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

2024 Resubmission

PREPARED BY:
HIV/AIDS, Hepatitis, STD and TB Administration (HAHSTA)

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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

This submission is an update to DC Department of Health's (DC Health) 2022-2026 Integrated HIV Prevention and Care Plan. It reflects changes made based on feedback from the Health Resources and Services Administration (HRSA) and the Centers for Disease Control and Prevention (CDC), as well as new information regarding actions that DC Health and our partners have taken since the full plan submission, most notably completion of the Washington, DC Eligible Metropolitan Area (DC EMA) Consumer Needs Assessment.

These updates take place against a backdrop of various levels of uncertainty. Budget discussions in Congress could have severe implications for domestic HIV funding. Our activities over the past several months were undertaken with this uncertainty in mind, to ensure that we continue to focus our efforts and resources where they are most needed and that we are working efficiently and effectively with community partners across the EMA. The updates are presented below by the Integrated Plan sections.

Section II: Community Engagement and Planning Process. Section II details how DC Health has continued to undertake the planning process with our community and governmental partners. Overall, the key priorities of the DC EMA remain unchanged. The DC EMA Integrated Plan Workgroup reconvened in February 2023 to discuss planning, the integration of new information from care assessments and ongoing refining of EMA goals and objectives.

Section III: Contributing Data Sets and Assessments. DC Health continues to work with jurisdictional partners to maintain accurate epidemiological data. Section III provides a brief update of the epidemiological profile for the DC EMA for the most recent five years. It also includes an update to our full inventory of public funding for HIV prevention, care and treatment across the EMA, by state and funding category, with funded subgrantees. It then describes key strengths identified since the 2022 submission, including increased access to ART and the "PSRA lite" allocation process undertaken in August 2023, as well as several identified weaknesses.

Section III also describes the implementation and analysis of our EMA-wide Consumer Needs Assessment (CNA), completed since the submission of our 2022 plan. This year's CNA represents the DC EMA's first explicitly status-neutral needs assessment, collecting information from DC Metro area residents both living with and vulnerable to HIV. Designing the CNA to be explicitly status-neutral allows for DC Health to identify both HIV prevention and HIV treatment needs in the DC EMA. The results of the CNA reflect many of the priorities in the initial HIV Integrated Plan submission in 2022 including those around general HIV prevention and treatment education, outreach efforts to heterosexual men, more support for healthy aging with HIV, and more. The CNA narrative offers several recommendations to address identified consumer needs as well as to continuously monitor these needs and incorporate results into ongoing solutions.

Section IV: Situational Analysis. DC Health has few updates to the situational analysis. This section highlights areas where there have been significant progress and/or updates related to the previous submission, including peer programs, the syndemic approach, the harm reduction vending machine program, and injectable PrEP. Modest updates were made to the strengths, challenges, and identified needs of the priority populations.

Section V: Goals and Objectives. DC Health's goals, strategies, activities, and outcomes continue to reflect the cultural diversity and focus populations in the DC EMA. Section V details how DC Health is currently working with our jurisdictional partners on emerging HIV topics, as well as modest changes we have made to the goals and objectives section of the plan based on data availability and reporting burden.

Section VI: 2022-2026 Integrated Planning Implementation, Monitoring, and Jurisdictional Follow-Up. Section VI outlines the complexity of tracking progress of the plan. The science of Integrated Plan measurement is underdeveloped nationally. Locally, DC Health continues to engage with internal and external stakeholders to forge a path forward in measuring the plan's progress to improve HIV prevention and care for DC EMA residents while making modest modifications.

Ia. Approach

As discussed above, DC Health has been working internally and with partners to monitor our integrated plan progress and continue to refine goals and objectives. Our needs assessment results will further inform our plan implementation including, to the extent data permits, any jurisdiction-specific changes or updates to our approach.

Ib. Documents Submitted to Meet Requirements

We are submitting the completed needs assessment report as an appendix; all other documents remain current from our 2022 submission.

SECTION II: COMMUNITY ENGAGEMENT AND PLANNING PROCESS

II-1. Jurisdiction Planning Process

This document was preceded by the Washington, DC Eligible Metropolitan Area (DC EMA) Integrated HIV Prevention and Care Plan, 2022-2026 submission in 2022 describing the planning process and other requirements set forth by the CDC and HRSA. This update describes the DC EMA needs assessment research findings and the impact of the findings on our planning, which were absent from last year's submission.

Integrated planning for the DC EMA falls into three main categories as previously described: (1) data-, (2) community-, and (3) local and national evidence-based priorities.

First, DC Health relies on various data sources for its planning processes, including the needs assessment, surveillance data, care and treatment data, and program monitoring.

Second, stakeholders across the community remain key partners in the planning process. These include:

- People living with HIV (PLWH);
- DC EMA's focus population groups—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);
- Providers;
- Jurisdictional partners (Maryland, Virginia, and West Virginia); and
- COHAH, the EMA's planning body

Lastly, at the broadest level, DC's 95-95-95 goals (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), and DC Ends HIV (DC EHE), as well as the National HIV/AIDS Strategy and Ending the HIV Epidemic in the U.S. by 2030 initiative, are all critical to the DC EMA's HIV prevention and care plan. Alongside DC's triple 95 goals, the DC EHE aims to increase utilization of pre-exposure prophylaxis (PrEP) to reach 50% of all those eligible on PrEP and 31 new HIV diagnoses by the year 2030.[1] Thus, the approach outlined in 2022 remains appropriate and accurately represents the planning process.

II-1a. Entities Involved in Process

Integrated planning is a resourced-informed, community influenced, and strategically influenced effort. The entities previously described in the planning process are consistent with this update as summarized above. DC Health also continues to maintain bidirectional relationships with internal and external partners as noted in the prior submission. Internally, DC Health recently worked with the DC Health Care Access Bureau to obtain Medicaid claims data.

For this update, the George Washington University's (GW) Department of Health Policy and

[1] U.S. Department of Health & Human Services. America's HIV Epidemic Analysis Dashboard (AHEAD). https://ahead.hiv.gov/data/geographic/indicators/district-of-columbia/district-of-columbia/. Revised November 7, 2023. Accessed December 7, 2023.

Management was integral in the DC EMA wide Financial and Human Resources Inventory (hereafter referred to as Resource Inventory) development, Integrated Plan Workgroup, and components of the Integrated Plan reporting. GW continues to provide research support on a wide range of topics including the needs assessment and an environmental scan of DC EMA providers to expand the HIV workforce capacity.

DC Health representatives remain committed to a coordinated effort across the jurisdiction in response to the local and national HIV epidemic. Investments in time, idea exchange, data sharing, and planning approaches are cornerstones to the integrated planning process. Many representatives, including the HIV Services Planner, consistently attend cross-jurisdictional meetings to coordinate DC EMA-wide planning initiatives.

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 DC EMA. The roster file of COHAH Commissioners was previously included and membership was based on the federally mandated 13 categories. The COHAH brings together service providers, health department staff, jurisdictional partners, PLWH, and other concerned members in its comprehensive engagement process, integrated planning process, and discussions around the five pillars of the EHE (four national pillars and one DC specific pillar)—Diagnose, Treat, Prevent, Respond and Engage. The five pillars, their relative goals and objectives, and current outcomes for this submission are in Section V: 2022-2026 Goals and Objectives.

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

The DC EMA Integrated Plan Workgroup reconvened in February 2023. The DC EMA Integrated Plan Workgroup provides guidance, oversight, and monitoring of all aspects of the Integrated Plan. The workgroup is composed of 18 members representing diverse HIV/AIDS expertise, including COHAH members, jurisdictional partners from Maryland and Virginia, academic partners from the George Washington University Milken Institute School of Public Health, and agency representatives from the HIV/AIDS, Hepatitis, STD and TB Administration's (HAHSTA) five divisions—STD & TB Control; Care and Treatment; Housing, Capacity Building, and Community Outreach; Prevention and Intervention Services; and Strategic Information. Workgroup meetings have offered an opportunity for members to 1) gain an understanding of the DC EMA Integrated Plan; 2) attain knowledge of other jurisdictional plans to inform the DC EMA plan; 3) engage in constructive dialogue with internal and external partners; and 3) develop preliminary tracking methods for the Integrated Plan goals and objectives, all 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). To date, the workgroup has held five meetings.

As previously mentioned, COHAH acts as a source for EHE engagement with the community and stakeholders. Updates to DC EHE are provided in subsequent sections.

DC Health remains an active member of the District of Columbia Center for AIDS Research (DC CFAR) to promote and support HIV research. No other significant updates are to be reported.

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

The DC EMA Integrated Plan was informed by multiple data sources at the time of submission, including the most current epidemiologic HIV/AIDS data (2020), and findings from community and stakeholder

engagement activities. This update includes DC EMA HIV data through 2022 and findings from the DC EMA Status-Neutral Consumer Needs Assessment.

There are no other significant updates to collaboration with RWHAP parts beyond the updates mentioned above. DC Health continues to integrate, collaborate, and partner with 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. Most recently, HAHSTA conducted community engagement activities with providers regarding childcare services for consumers. As a result of these activities, modest funding will be allocated to childcare services across the DC EMA for GY34.

While the COHAH serves as the planning body for RW Part A, the body is also the planning resource for Part B. The COHAH convenes monthly meetings to ensure progress on the operations, strategies, research, engagement, and planning of the Ryan White HIV/AIDS program. COHAH obtains input through a combination of presentations, discussion, and voting by committee members to streamline, simplify, and strengthen the DC EMA jurisdictional planning process. In combination, these efforts help reduce overlap, duplication, and fragmentation.

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. In July 2022, the COHAH adopted DC Health's status-neutral approach to prioritize the whole person in health care and service delivery in its DC EMA needs assessment. This approach aligns well with the DC EHE plan, CDC and HRSA's status neutral framework program, and national HIV and EHE strategies; and engages both PLWH and those who are behaviorally vulnerable to HIV.

As federally mandated, the COHAH includes PLWH members who were engaged, along with the full COHAH, in the recent priority setting allocation process. COHAH members are also integral in the Integrated Plan Workgroup and are encouraged to participate at every stage of integrated planning implementation, monitoring, evaluation, and improvement process. For brevity, please see the 2022 Integrated Plan submission regarding the engagement of PLWH.

II-1f. Priorities

The key priorities of the DC EMA remain the same from the 2022 Integrated Plan submission. The needs assessment findings, discussed in Section III-4. Needs Assessment, reflect the needs previously and currently identified from the statewide coordinated statement of need. The needs of increasing education, access, wellness, and youth engagement cut across the DC EMA's focus population groups. Overall, there is need for greater education to reduce stigma, HIV-related risk behaviors, and the spread of sexually transmitted infections (STIs); and increase engagement with young people, pre-exposure prophylaxis (PrEP)/post-exposure prophylaxis (PEP) programming, and wellness support. Increased education to consumers and providers on the availability of transportation services and health insurance options is a consideration moving forward as identified by the needs assessment.

These initiatives and programs continue to support the key priority areas: harm reduction, wellness services, molecular surveillance, HIV testing, rapid antiretroviral therapy (ART), U=U, PrEP and PEP, and data-to-prevention, as previously described. In addition to the status-neutral approach to HIV education, testing, and treatment, DC Health has also implemented a syndemic approach to prevention services to

identify and prevent HIV, STI, and hepatitis B and C (HBV/HCV) that ensures all people are aware of their health status and methods to reduce their risk for these diseases. All initiatives and programs are in support of the four federal pillars (Diagnose, Treat, Prevent, Respond) and DC Health's fifth (Engage) for the next four years. Please see the 2022 Integrated Plan submission describing the initiatives and programs.

Additionally, DC Health and Virginia agents have engaged in preliminary conversations on how to address the needs of older adults with HIV and seek to collaborate on future endeavors on this growing population group.

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 triple 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. No adjustment to the priorities were made since the needs assessment findings reflect the SCSN. Modest adjustments were made to the goals and objectives section of the plan based on data availability and reporting burden. Adjustments to the monitoring and evaluation timeframes and deliverables have been made based on the annual data collection timeframes across jurisdictions. DC Health continues to have ongoing discussions with focus population groups most affected by HIV and across jurisdictions to inform the planning process.

SECTION III: CONTRIBUTING DATA SETS AND ASSESSMENTS

III-1. Data Sharing and Use

There are no changes to the data systems utilized since the previous Integrated Plan submission. The DC EMA's testing, surveillance, and RW data systems include the CDC's Enhanced HIV/AIDS Reporting System (eHARS), HRSA's CAREWare, and CDC's administered web portal, EvaluationWeb. EHARS is a browser-based application for the collection, storage, and retrieval of HIV and AIDS data identified as necessary by the CDC. CAREWare is used to manage and monitor RW-funded HIV clinical and supportive care data. EvaluationWeb is used to collect information surrounding HIV testing data activities across the United States. The District of Columbia's HIV, hepatitis, STD and TB data system is the DC Public Health Information System (DC PHIS). DC PHIS is 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.

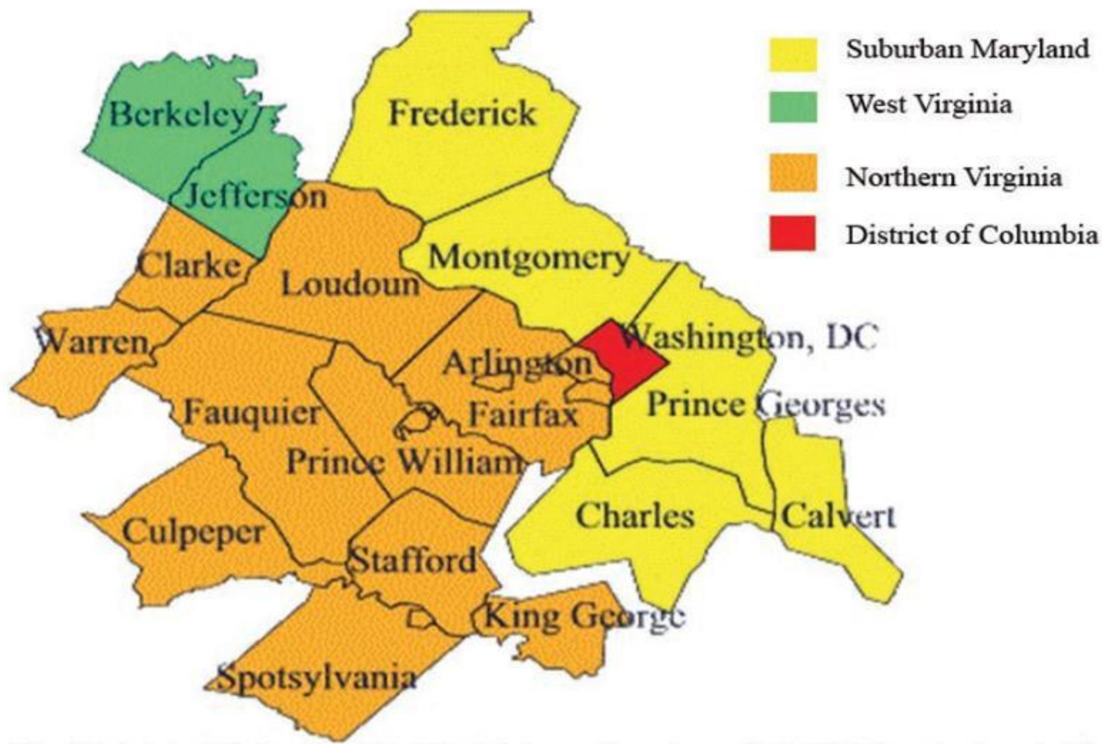
DC Health continues to collaborate with jurisdictional partners in Maryland, Virginia, and West Virginia, as well as sub-recipients on data integration efforts. As previously reported, the DC EMA CAREWare system is one of the largest networks in the nation with over 300 active unique users among 40 agencies. Facilitating data sharing and care coordination within the provider network remains a focus for DC Health in its continued efforts to link consumers to care, improve health outcomes, and assess efficiencies and service gaps in the DC EMA HIV care continuum.

DC Health continues to work very closely with surveillance colleagues in Maryland and Virginia through established data sharing agreements that facilitate the quarterly exchange of relevant client-level surveillance data between the three entities. DC Health also partners with health insurance carriers, and public health insurance programs (Medicaid and Medicare). These cooperative efforts are progressing at various paces.

III-2. Epidemiologic Snapshot

The DC EMA profile remains consistent as reported in 2022. Briefly, the DC EMA spans a wide metropolitan region of 6,922 square miles, comprising the District of Columbia, 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 6,224,799 people, according to 2022 US Census Bureau estimates. Figure 1. displays a visual map of the DC EMA.

Figure 1. Map of the District of Columbia Eligible Metropolitan Area (DC EMA), 2023



The information below provides a brief update of the epidemiological profile for the DC EMA for the most recent five years. Table 1 presents cumulative cases of HIV diagnosed and reported during 2018-2022 by jurisdiction. The HIV jurisdictional comparison highlights the complexity of developing a comprehensive plan for delivering HIV services across the different regions of the DC EMA.

Table 1. Cumulative Number of People Diagnosed and Living with HIV by Jurisdiction, DC EMA, 2018-2022[a]

Jurisdiction	Number of People Living with HIV 2018		Number of People Living with HIV 2019		Number of People Living with HIV 2020		Number of People Living with HIV 2021		Number of People Living with HIV 2022	
	N	%	N	%	N	%	N	%	N	%
Washington, DC	17,830	46.4	17,781	45.6	18,087	45.8	17,948	45.5	17,829	44.8
Maryland	12,558	32.7	12,859	33.0	13,095	33.2	13,305	33.7	13,536	34.1
Virginia	7,761	20.2	8,100	20.8	8,301	21.0	8,207	20.8	8,360	21.0
West Virginia	265	0.7	247	0.6	NA	NA	NA	NA	NA	NA
Total	38,414	100.0	38,987	100.0	39,483	100.0	39,460	100.0	39,725	100.0

[a]The number of individuals diagnosed with HIV residing in WV is only available through 2019

All data in the following section are jurisdictional health department data submitted to the DC Health's Surveillance, and Investigation Division. Data for 2020 -2022 from the DC EMA Counties in West Virginia were not available at the time of the report due to limited staffing availability for required data cleaning and analysis.

Demographics. As of December 31, 2022, 39,725 persons were diagnosed and living with HIV. The overall prevalence of people living with HIV (PLWH) for the DC EMA at the end of 2022 was 0.6% and was well above the national estimated prevalence rate of 0.4% for diagnoses of HIV. Despite accounting for 10.8% of the DC EMA general population, the District of Columbia (DC) is the region's epicenter of HIV with 45% of all diagnosed HIV cases. In 2022, Washington DC had the highest number of living diagnosed cases (17,829).

The HIV epidemic continues to impact communities of color in the DC EMA. People of color account for approximately half of the general DC EMA population, but over 78% of the estimated number of PLWH in the EMA. Blacks account for most cases at 65.7%; Whites, 16.1%; Hispanic/Latino/a/x, 11.5%; Asian/Pacific Islanders, 1.3%; and "Other/ Unknown," 5.2%. Most PLWH in the DC EMA are over 40 years of age (77.0%), with those over 50 years of age representing 56.4%. Approximately 5.7% are 29 years of age or younger. Males account for the majority of people living with HIV in the DC EMA (70.4%). Maryland has the highest proportion of cases among females (35.1%). The landscape for DC is similar to the regional level data with the majority of PLWH being Black (67.5%), male (73.3%), and over 40 years of age (81%).

Newly Diagnosed. Between 2018 and 2022, there was a total of 4,474 newly diagnosed cases of HIV in the DC EMA. Overall, the number of documented newly diagnosed HIV cases declined from 2018-2020 with a slight increase in 2021, as shown in Table 2 below. The proportion of new cases by race/ethnicity remained relatively constant across the five-year period. Newly diagnosed cases of HIV continue to predominantly impact people of color (87.2%), men (74.4%), and among those 20 to 39 years of age (61.9%). Most newly diagnosed HIV cases in 2022 can be attributed to transmission among men who have sex with men (49.3%). These trends are also consistent for DC. In 2022, DC had a total of 210 newly diagnosed cases of HIV with majority being Black (73.3%) and male (73.3%).

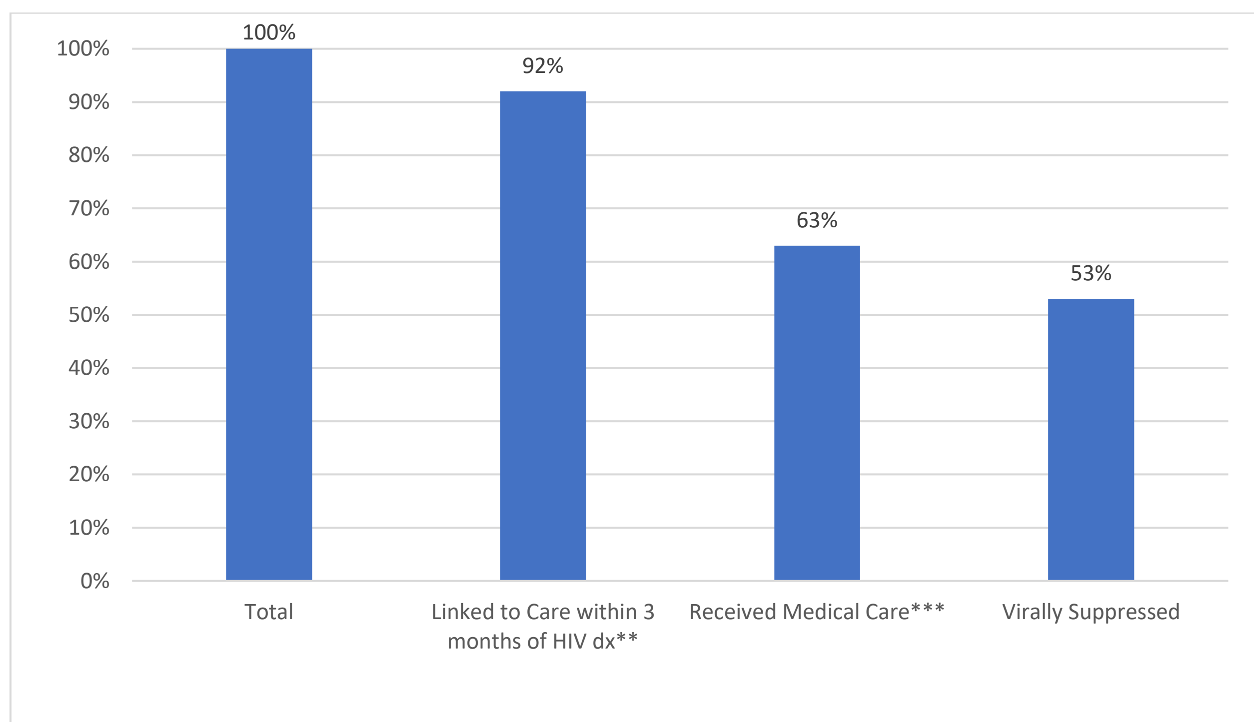
Table 2. Newly Diagnosed HIV Cases by Race/Ethnicity and Year, DC EMA, 2018-2022, N=4,474

	2018		2019		2020		2021		2022	
	N	%	N	%	N	%	N	%	N	%
Race/Ethnicity										
White, not Hispanic	129	11.6	110	10.8	74	10.4	99	12.0	84	10.2
Black, not Hispanic	770	69.4	689	67.8	492	69.2	517	62.6	523	63.7
Hispanic/Latino	143	12.9	169	16.6	109	15.3	154	18.6	174	21.2
Asian/Pacific Islander	26	2.3	20	2.0	12	1.7	23	2.8	18	2.2
American Indian/Alaskan Native	5	0.5	1	0.1	1	0.1	1	0.1	1	0.1
Other/Unknown	37	3.3	27	2.7	23	3.2	32	3.9	21	2.6
Total	1,100	100.0	1,016	100.0	711	100.0	826	100.0	821	100.0

Care Continuum. For several years, the DC EMA has employed the internationally recognized HIV care continuum framework to facilitate measurement, monitoring, and the provision of HIV care. The 2022 HIV Care Continuum for the EMA is below and shows a need for continued efforts to retain PLWH in care, ART initiation, and adherence support. Figure 2 below displays individuals diagnosed with HIV (inclusive of Ryan White consumers) based on laboratory surveillance data collected and analyzed by the Centers for Disease Control and Prevention (CDC) through December 31, 2022. There was a noticeable increase in new cases from 2020 to 2021, but some of this may be an artifact of decreased testing in 2020 because of COVID-19 related restrictions on access to regular screening.

Despite increased screening and better surveillance of new cases, opportunities for substantial improvement in HIV care engagement, retention, and viral suppression remain. Approximately 63.3% of the 39,725 individuals ≥ 13 years of age diagnosed with HIV living in the region had laboratory evidence (i.e., ≥ 1 viral load and/or CD4 report) of receiving HIV care in 2022, with slightly under 53% of individuals having laboratory evidence of being virally suppressed during the calendar year. With regards to the 821 individuals ≥ 13 years of age newly diagnosed with HIV in 2022, approximately 92% had laboratory evidence (i.e., ≥ 1 viral load and/or CD4 report) of being linked to HIV care within 1 month of diagnosis. Of the 210 new HIV cases in DC in 2022, 80% were linked to care within 30 days of diagnosis, 51% were virally suppressed within 90 days of diagnosis and 68% were virally suppressed within 6 months of diagnosis (having a viral load of <200 copies/mL). In 2021 for DC, 81.9% of new cases were linked within 3 months of diagnosis and 77.4% were virally suppressed within 12 months of HIV diagnosis.

Figure 2. DC EMA HIV Care Continuum, 2022



[*] The cumulative number of living cases diagnosed and reported to the local surveillance system
[**] The number of diagnosed cases with evidence of a CD4 or VL test within 3 months of HIV diagnosis
[‡]Having a viral load of <200 copies/mL in 2022; clients excluded if no care marker reported during time frame

HIV Clusters. Laboratory data was also used to identify clusters of HIV infection in which genotyping of active viral infections between individuals was determined to be related. Two molecular clusters meeting national priority criteria between 2016-2020 were reported in 2022. Please see the 2022 submission for a description of how clusters are prioritized, characteristics of clusters and cases linked to clusters from 2016-2020.

DC identified two clusters from 2021-2023 that meet national priority criteria. Cluster 1 was identified in April of 2021 and consisted of 6 individuals at the onset and 4 additional cluster members were added through the end of the year. Overall, 3 cluster members were diagnosed in the previous 12 months. The cluster met the 1.5% threshold with first degree linkages at the 0.5% level. This network underscored

the impact of anonymous partners through escort services, sex parties, and apps. It also highlighted naïve drug use in conjunction with anonymous sex and the exchange of sex for drugs and money. Cluster 2 was identified as a national priority cluster in June 2023. It currently has 5 cluster members, 3 from DC and 2 from Maryland. All 5 cluster members are young Latino men, diagnosed in the previous 12 months, and virally suppressed. DC continues to monitor local clusters and engage with Maryland and Virginia on clusters that cross jurisdictions. The cluster information below is presented for Maryland and Virginia.

Maryland
Between 2021 and 2023, Maryland identified one molecular cluster meeting the national priority criteria, Cluster 1. Cluster 2 below is presented but no longer meets the national priority criteria.

- Cluster 1: When identified, the cluster contained a total of 7 members (7 molecular cases) Key characteristics of the cluster are described in the Table 3 below:

Table 3. Key Characteristics of Cluster 1, 2021-2023[a,b]

Characteristic	HIV Positive Cases (n=4)	HIV Positive Partners (n=0)	Status-Unknown Partners (n=0)
Age at HIV Diagnosis			
13-19	0 (0.0%)	0 (0.0%)	0 (0.0%)
20-29	2 (50.0%)	0 (0.0%)	0 (0.0%)
30-39	2 (50.0%)	0 (0.0%)	0 (0.0%)
40-49	0 (0.0%)	0 (0.0%)	0 (0.0%)
50-59	0 (0.0%)	0 (0.0%)	0 (0.0%)
60+	0 (0.0%)	0 (0.0%)	0 (0.0%)
Current Age			
13-19	0 (0.0%)	0 (0.0%)	0 (0.0%)
20-29	2 (50.0%)	0 (0.0%)	0 (0.0%)
30-39	1 (25.0%)	0 (0.0%)	0 (0.0%)
40-49	1 (25.0%)	0 (0.0%)	0 (0.0%)
50-59	0 (0.0%)	0 (0.0%)	0 (0.0%)
60+	0 (0.0%)	0 (0.0%)	0 (0.0%)
Sex			
Male	4 (100.0%)	0 (0.0%)	0 (0.0%)
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	4 (100.0%)	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	0 (0.0%)	0 (0.0%)	0 (0.0%)
Transmission Category			
MSM	2 (50.0%)	0 (0.0%)	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	1 (25.0%)	0 (0.0%)	N/A
Other	0 (0.0%)	0 (0.0%)	N/A

Unknown	1 (25.0%)	0 (0.0%)	N/A
Current Viral Load Suppression Status (n=4)			
Suppressed (<200 c/mL)	2 (50.0%)	0 (0.0%)	N/A
Not Suppressed	2 (50.0%)	0 (0.0%)	N/A

[a]Based on last available viral load result within the prior 12 months (Sept 2023).
[b]Limited to Maryland residents at time of diagnosis

- Cluster 2: When first identified in December 2018, the cluster contained a total of 26 members (23 molecular cases and 3 named partners). As of December 2022, the cluster no longer meets the national priority criteria. As of September 2023, the cluster contains a total of 37 members (34 molecular cases and 3 named partners). Key characteristics of the cluster are described in Table 4 below:

Table 4. Key Characteristics of Cluster 2, 2021-2023[a,b]

Characteristic	HIV Positive Cases (n=34)	HIV Negative Partners (n=2)	Status-Unknown Partners (n=1)
Age at HIV Diagnosis			
13-19	6 (17.6%)	0 (0.0%)	0 (0.0%)
20-29	19 (55.9%)	0 (0.0%)	0 (0.0%)
30-39	7 (50.6%)	0 (0.0%)	0 (0.0%)
40-49	2 (5.9%)	0 (0.0%)	0 (0.0%)
50-59	0 (0.0%)	0 (0.0%)	0 (0.0%)
Current Age			
13-19	1 (2.9%)	0 (0.0%)	0 (0.0%)
20-29	16 (47.1%)	0 (0.0%)	0 (0.0%)
30-39	14 (41.2%)	0 (0.0%)	0 (0.0%)
40-49	2 (5.9%)	0 (0.0%)	0 (0.0%)
50-59	0 (0.0%)	0 (0.0%)	0 (0.0%)
Sex			
Male	29 (85.3%)	0 (0.0%)	0 (0.0%)
Female	5 (17.7%)	0 (0.0%)	0 (0.0%)
Unknown	0 (0.0%)	0 (0.0%)	0 (0.0%)
Race/Ethnicity			
White	7 (20.6%)	0 (0.0%)	0 (0.0%)
Black/African American	19 (55.9%)	0 (0.0%)	0 (0.0%)
Latino/Latino	5 (14.7%)	0 (0.0%)	0 (0.0%)
Multiple Races	3 (8.8%)	0 (0.0%)	0 (0.0%)
Unknown	0 (0.0%)	0 (0.0%)	0 (0.0%)
Transmission Category			
MSM	23 (67.6%)	N/A	N/A

MSM and IDU	0 (0.0%)	N/A	N/A
IDU	1 (2.9%)	N/A	N/A
Heterosexual Contact	6 (17.6%)	N/A	N/A
Other	0 (0.0%)	N/A	N/A
Unknown	4 (11.8%)	N/A	N/A
Current Viral Load Suppression Status (n=34)			
Suppressed (<200 c/mL)	20 (58.8%)	N/A	N/A
Not Suppressed	14 (41.2%)	N/A	N/A

[a]Based on last available viral load result within the prior 12 months (Sept 2023).
[b]Limited to Maryland residents at time of diagnosis

Virginia
Between 2021 and 2023, Virginia identified four molecular clusters meeting the national priority criteria (Clusters 1-4), and one time-space cluster (Cluster 5).

Cluster 1: The July 2021 local cluster analysis first discovered this cluster. There were originally five members found to be genetically linked, but there have been six additional members genetically linked to Cluster 1. The 11 individuals with genetically related HIV and their 21 named partners with HIV, brings the transmission cluster size to 32 individuals. Thirty-one members of the cluster were male, one was female. In terms of behavioral risk factors, 27 had an MSM risk, four had a heterosexual contact risk, and one had no identified risk. All members in the transmission cluster were Black or African American, except for one person who was Hispanic and one person who identified as two or more races. There were a wide range of ages in the cluster, with four members aged 13-19 years old, 22 members aged 20-29, five members aged 30-39, and one member aged 50-59. Of those cluster members, 69% were virally suppressed and in care.

Cluster 2: This cluster was first discovered during local cluster analysis in February 2022. There were originally five males genetically linked to the cluster, but the cluster has grown to nine. There are no additional named partners with HIV in the transmission cluster. The cluster members were all male, with three Black or African American males, three Asian males, and three Hispanic males. The members ranged in age, from two aged 13-19 years old, five aged 20-19, and two aged 40-49. All have an MSM risk, except for one that had a heterosexual contact risk. Of those cluster members, 89% were virally suppressed and in care.

Cluster 3: This cluster was first identified during local analysis in July 2023. There were five males who were genetically linked, and no additional partners have been added to the transmission cluster. Three males were White and two were Black or African American. Two members were aged 13-19 years old, two aged 20-24, and one aged 40-49. All have an MSM risk, except for one who had a heterosexual transmission risk. All are virally suppressed and in care.

Cluster 4: The March 2022 national analysis detected this cluster. The cluster contained three individuals living in Virginia, one member in Iowa (IA), and one member in Illinois (IL). Virginia's Department of Health contacted IA's Department of Health and Human Services and received the cluster member's IA eHARS state number. Through contact with IA, Virginia learned that this member had a Virginia eHARS state number, which allowed Virginia to add the member to the transmission cluster. Attempts to contact IL's Department of Public Health were unsuccessful. Since then, the transmission cluster grew to

eight people in Virginia's jurisdiction, including one named partner with HIV. All individuals were males except for one female. All individuals were White, except one who is Black or African American, and one who is Hispanic. Most have an MSM transmission risk, one member reported a heterosexual injection drug use (IDU) risk, and one reported no identified risk factor. One member was aged 13-19 years old, three were aged 20-29, one was aged 30-39, and three were aged 40-49. Of those cluster members, 63% were virally suppressed and in care.

Cluster 5: CDC notified Virginia of this time-space cluster in June 2022. Individuals from July 2021 - July 2022 were included in the cluster. Virginia identified 25 members in the time-space cluster, and two named partners with HIV, bringing the total number of people in the transmission cluster to 27. A total of 22 members are males, and five are females. In terms of behavioral risk factors, 13 had an MSM risk, three had a heterosexual IDU risk, seven had a heterosexual contact risk, two had an IDU risk, and two had an MSM and IDU risk. A total of 20 members were Black or African American, and seven were White. This cluster included nine members aged 20-29 years old, ten members aged 30-39, three members aged 40-49, three members aged 50-59, and two members aged 60 and over. Virginia also looked at any genotype sequences to see if there were genetic linkages. Only 12 members had genotype sequences and while there were several of genetic linkages identified, no linkages were notable or meaningful enough to describe the cluster or a larger network. Of those cluster members, 89% were virally suppressed and in care.

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

An inventory of funding for the services and providers offered through Ryan White, CDC, other federal agencies, and other funding sources has been updated for FY23 and is included as the Resource Inventory of the Appendix.

Jurisdictional Coordination of Substance Use and Treatment Services Provision with HIV Prevention and Care Services. No updates to provide. Please refer to the 2022 Integrated Plan submission.

Services And Activities Provided by Jurisdictional Organizations and Agency's Priority Population. HAHSTA is working to identify potential new partner organizations for both care and prevention programming, particularly in the portions of the DC EMA outside of the District. GW has completed an initial landscape assessment identifying organizations that are not currently HAHSTA partners but that are serving key populations living with, or at higher risk of, HIV across the DC EMA. HAHSTA compared the landscape assessment with 2022 Medicaid claims data and included high-volume Medicaid providers from those claims who were not previously identified in the assessment. Unfortunately, Medicaid claims data from partner jurisdictions have been challenging to obtain. HAHSTA aims to engage with potential providers to learn more about their barriers and interest in participating in the Ryan White HIV/AIDS Program.

Additionally, as mentioned in Section II: Community Engagement and Planning Process, HAHSTA is engaged in conversations with Virginia counterparts to discuss opportunities to address the needs of older adults with HIV. While discussions are preliminary, these discussions will inform possible future programming for this population.

How services will maximize the quality of health and support services available to people at-risk for or with HIV. While in preliminary stages, the inclusion of a broader range of HIV-care and prevention sites could potentially yield more people retained in HIV care, lower numbers of people disengaged from HIV-care, and prevent HIV acquisition and transmission. Additionally, with more people in the DC EMA living

longer with HIV, providing quality health and support services for this population is important. Broadly speaking, living longer isn't enough, it is imperative for PLWH to live better, healthier lives. Older adults with HIV face unique challenges, including greater risk of diabetes, liver disease, substance use disorder, chronic inflammation, among other conditions. Collaboratively addressing the needs of older PLWH could include providing appropriate care during the aging process. These efforts would align with the national and local triple 95 targets.

III-3a. Strengths and Gaps

The EMA provides HIV prevention and care services to encompass a range of medical, educational, and supportive services. These services are aimed at reducing the transmission of HIV and improving the health outcomes of those living with the virus. Quantitative and qualitative data gathered from needs assessments, surveillance, program monitoring, and other sources are integral to decisions regarding programs. Despite the consideration of data in program decision making, each jurisdiction within the EMA continues to experience strengths and gaps in its efforts due to the complex and dynamic landscape of HIV prevention and care services impacting service delivery.

Strengths

Notable strengths in HIV prevention, care, and treatment services across the DC EMA since the 2022 submission include: 1) increased access to antiretroviral therapy (ART), 2) resource allocation, 3) collaborations, 4) and increased access to HIV testing and other services.

Increased Access to ART. Last year, 1,080 consumers received ART or related prescriptions through DC Health's ADAP, with over 90% showing documented viral load suppression. To build and maintain this positive momentum, DC Health has implemented the Integrated Service Program (ISP). The ISP is an approach that provides more effective patient care and seeks to improve health outcomes for patients with uncontrolled HIV viral load—many of whom will have additional medical or psychosocial problems complicating their care. Ultimately, the goal of this program is to develop a model sustainable 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). Community health workers are hired as DC Health employees and deployed at provider sites to provide HIV intervention services. This approach works in tandem with other DC Health efforts to remove barriers, increase access, and improve health outcomes by working collaboratively with providers.

Resource Allocation. DC Health uses comprehensive data, including surveillance and service utilization, to allocate resources to areas with the highest HIV/AIDS prevalence and needs. Stakeholders also contribute to the formal allocation of resources, during the Priority Setting and Resource Allocation (PSRA) process, to ensure alignment with those directly impacted. In response to the Health Resources and Services Administration's (HRSA) shift from an annual application to a three-year cycle period, the DC EMA PSRA process has been conducting an annual 'review and adjustment' exercise which we have been calling "PSRA lite".

The "PSRA lite" helps streamline administrative efforts while ensuring the ongoing support of stakeholders. The process saves time by building on the previous year's decisions and exploring sub-recipient and consumer needs, gaps, and barriers. More time is available to focus on service delivery, but time is still allowed to make resource allocation adjustments based on emerging needs and other data. During the most recent PSRA lite in August 2023, allocations were made to support new pilot

programs and to fund expansion to the provider network based on reprogramming requests made during the previous grant period.

Collaborations. DC Health continues to collaborate through the DMV Collaboration, cross jurisdictional meetings, feedback from providers and consumers. These collaborations bring together diverse expertise and resources, making them vital in the provision of HIV prevention and care services. The synergy created through these collaborative efforts enhances the effectiveness of interventions, reduces barriers to care, contributes to reducing the spread of HIV, and improves the quality of life for individuals living with the virus.

Increased Access to HIV Testing and Other Services. HIV testing is a priority across the DC EMA. Thinking creatively beyond the resource inventory of providers, DC Health and Virginia continue to implement novel solutions to reach the most vulnerable populations. DC Health's GetCheckedDC (GCDC) launched during COVID-19 to offset HIV testing disruptions is still available for DC residents. GetCheckedDC is a free program that provides DC residents with confidential, convenient testing for both HIV and STDs. GetCheckedDC provides at-home HIV and STD test kits, and on demand Labcorp walk-in testing for HIV, STDs, and hepatitis. In 2022, an average of 459 requests were received per month. As of June 2023, an average of 745 requests were received per month, reflecting increased demand.

Virginia has also employed multiple methods to increase the availability of HIV testing, including the expansion of telehealth and mobile health service delivery to reach rural areas, increased options for HIV prevention and care services through state Medicaid expansion efforts, and legislation improving access to syringe services as a response to the Opioid Epidemic.

Gaps

While the DC EMA has a wide range of strengths, gaps in HIV prevention, care, and treatment remain. Notable gaps since the 2022 submission include: 1) aging population, 2) provider network expansion, and 3) unmet needs.

Aging Population. People with HIV are living longer due to advances in treatment. The result is a growing population aging with HIV. Currently, DC Health does not have the data or resources in place to address their unique needs. Because of this, DC Health plans to work with the DC EMA to develop effective HIV prevention strategies based on a comprehensive understanding of this demographic. As noted above, DC Health has engaged in preliminary conversations with Virginia regarding this growing population. Findings will be used to tailor HIV care for aging-specific concerns, like cognitive and medication interactions, appropriately.

Provider Network Expansion. Historically, the same Ryan White and CDC funded providers support HIV prevention and care efforts in the DC EMA each year. DC Health recognizes this as a gap that could lead to stymied innovation, reduced competition, limited diversity of services, stagnation of quality, and resistance to change. As a result, in partnership with GW, a landscape assessment was completed to determine outreach efforts of new providers. DC Health applied a broad approach to the DC EMA provider scan, focusing beyond those who can serve certain racial/ethnic groups as was done in prior years. Broadly, the assessment included providers who provide care for HIV or other sexual health; drug use; adolescent or young adult; lesbian, gay, bisexual, transgender, queer/questioning, and more (LGBTQ+); people aging with HIV, and immigrant services. While in the discussion phase, next steps may include in-depth conversations with providers identified from the assessment to inform a provider survey.

DC Health is in discussions with Maryland and Virginia to share resources and combine efforts in this area since both jurisdictions also face a similar challenge. Maryland plans to deliver several inventories (organizational inventory serving Maryland residents, locator inventory of existing service locator tools, and needs assessment inventory of similar assessments) as part of its first-year deliverables. DC Health has incorporated Maryland's organizational inventory in this work.

Unmet Needs. Historically, residents have faced challenges accessing health care due to competing social needs such as diversity of culture, language, literacy and health literacy, and stigma. Oftentimes, the social determinants of health (e.g., poverty, lack of employment opportunities, housing instability, behavioral health conditions, limited access to transportation) disproportionately impact minority populations, requiring additional resources for this population to facilitate access along the HIV care continuum. Due to a strong health care safety net, health care coverage does not limit health care access in DC, but health insurance access is still a barrier for some in Maryland and Virginia based on the DC EMA needs assessment findings. While the DC EMA has relatively low unmet needs, needs identified include financial assistance, housing, dental/oral health services, and wellness support. This information will help guide DC Health and its jurisdictional partners in prioritizing and responding to these needs in future planning to improve health outcomes. Virginia and DC Health have begun this work on increasing education on PrEP, substance use disorder, and HIV testing to reduce stigma.

III-3b. Approaches and Partnerships

All methodology and partners remain the same as in DC Health's previous submission. HAHSTA has obtained Medicaid claims for PLWH from DC's Health Care Access Bureau as previously mentioned. This information will inform HAHSTA's efforts to identify service utilization and gaps. Future possible work includes collaborating with the DC's Department of Health Care Finance, which administers Medicaid and dual Medicaid-Medicare coverage for the District, to obtain recent claims analyses for Medicaid and Medicare expenditures of PLWH as well as engage departments responsible for similar data in other jurisdictions within the DC EMA. HAHSTA hopes to work with Maryland, Virginia, and West Virginia to understand the role of Medicaid, particularly in Virginia, which expanded its Medicaid program most recently. Partnering with private insurers is still a priority for DC Health, but challenges remain in this area. In particular, assessing what resources private insurers are already allocating to HIV and HIV related services is difficult without extensive claims data that private insurers may be hesitant to share or are expensive to obtain.

III-4. Needs Assessment

The COHAH, HAHSTA, and GW completed the first anonymous DC EMA Status-Neutral Consumer Needs Assessment, where respondents were included regardless of their HIV status. This multi-year study—survey development in 2021, and a two-phase data collection effort in 2022 and 2023—closed June 30, 2023. The study was conducted to 1) understand the current care service needs and gaps of people living with HIV (PLWH) and those not living with HIV but who may benefit from prevention services and 2) inform the comprehensive planning process for the DC EMA.

Four hundred and twenty-nine (429) consumers completed the survey with most survey responses (58%) from DC. A majority of those who participated were male (50.8%); Black, not Hispanic (59%); heterosexual (50.7%); and US-born (75.3%); 28.3% were high school graduates and 31% were 25-34 years old. Over half (56.6%) of respondents were HIV-negative (56.6%). Nearly one of every five HIV-negative respondents was taking pre-exposure prophylaxis (19.1%); however, adherence to PrEP was at

69.8%. Of those living with HIV, people between 55 and 64 were the largest age group (28.2%) followed by 35 to 44 (19.4%) year olds.

For respondents living with HIV, adherence to the continuum of care was reported to be high with respondents engaged in care, retained in care, and adhering to antiretroviral therapy. HIV-positive respondents reported that within the last six months, they have seen their medical provider for HIV treatment (89.4%), seen their case manager (59.5%), and were informed of their viral load count (88.1%). Respondents had been taking ART (95.0%) and were virally undetectable (80.2%). Three out of every four HIV-positive respondents reported taking their ART medication all the time over the last 30 days (75.5%). HIV disproportionately affects Black, non-Hispanic residents of the District of Columbia (75.2%) and Maryland (76.5%), and Latino/a or Hispanic residents of Virginia (51.9%).

The most prominent barriers to accessing services for people in the DC EMA included not knowing where to get services (27.7%) and not wanting others to know their HIV status (12.6%). Mental health played a role in service utilization, with 19.5% of respondents stating that their depression prevented them from accessing the services. Respondents also cited mental health as a general life challenge (37.8%) over the last 12 months. Nearly 1 in 5 respondents (18.3%) reported having a substance use addiction; nearly all (18.1%) had received treatment.

Overall, there are still unmet needs in the DC EMA. Approximately one quarter of HIV-positive consumers reported not receiving financial assistance (25.7%), housing (23.7%), and dental/oral health services (21.2%) despite needing the services. Other services that were received but were difficult to get include dental/oral health services (14.5%), health insurance 12.5%), food bank vouchers (9.9%), and transportation services (9.2%). The needs assessment report is included in the Appendix.

III-4a. Priorities

The DC EMA needs assessment findings support the priorities previously described in the last Integrated Plan submission. Those needs identified include: 1) education to reduce HIV stigma and HIV-related behaviors, 2) education to prevent the spread of sexually transmitted infections, 3) improvement of youth-focused efforts to prevent HIV, 4) engagement with young people in youth programming, 5) increased PrEP/PEP programming, and 6) increased wellness support. The HIV epidemic in the DC EMA is still concentrated in key population groups including Black and Latino MSM, Black heterosexual men and women, people who inject drugs, transgender individuals, and youth 13-24. While the needs assessment focused on people 18 years and older, surveillance data suggests an increase in youth living with HIV, necessitating a youth-focused approach to HIV prevention, care, and treatment.

III-4b. Actions Taken

The needs assessment identified several continuing and emerging consumer needs that have been addressed and/or being addressed. These needs and solutions are described below.

- **Older adults** – A growing number of older people are living with HIV/AIDS with improved treatment in the DC EMA. Approximately 73% of respondents who were 65 years and over and 47.9% of 55–64-year-olds have been living with HIV for more than 20 years. As previously mentioned, DC Health has engaged in preliminary discussions with our jurisdictional partners to determine future efforts for this emerging topic. The COHAH's Integrated Strategies Committee (ISC) is also exploring this topic as possible committee work. The intersection of older adults and the social determinants of health is of particular interest to the ISC.

- **Transportation services** –A small percentage of consumers (9.2%) identified transportation services as difficult to get. Transportation services are provided under the medical transportation service category. Greater education to consumers and providers about the availability of transportation services will be considered moving forward.
- **Oral health services** – Oral health services were identified by consumers as being difficult to get (14.5%) or not received (21.2%). During the PSRA lite process, DC Health increased the oral health allocation percentage from 4% to 6%, recognizing the need and increased demand for this service category.
- **Health insurance** – The majority of needs assessment respondents reported having health insurance coverage at 81.1%, with 88.9% of respondents covered in DC, 78.1% in Maryland, and 55.7% in Virginia. Virginia had a higher proportion of respondents who did not have health insurance. Virginia's recent Medicaid expansion may assist with this need. The District of Columbia and Maryland adopted and implemented Medicaid expansion in 2014. While Medicaid expansion across the DC EMA is a strength, there are still coverage gaps as indicated by consumers which may require additional provider and consumer education on health insurance options.
- **Financial assistance** – Consumers identified financial assistance as a needed service that they were unable to get (25.7%). DC Health increased the allocation percentage from 4% to 8% recognizing the need, increased demand, and impact of inflation for this service category during the PSRA lite process.
- **Housing** – Housing is a local and national challenge. Locally, high housing costs, low supply, and inflation make finding and affording shelter increasingly difficult. A portion of the funds allocated to housing services will be used to support Housing Supportive Services and expand Housing Services, in partnership with HAHSTA's Housing Opportunities for Persons with HIV/AIDS (HOPWA) program.
- **Food bank** – A small percentage of respondents need food assistance and were able to receive such assistance but reported difficulty accessing this service. Greater education to consumers and providers about the availability of this service may be necessary moving forward as food bank/home-delivered meals is a covered service category.
- **Mental health** – While mental health/emotional well-being was a recurring challenge for respondents, over 50% indicated they were being cared for and/or treated for the condition. Maryland respondents were more likely to have been cared for and/or treated for a mental health disorder at 67.4%. Mental health services are a service category in the DC EMA. DC Health continues its ongoing efforts to address structural racism, stigma, equity, and wellness through its Dr. Ron Simmons Wellness Initiative under the DC-specific fifth strategy: Engage. DC Health currently 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 with the aim to improve health outcomes. The COHAH's ISC is exploring mental health and broader wellbeing as a potential topic area for future work to strengthen the DC EMA's integrated health efforts across the HIV continuum of care.
- **Substance use –** Few respondents reported having substance use disorder (SUD), and those that did reported having received SUD treatment. Based on these data, it appears that people who need SUD services are receiving them, but selection bias may have led to an underestimate of people having SUD since the needs assessment recruited participants directly from provider clinics and may have missed people who do not attend those clinics or seek care during the study. Therefore, it is possible respondents who meet clinical criteria for SUD have not received

a diagnosis and thus have not sought out necessary treatment. Substance use related to unsafe injection practices and other risk behaviors can make people more vulnerable to HIV acquisition. Accordingly, ensuring that those who need SUD treatment can access it is a major component of HIV prevention and one that DC Health continues to monitor, keeping substance use outpatient care funding at steady.

- **Prevention –** While PrEP is highly effective in preventing HIV acquisition, the level of use is still low in the DC EMA. The ISC and REC are exploring prevention as a topic area of work, including considering a targeted prevention needs assessment.

III-4c. Approach

Multiple stakeholders were involved in the DC EMA Status-Neutral Consumer Needs Assessment including the COHAH's REC, researchers from GW, jurisdictional partners, providers, and consumers. The COHAH's REC (includes jurisdictional partners and PLWH members) and GW developed the consumer status-neutral needs assessment survey. The survey was informed by existing surveys from across the nation, including status-neutral consumer needs assessments from Maryland, Virginia, and San Francisco, California; the 2019 DC EMA Survey; and the Community Needs Assessment Survey available on LinkU (linkudmv.org). The survey was administered in collaboration with providers and consumers. All RW providers promoted the survey to their consumers and student investigators facilitated survey administration at RW provider clinics in DC, Maryland, and Virginia.

SECTION IV: SITUATIONAL ANALYSIS

IV-1. Situational Analysis Update

This section provides an update to the situational analysis submitted in the DC EMA Integrated Plan. Since the submission of the DC EMA's Integrated Plan there have not been many changes related to strategies or interventions implemented. The DC EMA Integrated Plan is a living document, and it is expected that DC Health will revisit the plan on a regular basis to refine and update it to review and determine next steps. DC Health understands the importance and necessity of identifying strategies that engage stakeholders, members of the priority populations, and DC Health staff in meaningful planning activities. This update highlights areas where there have been significant progress and/or updates related to the previous submission.

- *Peer Programs*. In addition to the Peer Outreach Specialist program that utilizes a harm reduction approach to address the complex health needs of people who use drugs, DC Health added Clinical Care Coordinators and Community Health Workers (CHW). Clinical Care Coordinators and Community Health Workers were hired as DC Health employees and deployed to community health providers to increase the providers' capacity to offer early intervention, HIV care navigation and social support services. They are responsible for facilitating outreach and care coordination services to individuals who are most behaviorally vulnerable to HIV and/or diagnosed with HIV and not virally suppressed. CHWs and Clinical Care Coordinators will work to ensure timely, high quality, and efficient navigation, health, and support services through referrals to both internal and external resources.

- *Syndemic Approach:* DC Health/HAHSTA released a Prevention funding announcement utilizing a syndemic approach. To maximize a whole person-based approach, the funding announcement considers that individuals are multi-dimensional and may face multiple challenges at once. This along with a status neutral approach should ensure that people are made aware of their HIV, hepatitis, and sexually transmitted infection status, as well as linked to additional services such as PrEP/PEP, and harm reduction services. This programming also increases access to medical care and treatment services through "pop-up" medical services specifically for people who use drugs.

- *Harm Reduction Vending Machines.* The pilot Harm Reduction Vending Machine program launched in April 2023, since submission of the plan. The machines are a low-barrier access point for individuals in need of Narcan, fentanyl test strips, HIV test kits, and condoms. All materials are free of charge and available 24/7. There are a total of seven machines throughout the district, with four of them at Fire and EMS stations and three others in front of community partner locations. These vending machines are a stigma-reducing access point for individuals who might not normally engage with outreach teams and/or peer workers. DC Health is in the process of evaluating effectiveness and placement of the machines.

- *Injectable PrEP*: DC Health launched access to injectable PrEP (Apretude) in July 2023. To date, there has been a fair level of interest, with the sole complaints related to injection site pain. Approximately 25 people are on injectable PrEP now through DC Health, with plans for expansion in the coming year. DC Health will evaluate utilization and availability as the program continues. This further expands access and empowers individuals to take charge of their sexual health.

IV-1a. Priority Populations

After dealing with delays due to the COVID-19 pandemic and technical challenges, DC Health continued its needs assessment activities. Additional interns were hired and deployed within the DC EMA to conduct the comprehensive needs assessment. The findings are addressed above in Section III: Contributing Data Sets and Assessments. Broadly, the needs assessment findings were consistent with data gathered from surveillance, program monitoring, and other sources as described in Section III. This reenforces many of the needs and priority populations identified by these data and prioritized in the 2022 DC EMA Integrated Plan submission. As described above, priority areas include education to reduce stigma, HIV-related risk behaviors, and the spread of STIs; as well as increased youth prevention and engagement efforts, PrEP/PEP programming, and wellness support. Key population groups remain Black and Latino MSM, Black heterosexual men and women, people who inject drugs, transgender individuals, and youth 13-24.

Table 5 below displays the strengths, needs, and challenges in addressing HIV care and prevention of the priority population groups. The emerging needs identified from the needs assessment will be included as discussions continue across the jurisdictions and solutions are developed.

Table 5. 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; Injectable PrEP	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; Harm Reduction Vending Machines	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; Injectable PrEP	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; Injectable PrEP	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] Previously planned activity, now active
[c] Needs as identified by community member

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

V-1. Goals and Objectives Description

The DC EMA goals, objectives, strategies, and activities align with the national and local EHE diagnose, treat, prevent, and respond strategies. As previously submitted based on the Integrated Plan guidance, the goals and objectives section highlight at least 3 goals and objectives for each of the five strategies, including DC's Engage strategy. These goals, strategies, activities, and outcomes reflect the cultural diversity and focus populations in the DC EMA which remains to be: 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.

Updates to the DC EMA Integrated Plan Goals and Objectives. All DC EMA leaders and stakeholders collectively agree to coordinate a regional response to end the HIV epidemic. The elements of the goals and objectives from the prior year plan submission remain relevant for the DC EMA HIV community. As with all plans, 1) data, 2) community collaborations, and 3) local and national priorities impact the scope of the plan. Most notably, DC Health is concurrently working with its jurisdictional partners on emerging HIV topics and priorities as previously mentioned which may require a plan refinement in the future iteration. In the meantime, using feedback from data collection efforts, DC Health has made modest changes to the goals and objectives section of the plan based on two criteria: 1) data availability and 2) reporting burden. DC Health encountered some areas where the generally used vocabulary was unclear or unmeasurable, or where the outcomes were challenging to measure. In these cases, DC Health divisions that contribute to the data collection efforts discussed the ambiguities and provided content expertise to modifications. For example, outcome no. 1 for T3A under the treat strategy, has been amended to remove the word 'sustained' as there is no clear definition of 'sustained'; the CDC's viral suppression definition was substituted in for this measure:

T3A. Percentage of people with HIV with *sustained* viral suppression within past two years
Update. Percentage of people with HIV viral suppression within the past two years

In another example, outcome no. 4 for P2B under the prevent strategy has been amended to have inclusive language for all healthcare professionals with the recognition that nurse practitioners and physician assistants have prescriptive authority based on state law.

P2B. Number of family medicine and internal medicine physicians with at least two PrEP prescriptions covered by Medicaid
Update. Number of healthcare professionals with at least two PrEP prescriptions covered by Medicaid

Lastly, outcome no. 1 for P3A under the prevent strategy has been updated to measure the number of tests conducted within the syringe service programs rather than a percentage of people in the program.

P3A. Percentage of people in syringe service program tested for HIV
Update. Number of HIV tests conducted within syringe service programs

Please refer to the 2022 submission regarding goals and objectives development. A summary of the 2022- 2026 goals by strategy for the DC EMA are presented below in Figure 3. Table 6 provides a broad

overview of the goals, objectives, strategies, and activities. With this update, DC Health provides data for outcome measures where available for 2022 and 2023. As noted in Section IV: Situational Analysis, although the goals, objectives, strategies, and activities are identified within strategies below, some components may cross strategies.

Figure 3. Goals by Strategy for the DC EMA, 2022-2026

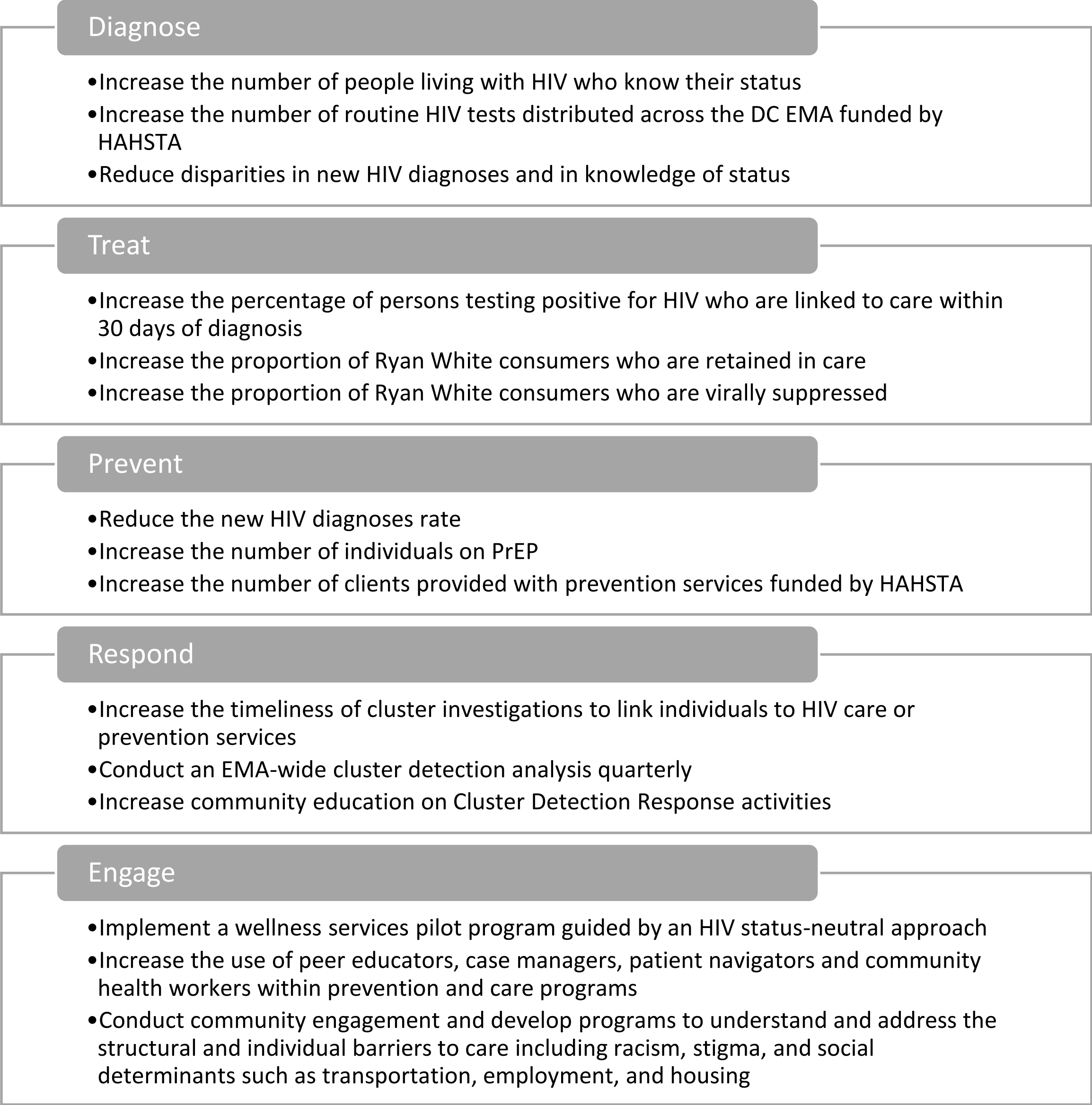


Table 6. Goals and Objectives for the DC EMA, 2022-2026

Diagnose					**2022**	**2023**
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 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.					**93.9%**	
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**	**2022 Outcomes**	**2023 Outcomes**
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	18,006	8,915
		Number of people who test positive in HIV testing programs	Annual	Ehars	299	128 (Jan-June 2023)
		Number of new HIV diagnoses with a simultaneous Stage 3 (AIDS) diagnosis	Annual	Ehars	455 Newly diagnosed stage 3 (AIDS) dx in the DCEMA	
	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)	Number of clients linked to services related to HIV/AIDS, HBV/HCV, and STIs funded through HAHSTA's Prevention RFA	Annual	Prevention	N/A Syndemic Programming did	210 (April-June 2023)

	including biomedical HIV prevention strategies, health screenings, health literacy, wellness, and behavioral health interventions.				not begin until April 2023	
	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	Care	Staff attrition impacted tracking of 2022 data;	85 providers through Case Management Operating Committee (CMOC) quarterly HIV best practices training (35 social workers, 33 case managers, 12 nurses, 5 CHW);
				Capacity Building	3 providers and 459 participants educated and trained to provide HIV screening/testing services	5 providers and 254 participants educated and trained to provide HIV screening/testing services
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	Annual	Capacity Building	5[a]	3[a]
Goal 2: Increase the number of HIV tests funded by HAHSTA distributed across the DC EMA					**2022**	**2023**
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:						
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**	**2022 Outcomes**	**2022 Outcomes**
D2A: Develop and expand implementation of effective, evidence-based, or evidence-informed models for HIV testing that improve convenience and access.	Expand convenience-based HIV and STD testing through continued implementation of GetCheckedDC	Number of HIV at home tests distributed Number of Labcorp Walk in HIV tests performed Number of people who test positive for HIV through convenience-based programs	Annual Annual Annual	Prevention/ GetCheckedDC Prevention/ GetCheckedDC Prevention/ GetCheckedDC	1,790 1,764 3 previously identified HIV positive individuals; 0 new HIV positive individuals[b]	934 (Jan-June 2023) 939 (Jan-June 2023) 5 previously identified HIV positive individuals; 0 new HIV positive individuals (Jan-June 2023)[b]
	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	Number of Expanded Testing Program Partners Number of people who test positive for HIV through Expanded Testing Program Partners	Annual Annual	Prevention Prevention	Not Tracked Not Tracked	6 0

	train new rapid testing partners in underserved communities.					
Goal 3: Reduce disparities in new HIV diagnoses.					**2022**	**2023**
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					The percentage of new dx in these groups have not changed. 23% women; 64% Black individuals; 49% MSM	
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**	**2022 Outcomes**	**2023 Outcomes**
D3A: Ensure resources are focused on the communities and populations where the need is greatest.	Augment services for youth and young adults by training peers and peer-based 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	Number of trainings held for youth-serving organizations; Number of clients served through augmented services for youth	Annual	Prevention/ Care	School-based programming were halted in 2022 due to COVID-19.	School-based screenings just resumed in 2023. No data is available now.

	clinics and CBOs and provide supports to address barriers to care such as transportation.					
	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	Not Tracked	2
Treat					**2022**	**2023**
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					92%	
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**	**2022 Outcomes**	**2023 Outcomes**
T1A: Link people to care immediately after diagnosis and provide low barrier access to HIV treatment	Increase the number of providers implementing rapid linkage to HIV care and ART initiation. Conduct a detailed epidemiological analysis to understand which demographic groups have not benefited from rapid linkage to HIV care and treatment initiation in order	Percentage of people newly diagnosed with HIV starting HIV medication within seven days Percentage of people newly diagnosed with HIV linked to medical care within one month.	Annual	CareWare/ Ehars	39.50% 95.24% 89.30%	38.36% (through 8/31/2023) 91.78% (through 8/31/2023) 88.56% (through 8/31/2023)

	to reconsider program designs and implementation	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	Not tracked	Not tracked
	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	Not tracked 28	Not tracked 27
	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	12	
Goal 2: Increase the proportion of Ryan White consumers who are retained in care to 90% from a baseline of 82% by 2026.					**2022**	**2023**
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**	**2022 Outcomes**	**2022 Outcomes**
T2A: Increase retention in care and adherence to HIV	Implement Intervention Services Program to increase early HIV identification, early	Number of clients served through Intervention Services Program	Annual	Careware	0	15 (through 8/31/2023)

treatment to achieve and maintain long-term viral suppression	HIV intervention, treatment adherence and viral load suppression using best practices and innovative services models such as Community Health Workers (CHW).					
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.					**2022**	**2023**
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**	**2022 Outcomes**	**2023 Outcomes**
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 viral suppression within past two years	Annual	Ehars	53%	
		Percentage of people with HIV missing two prescription refills within a 90-day period	Annual	Ramsell PBM System/Contracted Drug Utilization Review with Clinical Pharmacy Associates	12%[c]	
		Percentage of young people (ages 13–30) with HIV missing two prescription refills within a 90-day period.	Annual		27%[c]	
T3B: Integrate U=U as standard of care	Integrate U=U as standard of care in a status neutral approach for HIV care and	Number of provider trainings held	Annual	Capacity Building	51 workshops	19 workshops

	prevention services by providing training to medical and community-based providers and increasing social marketing.	Number of medical and community-based providers trained	Annual	Capacity Building	3 providers and 459 participants	4 community and medical providers and 245 participants trained
		Number of impressions on U=U social media campaigns	Annual	Capacity Building	1,452 from DC Beings; 34 from Bienestar	1,088 from DC Beings through October; 641 from Bienestar through October
Prevent					**2022**	**2023**
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					An approximate increase of 16%, from 711 new cases to 826 new cases in the DC EMA	
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**	**2022 Outcomes**	**2023 Outcomes**

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	Annual	Capacity Building	1 (PrEP and Pride)	See 2022 comment.
		Number of impressions on PrEP campaign social media posts	Annual	Capacity Building	46,330 PrEP related from DC Beings; 15,320 PrEP related from Bienestar	66, 808 PrEP related from DC Beings; 587 PrEP related from Beinstar
	Expand sexual health education social marketing for the general population in diverse media platforms and formats	Number of impressions on DC Beings campaign social media posts	Annual	Capacity Building	1,092,521	1,902,015 as of October
	Expand sexual health education social marketing for Latinx communities in diverse media platforms and formats	Number of impressions on Bienestar campaign social media posts	Capacity Building	Capacity Building	319,935	398,169 as of October
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	Annual	Capacity Building	15	20
		Number of providers who attend PrEP telehealth meetings and trainings	Annual	Capacity Building	10	15
Goal 2: Increase the number of individuals on PrEP in the DC EMA					**2022**	**2023**
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**	**2022 Outcomes**	**2023 Outcomes**
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	Annual	Capacity Building	6	530
		Number of participants in community engagement events	Annual	Capacity Building	5 series	910
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	Annual	Prevention	4	4
		Number of clients served through Peer navigation services	Annual	Prevention	N/A[d]	
	Continue expanding access to PrEP services, with an emphasis on increasing uptake among focus populations	Number of people prescribed PrEP	Annual	Prevention		11
		Number of healthcare professionals with at least two PrEP prescriptions covered by Medicaid.	Annual	Wellness Center	13	14
		Number of HIV-negative Medicaid enrollees who had a PrEP appointment at the clinic.	Annual	Wellness Center	97	88
	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	6	6

	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	Annual	Wellness Center	407 (between 4/1/2021 and 9/1/2022)	N/A
		Number of PEP prescriptions covered by Medicaid	Annual	Wellness Center	0[e]	0[e]
Goal 3: Increase the number of clients provided with prevention services funded by HAHSTA					**2022**	**2023**
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**	**2022 Outcomes**	**2023 Outcomes**
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.	Number of HIV tests conducted within syringe service programs	Annual	Prevention	Not tracked	489 (through June 2023)
	Implement harm reduction vending machine pilot	Number of products distributed from harm reduction vending machines	Annual	Prevention	N/A Vending machines piloted 2023	1486 (through June 2023)
Respond					**2022**	**2023**
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**	**2022 Outcomes**	**2023 Outcomes**
R1A: Improve cluster investigation processes through updated protocols and data systems	Establish new protocols for HIV diagnoses, with a new timeframe to process the diagnosis and issue a field record within 15 business days.	Number of new protocols developed Percentage of DC residents with HIV interviewed by DC Health within 30 days of diagnosis.	Annual Annual	Surveillance Surveillance	1 N/A	 N/A
	Conduct ongoing expanded review of both molecular and time/space clusters to expand the opportunities to identify and address clusters of interest through a Tableau Dashboard. Report on clusters of interest to DC Health HAHSTA Senior Leadership team.	Develop a Tableau outbreak dashboard Report national priority or unusual cluster activity to HAHSTA's senior leadership within 14 days of identification	Annual As needed	Surveillance Surveillance	In development 0	Completed for internal use 1
	Use continuous quality improvement techniques to improve the timeliness of molecular cluster detection by addressing lab-related delays in receipt of molecular	Increasing completeness of genotype sequences for newly dx cases	Annual	Surveillance	55.9%	44.7% (data as of 12/20/23)

	HIV sequences and delays in internal processing of molecular HIV sequences.					
	Use continuous quality improvement to improve patient contact standards and care linkage and reengagement timeliness	Percentage of people with HIV in an HIV transmission cluster achieving viral suppression within six months.	Annual	Surveillance	50%[f]	100% (data as of 12/20/23)
	Revive a DC Health 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	4 (3/7/2022, 5/2/2022, 7/11/2022, 11/7/2022)	11, Internal to HAHSTA[g]
	Establish a methodology to integrate the cluster information for HIV and STD activities to improve the time-lag of analysis for clusters.	Number of meetings to explore options for integrated data analysis	Annual	Surveillance Calendar	4 (9/30/2022, 10/21/2022, 10/31/2022, 12/1/2022)	5 (1/9/2023, 1/13/2023, 2/1/2023, 3/3/2023, 3/31/2023)[g]

Goal 2: Conduct an EMA-wide cluster detection analysis quarterly	**2022**	**2023**
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	2022 Outcomes	2023 Outcomes
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 and Virginia Department of Health 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	12	11[g]

Goal 3: Increase community education on Cluster Detection Response activities					2022	2023
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**	**2022 Outcomes**	**2023 Outcomes**
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	22 (4 DC, 12 MD, 6 VA)	32[c] (30 MD, 2 VA)
Engage					**2022**	**2023**
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**	**2022 Outcomes**	**2023 Outcomes**

Objective	Key Activities and Strategies	Outcomes	Reporting Frequency	Monitoring Data Source	2022 Outcomes	2023 Outcomes
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 Number of Wellness Initiative clients on PrEP Number of Wellness Initiative clients on ART Percent of clients who report decreased stress, decreased pain, or improved sleep because of participation in this Wellness program	Annual Annual Annual Annual	Careware Careware Careware Survey Data	177 1 115 Not measured	130 (through 8/31/2023) 5 (through 8/31/2023) 81 (through 8/31/2023) Working on an updated survey to collect this information
Goal 2: Increase the use of peer educators, case managers, patient navigators and community health workers within prevention and care programs					**2022**	**2023**
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**	**2022 Outcomes**	**2023 Outcomes**
E2A: Increase the diversity and capacity of the health workforce to prevent and diagnose HIV	Continue the use of Drug User Health Peers to address the health of people who use drugs through a harm reduction approach. Peers are individuals from the community they serve, and who have employment	Number of Drug User Health Peers hired Number of clients served through Drug User Health Peer activities	Annual Annual	Prevention Prevention	4 N/A[d]	4

Objective	Key Activities and Strategies	Outcomes	Reporting Frequency	Monitoring Data Source	2022 Outcomes	2023 Outcomes
	challenges such as recent incarceration experience or limited work experience in the formal economy					
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	Careware Careware	0 0	3 15
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.					**2022**	**2023**
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**	**2022 Outcomes**	**2023 Outcomes**
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	10	27
E3B: Reduce disparities in new HIV infections, in knowledge of status, and	Address housing and other social support needs by updating navigation programs to include navigation and referral for wrap	Number of clients provided or referred to essential support services	Annual	Prevention	7,308	1,247 (Jan-June 2023)

along the HIV care continuum	around services to enable people living with HIV to gain or maintain access to care and treatment.					

[a] Campaigns developed in 2022 were Condoms: What's Your Pleasure?; PrEP and Pride; MPox Vaccination; Fight COVID, Fight HIV; and DC Youth Advisory Board: Back to School Event. Campaigns developed in 2023 were U4U Tuberculosis; Positive Voices, Season 1; US Conference for HIV/AIDS Event Collateral. Campaigns that are under development or to be launched are Positive Voices: Season 2; and Link U. DC Health has several ongoing (Pre-2022) campaigns that include but are not limited to Get Checked DC; Condoms Campaign; PrEP for Her; and PEP Hotline.
[b] Programs identify previously diagnosed HIV-positive individuals and not new HIV cases.
[c] Data provided for grant year 4/1/2022- 3/31/2023.
[d] Data was not collected in a standardized way. The data previously collected in RedCap was not captured once the system went away. We are developing a data template to collect the data accurately and standardize the process.
[e] DC Health covers the costs of the PEP medication for all patients, including Medicaid patients.
[f] There were six cases identified in 2022.
[g] The cluster epidemiologist for DC Health transitioned to a new position.

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. There are no significant updates to report. Please see the 2022 submission of the DC EHE and DC EMA Integrated Plan comparison.

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

VI-1. 2022-2026 Integrated Planning Implementation Approach

All internal and external entities remain committed to working collaboratively to ensure progress in implementation, monitoring, evaluation, improvement, reporting, and dissemination of the plan. Details regarding these ongoing efforts have been described in prior sections and are summarized below.

VI-1a. Implementation

Over the past year, the DC EMA Integrated Plan was presented at various meetings to encourage awareness, reinforce information, and promote discussion of the plan. Presentations were conducted for the COHAH's Research and Evaluation Committee and General Body, DMV Collaboration, HAHSTA's Care and Treatment Division, HAHSTA's Planning and Evaluation Team, GY33 Ryan White Part A Sub-Recipient Kick-Off Meeting, and DC EMA Integrated Plan Workgroup. The COHAH is working collaboratively with jurisdictional partners, DC Health, and community stakeholders to ensure progress of the plan. As mentioned in Section III-3a. Strengths and Gaps, the COHAH conducted a "PSRA lite" process where allocations were made to support HAHSTA-funded activities in support of the DC EMA Integrated Plan. The plan was posted online for the public at DC Health's website on January 11, 2023, to rapidly reach a wide array of stakeholders who can act toward achieving the goals and objectives.

VI-1b. Monitoring

DC Health's HAHSTA uses Microsoft Excel to monitor and track the progress of the proposed activities, goals, and objectives highlighted in the Integrated Plan. As mentioned in Section V-1. Goals and Objectives Description, some elements have been modified based on 1) data availability and 2) reporting burden. The modified activities, goals, and objectives are included in this resubmission. Additional modifications may be made in future years based on system and program development.
Cross-jurisdictional collaboration is an integral component of Integrated Planning for the DC EMA to leverage engagement opportunities and expand access to HIV services. DC Health's HAHSTA actively collaborates with Maryland and Virginia's Departments of Health (DOH) to engage in dialogue, share knowledge, and confer on measured activities across jurisdictions. An example of this collaboration work is the DC EMA Integrated Plan Workgroup, which includes Maryland and Virginia DOH representation as mentioned in Section II. Community Engagement and Planning Process. While Maryland and Virginia have their own Integrated Plan, HAHSTA conducted a crosswalk analysis to understand the similarities and differences of these plans with the DC EMA Integrated Plan. The goal of the analysis was to bridge the gap between the compared plans and provide an opportunity for HAHSTA to adopt strategies proposed by our jurisdictional partners in future iterations of the Integrated Plan. These gaps are identified in Section III-3a. Strengths and Gaps, which include the 1) aging population, and 2) provider network expansion.

VI-1c. Evaluation

During this year, HAHSTA has experienced several challenges impacting the evaluation of the Integrated Plan. For example, core staff positions to collect and analyze program data have been vacant for several months, impacting DC Health's ability to conduct quarterly data collection efforts as previously proposed. DC Health has been actively recruiting, targeting efforts for these positions through hiring events and in collaboration with DC Human Resources. These staffing challenges have affected the monitoring timeline and data analysis needed for the proposed activities. This resubmission provides updates to some of the activities, goals, and objectives originally proposed. DC Health plans to develop a

more effective monitoring and tracking system that allows for consistent data collection and analysis of the Integrated Plan.

VI-1d. Improvement

DC Health has made initial improvements to the tracking and monitoring of the DC EMA Integrated Plan activities by having discussions with internal and external partners and comparing with other more successful approaches to identify recommendations for future work. Lessons learned from the monitoring, tracking, and evaluation process has enabled DC Health to adjust key activities and strategies, and outcome measures to better reflect the programs impact for the DC EMA communities. DC Health has actively pursued feedback from all its partners including: COHAH through its different committees, Maryland and Virginia through their collaboration and participation in the Integrated Plan Workgroup, and the populations served through the Needs Assessment. DC Health also plans to establish a new tracking system for the activities described in the Integrated Plan.

VI-1e. Reporting and Dissemination

In collaboration with the DC Health's Office of Communications and Community Relations, HAHSTA plans to develop a summary document of the DC EMA Integrated Plan for the public to raise awareness of the cross-jurisdictional work to end the HIV epidemic over the next year. The DC EMA Integrated Plan Workgroup will collect annual data in the Spring to be presented to the COHAH in early Summer.

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

There are no significant updates to report. The DC EMA Integrated Plan draws heavily from and is designed to complement the DC EHE Plan. It aligns with federal EHE plan goals and the National HIV/AIDS Strategy.

SECTION VII: LETTER OF CONCURRENCE

Please see the next page.

APPENDIX

Attached are the Resource Inventory and DC EMA Needs Assessment.