman-Walker Health) to provide wellness support services in conjunction with their existing core medical and support services through the Dr. Ron Simmons Wellness Initiative—a wellness support services program dedicated to the late Dr. Simmons. The aim of the integrated health and wellness initiative is to improve health outcomes and adherence to prevention or HIV treatment strategies for those who could benefit from the non-traditional support which include but are not limited to the DC EMA priority populations. Third, DC Health is funding a pilot program with MedStar Washington Hospital Center's Infectious Disease Clinic for an internal DIS position to enhance patient navigation services. This pilot program will address mandated disease reporting challenges with providers and ensure the delivery of services, such as timeliness of responses to new diagnoses, increase the number of newly identified partners within social networks and clusters, and reduce potential transmissions through connections to treatment or access to biomedical HIV prevention options like PrEP and PEP.

PrEP Housing is a transitional housing program intended to increased health outcomes for men who have sex with men (MSM) of color, ages 25 – 35, who are at risk of acquiring HIV. Clients will receive single room occupancy in a shared two bedroom apartment for a period of 18-24 months. During that time, the host community based organization, SMYAL, will provide clients with access to pre-exposure prophylaxis (PrEP) via the DC Health and Wellness Center. This includes routine labs, quarterly prescription refills, routine STI screening and treatment, and PrEP adherence case management. The host organization will provide co-located support and direct services in the form of case management, supportive services referrals, financial literacy, life skills trainings, workforce development along with additional PrEP retention and adherence counseling. The program will assist individuals experiencing or at risk of experiencing homelessness, bolstering the relationship between housing and health (physical, mental, and social). To date, one person has been housed; however a PrEP Housing provider open house is forth-coming.

Prevent

DC Health continues its work to increase comprehensive preventive health services capacity, including support for providers to offer PrEP services, outreach and wellness activities, linkages to STI and hepatitis C screening, condom distribution, and behavioral interventions. Additionally, to make PrEP more available to residents of the DC EMA, DC utilized the ADAP platform to implement the PrEP Drug Assistance Program (DAP). It is for insured & uninsured HIV negative residents in the DC metropolitan area who are at high risk of HIV infection and are prescribed Truvada as PrEP.

Based on data reported by DC Health funded PrEP providers, 67% (7,942/11,925) of individuals were screened for PrEP; and of those, 99% (7,891/7,942) were eligible for a PrEP referral. Of the individuals who were eligible for PrEP referrals, 62% (4,811/7,891) were referred to a PrEP provider, 13% (993/7,891) were linked to a PrEP Provider, and 18% (1,400/7,891) were prescribed PrEP (the lower numbers can be attributed to services being offered at only one location- the DC Health and Wellness Center). In April 2022, DC Health awarded Ryan White Part B program funding to eight community organizations to provide status neutral care continuum services that include: 1) linkage to care/navigation services; 2) rapid initiation of ART/PrEP; 3) treatment adherence and retention services, and 4) customer re-engagement and recapture services.

On March 31, 2021, DC Health launched its 24/7 clinician staffed Nonoccupational Post-Exposure Prophylaxis (nPEP) hotline in collaboration with an academic physician group (Georgetown University Hospital Infectious Diseases Physician Group) for evening and weekend coverage. Eligible callers receive a 3-5-day starter nPEP regimens through local contract pharmacies and follow up care at DC Health's government run sexual health clinic. Between April 2021 and September 2021 there were 338 callers. Of those, 59% (n=201/338) were eligible for nPEP; 70% (n=141/201) received a starter prescription; 84% (n=173/201) attended an initial nPEP clinic consultation; and 45% (n=91/201) of referred individuals were located in ZIP codes representing DC's top ten HIV incidence rates. Of those eligible, 55% (n=95/201) attended a 28-day follow-up visit and 68% of those that followed-up at 28 days (n=65/95) transitioned to pre-exposure prophylaxis (PrEP). Compared to individuals diagnosed with HIV in 2019, the nPEP cohort was more likely to be White than Latino/a/x (OR: 0.38 95% CI 0.19-0.75) or Black (OR: 0.12, 95% CI 0.064-0.21). There was a larger proportion of White MSM in the nPEP cohort (25.2%) than were newly diagnosed in 2019 (7.3%), p<.001.

DC Health maintained its public sector condom distribution program, which is comprised of more than 300 community/business distribution sites and a direct mail component to DC residents. In 2021, DC Health distributed more than 2,439,000 male and female condoms.

Due to COVID-19, many prevention activities were delivered through virtual and telehealth modalities, including individual, group and community level interventions. Harm reduction services, such as syringe service programs (SSP) and condom distribution, continued under a limited basis. Community partners providing in-person services have employed best practices in minimizing COVID-19 exposure. The SSP's devised techniques that allowed their staff and clients to maintain social distance while providing access to clean syringes and Narcan. Anecdotally, the providers shared that they placed supplies in locations where clients were able to access them without coming into close contact with the SSP staff.

The funds that support most DC Health harm reduction programs are only intended for use within DC for DC residents. As such, the activities described below are implemented within DC Health. DC Health has expansive harm reduction and opioid related service programming in partnership with the DC Department of Behavioral Health (DBH). This includes hepatitis C screening and treatment, medication

assisted treatment (MAT) services, syringe exchange, women's wellness initiative, and harm reduction activities such as wraparound services for people living with HIV. DC Health supported four syringe service providers (SSP) serving approximately 10,000 persons who use drugs. In FY 21, 868,572 syringes were exchanged. Although the SSP's were faced with the COVID-19 pandemic, there was no decrease in syringe exchange activities. DC Health is in the process of implementing a Harm Reduction Vending Machine pilot program. With the provision of Harm Reduction Vending Machines, DC Health will provide access to needed harm reduction products such as Safer Use Kits, Narcan, HIV/Hep C home tests, and hygiene kits. Six vending machines were purchased, five of which will be located outdoors, and one will be indoors. Of the six vending machines, three will be placed at DC Fire and Emergency Services (FEMS) locations that are near opioid overdose locations. Harm reduction serves a critical role in a continuum of services for people who use drugs.

The DC EMA acknowledges that socio-economic conditions, trauma, social isolation, discrimination, stigma, and other inequities are factors in the lives of persons who use drugs and works with providers to incorporate them in harm reduction approaches. In response to these concerns, DC Health integrated overdose prevention into syringe exchange programs and increased naloxone distribution. DC Health has also implemented a Peer Outreach Specialists (POS), formerly known as the Rapid Peer Responder (RPR), program to link individuals with active opioid use disorder at high risk for overdose to buprenorphine-based MAT, including screening and potential linkage to care. Peer referral specialists serve as rapid responders to those recently experiencing overdose and are trained in the SBIRT (Screening, Brief Intervention and Referral to Treatment) intervention model. Linkage occurs through a web-based appointment system, Link U, linking individuals in need of rapid engagement into treatment to clinicians trained to provide buprenorphine. In September 2022, SSP and MAT programming transitioned to the DC Department of Behavioral Health, but DC Health continues to work with current syringe service providers to increase capacity to provide comprehensive preventive health services and increase linkage to care of HIV and hepatitis C. DC Health implemented a community outreach program that addresses Substance Use Disorder (SUD) and its collateral consequences. Peer Outreach Specialists, formerly known as the Rapid Peer Responders, are cross trained to engage individuals in high incident areas with active opiate use disorder at high risk for overdose. Their trainings include the SBIRT (Screening, Brief Intervention and Referral to Treatment) intervention model; overdose reversal, harm reduction responses, and client-appropriate linkages to supportive services that include clinicians trained to provide buprenorphine-based Medication Assisted Therapy (MAT), testing and treatment for HIV/AIDS, Hepatitis C, STD, TB, COVID-19; housing counseling, food pantries, primary medical care, and mental health services.

Utilizing a mix of federal and local funds, DC Health is in the process of developing a funding announcement that will support a syndemics approach to identifying and preventing HIV, STI, and HBV/HCV. It will ensure that all people are aware of their health status and methods to reduce their risk for these diseases. This approach may lead to improved health outcomes, enhanced self-efficacy, improved health literacy, viral suppression, and a reduction is new infections. DC Health will request applications that build on existing program models that also include access to and/or provision of additional services such as access to PrEP/PEP, "Pop-UP' medical services, "Drop-In" services for people who inject drugs, and HIV prevention programs within syringe service programs. The proposed programs will seek to provide services to Black and Latino MSM, Black heterosexual men and women, transgender individuals, youth aged 13-24, and PWID.

Respond

DC Health submitted the Cluster and Outbreak Response Plan to CDC in July 2021. The plan is currently under review with DC Health Leadership in preparation for community feedback in 2022. Training was provided to HAHSTA staff on the plan in September 2021 with a more formal tabletop exercise planned for fall 2022. Additionally, HAHSTA received a nationally identified cluster for investigation in April 2021, completed the investigation and transitioned it to monitoring status in July 2021, and closed the network in December 2021 with a cluster report submission to the CDC. This network opened communications about cluster detection and response efforts across HAHSTA and facilitated collaboration and discussion. On a monthly basis, the HAHSTA Senior Leadership Team meet to discuss the investigation of the cluster, provide input into investigation strategies, and address potential programmatic gaps. Among those were naive drug use, particularly during anonymous sex and improved data collection among injection drug use (IDU). The HAHSTA Senior Leadership Team also discussed the possibility of developing a linkage between the HIV/STD home-testing program when large volume condom orders are placed through the condom distribution program. Discussions of how to implement this strategy are ongoing.

The Data to Care (D2C) team are having ongoing meetings with the Care and Treatment Division to leverage Ryan White provider partnerships to improve and increase communications between providers and the D2C team. In the next year, the D2C team will work with Ryan White Project Officers to incorporate data-to-care activities into regular meetings and reports. The D2C team has a dedicated Disease Intervention Specialist to conduct the data-to-care activities and is now more experienced in the processes and investigations. Documentation in both internal DC Public Health Information System (DC PHIS) and REDCap and CDC reporting has improved. A recurring barrier to data availability is obtaining participation and responses from providers due to competing priorities related to the pandemic.

Engage

DC Health added Engage as a fifth pillar to address the structural and individual challenges for uptake of health activities across various HIV strategies. In this effort, a network of wellness services, guided by an HIV status neutral approach, address barriers to prioritizing HIV health and advance HIV care and prevention services. These barriers include mental health (stress), structural racism, stigma, and equity. DC Health laid the groundwork for some of these conditions with more needed. It centered sexual well-being in its social marketing programs comprised of two components: (1) general and focus populations, and (2) youth and young adult. DC Health maintains the Sexual Being campaign for its general population program. The program featured directed action messages on HIV testing, PrEP, HIV treatment, and Undetectable equals Untransmittable. Bienestar DC, a new campaign for the Latino community, which translates to well-being was launched to provide information on general sexual health, as well as STD and HIV related information. DC Health's LatinX Working Group, Mi Gente, conducted community engagement on messages that would be most effective for Latinos. DC Health continues its youth and young adult (ages 12 to 24) focused program called Sex is... and launched a Spanish language version Sexo es... with a web site and promotional materials.

DC Health redesigned its funding process for non-profit organizations to make funding more equitable. It eliminated a requirement for a lengthy written narrative application to encourage funding submissions from disadvantaged, smaller, population-focused organizations without skilled grant-writing staff or resources. Funding mechanisms take into consideration health equity, social determinants of health, and self-efficacy within populations of focus to ensure that equal access is afforded to community partners. These changes resulted in the development of innovative programs that serve diverse populations.

SECTION V: 2022- 2026 GOALS AND OBJECTIVES FOR THE DC EMA

V-1. Goals and Objectives Description

The DC EMA is committed to collaboration, efficiency, and innovation to achieve a more coordinated regional response to end the HIV epidemic. As previously mentioned, DC Health developed the Integrated Plan in alignment with the NHAS goals, lessons learned from the first DC EMA's Integrated Plan iteration, DC's 95/95/95 goals and the DC EHE plan.

DC EMA Integrated Plan Goals and Objectives Structure

The following section lists and describes goals, objectives, strategies, and activities for how the DC EMA will diagnose, treat, prevent, and respond to HIV, while taking care to address the barriers and needs identified during the planning process and engaging with our community and stakeholders. This input is reflected in the strategies and activities of the Integrated Plan, particularly regarding housing activities, support services, availability of community health workers, and efforts to improve the regional coordination of care for people living with HIV in the DC EMA. Following the Integrated Plan program guidance, the goals and objectives section highlight at least 3 goals and objectives for each of the five pillars, including DC's Engage pillar. It is important to note that currently, implemented goals, strategies, activities, and outcomes reflect the cultural diversity and focus populations in DC that include: Black and Latino men who have sex with men (MSM), Black heterosexual men and women, transgender individuals, youth aged 13-24, and people who inject drugs (PWID). While DC government plays a fundamental role in implementing this plan, all sectors of the regional community have an opportunity to contribute to preventing HIV transmission and supporting persons with HIV to be successful in treatment.

A summary of the 2022- 2026 goals by pillar for the DC EMA are presented below in Figure 24. The goals, objectives, strategies, and activities are discussed in detail in Table 12. As noted in Section IV: Situational Analysis, although the goals, objectives, strategies, and activities are identified within pillars below, some components may cross pillars.

Figure 24. Goals by Pillar for the DC EMA, 2022-2026

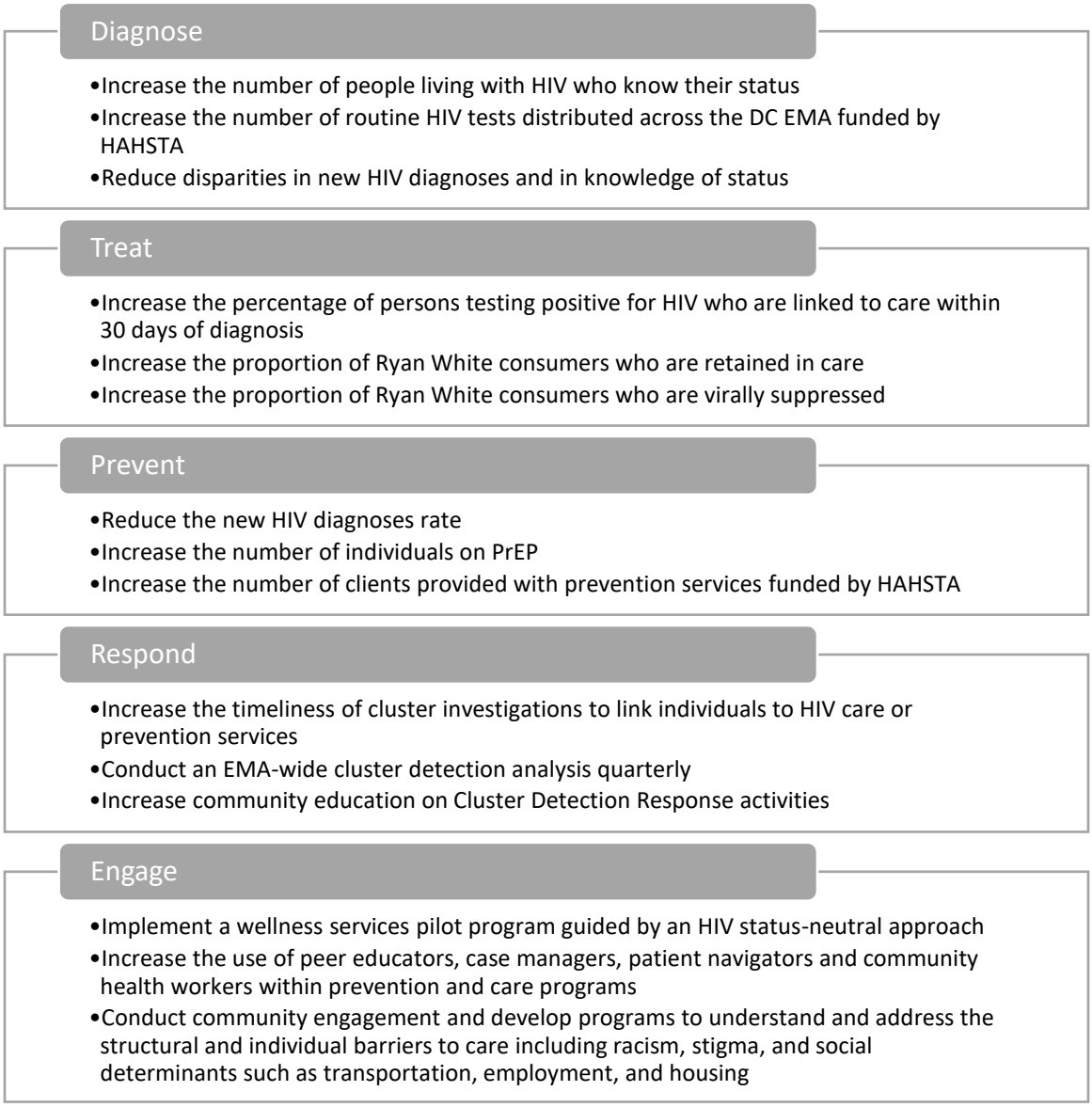


Table 12. Goals and Objectives for the DC EMA, 2022-2026

Diagnose				
Goal 1: Increase the number of people living with HIV who know their status in the DC EMA from a baseline of 87% to a target of 95%				
Associated NHAS Goal(s): Goal 1 – Prevent New HIV Infections; Goal 2 – Improve HIV-related health outcomes for people with HIV; Goal 3 – Reduce HIV-Related Disparities and Health Inequities; Goal 4 – Achieve Integrated, Coordinated Efforts That Address the HIV Epidemic among All Partners and Interested Parties				
Metric: Proportion of people living with HIV in the DC EMA who are diagnosed as reported to the jurisdiction's surveillance system				
Calculation: Number of people living with HIV in in the EMA diagnosed and reported to DCHSS compared with the estimated number of people living with HIV in the EMA based on CDC estimates using the CDC supplied SAS program for estimating unmet need.				
Key Partners: Federally Qualified Health Centers, community-based providers, hospital-based and private practices, youth-focused community organizations, DC Health and Wellness Center (operated by DC Health), pharmacies, pharmacy associations, mental health providers, Department of Health Care Finance, Department of Insurance, and health care and medical provider associations.				
Estimated Funding Allocation: $12.5M				
Potential funding resources: Medicaid, private health insurance, CDC HIV Prevention and Surveillance Program, CDC EHE Implementation funding, HRSA EHE Implementation funding, CDC STD Program, CDC Division of Adolescent and School Health, State/Local funding, foundation grant making, and private funding.				
Expected Impact on the HIV Care Continuum: Increase the number of people who know their HIV diagnosis to 95%;				
Objectives	**Key Activities and Strategies**	**Outcomes**	**Reporting Frequency**	**Monitoring Data Source**
D1A: Develop new and expand implementation of effective, evidence-based, or evidence-informed models for HIV testing that improve convenience and access.	Increase routine HIV screening within clinical settings. DC Health will work in concert with prioritized clinical settings to ensure the provision and increase of routine HIV screening.	Number of DC EMA residents receiving a HIV test in the past 12 months	Annual	Prevention
		Number of people who test positive in HIV testing programs	Annual	Ehars
		Number of new HIV diagnoses with a simultaneous Stage 3 (AIDS) diagnosis	Annual	Ehars
	Expand use of the syndemic approach where all clients are screened and/or linked to services related to HIV/AIDS, HBV/HCV, and sexually transmitted infections (STIs) including biomedical HIV prevention	Number of clients linked to services related to HIV/AIDS, HBV/HCV, and STIs funded through HAHSTA's Prevention RFA	Annual	Prevention

	strategies, health screenings, health literacy, wellness, and behavioral health interventions.			
	Refresh medical provider education on routine HIV screening by compiling a list of reporting providers, obtaining Medicaid data on screening rates by provider, and conducting outreach.	Number of providers receiving outreach	Annual	Prevention
D1B: Develop and implement educational campaigns, interventions, and resources.	Develop new outreach campaigns about comprehensive sexual health, HIV risks, options for prevention, testing, care, and treatment, and/or HIV-related stigma reduction for specific populations, including homeless individuals and older adults.	Number campaigns developed; Est. reach of social marketing campaigns/ ads	Annual	Capacity Building
Goal 2: Increase the number of HIV tests funded by HAHSTA distributed across the DC EMA				
Associated NHAS goal(s): Goal 1 – Prevent New HIV Infections; Goal 3 – Reduce HIV-Related Disparities and Health Inequities				
Metric: Percent change between the number of HIV tests distributed each year compared to the number of HIV tests distributed during baseline year				
Calculation: The difference between the baseline number and the current number compared with the baseline number				
Key Partners: Federally Qualified Health Centers, community-based providers, hospital-based and private practices, youth-focused community organizations, DC Health and Wellness Center (operated by DC Health), pharmacies, pharmacy associations, mental health providers, Department of Health Care Finance, Department of Insurance, and health care and medical provider associations.				
Estimated Funding Allocation: $10.4M				
Potential funding resources: Medicaid, private health insurance, CDC HIV Prevention and Surveillance Program, CDC EHE Implementation funding, HRSA EHE Implementation funding, CDC STD Program, CDC Division of Adolescent and School Health, State/Local funding, foundation grant making, and private funding.				
Expected Impact on the HIV Care Continuum: Increase the number of people who know their HIV diagnosis to 95%; Increase the number of people linked to medical care within 30 days to 85%.				
Objective	**Key Activities and Strategies**	**Outcomes**	**Reporting Frequency**	**Monitoring Data Source**
D2A: Develop and expand implementation of effective, evidence-based, or evidence-informed models for HIV	Expand convenience-based HIV and STD testing through continued implementation of GetCheckedDC and the Virginia & Maryland Home HIV Testing Program.	Number of HIV at home tests distributed	Annual	Prevention/ GetCheckedDC

testing that improve convenience and access.		Number of people who test positive for HIV through convenience-based programs		
	Improve and expand convenience-based HIV and STD testing in non-traditional settings by hosting education and testing events in community spaces to meet people where they are, at places where they are already gathered. This includes building partnerships with community-based organizations, businesses, churches, and pharmacies, for example. Develop and train new rapid testing partners in underserved communities.	Number of testing events held in community spaces Number of new rapid testing partners trained Number of people who test positive for HIV through convenience-based testing events	Annual	Prevention
Goal 3: Reduce disparities in new HIV diagnoses.				
Associated NHAS goal(s): Goal 1 – Prevent New HIV Infections; Goal 2 – Improve HIV-related health outcomes for people with HIV; Goal 3 – Reduce HIV-Related Disparities and Health Inequities; Goal 4 – Achieve Integrated, Coordinated Efforts That Address the HIV Epidemic among All Partners and Interested Parties				
Metric: Percent change in new HIV diagnoses among Black MSM, Black heterosexual men, Black heterosexual women, and Latino MSM compared to the baseline number of new HIV diagnoses.				
Calculation: The percent difference in new HIV diagnoses for each group (Black MSM, Black heterosexual men, Black heterosexual women, and Latino MSM) by the baseline number of new HIV diagnoses				
Key Partners: Federally Qualified Health Centers, community-based providers, hospital-based and private practices, youth-focused community organizations, DC Health and Wellness Center (operated by DC Health), pharmacies, pharmacy associations, mental health providers, Department of Health Care Finance, Department of Insurance, and health care and medical provider associations.				
Estimated Funding Allocation: $26M				
Potential funding resources: Medicaid, private health insurance, CDC HIV Prevention and Surveillance Program, CDC EHE Implementation funding, HRSA EHE Implementation funding, CDC STD Program, CDC Division of Adolescent and School Health, State/Local funding, foundation grant making, and private funding.				
Expected Impact on the HIV Care Continuum: Increase the number of people who know their HIV diagnosis to 95%				
Objective	**Key Activities and Strategies**	**Outcomes**	**Reporting Frequency**	**Monitoring Data Source**
D3A: Ensure resources are focused on the communities	Augment services for youth and young adults by training peers and peer-based	Number of trainings held for youth-serving organizations; Number of	Annual	Prevention/ Care

and populations where the need is greatest.	organizations to conduct HIV and STD testing, expanding testing hours, and supporting HIV and STD testing at college/university health centers. Develop new strategies to reach youth with education and testing in settings outside of clinics and CBOs and provide supports to address barriers to care such as transportation.	clients served through augmented services for youth		
	Increase enrollment in PrEP services for Black and Latino men who have sex with men (MSM), Black heterosexual men and women, transgender individuals, youth aged 13-24, people who inject drugs (PWID).	Number of Black and Latino men who have sex with men (MSM), Black heterosexual men and women, transgender individuals, youth aged 13-24, people who inject drugs (PWID) prescribed PrEP	Annual	Prevention
Treat				
Goal 1: Increase the percentage of persons testing positive for HIV who are linked to care within 30 days of diagnosis in the DC EMA				
Associated NHAS Goal(s): Goal 2 – Improve HIV-Related Health Outcomes of People with HIV; Goal 3 – Reduce HIV-Related Disparities and Health Inequities; Goal 4 – Achieve Integrated, Coordinated Efforts That Address the HIV Epidemic among All Partners and Interested Parties				
Metric: Percent change between the number of new HIV diagnosis among DC EMA residents linked to care within 30 days of diagnosis and the baseline number of new HIV diagnosis among DC EMA residents linked to care within 30 days of diagnosis				
Calculation: The difference between the baseline number and the current number compared with the baseline number				
Key Partners: Regional health departments, clinicians and providers of HIV services, community-based providers, Washington DC Regional Planning Commission on Health and HIV (COHAH)				
Estimated Funding allocation: $16.4M				
Potential funding resources: Medicaid, private health insurance, CDC HIV Prevention and Surveillance Program, Ryan White HIV/AIDS Program, CDC EHE Implementation funding, HRSA EHE Implementation funding, State/Local funding, foundation grant making, and private funding.				
Expected Impact on care continuum: Increase the number the people receiving ART by 90%; Increase viral suppression rate in Ryan White consumers to 95%				
Objective	**Key Activities and Strategies**	**Outcomes**	**Reporting Frequency**	**Monitoring Data Source**
T1A: Link people to care immediately after diagnosis	Increase the number of providers implementing rapid linkage to HIV care and ART initiation.	Percentage of people newly diagnosed with HIV starting HIV medication within seven days	Annual	CareWare/ Ehars

and provide low barrier access to HIV treatment	Conduct a detailed epidemiological analysis to understand which demographic groups have not benefited from rapid linkage to HIV care and treatment initiation in order to reconsider program designs and implementation	Percentage of people newly diagnosed with HIV linked to medical care within one month. Percentage of people newly diagnosed with HIV reaching viral suppression within three months.		
T1B: Increase the capacity of the health care delivery systems within DC's HIV prevention and care network to effectively identify, diagnose, and provide holistic care and treatment for people with HIV	Review and assess all regional HIV partner services protocols to develop a regional model for use in the DC EMA.	Number of regional partner services protocols reviewed	Annual	Care
	Expand provider community of practice where local clinicians who implement rapid ART initiation can learn from DC Health and their peers.	Number of meetings of rapid ART community of practice held Number of providers who attend meetings	Annual	Care
	Convene an inter-jurisdictional surveillance workgroup to discuss best practices and opportunities for data systems integration and improvements and discuss the opportunities to standardize data collection forms and platforms.	Number of workgroup meetings held	Annual	Surveillance Calendar
Goal 2: Increase the proportion of Ryan White consumers who are retained in care to 90% from a baseline of 82% by 2026.				
Associated NHAS goal: Goal 2 – Improve HIV-Related Health Outcomes of People with HIV; Goal 3 – Reduce HIV-Related Disparities and Health Inequities; Goal 4 – Achieve Integrated, Coordinated Efforts That Address the HIV Epidemic among All Partners and Interested Parties				
Metric: Percent change between the number of RW consumers in the current year compared with the baseline year				
Calculation: The difference between the baseline number and the current number compared with the baseline number				
Key Partners: Regional health departments, clinicians and providers of HIV services, community-based providers, Washington DC Regional Planning Commission on Health and HIV (COHAH)				
Estimated Funding Allocation: $21M				
Potential funding resources: Potential funding resources: Medicaid, private health insurance, CDC HIV Prevention and Surveillance Program, Ryan White HIV/AIDS Program, CDC EHE Implementation funding, HRSA EHE Implementation funding, State/Local funding, foundation grant making, and private funding.				

Expected Impact on care continuum: Increase the number the people receiving ART by 90%; Increase viral suppression rate in Ryan White consumers to 95%				
Objective	**Key Activities and Strategies**	**Outcomes**	**Reporting Frequency**	**Monitoring Data Source**
T2A: Increase retention in care and adherence to HIV treatment to achieve and maintain long-term viral suppression	Implement Intervention Services Program to increase early HIV identification, early HIV intervention, treatment adherence and viral load suppression using best practices and innovative services models such as Community Health Workers (CHW).	Number of clients served through Intervention Services Program	Annual	Careware
Goal 3: Increase the proportion of Ryan White consumers who are virally suppressed to at least 95% by 2026 from a baseline of 82% in 2020.				
Associated NHAS goal: Goal 2 – Improve HIV-Related Health Outcomes of People with HIV; Goal 3 – Reduce HIV-Related Disparities and Health Inequities; Goal 4 – Achieve Integrated, Coordinated Efforts That Address the HIV Epidemic among All Partners and Interested Parties				
Metric: Percent change between the number of RW consumers in the current year compared with the baseline year				
Calculation: The difference between the baseline number and the current number compared with the baseline number				
Key Partners: Regional health departments, clinicians and providers of HIV services, community-based providers, Washington DC Regional Planning Commission on Health and HIV (COHAH)				
Estimated Funding Allocation: $21M				
Potential funding resources: Medicaid, private health insurance, CDC HIV Prevention and Surveillance Program, Ryan White HIV/AIDS Program, CDC EHE Implementation funding, HRSA EHE Implementation funding, State/Local funding, foundation grant making, and private funding.				
Expected Impact on care continuum: Increase the number the people receiving ART by 90%; Increase viral suppression rate in Ryan White consumers to 95%				
Objective	**Key Activities and Strategies**	**Outcomes**	**Reporting Frequency**	**Monitoring Data Source**
T3A: Increase retention in care and adherence to HIV treatment to achieve and maintain long-term viral suppression	Support re-engagement and retention in HIV care and treatment adherence for people living with HIV in care through Data to Care programs.	Percentage of people with HIV with sustained viral suppression within past two years Percentage of people with HIV missing two prescription refills within a 90-day period Percentage of young people (ages 13–30) with HIV missing two	Annual Annual Annual	Ehars Ramsell PBM System/Contracted Drug Utilization Review with

		prescription refills within a 90-day period.		Clinical Pharmacy Associates
T3B: Integrate U=U as standard of care	Integrate U=U as standard of care in a status neutral approach for HIV care and prevention services by providing training to medical and community-based providers and increasing social marketing.	Number of provider trainings held Number of medical and community-based providers trained Number of impressions on U=U social media campaigns	Annual	Prevention
Prevent				
Goal 1: Reduce the rate of new HIV diagnoses in the DC EMA				
Associated NHAS Goal(s): Goal 1 – Prevent New HIV Infections; Goal 2 – Improve HIV-Related Health Outcomes of People with HIV; Goal 3 – Reduce HIV-Related Disparities and Health Inequities; Goal 4 – Achieve Integrated, Coordinated Efforts That Address the HIV Epidemic among All Partners and Interested Parties				
Metric: Percent change between the rate of new diagnoses in the current year compared with the baseline year				
Calculation: The difference between the baseline number and the current number compared with the baseline number				
Key Partners: Federally Qualified Health Centers, community-based providers, hospital-based and private practices, youth-focused community organizations, health care associations, DC Health and Wellness Center (operated by DC Health).				
Estimated Funding Allocation: $6M				
Potential Funding Resources: Medicaid, private health insurance, CDC HIV Prevention and Surveillance Program, CDC EHE Implementation funding, HRSA EHE Implementation funding, CDC STD Program, SAMHSA funding. State/Local funding, Patient Assistance Programs, foundation grant making, and private funding.				
Expected Impact on Status Neutral Approach: Increase the number of people prescribed PrEP by 50%; Increase the number of people linked to PrEP services to 6,500				
Objective	**Key Activities and Strategies**	**Outcomes**	**Reporting Frequency**	**Monitoring Data Source**
P1A: Increase community awareness of HIV	Expand PrEP social marketing and educational materials in diverse media platforms and formats.	Number of PrEP social marketing campaigns developed Number of impressions on PrEP campaign social media posts	Annual	Capacity Building

P1B: Expand and improve implementation of safe, effective prevention interventions	Expand PrEP telehealth by training providers on its benefits and effectiveness, sharing PrEP protocols, and identifying and addressing barriers to PrEP telehealth use by certain populations.	Number of provider meetings and trainings held on PrEP telehealth Number of providers who attend PrEP telehealth meetings and trainings	Annual	Capacity Building
Goal 2: Increase the number of individuals on PrEP in the DC EMA				
Associated NHAS Goal(s): Goal 1 – Prevent New HIV Infections; Goal 4 – Achieve Integrated, Coordinated Efforts That Address the HIV Epidemic among All Partners and Interested Parties				
Metric: Percent change between the estimated number of people on PrEP in the current year compared with the baseline year				
Calculation: The difference between the baseline number and the current number compared with the baseline number				
Key Partners: Federally Qualified Health Centers, community-based providers, hospital-based and private practices, youth-focused community organizations, health care associations, DC Health and Wellness Center (operated by DC Health).				
Estimated Funding Allocation: $15M				
Potential funding resources: Medicaid, private health insurance, CDC HIV Prevention and Surveillance Program, CDC EHE Implementation funding, HRSA EHE Implementation funding, CDC STD Program, SAMHSA funding. State/Local funding, Patient Assistance Programs, foundation grant making, and private funding				
Expected Impact on Status Neutral Approach: Increase the number of people prescribed PrEP by 50%; Increase the number of people linked to PrEP services to 6,500				
Objective	**Key Activities and Strategies**	**Outcomes**	**Reporting Frequency**	**Monitoring Data Source**
P2A: Increase community awareness of biomedical prevention options	Conduct innovative community engagement activities to increase acceptability for PrEP and post-exposure prophylaxis (PEP) in focus populations	Number of community engagement events held Number of participants in community engagement events	Annual Annual	Capacity Building Capacity Building
P2B: Expand and improve implementation of safe, effective prevention interventions, including treatment as prevention, PrEP, PEP, and SSPs, and develop new options	Recruit diverse and culturally affirming peer navigators to educate and connect individuals to PrEP services to address individual risk perception and address perceived stigma and safety concerns.	Number of peer navigators hired Number of clients served through Peer navigation services	Annual Annual	Prevention Prevention
	Continue expanding access to PrEP services, with an emphasis on increasing uptake among focus populations	Number of people prescribed PrEP	Annual	Prevention

		Number of family medicine and internal medicine physicians with at least two PrEP prescriptions covered by Medicaid. Number of HIV-negative Medicaid enrollees filling at least one PrEP prescription within the year.	Annual Annual	Wellness Center Wellness Center
	Continue implementation PrEP Housing Pilot to provide temporary housing and case management to address social determinant needs of young men who have sex with men of color utilizing PrEP. If model is proven successful, expand to additional focus populations (e.g., transgender persons, Black heterosexual women).	Number of HIV-negative individuals receiving housing assistance starting PrEP and remaining adherent for up to one year.	Annual	Capacity Building/ HOWPA
	Continue expanding access to post-exposure prophylaxis through a 24/7 PEP hotline and access program with immediate prescription availability and by increasing the number of providers prescribing PEP.	Number of people prescribed PEP through DC Health nPEP hotline Number of people prescribed PEP Number of PEP prescriptions covered by Medicaid	Annual Annual Annual	Prevention Prevention Wellness Center
Goal 3: Increase the number of clients provided with prevention services funded by HAHSTA				
Associated NHAS goal: Goal 1 – Prevent New HIV Infections; Goal 4 – Achieve Integrated, Coordinated Efforts That Address the HIV Epidemic among All Partners and Interested Parties				
Metric: Percent change between the number of people using prevention services in the current year compared with the baseline year				
Calculation: The difference between the baseline number and the current number compared with the baseline number				
Key Partners: Federally Qualified Health Centers, community-based providers, hospital-based and private practices, youth-focused community organizations, health care associations, DC Health and Wellness Center (operated by DC Health)				
Estimated Funding Allocation: $3.4M				

Potential funding resources: Medicaid, private health insurance, CDC HIV Prevention and Surveillance Program, CDC EHE Implementation funding, HRSA EHE Implementation funding, CDC STD Program, SAMHSA funding. State/Local funding, Patient Assistance Programs, foundation grant making, and private funding				
Expected Impact on Status Neutral Approach: Increase the number of people prescribed PrEP by 50%; Increase the number of people linked to PrEP services to 6,500				
Objective	**Key Activities and Strategies**	**Outcomes**	**Reporting Frequency**	**Monthly Data Source**
P3A: Expand and improve implementation of safe, effective prevention interventions, including treatment as prevention, PrEP, PEP, and SSPs, and develop new options	Enhance integrated syringe service programs by increasing number of community partners using harm reduction approaches (including peer-led), building capacity to address polysubstance use, and combination HIV prevention (including PrEP) and opioid treatment.	Percentage of people in syringe service program tested for HIV	Annual	Prevention
	Implement harm reduction vending machine pilot	Number of clients accessing harm reduction materials from vending machines	Annual	Prevention
Respond				
Goal 1: Increase the timeliness of cluster investigations to link individuals to HIV care or prevention services				
Associated NHAS Goal(s): Goal 2 – Improve HIV-Related Health Outcomes of People with HIV; Goal 3 – Reduce HIV-Related Disparities and Health Inequities; Goal 4 – Achieve Integrated, Coordinated Efforts That Address the HIV Epidemic among All Partners and Interested Parties				
Metric: Percent change between the average time to complete a cluster investigation in the current year compared with the baseline year				
Calculation: The difference between the baseline number and the current number compared with the baseline number				
Key Partners: Regional health departments, Washington DC Regional Planning Commission on Health and HIV (COHAH), medical providers, laboratories, and community-based providers				
Estimated Funding Allocation: $4.5M				
Potential Funding Resources: CDC HIV Prevention and Surveillance Program, Ryan White HIV/AIDS Program, CDC STD Program, CDC EHE Implementation funding, HRSA EHE Implementation funding, and State/Local funding				
Expected Impact on Status Neutral Approach: Increase the number the cluster members receiving testing and prevention services by 10%; Improve the viral suppression rate in among cluster members by 10%				
Objective	**Key Activities and Strategies**	**Outcomes**	**Reporting Frequency**	**Monitoring Data Source**
R1A: Improve cluster investigation processes	Establish new protocols for HIV diagnoses, with a new timeframe to process the	Number of new protocols developed	Annual	Surveillance

through updated protocols and data systems	diagnosis and issue a field record within seven days.			
	Conduct ongoing expanded review of both molecular and time/space clusters to expand the opportunities to identify and address clusters of interest. Report on clusters of interest DC Health HAHSTA Senior Leadership team. Report findings at Monthly Regional MHS Meetings between DC, Maryland, and Virginia DOH staff to discuss generalized cluster information of regional concern.	Percentage of people with HIV interviewed by DC Health within 30 days of diagnosis.	Annual	Surveillance
	Use continuous quality improvement techniques to improve the timeliness of molecular cluster detection by addressing lab-related delays in receipt of molecular HIV sequences and delays in internal processing of molecular HIV sequences.	Percentage of people with HIV in an HIV transmission cluster achieving viral suppression within six months.	Annual	Surveillance
	Establish a Cluster Response Committee to review cluster data and make plans to tailor HIV prevention, testing, and care and treatment messages and services based on the findings.	Number of meetings of Cluster Response Committee	Annual	Surveillance Calendar
	Explore and implement options to integrate and centralize both HIV and STD surveillance activities into one data system to improve the time-lag to analysis for clusters.	Number of meetings to explore options for integrated data system	Annual	Surveillance Calendar
Goal 2: Conduct an EMA-wide cluster detection analysis quarterly				
Associated NHAS goal: Goal 2 – Improve HIV-Related Health Outcomes of People with HIV; Goal 3 – Reduce HIV-Related Disparities and Health Inequities; Goal 4 – Achieve Integrated, Coordinated Efforts That Address the HIV Epidemic among All Partners and Interested Parties				
Metric: Number of EMA-wide cluster detection analyses completed				
Calculation: Number of EMA-wide cluster detection analyses completed				

Key Partners: Regional health departments, Washington DC Regional Planning Commission on Health and HIV (COHAH), medical providers, laboratories, and community-based providers				
Estimated Funding Allocation: $130,000				
Potential funding resources: CDC HIV Prevention and Surveillance Program, Ryan White HIV/AIDS Program, CDC STD Program, CDC EHE Implementation funding, HRSA EHE Implementation funding, and State/Local funding				
Expected Impact on Status Neutral Approach: Increase the number the cluster members receiving testing and prevention services by 10%; Improve the viral suppression rate in among cluster members by 10%				
Objective	**Key Activities and Strategies**	**Outcomes**	**Reporting Frequency**	**Monitoring Data Source**
R2A: Increase coordination among the different DC EMA government agencies, including the sharing of best practices from HIV programs	Collaborate with Maryland Department of Health; Virginia Department of Health; Montgomery County, MD; and Prince George's County, MD to evaluate and enhance the regional approach to HIV cluster detection and response.	Number of cross-jurisdictional meetings on HIV cluster detection and response held	Annual	Surveillance Calendar
Goal 3: Increase community education on Cluster Detection Response activities				
Associated NHAS goal: Goal 2 – Improve HIV-Related Health Outcomes of People with HIV; Goal 3 – Reduce HIV-Related Disparities and Health Inequities; Goal 4 – Achieve Integrated, Coordinated Efforts That Address the HIV Epidemic among All Partners and Interested Parties				
Metric: Percent change in the number of community engagement events attend or held during the current year compared with the previous year				
Calculation: The difference between the baseline number and the current number compared with the baseline number				
Key Partners: Regional health departments, Washington DC Regional Planning Commission on Health and HIV (COHAH), medical providers, laboratories, and community-based providers				
Estimated Funding Allocation: $130,000				
Potential funding resources: CDC HIV Prevention and Surveillance Program, Ryan White HIV/AIDS Program, CDC STD Program, CDC EHE Implementation funding, HRSA EHE Implementation funding, and State/Local funding				
Expected Impact on Status Neutral Approach: Increase the number the cluster members receiving testing and prevention services by 10%; Improve the viral suppression rate in among cluster members by 10%				
Objective	**Key Activities and Strategies**	**Outcomes**	**Reporting Frequency**	**Monitoring Data Source**
R3A: Increase community understanding of cluster detection activities	Present on cluster detection activities at community engagement events /meetings	Number of community engagement events attend or held	Annual	Surveillance
Engage				
Goal 1: Implement a wellness services pilot program guided by an HIV status-neutral approach				

Associated NHAS Goal(s): Goal 1 – Prevent New HIV Infections; Goal 2 – Improve HIV-Related Health Outcomes of People with HIV; Goal 3 – Reduce HIV-Related Disparities and Health Inequities; Goal 4 – Achieve Integrated, Coordinated Efforts That Address the HIV Epidemic among All Partners and Interested Parties				
Metric: Percentage of Wellness Initiative clients who are on PrEP or ART				
Calculation: Numerator: Number of Wellness clients who are either on PrEP or ART, Denominator: All clients who have received Wellness Services in the past year				
Key Partners: Wellness services providers, Federally Qualified Health Centers, health service providers, community-based providers, Washington DC Regional Planning Commission on Health and HIV (COHAH)				
Estimated Funding Allocation: $300,000				
Potential funding resources: CDC HIV Prevention and Surveillance Program, Ryan White HIV/AIDS Program, CDC EHE Implementation funding, HRSA EHE Implementation funding, State/Local funding, foundation grant making, and private funding				
Expected Impact on Status Neutral Approach: Increase the number the people receiving ART by 90%; Increase the number of people prescribed PrEP by 50%				
Objective	**Key Activities and Strategies**	**Outcomes**	**Reporting Frequency**	**Monitoring Data Source**
E1A: Pilot a status-neutral approach to HIV programs	Implement status-neutral Wellness Initiative to support improved health outcomes and adherence to prevention or HIV treatment strategies for those who could benefit from the non-traditional support	Number of clients served through Wellness Initiative	Annual	Careware
		Number of Wellness Initiative clients on PrEP	Annual	Careware
		Number of Wellness Initiative clients on ART	Annual	Careware
		Percent of clients who report decreased stress, decreased pain, or improved sleep because of participation in this Wellness program	Annual	Survey Data
Goal 2: Increase the use of peer educators, case managers, patient navigators and community health workers within prevention and care programs				
Associated NHAS goal: Goal 1 – Prevent New HIV Infections; Goal 2 – Improve HIV-Related Health Outcomes of People with HIV; Goal 3 – Reduce HIV-Related Disparities and Health Inequities; Goal 4 – Achieve Integrated, Coordinated Efforts That Address the HIV Epidemic among All Partners and Interested Parties				

Metric: Percent change in the numbers of programs using each of the staff categories during the current year compared with the baseline year				
Calculation: The difference between the baseline number and the current number compared with the baseline number				
Key Partners: Federally Qualified Health Centers, health service providers, community-based providers				
Estimated Funding Allocation: $700,000				
Potential funding resources: CDC HIV Prevention and Surveillance Program, Ryan White HIV/AIDS Program, CDC EHE Implementation funding, HRSA EHE Implementation funding, State/Local funding, foundation grant making, and private funding				
Expected Impact on Status Neutral Approach: Increase the number the people receiving ART by 90%; Increase the number of people prescribed PrEP by 50%				
Objective	**Key Activities and Strategies**	**Outcomes**	**Reporting Frequency**	**Monitoring Data Source**
E2A: Increase the diversity and capacity of the health workforce to prevent and diagnose HIV	Continue the use of Rapid Peer Responders address the health of people who use drugs through a harm reduction approach. Responders are individuals from the community they serve, and who have employment challenges such as recent incarceration experience or limited work experience in the formal economy	Number of Rapid Peer Responders hired Number of clients served through Rapid Peer Responder activities	Annual Annual	Prevention Prevention
E2B: Increase the capacity of the public health, health care delivery systems, and health care workforce to effectively identify, diagnose, and provide holistic care and treatment for people with HIV	Expand the community health worker and peer navigator models. Community health workers have access to and the trust of communities, making them an integral part of linkage and retention to care efforts, particularly for those who are marginalized, have stopped receiving care, or are newly diagnosed.	Number of community health workers hired Number of clients served through community health worker activities	Annual Annual	Prevention/ Careware Prevention/ Careware
Goal 3: Conduct community engagement and develop programs to understand and address the structural and individual barriers to care including racism, stigma, and social determinants such as transportation, employment, and housing.				
Associated NHAS goal: Goal 1 – Prevent New HIV Infections; Goal 2 – Improve HIV-Related Health Outcomes of People with HIV; Goal 3 – Reduce HIV-Related Disparities and Health Inequities; Goal 4 – Achieve Integrated, Coordinated Efforts That Address the HIV Epidemic among All Partners and Interested Parties				
Metric: Number of community members attending community engagement sessions held by DC Health				
Calculation: Number of community members attending community engagement sessions held by DC Health				

Key Partners: Federally Qualified Health Centers, health service providers, community-based providers, Washington DC Regional Planning Commission on Health and HIV (COHAH).				
Estimated Funding Allocation: $12.7M				
Potential funding resources: CDC HIV Prevention and Surveillance Program, Ryan White HIV/AIDS Program, CDC EHE Implementation funding, HRSA EHE Implementation funding, State/Local funding, foundation grant making, and private funding				
Expected Impact on Status Neutral Approach: Increase the number the people receiving ART by 90%; Increase the number of people prescribed PrEP by 50%				
Objective	**Key Activities and Strategies**	**Outcomes**	**Reporting Frequency**	**Monitoring Data Source**
E3A: Conduct ongoing community engagement	Conduct ongoing community engagement activities to better understand community needs around HIV care and prevention services and to address barriers and stigma.	Number of community engagement sessions held	Annual	Capacity Building
E3B: Reduce disparities in new HIV infections, in knowledge of status, and along the HIV care continuum	Address housing and other social support needs by updating navigation programs to include navigation and referral for wrap around services to enable people living with HIV to gain or maintain access to care and treatment.	Number of clients referred for wrap around services	Annual	Prevention/ Careware

V-1a. Updates to Other Strategic Plans Used to Meet Requirements

The 2022 DC EMA HIV Care and Prevention Integrated Plan draws heavily from and is designed to complement the DC EHE Plan. The goals, activities, strategies, and activities contained in the Integrated Plan reflect the key learnings and implementation successes and challenges of DC EHE activities. The Integrated plan offers an opportunity to assess our progress with DC EHE plan implementation, make changes based upon the data (including community and stakeholder feedback), and apply those strategies and activities across the DC EMA.

The Integrated Plan differs from the DC EHE plan in its geographic focus. While the DC EHE plan focuses on the District of Columbia, the Integrated Plan includes the entire DC EMA. Although all four jurisdictions comprising the DC EMA border each other more or less, they each have unique and substantial variations in population characteristics and public policies that impact HIV service planning and delivery. Each jurisdiction also addresses the health and social service needs of its residents in a different way. As a result, the Integrated Plan reflects different focus populations, collaborators, and areas of need inclusive of the DC EMA. While many of the strategies and activities have been pulled from the DC EHE plan and updated, the goals and objectives have been newly developed specifically for the Integrated plan. Table 13 below summarizes key differences between the DC EHE plan and the Integrated Plan.

Table 13. DC EHE and Integrated Plan Differences, 2022

Name	Focus Populations	Activities by Pillar
DC EHE Plan (launched December 2020)	Washington DC: Black men, Black women, Latino gay men, young Black gay men, transgender individuals, and people who use drugs	**Diagnose –** Increase access to HIV testing through programs such as the new at-home and walk-in testing program, GetCheckedDC.org, and advance policy and process approaches for routine HIV and STD screening. **Treat –** Start HIV treatment rapidly, such as the day a person is diagnosed, and prioritize Undetectable Equals Untransmittable (U=U) to promote staying on treatment. **Prevent –** Increase access and support for PrEP and post-exposure prophylaxis (PEP), expand harm-reduction programs for people who use drugs, and promote U=U because people who are virally suppressed cannot transmit HIV to a sexual partner **Respond** – Connect with people who have been newly diagnosed with HIV faster to intervene in clusters, among social networks, and connect individuals to care or prevention. **Engage -** Launch new wellness services to address the stress residents expressed as a barrier for prioritizing HIV health and advance approaches to reduce stigma, support stable housing and economic opportunity, ensure cultural humility is integral to services, and promote accurate information.
Integrated Plan	DC EMA: Black and Latino men who have sex with men (MSM), Black heterosexual men and women, transgender individuals, youth aged 13-24, people who inject drugs (PWID)	**Diagnose –** Increase access to testing through healthcare and non-health settings, including continued implementation of at-home testing programs. **Treat –** Increase the number of people in DC EMA who to linked to ART; improve health outcomes for Ryan White consumers, including retention in care and viral suppression **Prevent –** Increase access to prevention services in the DC EMA including PrEP, PEP, SSP, harm reduction programs and develop social marketing to provide education and address stigma in focus populations **Respond** – Improve cluster detection processes and engage with community members to provider education and address concerns **Engage-** Continue implementation of status neutral wellness initiative. Conduct ongoing community engagement to address barriers and stigma.

SECTION VI: 2022-2026 INTEGRATED PLANNING IMPLEMENTATION, MONITORING, AND JURISDICTIONAL FOLLOW – UP

VI-1. 2022-2026 Integrated Planning Implementation Approach

The 2022-2026 DC EMA Integrated Plan is supported by the DC EMA jurisdictional partners (Maryland, Virginia, and West Virginia [HAHSTA administrative oversight]) and planning body (COHAH), and strong leadership from four DC Health divisions (Divisions of Care and Treatment, Prevention and Intervention Services, Capacity Building, Housing & Community Partnership, and Strategic Information). The COHAH will work collaboratively with jurisdictional partners, DC Health, and community stakeholders to ensure progress in implementation, monitoring, evaluation, improvement, reporting, and dissemination of the plan. Details regarding these efforts, including a flexible timeline, are outlined below.

VI-1a. Implementation

In addition to its General Body, the COHAH has several committees responsible for the overall operations, engagement, monitoring, recruitment, and priority setting and resource allocation of the Ryan White HIV/AIDS Program. The COHAH's Research and Evaluation Committee (REC) will utilize a holistic approach to successfully guide implementation, continuously monitor, and track progress against the goals, objectives, strategies, and activities identified in the plan to improve HIV prevention and care service delivery and outcomes for priority populations. In this effort, the REC will collaborate with several COHAH committees including the Integrated Strategies (ISC), Community Engagement and Education (CEEC), and Comprehensive Planning (CPC) committees. As noted in Section II: Community Engagement and Planning Process, the COHAH's membership includes a variety of partners integral to informing the progress of the plan, such as PLWH, community members, key stakeholders, and HIV service providers. The COHAH's CEEC will continue to lead efforts to identify new partners, PLWH, people at high risk for exposure to HIV, and providers and administrators from different funding streams involved in HIV prevention, care, and treatment services to meet the plan goals and objectives. The REC will meet monthly to carefully review progress on the goals, objectives, strategies and activities outlined in the plan and to ensure proper coordination of tracking and reporting efforts. The HIV Services Planner and the DC EHE Coordinator will participate in COHAH monthly committee meetings (i.e., REC, ISC, and CEEC), as well as cross-jurisdictional meetings to ensure alignment, and coordinate efforts with support from staff and senior leadership across DC Health divisions.

VI-1b. Monitoring

DC Health's HAHSTA will develop and utilize a Microsoft Excel tracking tool to monitor and track progress on plan goals, objectives, strategies, and activities and to ensure that all documented performance metrics are being measured as outlined in Section V: 2022-2026 Goals and Objectives. HAHSTA's leadership will review the status of progress made bi-annually and work collaboratively with COHAH committees and the HIV Services Planner to ensure performance metrics from various programs are on track or make programming adjustments as needed to meet plan targets. The DC EMA Integrated Plan is a dynamic "living document" and modifications will be made to the plan annually as needed according to the needs of the priority populations.

DC Health has a comprehensive collaboration with the Maryland and Virginia Departments of Health, known as the DMV Collaboration. The Collaboration consists of a data sharing agreement for surveillance data, regular meetings to plan and coordinate service delivery and resource allocation, integrated planning efforts (e.g., the three jurisdictions co-developed the Ryan White Program needs assessment to be conducted across the region), and joint participation in projects and engagement in

regional EHE strategies. The DMV Collaboration will utilize its existing joint infrastructure to avoid the duplication of effort and potential gaps in service provision.

VI-1c. Evaluation

DC Health's HAHSTA will collect and analyze data for the performance measures from sub-recipients, jurisdictional partners, community engagement activities, program documents, and COHAH's DC EMA needs assessment to evaluate the plans effectiveness at reaching outlined goals and objectives. The plan objectives, key activities and strategies will be evaluated bi-annually, while the outcomes and impact will be evaluated annually. Progress will be measured by comparing the change between the baseline measures with the current measures. Progress on the plan will be shared bi-annually at the COHAH's General Body meetings and quarterly at COHAH's committee meetings.

A high-level, flexible timeline of key monitoring and evaluation milestones are presented in Table 14 below.

Table 14. Timeline of Key Evaluation and Monitoring Milestones

Timeframe	Activities
Ongoing	Collect data for all evaluation metrics from reporting parties
Quarterly	Present progress update at COHAH Committee Meetings (REC)
Quarterly	Collect and analyze program data for key activities and strategies
Bi-annually	Present progress update at COHAH General Body Meeting
Bi-annually	Review of progress by HAHSTA leadership
Annually	Surveillance data analysis
January	Review most recent program evaluation data with COHAH and document successes/challenges, and solicit feedback for improvement[a]
February	Disseminate previous year program evaluation findings to community partners and solicit feedback for improvement
March	Review evaluation data compared with baseline year with COHAH and document successes/challenges, and solicit feedback for improvement
April-June	Freeze and finalize current year data
July-August	Disseminate findings presented to COHAH to community partners and solicit feedback for improvement
October-December	Develop and publish annual Integrated Plan progress report

[a]Surveillance data is a year behind the current year

VI-1d. Improvement

The DC EMA will approach the improvement process holistically and organically, guided by practical considerations from the COHAH and data resources. The DC EMA Integrated Plan will be improved, as necessary, based on community and stakeholder feedback, jurisdictional discussions, program and operational documents, and data gathered from across the jurisdictions. These mechanisms will aid in solidifying a deeper understanding of how best to improve HIV prevention and care services in the DC EMA. The plan and procedures for monitoring and evaluation are not meant to be prescriptive, but as a guide to stimulate the DC EMA's thinking about how to support our jurisdictional efforts to reach the goals and objectives outlined in the plan. The DC EMA anticipates learning from successful programming and developing new initiatives to meet the needs of the priority populations. All voices (i.e., community partners, planning bodies [i.e., EHE, District of Columbia Center for AIDS Research, COHAH], service providers, PLWH, new partners) will be elevated through ongoing discussions in various meetings

(described above) as part of the improvement process. The HIV Services Planner will take community and stakeholder recommendations and knowledge gained from the data to the COHAH for consideration. The COHAH will make plan improvement decisions based on the information provided on an ongoing basis and HAHSTA will work with jurisdictional partners to share and coordinate any revisions.

VI-1e. Reporting and Dissemination

HAHSTA will develop brief monitoring and evaluation reports and/or presentations bi-annually. The reports will be made publicly available on the DC Ends HIV and DC Health's websites. The HIV Services Planner will present updates at COHAH meetings and seek opportunities to present to community partners, stakeholders, as applicable. As mentioned above, COHAH's membership includes PLWH.

VI-1f. Updates to Other Strategic Plans Used to Meet Requirements

The 2022 DC EMA HIV Care and Prevention Integrated Plan draws heavily from and is designed to complement the DC EHE Plan. The goals, activities, strategies, and activities contained in the Integrated Plan reflect the key learnings and implementation successes and challenges of EHE activities. The Integrated plan offers an opportunity to assess our progress with EHE plan implementation, make changes based upon the data (including community and stakeholder feedback), and apply those strategies and activities across the EMA.

SECTION VII. LETTER OF CONCURRENCE

Please see the next page.

APPENDIX

Please see Appendix attachments.

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.*

October 6, 2022

Attention:
José E. Au Lay, HRSA Project Officer
Shuenae Smith, CDC Project Officer

Dear Mr. Au Lay and Ms. Smith:

The Washington DC Regional Planning Commission on Health and HIV (COHAH) concurs with the following submission by the District of Columbia Department of Health in response to the guidance set forth for health departments and HIV planning groups funded by the CDC's Division of HIV/AIDS Prevention (DHAP) and HRSA's HIV/AIDS Bureau (HAB) for the development of the Integrated HIV Prevention and Care Plan Guidance, including the Statewide Coordinated Statement of Need, CY 2022- 2026.

The COHAH has reviewed the Integrated HIV Prevention and Care Plan submission to CDC and HRSA. The plan describes the programmatic activities, coordination of the HIV planning process and resources allocated to the most disproportionately affected populations and geographical areas that bear the greatest burden of HIV disease in the metropolitan area. The COHAH concurs that the Integrated HIV Prevention and Care Plan submission fulfills the requirements put forth by CDC's Notice of Funding Opportunity for Integrated HIV Surveillance and Prevention Programs for Health Departments and the Ryan White HIV/AIDS Program legislation and program guidance.

The engagement process to develop the District of Columbia's Integrated HIV Prevention and CARE Plan began with a collaborative process between the COHAH and the DC Department of Health. The DC Department of Health, COHAH Staff, and COHAH members met during COHAH's Integrated Strategies Committee (ISC) meetings (the ISC serves as the EHE Advisory Body). The ISC includes individuals from affected communities, including people with HIV/AIDS, members of a federally recognized Indian tribe as represented in the population, individuals co-infected with Hepatitis B or C, and historically underserved groups and subpopulations.

The signatures below confirms the concurrence of the planning body with the Integrated HIV Prevention and Care Plan.

Regards,

Lamont Clark
Washington DC Regional Planning Commission on Health and HIV (COHAH) Government Co-Chair
Lamont.Clark@dc.gov

Betelhem Mekonnen
Washington DC Regional Planning Commission on Health and HIV (COHAH) Community Co-Chair
Betelhem123@gmail.com

Jane Wallis
Washington DC Regional Planning Commission on Health and HIV (COHAH) Community Vice Chair
jane.wallis@dcbc.dc.gov

APPENDIX

1. Resource Inventory

The documents below are available upon request. Please contact the HIV Services Planner, Julie Orban, MPH at julie.orban@dc.gov.

2. Integrated Plan Checklist
3. Focus Populations for Community Engagement
4. 2017-2021 DC EMA Integrated Plan
5. DC EHE
6. Ryan White Part A Application
7. Ryan White Part B Application
8. CDC-RFA-PS18-1802 Application
9. COHAH Membership (Roster File)
10. COHAH Structure and Responsibilities

Coordination of Services and Funding Streams

This table is an HIV resource inventory which includes public and private funding sources for HIV prevention, care, and treatment services in the DC EMA; the dollar ($) amount of available funds from that source; and allocations across each of the four jurisdictions in the EMA. Data are for the most recent fiscal year available, as indicated. When an organization has a primary focus on a specific population, that is indicated in parentheses. **Because of variations in fiscal year as well as multiple other limitations (as indicated), this should be considered an estimate rather than a precise accounting.**

(1)(a) Jurisdiction	(1)(b) Funding Amount ($) from (1)(a)	Agencies	Notes
Ryan White Part A			
DC	$16,752,342	AIDS Healthcare Foundation, La Clinica del Pueblo (Latino community, esp immigrants), Children's National Medical Center (pediatric), Community Family Life Services (Black women,re-entry, PWID), Damien Ministries, Family & Medical Counseling Services, Food and Friends, Homes for Hope, Housing Counseling Services, Howard University/CIDMAR, Joseph's House, Mary's Center, Metro Health, Restoration Community Alliance (people experiencing homelessness, mental illness, SUD, and other challenges), Terrific Inc (seniors), The Women's Collective (women), Unity Health Care, Us Helping Us (people of color living with HIV), Washington Health Institute, Whitman-Walker Health	FY22 allocations to providers Includes MAI.
MD	$5,361,639	AIDS Healthcare Foundation, Children's National Medical Center (pediatric), Greater Baden Medical Services, Heart to Hand, Medstar Health Research Institute, Montgomery County Health Department, Prince George's County Health Department, SLK Health Services, Us Helping Us (people of color living with HIV)	FY22 allocations to providers Includes $1,484,738 in EHE awards to MCHD and PGHD
VA	$1,966,239	Fredericksburg Area HIV/AIDS Support Services, INOVA, Mary Washington Healthcare, Mary Washington Healthcare, Neighborhood Health, NovaSalud, Inc., Virginia Health Options (VHO)	FY22 allocations to providers Includes MAI.
WV	$402,454	Shenandoah Valley Medical System	FY22
Fee for value/value enhancement	$3,291,973		Funds available across EMA
RW Part A EMA Total	**$27,774,647**		
Ryan White Part B			
DC	$13,528,194	Children's National Medical Center, Family & Medical Counseling Services, Howard University/CIDMAR, Metro Health, Unity Health Care, Us Helping Us (people of color living with HIV), Washington Health Institute, Whitman-Walker Health	FY 22 allocations to subgrantees ($2,455,865) plus ADAP ($11,072,329)
MD	$13,063,117	Charles County Health Department, Children's National Medical Center (pediatric), Frederick County Health Department, Montgomery County Health Department, Us Helping Us (people of color living with HIV)	SFY22 allocations to EMA counties Part B and supplemental (plus Part B COVID funds) plus total MADAP expenditures times prorated to EMA
VA	$12,039,943	Fredericksburg Area HIV/AIDS Support Services, INOVA, Legal Services of Virginia, Mary Washington Healthcare, Neighborhood Health, Northern Virginia Family Services, Northern Virginia Regional Commision (NRVC), NovaSalud, Inc., Virginia Health Options (VHO)	FY22 ADAP for EMA: $5,925,913 allocations: $6,710,030 plus $34,000 Rapid Start
WV	$501,681	AIDS Task Force	Total for 4/1/21-3/31/22. WV does not receive MAI
RW Part B EMA Total	**$39,132,935**		
Ryan White Part C EIS and Capacity Development			
DC	$2,098,879	Family & Medical Counseling Services, Howard University/CIDMAR, Unity Health Care, Whitman-Walker Health	FY22
MD	$361,030	Daydream Sunshine Initiative, Medstar Health Research Institute	FY22
VA	$741,777	INOVA, Mary Washington Healthcare	FY22
WV			
RW Part C EMA Total	**$3,201,686**		
Ryan White Part D			
DC			
MD	$410,586	Medstar Health Research Institute	FY22
VA	$585,866	INOVA	FY22
WV			

RW Part D Total	**$996,452**		
RW EMA TOTAL	**$71,105,720**		
EtE Awards to HDs (HRSA and CDC combined)			
DC	$6,089,635	DC DOH, DHCF	FY22. Incl $2,939,782 from HRSA for EMA; plus $3,149,853 from CDC for DC DHCF
MD	$2,659,458	Montgomery County Health Department, Prince George's County Health Department	FY22. $4,081,428 from CDC, prorated to EMA counties
VA	$0		not EtE jurisdiction
WV	$0		not EtE jurisdiction
EtE HDs EMA total	**$8,749,093**		
EtE TOTAL	**$8,749,093**		
CDC HIV Prevention and Surveillance			
DC	$6,947,609	Children's National Medical Center, Community Family Life Services, Damien Ministries, Family Medical Counseling Services, HBI-DC, HIPS, Howard University, La Clinica Del Pueblo, Latin American Youth Center, Mary's Center, Metro Heatlh, One Tent Health,Sasha Bruce FP, Athletes United for Social Justice dba The Grassroots Project, The Women's Collective, Us Helping Us, Whitman-Walker Health	FY 22. Includes HIV/AIDS behav. Surveillance; Integrated Surveillance and Prevention; and de-duplication
MD	$3,195,255	Calvert County, Charles County Health Department, Frederick County Health Department, Montgomery County Health Department, Prince George's County Health Department	FY22 award to state prorated to EMA
VA	$2,731,513	Chris Atwood Foundation, Fredericksburg Area HIV/AIDS Support Services, INOVA, Lord Fairfax Health District, NovaSalud, Inc.	FY22 award to state plus Medical Monitoring prorated to EMA
WV	$166,075		FY22 award to state prorated to EMA
CD Prevention and Surveillance	**$13,040,452**		
CDC HIV CBOs			
DC	$1,732,602	La Clinica del Pueblo (Latino community, esp immigrants),	FY22
MD	$441,625		FY22
VA	$841,625	INOVA	FY22
WV	$0		
CDC CBOs EMA Total	**$3,015,852**		
CDC HIV School Health			
DC	$333,434		FY22. $245,934 to DC Board of Ed; $87,500 to DC State Education Office
MD	$40,388		FY22 award to state prorated to EMA
VA	$35,554		FY22 award to state prorated to EMA
WV	$12,883		FY22 award to state prorated to EMA
CDC schools EMA Total	**$422,258**		
CDC EMA Total	**$16,478,562**		
SAMHSA Block Grant Set Aside			
DC	$357,765		FY22 set aside total
MD	$696,159	County Health Departments	FY22 set aside prorated to EMA
VA	$0		n/a
WV	$0		n/a
SAMHSA block grant EMA Total	**$1,053,924**		
HOPWA Formula + HOPWA/VAWA			
DC	$9,543,596	Community Family Life Services, Homes for Hope, Housing Counseling Services, DC Housing Authority (also covers Montgomery County and Prince George's County in Maryland)	FY22 allocation
MD	$4,328,347	Southern Maryland Calvert County	FY22 allocation from DC EMSA plus SFY22 state HOPWA

VA	$2,400,000	Arlington County, Fredericksburg Area HIV/AIDS Support Services, Homestretch (homeless families), Northern Virginia Family Services, Northern Virginia Regional Commision (NRVC)	FY22 allocation
WV	$55,000	Community Networks, Inc.	FY22 allocation
HOPWA EMA Total	**$16,326,943**		
HRSA Bureau of Primary Health Care (times HIV prevalence among patients)			
DC	$1,902,596	Community Family Life Services (Black women,re-entry, PWID), Family & Medical Counseling Services, Homes for Hope, Housing Counseling Services, La Clinica del Pueblo (Latino community, esp immigrants), Mary's Center, Unity Health Care, Whitman-Walker Health	2022 awards (most recent avail) times clinic HIV prevalence levels in 2020 (most recent available).
MD	$92,470	City of Frederick, Community Clinic Inc.(majority Hispanic/Latino, incl. refugees), Daydream Sunshine Initiative, Greater Baden Medical Services, Mobile Medical Care	see above
VA	$78,076	Greater Prince William Community Health Center, Loudoun Community Health Center, Neighborhood Health	see above
WV	$31,413	Shenandoah Valley Medical System	see above
BPHC EMA Total	**$2,104,555**		
Other Federal Grant EMA Total	**$19,485,422**		
State appropriations plus special funds			
DC	$9,920,000		Budget FY2023 tables: HAHSTA local (dedicated taxes) $6,549,000minus TB and STD specific lines Plus $5M "federal payment"
Maryland	$5,556,444		SFY21 state special funded plus state special funded - emergent need
VA	$0		
West Virginia	$0		
State Funding EMA Total	**$15,476,444**		
DC	$265,806,982		DHCF FY17 expenditures, FFS ($139,733,065.16) + Managed Care ($126,073,917.11)
MD	$106,441,809		Using April 2017 enrollment and capitation figures with 2018 EMA prev data; no update available.
VA	$17,471,225		FY2013 (most recent avail) KFF state estimate ($56,511,167) prorated by cases within the EMA
WV	$544,929		No update available 2018. Statewide (2015; most recent): $3,707,000, prorated to EMA
Medicaid EMA Total	**$390,264,945**		
DC Alliance and Immigrant Kids			
	$2,847,301		DHCF FY17.
Alliance and Immigrant Kids	**$2,847,301**		
Medicare			

Medicare	**$344,160,866**		ROUGH ESTIMATE: $11,040B Medicare Spending for HIV/AIDS in US in FY2019 (most recent available), prorated to DC region (KFF).
Medicare EMA Total	**$344,160,866**		
Veterans Health Administration			
VHA	$49,586,406	Based on 2013 enrollment and 2019 expenditure data.	ROUGH ESTIMATE based on proportion of national VHA clients receiving HIV care in DC and total VA HIV expenditure from KFF.
VHA EMA Total	**$49,586,406**		
EMA INSURANCE AND VHA Total	**$786.859.518**		
TOTAL EMA FUNDING	**$918,154,761**		