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)

DC | HEALTH
GOVERNMENT OF THE DISTRICT OF COLUMBIA

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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)

TABLE OF CONTENTS

SECTION I: EXECUTIVE SUMMARY OF INTEGRATED PLAN AND STATEWIDE COORDINATED STATEMENT OF NEED (SCSN) 4
I. Executive Summary of Integrated Plan and SCSN 4
Ia. Approach 5
Ib. Documents Submitted to Meet Requirements 5
SECTION II: COMMUNITY ENGAGEMENT AND PLANNING PROCESS 6
II-1. Jurisdiction Planning Process 6
II-1a. Entities Involved in Process 6
II-1b. Role of RWAP Part A Planning Council/Planning Body 7
II-1c. Role of Planning Bodies and Other Entities 7
II-1d. Collaboration with RWHAP Parts (SCSN Requirement) 7
II-1e. Engagement of People with HIV (SCSN Requirement) 8
II-1f. Priorities 8
II-1g. Updates to Other Strategic Plans Used to Meet Requirements 9
SECTION III: CONTRIBUTING DATA SETS AND ASSESSMENTS 10
III-1. Data Sharing and Use 10
III-2. Epidemiologic Snapshot 10
III-3. HIV Prevention, Care and Treatment Resource Inventory 18
III-3a. Strengths and Gaps 19
III-3b. Approaches and Partnerships 21
III-4. Needs Assessment 21
III-4a. Priorities 22
III-4b. Actions Taken 22
III-4c. Approach 24
SECTION IV: SITUATIONAL ANALYSIS 25
IV-1. Situational Analysis Update 25
IV-1a. Priority Populations 26

SECTION V: 2022-2026 GOALS AND OBJECTIVES FOR THE DC EMA 28
V-1. Goals and Objectives Description 28
V-1a. Updates to Other Strategic Plans Used to Meet Requirements 47
SECTION VI: 2022-2026 INTEGRATED PLANNING IMPLEMENTATION, MONITORING, AND JURISDICTIONAL FOLLOW-UP 48
VI-1a. Implementation 48
VI-1b. Monitoring 48
VI-1c. Evaluation 48
VI-1d. Improvement 49
VI-1e. Reporting and Dissemination 49
VI-1f. Updates to Other Strategic Plans Used to Meet Requirements 49
SECTION VII: LETTER OF CONCURRENCE 50
APPENDIX 50

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.

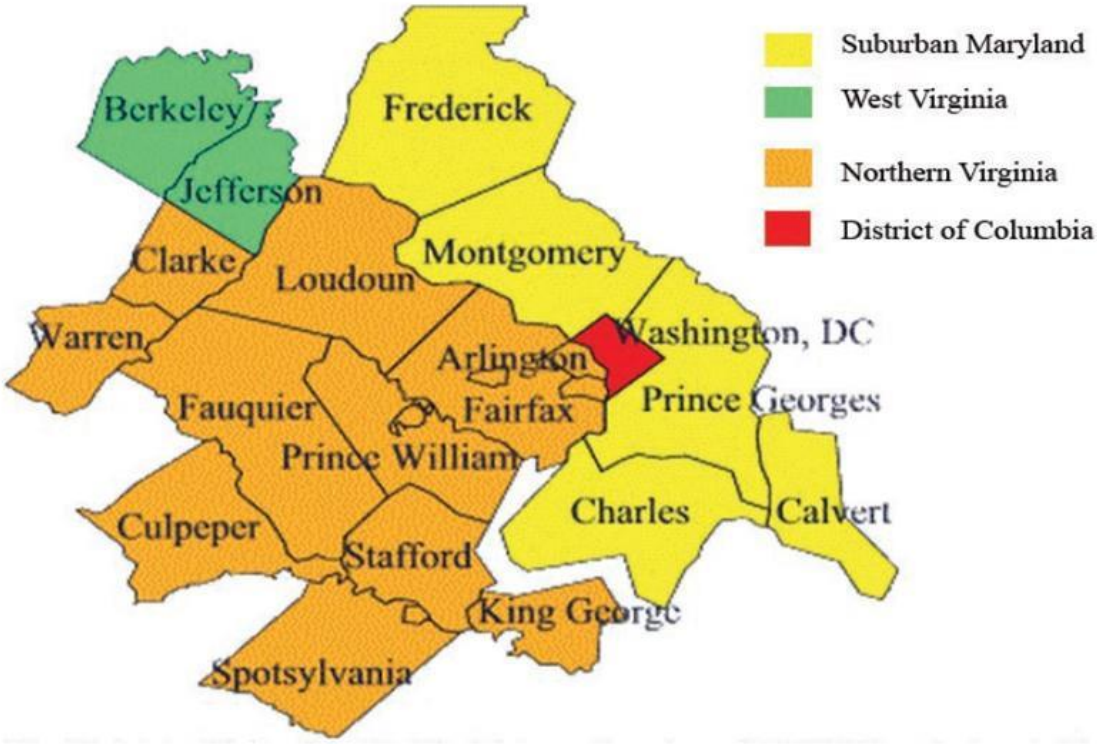
DC Health continues to collaborate with jurisdictional partners in Maryland, Virginia, and West Virginia, as well as sub-recipients on data integration efforts. As previously reported, the DC EMA CAREWare system is one of the largest networks in the nation with over 300 active unique users among 40 agencies. 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%).

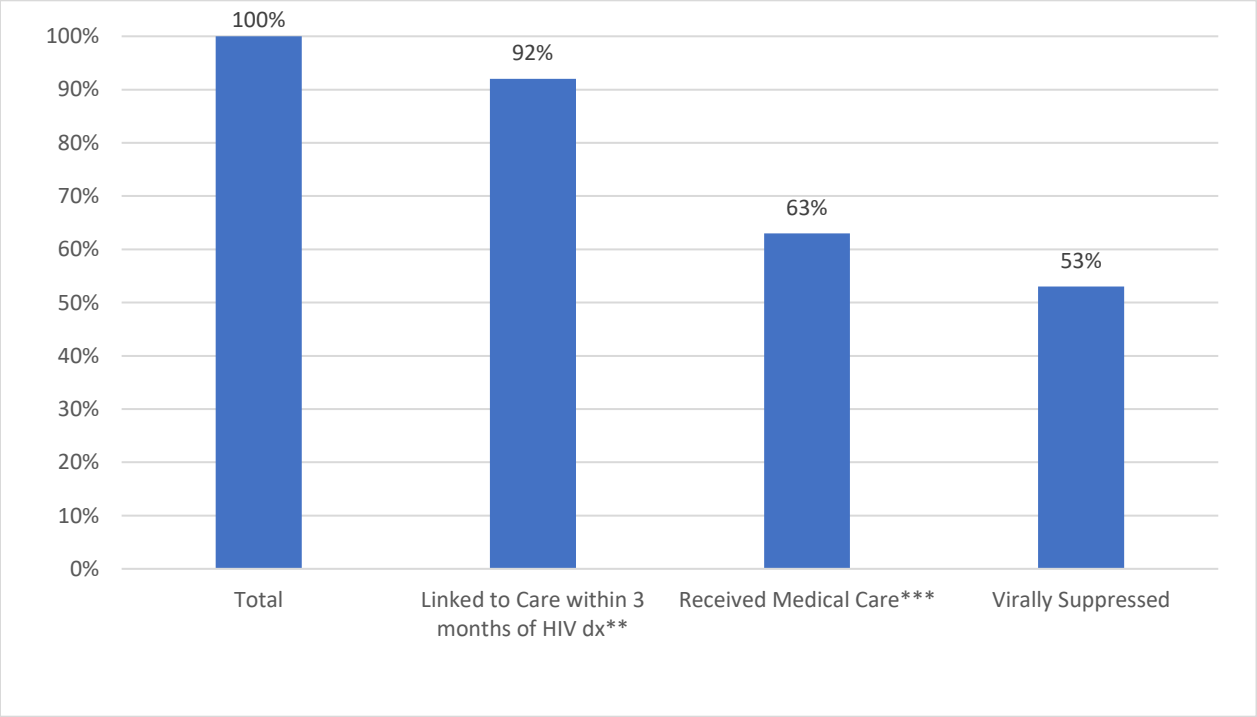
Table 2. Newly Diagnosed HIV Cases by Race/Ethnicity and Year, DC EMA, 2018-2022, N=4,474

	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

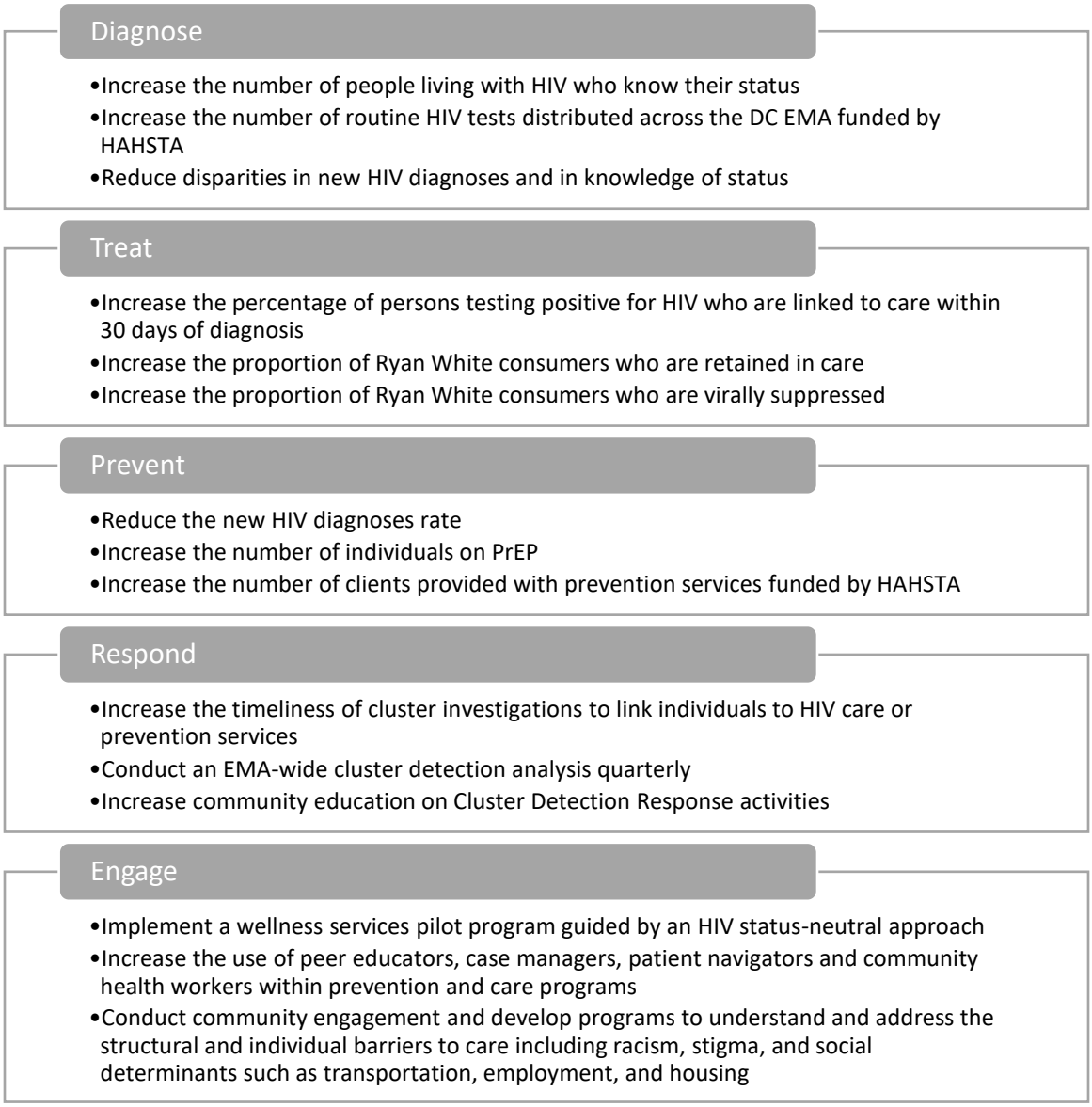


Table 6. Goals and Objectives for the DC EMA, 2022-2026

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 Capacity Building	Staff attrition impacted tracking of 2022 data; 3 providers and 459 participants educated and trained to provide HIV screening/testing services	85 providers through Case Management Operating Committee (CMOC) quarterly HIV best practices training (35 social workers, 33 case managers, 12 nurses, 5 CHW); 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: 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 Percentage of people with HIV missing two prescription refills within a 90-day period Percentage of young people (ages 13–30) with HIV missing two prescription refills within a 90-day period.	Annual Annual Annual	Ehars Ramsell PBM System/Contracted Drug Utilization Review with Clinical Pharmacy Associates	53% 12%[c] 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 Number of participants in community engagement events	Annual Annual	Capacity Building Capacity Building	6 5 series	530 910
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 Number of clients served through Peer navigation services	Annual Annual	Prevention Prevention	4 N/A[d]	4
	Continue expanding access to PrEP services, with an emphasis on increasing uptake among focus populations	Number of people prescribed PrEP Number of healthcare professionals with at least two PrEP prescriptions covered by Medicaid. Number of HIV-negative Medicaid enrollees who had a PrEP appointment at the clinic.	Annual Annual Annual	Prevention Wellness Center Wellness Center	 13 97	11 14 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**

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

	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.

Washington, DC Regional PLANNING COMMISSION on HEALTH and HIV

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

December 22, 2023

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

Dear Mr. Au Lay and Ms. Smith:

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

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

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

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

Regards,

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

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

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

DC EMA Resource Inventory			
This table is an HIV resource inventory which includes public and private funding sources for HIV prevention, care, and treatment services in the DC EMA; the dollar ($) amount of available funds from that source; and allocations across each of the four jurisdictions in the EMA. Data are for the most recent fiscal year available, as indicated. When an organization has a primary focus on a specific population, that is indicated in parentheses. **Because of variations in fiscal year as well as multiple other limitations (as indicated), this should be considered an estimate rather than a precise accounting.**			
(1)(a) Jurisdiction	**(1)(b) Funding Amount ($) from (1)(a)**	**Agencies**	**Notes**
Ryan White Part A			
DC	$16,682,784	AIDS Healthcare Foundation, Children's National Medical Center, Community Family Life Services, Damien Ministries, Family & Medical Counseling Services, Food and Friends, Homes for Hope, Housing Counseling Services, Howard University/CIDMAR, Joseph's House, La Clinica del Pueblo, Metro Health, Terrific Inc, The Women's Collective, Unity Health Care, Us Helping Us, Washington Health Institute, Whitman-Walker Health	FY23 allocations to providers Includes MAI.
MD	$3,879,279	AIDS Healthcare Foundation, Children's National Medical Center, Greater Baden Medical Services, Heart to Hand, La Clinica del Pueblo, Medstar Health Research Institute, Montgomery County Health Department, Prince George's County Health Department, SLK Health Services, Us Helping Us	FY23 allocations to providers ($3,879,279).
VA	$2,143,904	Fredericksburg Area Health Support Services, INOVA, Neighborhood Health, NovaSalud, Inc., Virginia Health Options	FY23 allocations to providers
WV	$402,454	Shenandoah Valley Medical System	FY23
Fee for value/value enhancement	$5,375,352		Funds available across EMA
RW Part A EMA Total	**$28,483,773**		
Ryan White Part B - excluding ADAP			
DC	$2,455,870	Children's National Medical Center, Family & Medical Counseling Services, Howard University/CIDMAR, Metro Health, Unity Health Care, Us Helping Us, Washington Health Institute, Whitman-Walker Health	GY33 allocations to subgrantees
MD	$1,445,770	Charles County Health Department, Frederick County Health Department,	SFY24 Part B base and MAI allocations to EMA counties
VA	$7,072,329	Fredericksburg Area Health Support Services, INOVA, Legal Services of Virginia, Mary Washington Healthcare, Neighborhood Health, Northern Virginia Family Services, Northern Virginia Regional Commision (NRVC), NovaSalud, Inc., Virginia Health Options (VHO)	GY23 Part B allocations: $7,072,329 (incl Rapid Start). VA does not receive MAI
WV	$105,101	AIDS Task Force	4/1/22-3/31/23. WV does not receive MAI.
RW Part B EMA Total	**$11,079,070**		
Ryan White ADAP			
DC	$10,758,401		4/1/23-3/31/24 total ADAP award
MD	$19,615,094		Prorated share of state MADAP (state total $47,470,361)
VA	$5,321,582		GY23 ADAP for EMA: $5,321,582.
WV	$384,620		4/1/22-3/31/23.
RW Part ADAP Total	**$36,079,697**		
Ryan White Part C EIS and Capacity Development			
DC	$2,248,879	Family & Medical Counseling Services, Howard University/CIDMAR, Unity Health Care, Whitman-Walker Health	FY22 (last full fiscal year available on Taggs)

MD	$683,380	Daydream Sunshine Initiative, Medstar Health Research Institute	FY22 (last full fiscal year available on Taggs)
VA	$741,777	INOVA, Mary Washington Healthcare	FY22 (last full fiscal year available on Taggs)
WV			
RW Part C EMA Total	**$3,674,036**		
Ryan White Part D			
DC			
MD	$368,266	Medstar Health Research Institute	FY23
VA	$585,866	INOVA	FY23
WV			
RW Part D Total	**$954,132**		
RW EMA TOTAL	**$80,270,708**		
EtE Awards to HDs (HRSA and CDC combined)			
DC	$4,068,127	DC DOH, DHCF	FY23. Incl $3,755,939 from HRSA for EMA minus $2,312,690 to Mont & PG Counties; plus $2,624,878 from CDC for DC DHCF
MD	$5,354,274	Montgomery County Health Department, Prince George's County Health Department	FY23. $2,312,690 HRSA via DC EMA; plus $3,041,584 CDC EHE via MDH
VA	$0		not EtE jurisdiction
WV	$0		not EtE jurisdiction
EtE HDs EMA total	**$9,422,401**		
EtE TOTAL	**$9,422,401**		
CDC HIV Prevention and Surveillance			
DC	$10,050,462	Family Medical Counseling Services, HealthHIV, HBI-DC, HIPS, La Clinica Del Pueblo, Latin American Youth Center, The Women's Collective, Us Helping Us, Washington Health Institute, Whitman-Walker Health	FY23. Includes Integrated Surveillance and Prevention; and de-duplication at DOH, plus Community to Care surv at Whitman-Walker
MD	$1,904,733	Calvert County Health Department, Charles County Health Department, Frederick County Health Department, Montgomery County Health Department, Prince George's County Health Department	State FY24, allocations to EMA
VA	$1,167,690	Chris Atwood Foundation, Fredericksburg Area Health Support Services, INOVA Health System, NovaSalud, Fairfax Health District	$763,301 prevention grants, plus $316,851 testing grants, plus surveillance prorated to EMA
WV	$146,279		FY23 award to state prorated to EMA
CDC Prevention and Surveillance EMA Total	**$13,269,164**		
CDC HIV CBOs			
DC	$883,249	La Clinica del Pueblo, Whitman-Walker	FY23
MD			
VA	$400,000	INOVA	FY23. Mary Washington Hosp./Medicorp Health
WV			
CDC CBOs EMA Total	**$1,283,249**		
CDC HIV School Health			

DC	$467,500	Components One and Two School-Based HIV/STI Prevention Program; YRBS	FY23. $380,000 to DC Board of Ed; $87,500 re YRBS to DC Gov
MD	$41,194		FY23 award to state prorated to EMA
VA	$33,194		FY23 award to state prorated to EMA
WV	$11,352		FY22 award to state prorated to EMA
CDC schools EMA Total	**$553,241**		
CDC EMA Total	**$15,105,653**		
SAMHSA Direct Awards			
DC	$775,000	La Clinica del Pueblo, for Substance Abuse and HIV Prevention Navigator Program for Racial/Ethnic Minorities and for TCE-HIV: High-Risk Populations	FY22 awards
MD	$0		
VA	$0		
WV	$0		
SAMHSA block grant EMA Total	**$775,000**		
SAMHSA Block Grant Set Aside			
DC	$376,515		FY23 set aside total
MD	$710,056	County Health Departments	FY22 set aside ($1,718,401)prorated to EMA
VA	$0		no set aside in state
WV	$0		no set aside in state
SAMHSA block grant EMA Total	**$1,086,571**		
HOPWA Formula			
DC	$6,902,719	Community Family Life Services, Homes for Hope, Housing Counseling Services, DC Housing Authority (also covers Montgomery County and Prince George's County in Maryland)	FY23 allocation
MD	$4,052,142	Prince George's, Calvert, Charles, Frederick, and Montgomery Counties	State FY24 allocation from Maryland $1,852,142 plus $2,200,000 from DC
VA	$2,600,000	Arlington County, Fredericksburg Area Health Support Services, Homestretch (homeless families), Northern Virginia Family Services, Northern Virginia Regional Commision (NRVC)	FY23 allocation to NVRC from DC
WV	$153,306	Community Networks, Inc.	FY23 from WV to Berkeley and Jefferson $98,306 + $55,000 from DC EMSA
HOPWA EMA	**$13,708,167**		
HRSA Bureau of Primary Health Care (times HIV prevalence among patients)			
DC	$1,852,891	Bread for the City, Community of Hope, Elaine Ellis Center of Health, Family & Medical Counseling Services, La Clinica del Pueblo, Mary's Center, Unity Health Care, Whitman-Walker Health	2023 awards (most recent avail) times clinic HIV prevalence levels in 2021 (most recent available).
MD	$77,256	Mobile Medical Care, City of Frederick, Greater Baden Medical Services, Community Clinc	see above
VA	$79,387	Greater Prince William Community Health Center, Loudoun Community Health Center, Neighborhood Health	see above
WV	$37,021	Shenandoah Valley Medical System	see above
BPHC EMA Total	**$2,046,555**		
Other Federal Grant EMA Total	**$16,841,293**		
State appropriations plus special funds			
DC	$3,883,000		Budget FY2023 tables: HAHSTA local (dedicated taxes) minus TB and STD
Maryland	$9,430,304		SFY24 Ryan White Part B state special funds

VA	$0		
West Virginia	$0		
State Funding EMA Total	**$13,313,304**		
Medicaid			
DC	$265,806,982		DHCF FY17 expenditures, FFS ($139,733,065.16) +
MD	$106,441,809		Using April 2017 enrollment and capitation figures with 2018 EMA prev data; no update available.
VA	$17,517,645		FY2013 (most recent avail) KFF state estimate ($56,511,167) prorated by cases within the EMA
WV	$544,929		No update available 2018. Statewide (2015; most recent): $3,707,000, prorated to EMA
Medicaid EMA Total	**$390,311,365**		
DC Alliance and Immigrant Kids			
	$2,847,301		DHCF FY17.
Alliance and Immigrant Kids Total	**$2,847,301**		
Medicare			
Medicare	**$363,699,808**		$11,300B Medicare Spending for HIV/AIDS in US in FY2022 (most recent
Medicare EMA Total	**$363,699,808**		
Veterans Health Administration			
VHA	$49,586,406	Based on 2013 enrollment and 2019 expenditure data.	ROUGH ESTIMATE based on proportion of national VHA clients receiving HIV care in DC and total VA HIV
VHA EMA Total	**$49,586,406**		
EMA INSURANCE AND VHA Total	**$806,444,880**		
TOTAL EMA FUNDING	**$941,398,240**		

September 21, 2023

FINAL NARRATIVE REPORT

Washington, DC Regional Planning Commission on Health and HIV, District of Columbia Eligible Metropolitan Area Consumer Status Neutral Needs Assessment, 2022-2023

PREPARED BY:

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

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DC | HEALTH

GOVERNMENT OF THE DISTRICT OF COLUMBIA

District of Columbia Eligible Metropolitan Area
Consumer Status Neutral Needs Assessment,
2022-2023

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

TABLE OF CONTENTS

INTRODUCTION 3
Background 3
METHODS 4
Survey Development 5
Survey Administration 5
Data Analysis 6
RESULTS 6
Survey Response and Characteristics 6
Living Environment and Social Support 9
Work and Finance 10
Insurance and Care 11
HIV Status 12
Service Utilization 13
HIV Treatment and Prevention 14
Other Health Conditions and Substance Use 17
Transgender Services, Health Care and Access to Services 18
DISCUSSION 19
Recommendations 21
Limitations 22
CONCLUSION 23
ACKNOWLEDGMENTS 23

INTRODUCTION

The Washington, DC Regional Planning Commission on Health and HIV (COHAH), the HIV/AIDS, Hepatitis, STD and TB Administration (HAHSTA), and the George Washington University (GW) Milken Institute School of Public Health conducted a consumer status neutral needs assessment study to inform the comprehensive planning process for the Washington, DC Eligible Metropolitan Area (DC EMA). The study aims to understand the current care service needs and gaps of people living with HIV (PLWH) and those not living with HIV but may benefit from prevention services. Incorporating consumer viewpoints is an essential component of COHAH's annual priority-setting and resource allocation process.

Background

Over the past four decades, there has been a great deal of progress in science, policy, and programming to end the HIV/AIDS (human Immunodeficiency virus; acquired immunodeficiency syndrome) epidemic. From an epidemiological perspective, researchers and public health professionals have set a goal of reducing the number of new infections per year in the United States (U.S.) to less than 3,000 cases by 2030.[1] Accordingly, efforts to "end" the HIV/AIDS epidemic seek to make new HIV/AIDS infections so rare HIV will be eventually eradicated.[2]

HIV is a virus and acquired AIDS is the syndrome that results from long-term untreated infection with the virus. HIV transmission can occur through sexual contact; sharing of needles, syringes, or other drug injection equipment; or from mother to baby. There is still no vaccine or cure for HIV; however, the disease can be managed with antiretroviral therapy (ART) to achieve sustained HIV viral load suppression (VLS). Additionally, individuals who have a sexually transmitted disease (STD) are more likely to get HIV or transmit it to others. These STDs include chlamydia trachomatis, gonorrhea, syphilis, and herpes.

In recent years, the U.S. and the DC EMA have adopted a status neutral HIV prevention and care approach for engagement to accelerate progress toward ending the epidemic. The multidirectional continuum begins with an HIV test and proposes two pathways depending on the test results: 1) a prevention pathway for those testing negative and 2) a treatment pathway for those testing positive. Both pathways lead to a common final position where people are engaged in clinical care, either taking daily pre-exposure prophylaxis (PrEP) for those behaviorally vulnerable to HIV or achieving sustained VLS for PLWH. The status neutral continuum has the following implications: 1) emphasizes HIV testing as the gateway to prevention and care, 2) supports integrated prevention and care programs by recognizing the same approach used for achieving VLS treatment is necessary for HIV prevention, 3) highlights that approaches to serving people for prevention and treatment are indistinguishable, and 4) eliminates the stigma of HIV by placing consumer needs above their HIV status.[3]

The DC EMA includes the District of Columbia (DC), five counties in suburban Maryland, 11 counties and six independent cities in Northern Virginia, and two counties in West Virginia. While these jurisdictions share borders, they may prioritize HIV-related services based on their unique needs. Figure 1 is a visual depiction of the DC EMA.

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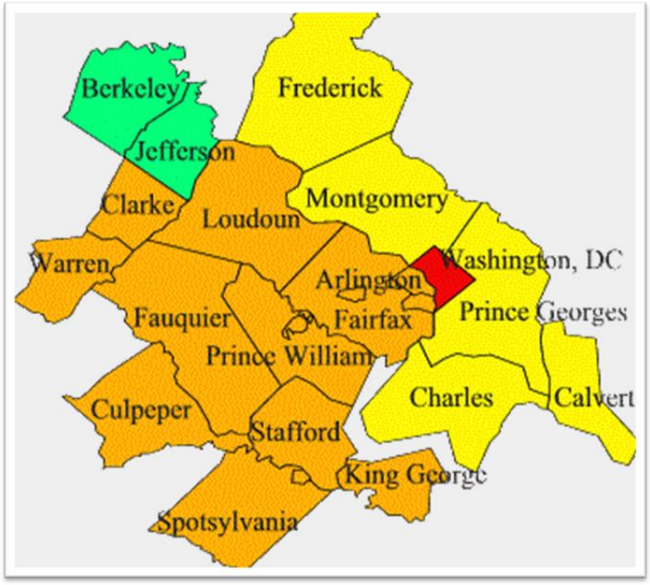
[1] Guilamo-Ramos V, Thimm-Kaiser M, Benzekri A. Is the USA on track to end the HIV epidemic?. Lancet HIV. 2023;10(8):e552-e556. doi:10.1016/S2352-3018(23)00142-X

[2] Eisinger RW, Fauci AS. Ending the HIV/AIDS Pandemic. Emerg Infect Dis. 2018;24(3):413-416. doi:10.3201/eid2403.171797

[3] Myers JE, Braunstein SL, Xia Q, et al. Redefining Prevention and Care: A Status-Neutral Approach to HIV. Open Forum Infect Dis. 2018;5(6):ofy097. Published 2018 May 2. doi:10.1093/ofid/ofy097

Figure 1. Map of the DC EMA, 2023



There are a total of 39,725 individuals living with HIV in the DC EMA. The District of Columbia is the epicenter of diagnosed HIV cases despite accounting for 10.8% of the DC EMA general population. In 2022, 17,829 (44.8%) diagnosed HIV cases were from DC; 13,536 (34.1%) from Maryland; 8,360 (21.0%) from Virginia; and 265 (<1%%) from West Virginia.[4] Across the region, the HIV epidemic disproportionally impacts people of color (78%), men (70.4%), and those over 40 years of age (77.0%) with the most common mode of transmission being sexual contact (78%). There are jurisdictional variations to these trends, Maryland had the highest proportion of transmission from heterosexual contact (46%).

The DC EMA is a unique region that spans multiple jurisdictions, each with its own specific HIV-related needs. The prevalence of HIV varies among these jurisdictions, with DC having the highest rates. Understanding the demographic breakdown and transmission patterns within the DC EMA is crucial for implementing targeted prevention and support initiatives to combat the spread of HIV and address the unique challenges faced by each jurisdiction.

The aim of this study is to 1) understand the current service utilization and barriers to receiving and remaining engaged in comprehensive care; and 2) assess the demographic, economic, and social characteristics that may affect access to medical care and support services for PLWH and people behaviorally vulnerable to HIV. This approach aligns with the status neutral continuum and the integration of prevention and care strategic planning of the COHAH. The analysis will inform the COHAH's priority setting and resource allocation process to improve the health and well-being of people and communities in the DC EMA.

METHODS

This cross-sectional survey study was administered in two phases from July 6, 2022 to June 30, 2023, in Spanish and English. A convenience sample of DC EMA consumers was invited to participate using a

[4] The number of individuals diagnosed with HIV residing in West Virginia is only available through 2019 due to limited staffing availability.

mixed-mode approach. The DC Department of Health (DC Health) Institutional Review Board for the Public Health approved the study on April 22, 2022, IRBPH# 2022-4.

Survey Development

Between March 2021 and June 2022, the COHAH's Research and Evaluation Committee (REC) and researchers from GW developed a 68-question consumer status neutral needs assessment survey (hereafter referred to as *survey*)—the first status neutral survey for the DC EMA. 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) to build an organizing framework that defines the current and past topics and questions to be addressed.

These questions (and the consumer response options) were categorized by topic and cross-walked. The REC selected the survey topics and questions for inclusion, and, where applicable, modified or wrote new questions to collect data of interest to the REC. REC members reviewed the questions, question order, and skip logic of the survey in late spring through early summer of 2021. GW built the REC-approved survey in the DC Health REDCap (Research Electronic Data Capture), a secure online survey application. REC members tested the survey length, usability, and comprehensibility. The anonymous survey was composed of questions across 11 domains:

- Demographic information
- HIV status
- Service utilization (Ryan White)
- Living environment
- Work and finances
- Insurance and care
- HIV treatment or prevention
- Other health conditions
- Substance use
- Transgender services
- Healthcare access and interactions

The survey included a combination of Likert scale, multiple choice (both mutually exclusive and not mutually exclusive), dichotomous, and short open-ended questions. The survey also included questions on how the COVID-19 pandemic impacted many of these domains.

Survey Administration

The study team administered the survey in two phases through multiple modes, inviting responses to a paper survey or an online survey. During summer 2021, REDCap experienced a system failure after the creation of the online survey that could not be recovered, and an alternative survey platform was not immediately accessible. The paper version of the survey was therefore fielded at two DC Ryan White (RW) HIV/AIDS Program provider clinics from July 6, 2022 to November 9, 2022 by four student investigators to facilitate data quality and survey completion.

In tandem, researchers rebuilt the survey in DC Health Salesforce, a customer relationship management software, in July 2022 as the platform was the only alternative available. The team encountered technical challenges with Salesforce for several months; the platform was actively working by

September 2022. All RW providers were encouraged to promote the survey to their consumers using a flyer with a quick response (QR) code for self-administration as well.

In February 2023, all RW providers were encouraged to continue promoting the survey to increase the survey response rate and to achieve a representative sample of the DC EMA. A secondary group of four student investigators facilitated survey administration using the paper and online Salesforce survey at RW provider clinics in Maryland (two clinic locations) and Virginia (one clinic location), from April 26, 2023 to June 30, 2023. Researchers also recruited consumer participants at the Pride in the Plaza festival in Silver Spring, Maryland on June 25, 2023. The primary aim of the secondary phase was to gather a representative sample across the DC EMA.

Across both phases, the student investigators entered the paper responses into Salesforce. The survey took 15-20 minutes to complete, depending on skip logic used for the survey response (e.g., consumers who were HIV-positive answered questions related to HIV treatment and HIV-negative consumers answered questions related to HIV prevention). Verbal and written informed consent were obtained from the participants and no personal identifying information (e.g., name, email, address, or phone number) was collected; consumers remained entirely anonymous. All respondents were 18 years of age or older, HIV status neutral (both negative and positive), and residing in the DC EMA. A modest financial incentive ($15 Walmart gift card) was provided for participation.

Data Analysis

We defined survey completion as returned surveys with respondent consent and HIV status. One of us (J.O.) conducted the analysis using $\chi 2$ and Fisher exact tests to compare the characteristics of survey respondents and DC EMA jurisdictions, assess the association between survey responses and respondents' characteristics, and survey responses and jurisdictions. Statistical significance was set at a threshold of $P= 0.05$. The survey respondents' characteristics analyzed included age, racial and ethnic minority group, country of birth, gender, educational attainment, sexual orientation, and place of residence. Descriptive analysis was conducted using IBM SPSS Statistics, version 25 (IBM Corp).

RESULTS[5]

Survey Response and Characteristics

A total of 429 surveys were submitted with varying levels of completion from the District of Columbia (246 of 425 [57.9%]); Maryland (99 of 425 [23.3%]); Virginia (67 of 425 [15.8%]); West Virginia (3 of 425 [0.7%]); (10 of 425 [2.3%]) Other; and 4 respondents did not identify their place of residence. A priori estimates of the number of surveys needed were 212 (51.5%) for the District of Columbia, 131 (31.7%) for Maryland, 64 (15.6%) for Virginia, and 5 (1.2%) for West Virginia. The survey targets were reached and/or exceeded for the District of Columbia and Virginia.

The majority of those who participated were 25-34 years of age (126 of 407 [31.0%]), male (216 of 425 [50.8%]), Black not Hispanic (246 of 417 [59.0%]), heterosexual (214 of 422 [50.7%]), US-born (314 of 417 [75.3%]), and high school graduates (119 of 420 [28.3%]). Table 1 shows the representation of the demographic characteristics of the survey respondents across the different jurisdictions of the DC EMA.

[5] Statistically significant results with $p < .05$ are indicated with a single dagger (†); $p < .001$ are indicated with a double dagger (‡). In cases where the small number of responses (referred to statistically as "small cells") prevented analysis from measuring the level of statistical significance in jurisdictional differences, results are marked with a section symbol (§)

Table 1. Characteristics of Consumer Respondents in the Needs Assessment, 2022-2023[a]

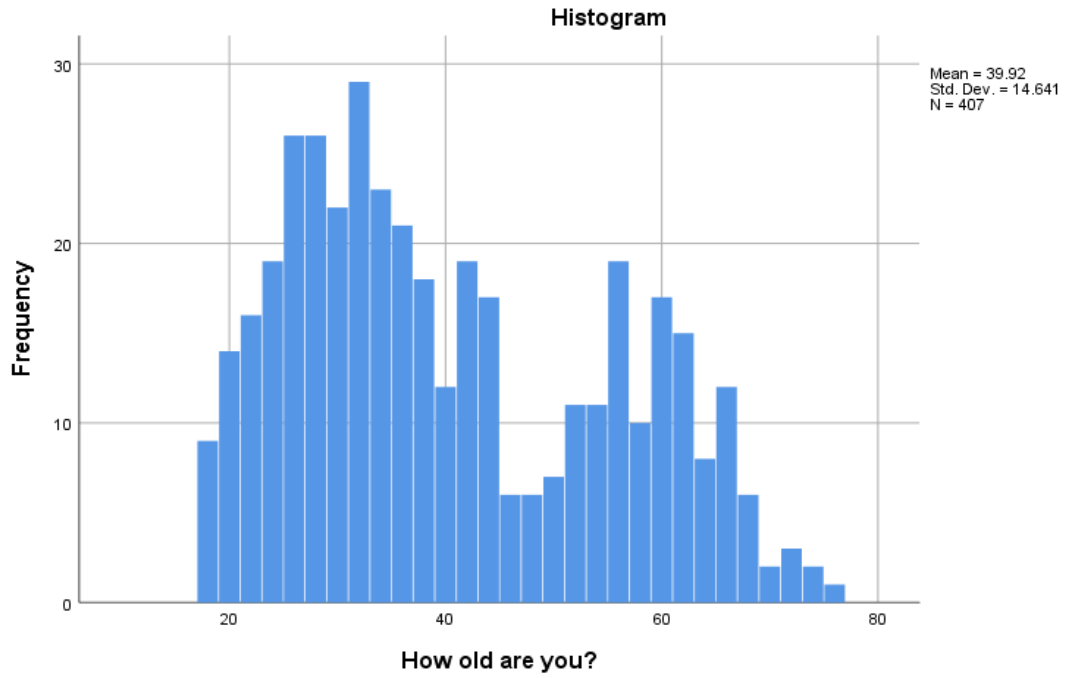
Characteristics	District of Columbia	Maryland	Virginia	West Virginia
Age[d]	**No. (%)**	**No. (%)**	**No. (%)**	**No. (%)**
18-24	33 (13.7)	10 (10.6)	12 (20.7)	0 (0)
25-34	71 (29.5)	26 (27.7)	26 (44.8)	0 (0)
35-44	51 (21.2)	27 (28.7)	4 (6.9)	3 (100.0)
45-54	28 (11.6)	7 (7.4)	5 (8.6)	0 (0)
55-64	39 (16.2)	19 (20.2)	10 (17.2)	0 (0)
65+	19 (7.9)	5 (5.3)	1 (1.7)	0 (0)
Race and ethnicity[e]				
Asian, not Hispanic	6 (2.5)	0 (0)	1 (1.5)	0 (0)
Black, not Hispanic	159 (66.0)	63 (65.6)	16 (24.6)	1 (33.3)
Latino/a or Hispanic	14 (5.8)	17 (17.7)	31 (47.7)	0 (0)
White, not Hispanic	28 (11.6)	6 (6.3)	5 (7.7)	1 (33.3)
Middle Eastern/North African, not Hispanic	0 (0)	0 (0)	1 (1.5)	0 (0)
Two or more races	27 (11.2)	9 (9.4)	6 (9.2)	1 (33.3)
Other	3 (1.2)	0 (0)	2 (3.1)	0 (0)
Prefer not to answer	4 (1.7)	1 (1.0)	3 (4.6)	0 (0)
Gender[e]				
Female	109 (44.3)	47 (48.0)	17 (25.8)	2 (66.7)
Male	121 (49.2)	47 (48.0)	41 (62.1)	1 (33.3)
Transgender	9 (3.7)	1 (1.0)	6 (9.1)	0 (0)
Non-Binary	6 (2.4)	2 (2.0)	0 (0)	0 (0)
Prefer not to answer	1 (0.4)	1 (1.0)	2 (3.0)	0 (0)
Education[e]				
8th grade	1 (0.4)	1 (1.0)	2 (3.2)	0 (0)
Some high school	16 (6.5)	3 (3.1)	10 (15.9)	0 (0)
High school graduate/GED	79 (32.2)	22 (22.4)	13 (20.6)	1 (50.0)
Technical/vocational school	15 (6.1)	4 (4.1)	1 (1.6)	0 (0)
Some college	50 (20.4)	22 (22.4)	9 (14.3)	0 (0)
Associate's degree	12 (4.9)	9 (9.2)	5 (7.9)	0 (0)
Bachelor's degree	35 (14.3)	16 (16.3)	9 (14.3)	1 (50.0)
Some graduate school	2 (0.8)	5 (5.1)	1 (1.6)	0 (0)
Graduate degree	32 (13.1)	9 (9.2)	9 (14.3)	0 (0)
Other	0 (0)	4 (4.1)	1 (1.6)	0 (0)
Prefer not to answer	3 (1.8)	3 (3.1)	3 (4.8)	0 (0)
Sexual orientation[e]				
Heterosexual	130 (53.3)	46 (46.9)	32 (48.5)	1 (50.0)
Gay/Lesbian/Same Gender Lover	75 (30.7)	31 (31.6)	23 (34.8)	0 (0)
Bisexual	23 (9.4)	14 (14.3)	8 (12.1)	0 (0)
Queer	7 (2.9)	0 (0)	0 (0)	1 (50.0)

Pansexual[b]	0 (0)	3 (3.1)	0 (0)	0 (0)
Not sure/Questioning	3 (1.2)	2 (2.0)	0 (0)	0 (0)
Other	1 (0.4)	1 (1.0)	0 (0)	0 (0)
Prefer not to answer	5 (2.0)	1 (1.0)	3 (4.5)	0 (0)
Income[e]				
$499 or less	33 (14.9)	13 (14.1)	19 (31.1)	0 (0)
$500-$999	33 (14.9)	7 (7.6)	5 (8.2)	1 (33.3)
$1,000-$1,999	39 (17.6)	13 (14.1)	8 (13.1)	1 (33.3)
$2,000-$2,999	23 (10.4)	11 (12.0)	4 (6.6)	0 (0)
$3,000-$3,999	19 (8.6)	14 (15.2)	7 (11.5)	1 (33.3)
$4,000 or more	44 (19.8)	18 (19.6)	8 (13.1)	0 (0)
Don't know	11 (5.0)	7 (7.6)	7 (11.5)	0 (0.0)
Prefer not to answer	20 (9.0)	9 (9.8)	3 (4.9)	0 (0)

[a]Excludes "Other" as place of resident selection due to low cell responses and specificity.
[b]Includes "Pansexual" extracted from the "Other" category.
[c] $p < .05$
[d] $p < .001$
[e] Small cell responses precluded statistical analysis by jurisdiction.

The survey respondents ranged from 18-75 years of age, with a median age of 36 years. The age distribution is bimodal with two peaks—a major mode (value that occurs more frequently) between 20-40 years and a minor mode between 50-70 years. Figure 1. shows the bimodal distribution of respondents by age.

Figure 1. Distribution of Consumer Respondents in the Needs Assessment by Age, 2022-2023[a]



[a]Excludes "Prefer not to answer" responses.

Of the 415 responses, the District of Columbia (159 of 241 [66%]) and Maryland (63 of 96 [65.6%]) had a higher proportion of Black, not Hispanic respondents, while Virginia (31 of 65 [47.7%]) had the highest proportion of Latino/a or Hispanic respondents.[§] The District of Columbia had the most respondents who identified as two or more races (27 of 45 [60%]) than the other jurisdictions.[§] The gender distribution is consistent across jurisdictions with a higher proportion of respondents who identified as transgender (9 of 16 [56.3%]) and non-binary (6 of 8 [75%]) in the District of Columbia compared with responses from other jurisdictions.[§] Educational attainment was reported at varying levels among the 420 responses, with 28.3% (119) of respondents being high school graduates, 19.8% (83) having some college, and 14.8% (62) obtaining a bachelor's degree.[§] While most respondents reported being US-born in the District of Columbia (214 of 243 [88.1%]) and Maryland (65 of 95 [68.4%]), Virginia (40 of 64 [62.5%]) had the highest proportion of respondents who were not US-born.[‡]

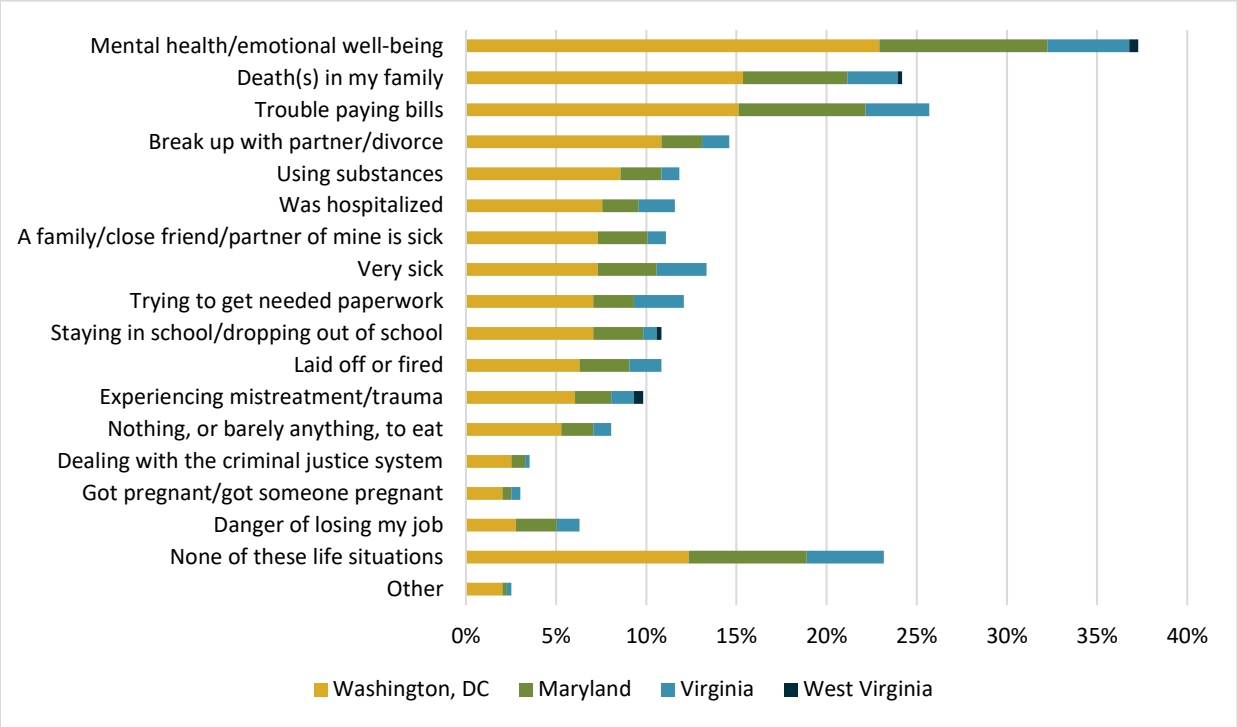
Living Environment and Social Support

Most respondents (241 of 404 [59.8%]) reported living in a house, apartment, or condo which they rented and approximately 1 out of every 5 respondents (79 of 404 [19.6%]) owned their homes. Nearly 8% (31 of 404) reported living in a house, apartment, or condo they got through federal housing assistance. Housing instability was reported to be a challenge, with 11.1% (45 of 404) of respondents living temporarily with friends or family, in a homeless shelter, anywhere outside, and in a motel/hotel. While responses were consistent across jurisdictions, respondents from the District of Columbia were less likely to live in a house, apartment, or condo that they owned (35 of 231 [15.2%]) compared with other jurisdictions.[§] Nearly all respondents (347 of 401 [86.5%]) have been in the living situation for more than three months.

Most respondents (328 of 403 [81.4%]) reported they had never been incarcerated. Of the 63 respondents who identified that they had been incarcerated, over half (42 [66.7%]) had been incarcerated more than five years ago.

While over half of respondents (265 of 406 [65.3%]) did not receive any late notices for unpaid utility in the past three months, over a quarter (104 of 400 [26%]) reported having trouble paying their bills. Respondents frequently cited life situations including having a death in the family (96 of 400 [24%]) and mental health issues (151 of 400 [37.8%]) as challenges they faced over the last 12 months. Figure 2. Displays the challenges respondents experienced over the past 12 months by the percentage of the total number of observations.

Figure 2. Life Situations of Respondents in the Past 12 Months, 2022-2023



While responses were consistent across jurisdictions, Virginia respondents (11 of 63 [17.5%]) were less likely to have had a death in the family, and West Virginia respondents (2 of 3 [66.7%]) were more likely to have suffered from mental health issues over the last 12 months.[§] There were no major changes to the challenges of the respondents' life experiences during the COVID-19 pandemic. Respondents from the District of Columbia (48 of 201 [23.9%]) were more likely to have trouble paying their bills during the COVID-19 pandemic than the other jurisdictions.[§]

Of the 394 survey responses, most respondents (354 [90.1%]) reported having a social support system in place. These included the ability to rely on family (282 [71.6%]), friends (242 [61.4%]), service providers (84 [21.3%]), support groups (58 [14.7%]), and spiritual advisors (57 [14.5%]). However, nearly 10% (39) of respondents disclosed they lacked a support system. Respondents from the District of Columbia (55 of 224 [24.6%]) were more likely to rely on service providers for support compared to the other jurisdictions; there were no responses from West Virginia for service providers.[§]

Work and Finance

Over half of respondents reported being employed full-time (190 of 391 [48.6%]) or part-time (49 of 391 [12.5%]), with most respondents being employed in the District of Columbia (162 of 352 [46%]).[§] Nearly 13% (49 of 391) of respondents reported being disabled and 19.6% (69 of 352) of respondents reported being unemployed.[6] A large proportion of respondents who live in the District of Columbia also work in DC (126 of 199 [63.3%]).[§]

[6] Categories for current work status were not mutually exclusive. For instance, a respondent could respond they were both employed full-time and employed part-time.

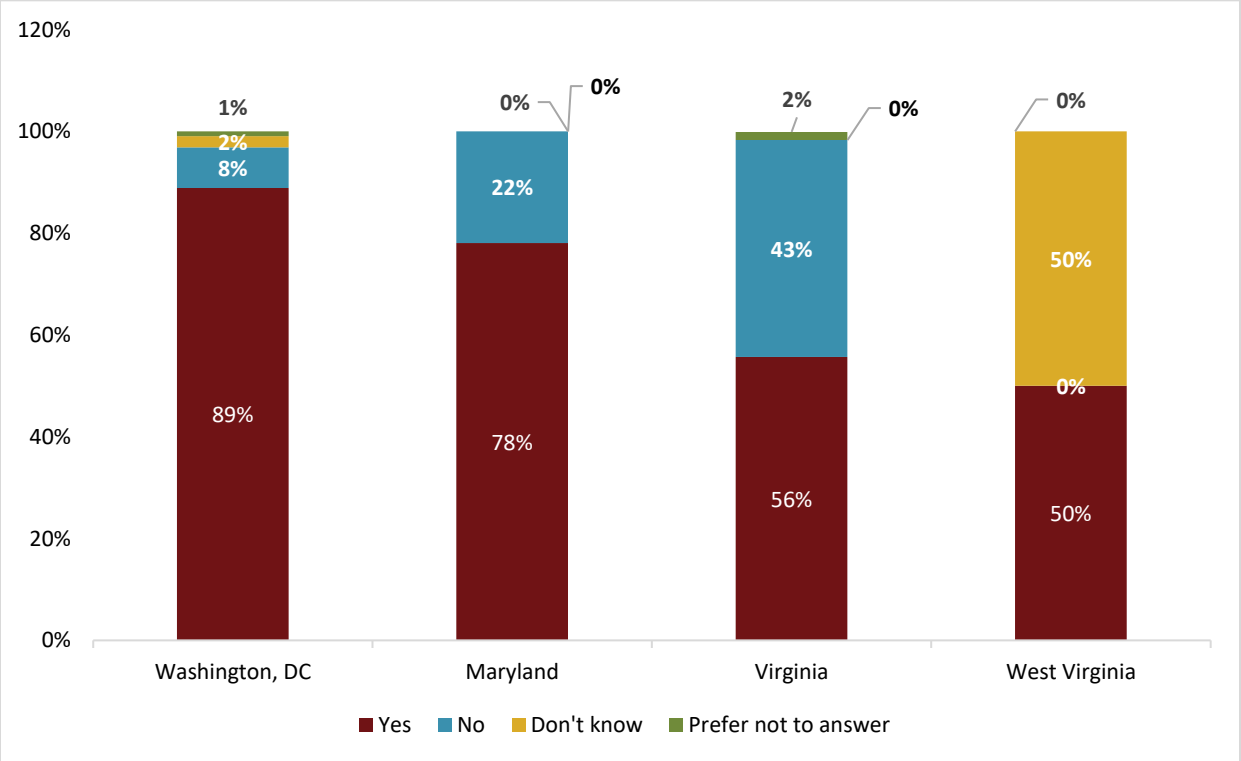
When questioned about finances, most respondents reported their primary source of income being work (243 of 399 [60.9%]). In contrast, 12.3% (49 of 399) of respondents reported having no income source, with more respondents from Virginia reporting no income source (12 of 61 [19.7%]) compared with other jurisdictions.§ Two of three respondents (66.7%) from West Virginia relied on Supplemental Security Income (SSI) as their primary source of income.

Respondents also reported varying levels of income, with 18% (70 of 389) of respondents earning $4,000 or more, 16.7% (65 of 389) earning $499 or less, and 16.5% (64 of 389) earning $1,000 to $1,999 in the last 30 days. Virginia had a higher proportion (19 of 61 [31.1%]) of respondents who reported earning $499 or less and a lower proportion (8 of 61 [13.1%]) earning $4,000 or more. § There were mixed responses on the impact of COVID-19 and income, with 42.6% (166 of 390) reporting their income had not been impacted and 31.3% (122 of 390) reporting an income decrease due to the pandemic. Virginia respondents were more likely (27 of 59 [45.8%]) to report an income decrease due to COVID-19. § When questioned about how their income had been impacted, most respondents reported a decrease in income due to job loss or decreased working hours, while some cited a decrease in food stamps.

Insurance and Care

The majority of respondents reported having health insurance coverage (321 of 396 [81.1%]), with 88.9% 201 of 226) from the District of Columbia, 78.1% (75 of 96) from Maryland, and 55.7% (34 of 61) from Virginia. § Virginia had a higher proportion (26 of 61 [42.6%]) of respondents who did not have insurance.§ Figure 3. shows respondents' health insurance coverage by jurisdiction.

Figure 3. Health Insurance Coverage by Jurisdiction, 2022-2023



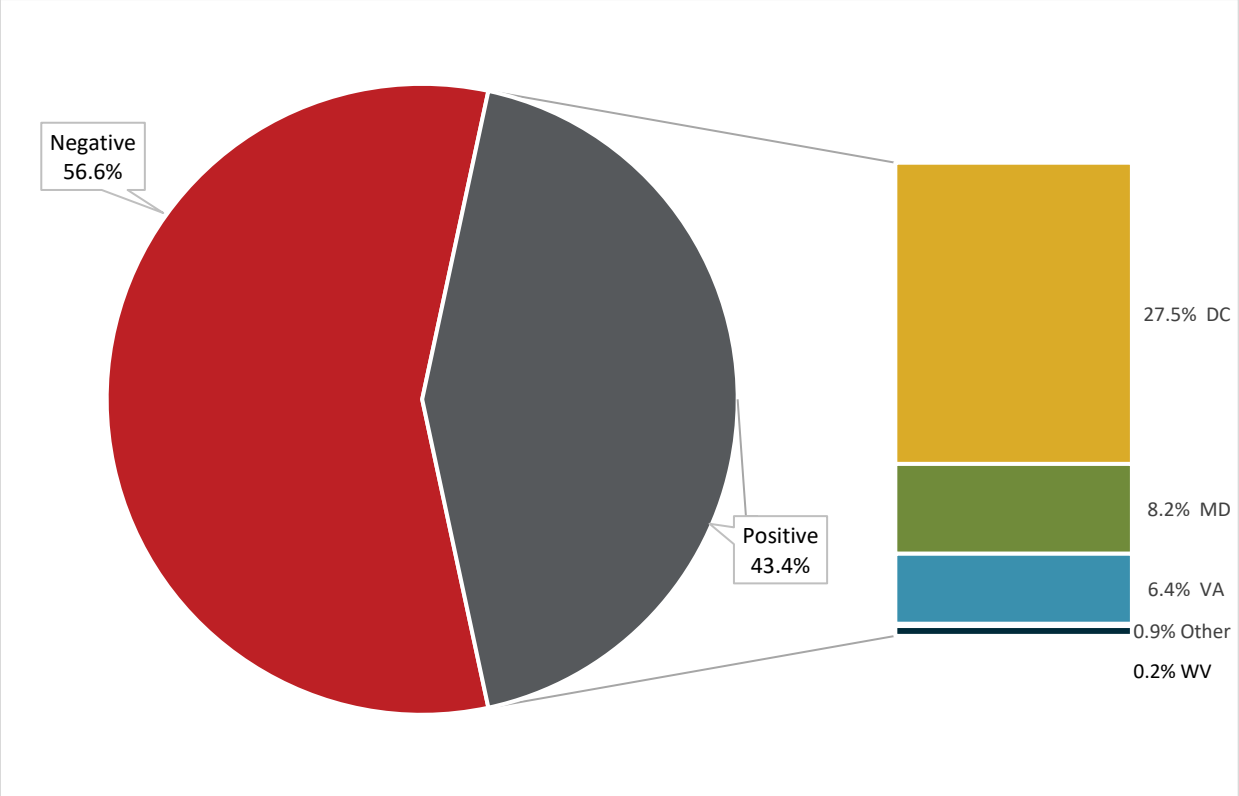
About half of respondents (143 of 313 [45.7%]) are insured by Medicaid, while a third (108 of 313 [34.5%]) are insured by private, employer-sponsored coverage. A higher percentage of respondents

from the District of Columbia are covered under Medicaid (100 of 197 [50.8%])[§] than other jurisdictions likely due to its generous Medicaid eligibility threshold. Maryland had a higher proportion of respondents (31 of 71 [43.7%]) who had private, employer sponsored coverage than other jurisdictions.[§] Two out of three consumers felt that their insurance coverage was affordable (214 of 316 [67.7%]).

HIV Status

A nearly equal proportion of respondents reported being HIV negative (243 of 429 [56.6%]) or positive (186 of 429 [43.4%]). While 52.4% (129 of 246) of respondents from the District of Columbia stated they were HIV negative, DC had a higher proportion of HIV positive respondents (117 of 184 [63.6%]) than Maryland (35 of 184 [19.0%]), Virginia (27 of 184 [14.7%]), West Virginia (1 of 3 [0.5%]), and those living outside the DC EMA (4 of 184 [2.1%]).[§] HIV disproportionately affect Black, not Hispanic in the District of Columbia (85 of 113 [75.2%])[†] and Maryland (26 of 34 [76.5%]), and Latino/a or Hispanic in Virginia (14 of 27 [51.9%]). Figure 4. shows the distribution of HIV status of respondents and the jurisdictional proportions for HIV-positive respondents based on the percentage of the total.

Figure 4. Distribution of Respondents' HIV Status, 2022-2023[a]



[a]DC represents Washington, DC; MD represents Maryland; VA represents Virginia; Other represents respondents who reside outside of the DC EMA; WV represents West Virginia

Sixty-two of 182 respondents (34.1%) have lived with HIV for more than 20 years, 49 of 182 respondents (26.9%) for 11 to 20 years, 34 of 182 (18.7%) for 6-10 years, and 25 of 182 (13.7%) for 1-5 years. There was some variability at the jurisdictional level, with 37.1% (13 of 35) of Maryland respondents and 37.6% (44 of 117) of District of Columbia respondents reporting living with HIV for 11-20 years, and 36% (9 of 25) of Virginia respondents reporting living with HIV for more than 20 years.[§] Black, not Hispanic represented the highest proportion of those living 11-20 years (38 of 47 [80.9%]) and more than 20

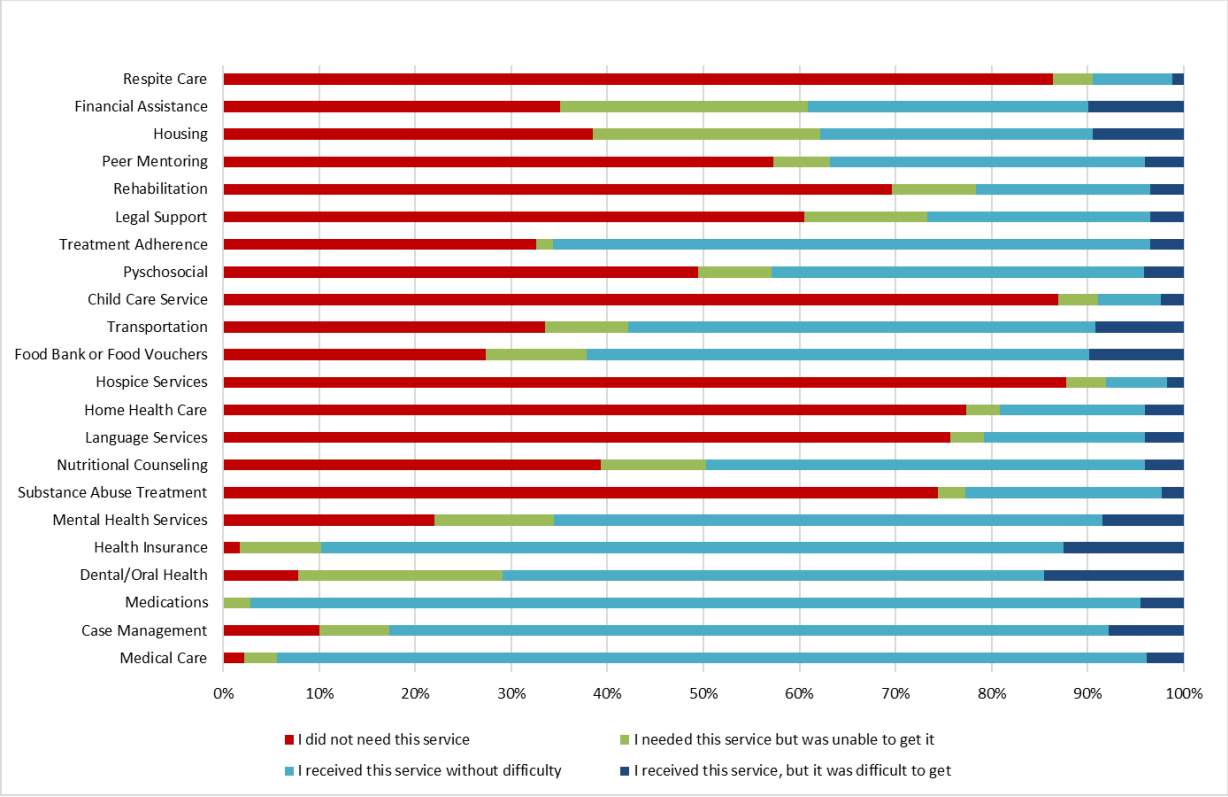
years (39 of 61 [63.9%]) with HIV.[§] Approximately 73% of respondents who were 65 years and over (16 of 22) and nearly half of 55-64 year olds (23 of 48 [47.9%]) have been living with HIV for more than 20 years.

People living with HIV between the ages 55 and 64 were the largest age group of respondents living with HIV (48 of 170 [28.2%]) followed by those ages 35 to 44 (33 of 170 [19.4%], ages 45 to 54 (30 of 170 [17.6%]), 25 to 34 (28 of 170 [16.5%]), 65 and older (22 of 170 [12.9%]), and ages 18-24 (9 of 170 [5.3%]). People living with HIV for longer tended to be older, however, there were still 10 respondents between the ages of 18 and 34 who reported living with HIV for 11 to 20+ years.

Service Utilization

Respondents were asked to rank the ease with which they were able to receive care across 22 service areas. Figure 5. shows the met and unmet needs of respondents.

Figure 5. Met and Unmet Needs, 2022-2023

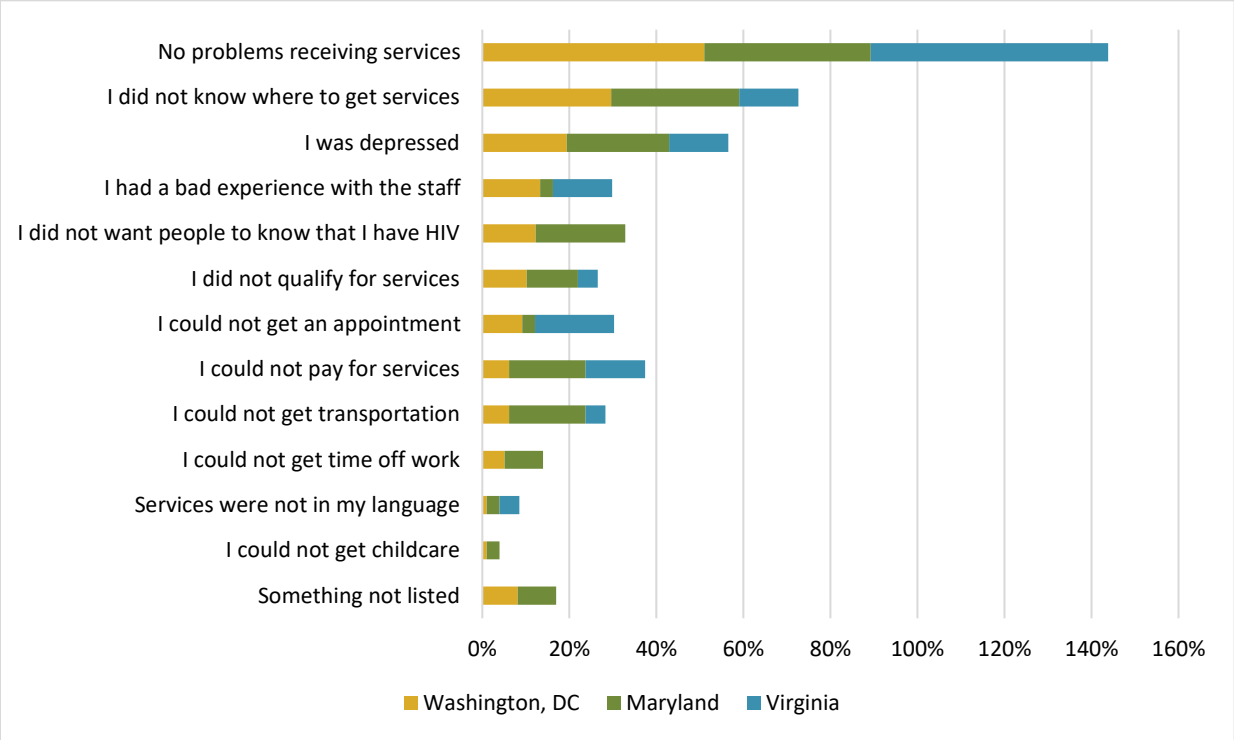


Respondents reported receiving medication services (165 of 178 [92.7%]), health insurance (136 of 176 [77.3%]), case management (134 of 179 [74.9%]), and medical care (163 of 180 [90.6%]) without difficulty. Unmet needs were reported to be low with some services received, but difficult to get, including dental/oral health services (26 of 179 [14.5%]), health insurance (22 of 176 [12.5%]), food bank vouchers (17 of 172 [9.9%]), and transportation services (16 of 173 [9.2%]). Financial assistance (44 of 171 [25.7%]), housing (40 of 169 [23.7%), and dental/oral health services (38 of 179 [21.2%]) were needed, but not received by respondents. Maryland respondents were more likely to report needing financial assistance (15 of 34 [44.1%])[†] and housing (11 of 33 [33.3%]) but were unable to get the

services. Respondents from Virginia (8 of 26 [30.8%]) were more likely to need dental/oral health services but were unable to get them than other jurisdictions.[†] Respondents specifically listed grief counseling and wellness services as service areas that they needed but were unable to get. Respite care (146 of 169 [86.4%]), rehabilitation (119 of 171 [69.6%]), childcare (146 of 168 [86.9%]), hospice (151 of 172 [87.8%]), home health care (133 of 172 [77.3%]), language services (131 of 173 [75.7%]), and substance abuse services (131 of 176 [74.4%]) were identified as not needed by respondents.

When HIV-positive respondents across the DC EMA were asked about the reasons why they did not access a specific service related to HIV, 27.7% (44 of 159) reported it was because they did not know where to obtain the service they required. Virginia had the lowest proportion of respondents (3 of 22 [13.6%]) who did not know where to get services. Approximately 12.6% (20 of 159) of respondents did not want people to know about their HIV status, with Maryland respondents more likely to report not wanting other people to know (7 of 34 [20.6%]).[§] Mental health played a role in service utilization as well, with 19.5% (31 of 159) respondents stating that their depression prevented them from accessing the services. Figure 6. summarizes the challenges causing people to not have access to services by jurisdiction.

Figure 6. Challenges Receiving Services by Jurisdiction, 2022-2023[a]



[a]No responses were received from West Virginia

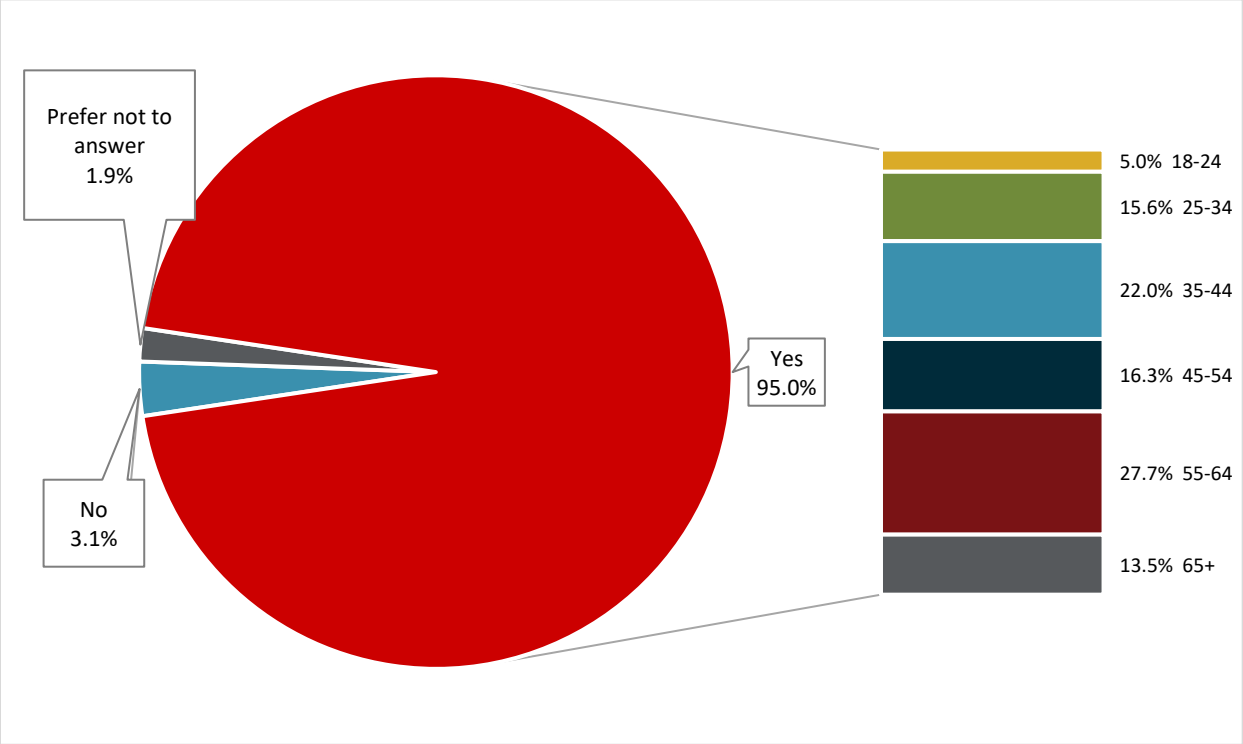
HIV Treatment and Prevention

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 (144 of 161 [89.4%]), seen their case manager (94 of 158 [59.5%]), and were informed of their viral load count (141 of 160 [88.1%]). Respondents have also been taking ART (152 of 160 [95.0%]) and are virally undetectable (130 of 162 [80.2%]). Three out of every four HIV-positive respondents reported

taking their ART medication all of the time over the last 30 days (120 of 159 [75.5%]) and another 15.1% (24 of 159) reported taking their ART medication most of the time over the same period. Among the consumers who have not taken ART consistently in the last 30 days, missed dosage was due to forgetfulness (41 of 82 [50.0%]).

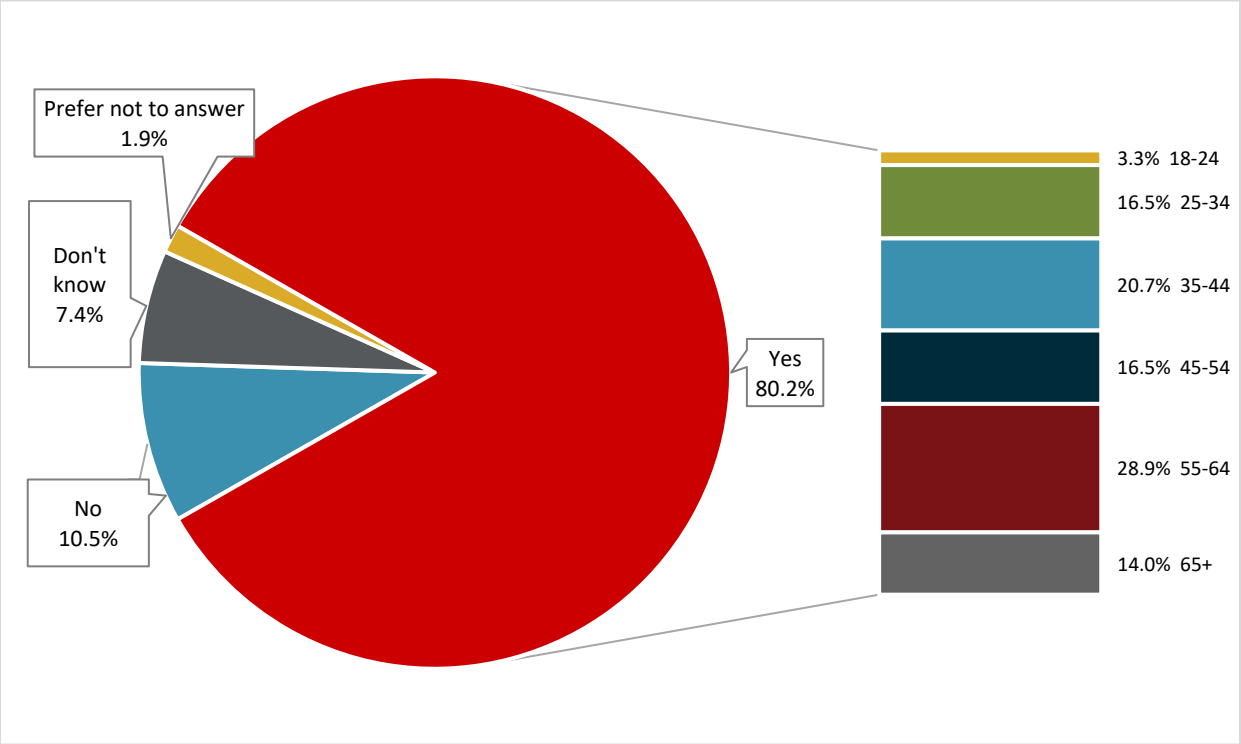
ART adherence across jurisdictions by race and/or ethnicity was relatively consistent with 81.3% (26 of 32) of Black, not Hispanic respondents currently taking ART in Maryland[§] and 79.6% (74 of 93) of Black, not Hispanic respondents in the District of Columbia taking ART[†]. Of the 21 Latino/a or Hispanic respondents currently taking ART, 61.9% (13) were from Virginia. Figure 7. shows the breakdown of respondents taking ART by age group.

Figure 7. Respondents' Taking ART by Age Group, 2022-2023



A similar pattern for nondetectable levels of HIV viral load was observed across jurisdictions as well. Nearly 83% (24 of 29) of Black, not Hispanic respondents in Maryland reported being virally undetectable and 77.2% (61 of 79) of Black, not Hispanic respondents in the District of Columbia reported being virally undetectable. Of the 18 Latino/a or Hispanic who are virally undetectable, 61.1% (11) were from Virginia. Figure 8. shows the breakdown of respondents who are virally undetectable by age group.

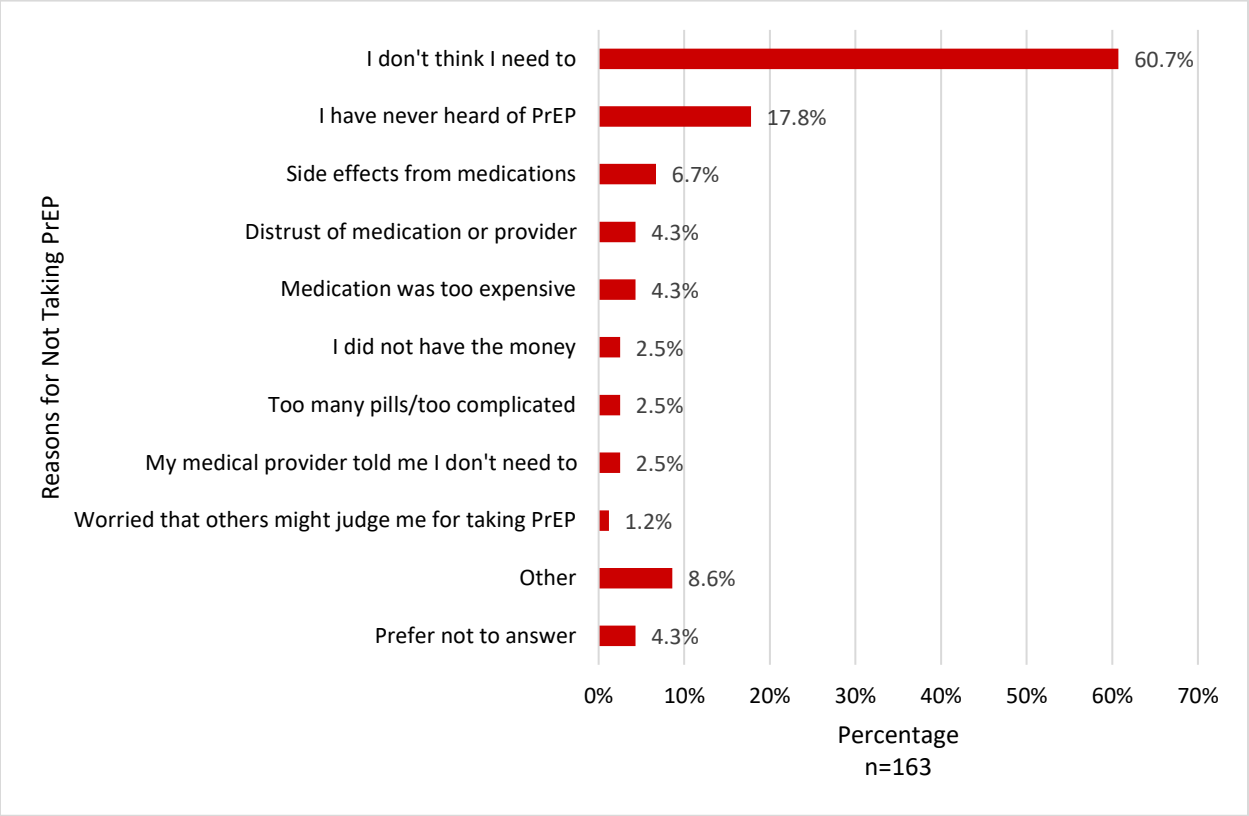
Figure 8. Virally Undetectable by Age Group, 2022-2023



For HIV-negative respondents, 59.4% (133 of 224) have seen their medical provider or doctor for HIV prevention services within the last six months and 17% (38 of 224) have never seen a medical provider for HIV prevention services. Over half (13 of 20 [65.0%]) of respondents felt that they were not at risk of getting infected. One out of every 5 HIV-negative respondents (43 of 225 [19.1%]) currently take pre-exposure prophylaxis (PrEP) medication. Of those who reported taking PrEP, 69.8% (30 of 43) reported taking their PrEP medication all of the time and 23.3% (10 of 43) reported taking their PrEP medication most of the time. The highest proportion of respondents taking PrEP were from the 25-34 age group across jurisdictions. An equal proportion of Black, not Hispanic, and White, not Hispanic in the District of Columbia reported they are currently taking PrEP (11 of 31 [35.5%]).[†] Black, not Hispanic had the highest proportion of people who are not currently taking PrEP in the District of Columbia (52/83 [62.7%])[†] and Maryland (29 of 42 [69%]). All respondents 100% (37 of 37) from Virginia reported not taking PrEP.[§]

Among the reasons that consumers do not use PrEP, 60.7% (99 of 163) reported that they do not believe they need to, 17.8% (29 of 163) have never heard of PrEP and 6.7% (11 of 163) were concerned about side effects from the medication. Figure 9. displays respondents' reasons for not taking PrEP.

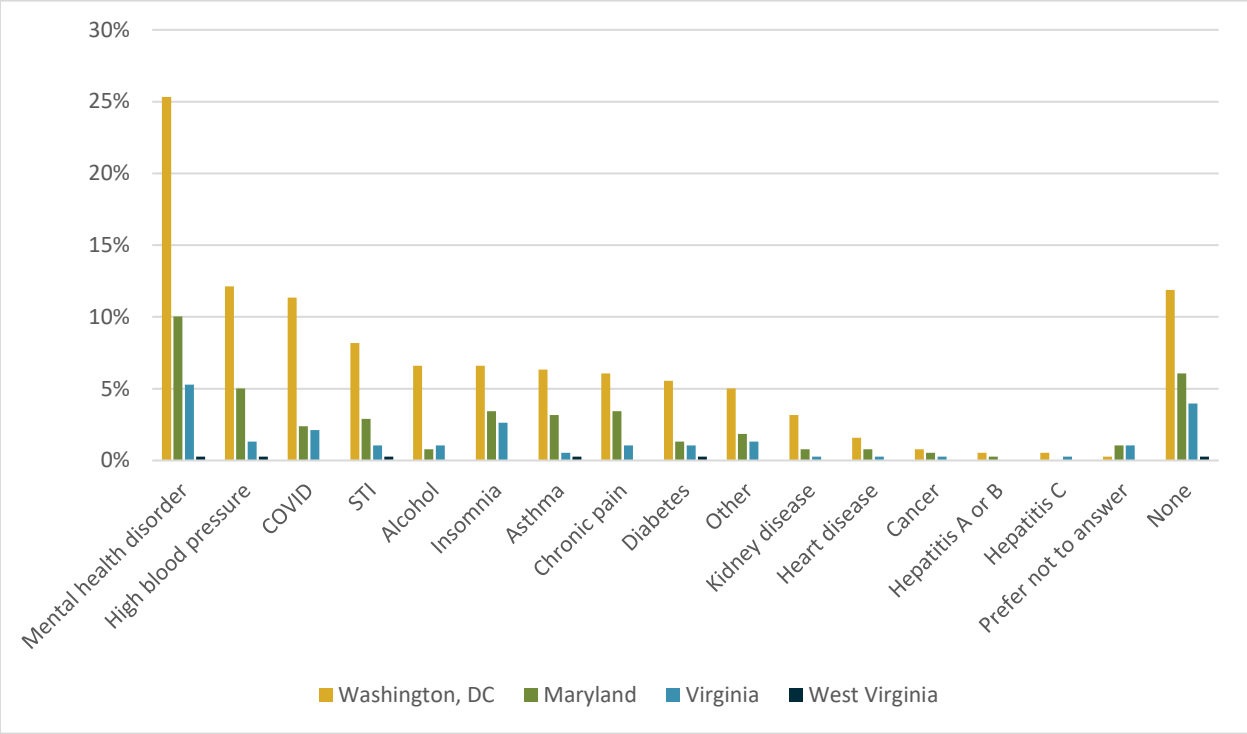
Figure 9. Reasons for Not Taking PrEP, 2022-2023



Other Health Conditions and Substance Use

Among the responses received, many of the respondents experienced several health conditions over the past 12 months of taking the survey. Of these health conditions, the most common condition participants reported was mental health disorder (157 of 381 [41.2%]). Over 19% (73 of 381) indicated high blood pressure and nearly 16% indicated COVID-19 as other areas of struggle over the past 12 months. When prompted, respondents entered monkeypox, surgery, and broken ligaments as other conditions. While the distributions were consistent across jurisdictions, the respondents from the District of Columbia were more likely to have been dealing with COVID-19 over the past 12 months.[§] Figure 10. displays the health conditions by jurisdiction.

Figure 10. Other Health Conditions by Jurisdiction, 2022-2023[a]



[a]STI refers to sexually transmitted infections

In the past 12 months, 59.3% (211 of 356) of respondents received care and/or treatment for the selected health conditions. Of these health conditions, the primary conditions that were cared for and /or treated were mental health disorders (104 of 204 [51.0%]), high blood pressure (50 of 204 [24.5%]), and sexually transmitted infections (41 of 204 [20.1%]). Respondents indicated similar other conditions not listed when prompted, including Monkeypox. Across the jurisdictions, Maryland respondents were more likely to have been cared for and/or treated for a mental health disorder (31 of 46 [67.4%]) and asthma (11 of 46 [23.9%]), and the District of Columbia respondents were more likely to have been cared for and/or treated for COVID-19 (27 of 125 [21.6%]).[§]

In addition to mental health issues, 31.9% (122 of 383) of respondents reported using tobacco or nicotine-based products and 32.3% (120 of 372) reported using Marijuana or hashish. Alcohol consumption was commonly reported at a frequency of 2-4 times a month (94 of 381 [24.7%]) or monthly or less (91 of 381 [23.9%]). Nearly 1 of 5 respondents (70 of 383 [18.3%]) reported having a substance use addiction and had received treatment (69 of 381 [18.1%]).

Transgender Services, Health Care and Access to Services

Transgender services were not widely used by respondents with 3.2% (12 of 373) indicating seeking gender-affirming care, 66.7% (8 of 12) successfully accessing care, and 75% (6 of 8) currently taking hormones. Responses to accessing care and taking hormones survey questions were from respondents in the District of Columbia and Virginia.

Respondents were asked about their usual source of health care and an indication of whether their usual place met their needs. For annual check-ups and wellness visits, consumers primarily go to a private medical provider's office (131 of 372 [35.2%]) and community health centers (95 of 372 [25.5%]).

Respondents predominately visited facilities located in the District of Columbia (193 of 330 [58.5%]) and Maryland (77 of 330 [23.3%]). The majority of respondents (288 of 330 [87.3%]) were satisfied with the services they received from their usual place of care for annual check-ups and wellness visits. When sick, consumers sought care from a private medical provider's office (89 of 377 [23.6%]), a community health center (64 of 377 [17%]), or an urgent care facility (62 of 377 [16.4%]). Respondents seeking medical care when sick primarily visited facilities in the District of Columbia (180 of 327 [55%]) and Maryland (87 of 327 [26.6%]). The majority of respondents (286 of 323 [88.5%]) were satisfied with the services they received for sick care and did not experience any challenges when they wanted to see a medical provider (186 of 373 [49.9%]). Measures of consumer-provider encounters were also included in the survey. Respondents reported high levels of comfort talking about sexual health (246 of 380 [64.7%]), feeling cared for (261 of 377 [69.2%]), listened to (263 of 376 [69.9%]), and not stigmatized (269 of 374 [71.9%]).

COVID-19 variably affected healthcare access, with most respondents (179 of 367 [48.8%]) reporting their healthcare access was not affected, 20.4% (75 of 367) reporting a neutral impact, and 30.8% (113 of 367) reporting a negative effect.

DISCUSSION

This study was the first status neutral consumer needs assessment fielded in the DC EMA. It was successful in surveying the needs of both people living with, and behaviorally vulnerable to HIV; just over half of respondents (56.6%) reported they were HIV-negative. While biological factors contribute, HIV transmission is underpinned by the social determinants of health or the conditions in the environments where people are born, live, learn, work, play, worship, and age.[7] Recognizing the role of these social factors in perpetuating health conditions, including the risk of HIV, is imperative for public health stakeholders in ending the HIV epidemic. Therefore, elevating consumer voices of both those living with HIV as well as those who are behaviorally vulnerable to HIV is essential to maintain viral suppression and prevent HIV acquisition.

The DC EMA survey findings suggest that most respondents living with HIV reside in the District of Columbia. This may be due to a higher respondent rate from the District of Columbia than in other jurisdictions, but it is consistent with jurisdictional annual surveillance reports suggesting a plurality of people living with HIV in the DC EMA (45%) live in DC.[8] Accordingly, efforts to address HIV in the region must emphasize the impact HIV has on District residents.

Overall, Black, not Hispanic respondents are disproportionately affected by HIV, largely influenced by the disproportionate burden Black individuals bear in DC and Maryland. Virginia respondents with HIV were more likely to be Latino/a or Hispanic than in other jurisdictions. These survey findings are also relatively consistent with epidemiological findings across the EMA that suggest Black individuals have the highest HIV burden overall carried largely by the majority of people living with HIV identifying as

[7]Sprague C, Simon SE. Ending HIV in the USA: integrating social determinants of health. Lancet. 2021;398(10302):742-743. doi:10.1016/S0140-6736(21)01236-8

[8]Annual Epidemiology & Surveillance Report: Data Through December 2021. District of Columbia Department of Health, HIV/AIDS, Hepatitis, STI, & TB Administration 2022. Accessed September 6, 2023 at https://dchealth.dc.gov/service/hiv-reports-and-publications

Black in DC (68%), Maryland (75%),[9] and Virginia (48%)[10]. Additionally, surveillance data suggest the highest proportion of people living with HIV who are Latino/a or Hispanic reside in Virginia (18% compared to 9% in DC and 11% in Maryland). [11,12,13]

Survey responses indicate people living with HIV are older and living with HIV for longer. Approximately one out of every three respondents living with HIV reported they are 20+ year survivors and around one in four reported having HIV for between 11 and 20 years. Additionally, a plurality of respondents were between the ages of 55 and 64 and a majority of respondents were 45 or older. Addressing the needs of older people with HIV is important as more people are aging with HIV and will require healthy aging support, as well as support for comorbidities.

Respondents living with HIV reported high adherence to the continuum of care including around nine out of every 10 respondents living with HIV reported seeing their medical provider within the last six months, knowing their viral load count, and taking ART. Similarly, eight out of every 10 respondents living with HIV reported being virally undetectable. These results suggest that when people living with HIV are engaged in treatment they are generally adherent to this treatment. However, any ART adherence rate of less than 100% is an opportunity for education about the benefits of being undetectable.

In contrast, among HIV-negative respondents, just one out of every five are taking PrEP. PrEP is a medicine that is highly effective for preventing HIV when taken as prescribed. Low uptake of PrEP from respondents due to a lack of perceived risk or awareness of PrEP indicates a greater need for PrEP education. Additionally, there may be possible gaps in HIV diagnosis among self-reported HIV-negative respondents (i.e. people who report being HIV-negative may be HIV-positive but lack a diagnosis). Further education on HIV testing and the rest of the care continuum could identify such individuals.

Respondents living with HIV reported difficulty accessing needed services like dental care, financial assistance, and housing services. They also reported dealing with mental health conditions, high blood pressure, and COVID. One in three said their needs were unmet because they did not know how or where to access these services.

Respondents, both living with and behaviorally vulnerable to HIV reported co-occurring mental health conditions most often when asked what other health conditions they had. Addressing mental health

[9] Maryland Annual HIV Epidemiological Profile 2021. Center for HIV Surveillance, Epidemiology and Evaluation, Maryland Department of Health, Baltimore, MD. 2022. Accessed September 8, 2023 at https://health.maryland.gov/phpa/OIDEOR/CHSE/SiteAssets/Pages/statistics/Maryland-Annual-HIV-Epidemiological-Profile-2021.pdf

[10] Virginia HIV Surveillance Annual Report. Virginia Department of Health. 2023. Accessed September 11, 2023 at https://www.vdh.virginia.gov/content/uploads/sites/10/2023/07/VDH_HIV-Surveillance_Annual-Report_2022.pdf

[11] Annual Epidemiology & Surveillance Report: Data Through December 2021. District of Columbia Department of Health, HIV/AIDS, Hepatitis, STI, & TB Administration 2022. Accessed September 6, 2023 at https://dchealth.dc.gov/service/hiv-reports-and-publications

[12] Maryland Annual HIV Epidemiological Profile 2021. Center for HIV Surveillance, Epidemiology and Evaluation, Maryland Department of Health, Baltimore, MD. 2022. Accessed September 8, 2023 at https://health.maryland.gov/phpa/OIDEOR/CHSE/SiteAssets/Pages/statistics/Maryland-Annual-HIV-Epidemiological-Profile-2021.pdf

[13] Virginia HIV Surveillance Annual Report. Virginia Department of Health. 2023. Accessed September 11, 2023 at https://www.vdh.virginia.gov/content/uploads/sites/10/2023/07/VDH_HIV-Surveillance_Annual-Report_2022.pdf

needs is especially relevant for HIV prevention efforts as research suggests mental health conditions may increase the likelihood of personal HIV acquisition or putting others at risk for HIV acquisition through risk behavior or poor ART adherence.[14] While the survey did not ask specifically about the utilization of syringe services programs, unsafe injection practices are not the sole SUD-related risk factor affecting HIV acquisition; substance use may also affect judgment and inhibition that can lead to people engaging in risk behaviors that make them more vulnerable to acquiring HIV.[15] While few respondents reported needing substance use disorder treatment services, it is possible respondents who meet clinical criteria for substance use disorder have not received a diagnosis yet and thus have not sought out necessary treatment. Accordingly, ensuring access to SUD treatment is a major component of HIV prevention for those in need of it.

Stigma surrounding HIV impacts the mental health of those living with HIV as well.[16] While most respondents reported high comfort levels talking about sexual health; feeling cared for, and listened to; and not stigmatized, approximately 30% of respondents reported neutral or unfavorable experiences. DC Health cannot address the stigma associated with HIV alone but can participate in cross-departmental and cross-jurisdictional efforts to provide more education about HIV that is destigmatizing.

Recommendations

The findings from this study identified five key recommendations to support consumers' care and service needs regarding HIV and overall health:

Survey refinement. To increase participation, consider modifying the survey. Participation rates may have been impacted by factors including survey length (68 questions), duration (15-20 minutes), salience (the importance or current relevance of questions), and complexity (sentences with too many clauses or unusual constructs). Survey data showed that several consumers began the survey but did not continue past the demographic section.

Taking inventory. The first step in addressing consumer needs is taking inventory of what services already exist. Creating inventories of available services and making sure that all providers and/or case managers working across the healthcare and social safety net systems have sufficient knowledge of available services may help connect people living with HIV to critical support services. Additionally, allocating more resources to areas with greater unmet needs may assist in expanding the impact of these services.

Target efforts. Targeted efforts to improve consumer-provider interactions may also help reduce stigma, racial disparities, and the needs of people aging with HIV in care as well. Broadly, future planning could include provider and consumer education to increase awareness of free or low-cost services,

[14] Walkup, J., Blank, M. B., Gonzalez, J. S., Safren, S., Schwartz, R., Brown, L., ... & Schumacher, J. E. (2008). The impact of mental health and substance abuse factors on HIV prevention and treatment. *JAIDS Journal of Acquired Immune Deficiency Syndromes*, *47*, S15-S19.

[15] National Institute on Drug Abuse. Common Comorbidities with Substance Use Disorders Research Report. Part 3: The Connection between Substance Use Disorders and HIV. 2021. Accessed September 11, 2023 at https://nida.nih.gov/publications/research-reports/common-comorbidities-substance-use-disorders/part-3-connection-between-substance-use-disorders-hiv

[16] Walkup, J., Blank, M. B., Gonzalez, J. S., Safren, S., Schwartz, R., Brown, L., ... & Schumacher, J. E. (2008). The impact of mental health and substance abuse factors on HIV prevention and treatment. *JAIDS Journal of Acquired Immune Deficiency Syndromes*, *47*, S15-S19.

improve consumer satisfaction with service providers, and reduce HIV disparities for people living with or behaviorally vulnerable to HIV.

Joint needs assessment. Because of the cross-jurisdictional nature of the DC EMA, there have been some very preliminary discussions about fielding a joint consumer needs assessment across the entirety of DC, Maryland, and Virginia. Many of the questions asked of consumers across jurisdictions remain similar if not identical. A coordinated consumer needs assessment that includes multiple EMAs (DC and Baltimore) as well as additional counties in Maryland and Virginia would likely require strong data-sharing agreements and heightened cross-jurisdictional cooperation. These hurdles are likely worth the benefit of collecting similar data across EMAs and larger jurisdictions to better compare the efficacy of and coordinate efforts to address the needs of people living with and behaviorally vulnerable to HIV in the region. Jurisdictions should also have the flexibility to include questions in their consumer needs assessments that address the specific goals of their Integrated Plans, which this arrangement would not preclude them from doing.

Field topic-specific surveys. There are statutory requirements for EMAs to field consumer needs assessment once every 3 years. However, EMAs may field consumer needs assessments more frequently. Stakeholders in the DC EMA have discussed fielding smaller, more targeted consumer needs assessments to collect more information about specific areas of need (i.e. housing, financial services) or specific priority populations (i.e. older adults, heterosexual men) between the gap period of the next full consumer needs assessment to gain insights from these efforts to inform programming and future needs assessments.

Limitations

There were several limitations to the generalizability of these findings beyond the technological and logistical challenges of fielding the survey. Although convenience sampling was used and student investigators facilitated data quality and survey completion, the relatively small sample size from some jurisdictions may have led to a sample that is not representative of the population and few of the findings have enough power to be statistically significant. Even findings that have p-values suggesting statistical significance suffer from a majority of the cells under analysis containing fewer than five respondents. These small cell sizes call into question the validity of statistical tests with statistically significant p-values and forced researchers to be conservative in identifying results of statistical significance.

Many of the findings of the consumer needs assessment are consistent with jurisdictional surveillance data which suggests at least some external validity/generalizability. Nevertheless, given the lack of statistical significance and/or sample power for most of the analyses conducted, results of the consumer needs assessment do not indicate any changes in priorities to the 2022-2026 DC EMA Integrated HIV Prevention and Care Plan (DC EMA Integrated Plan) are necessary in the Integrated plan resubmission.

Further, the response burden due to survey length impeded survey participation since the survey tried to capture status neutrality across the DC EMA. Balancing the desire to collect as much information on consumer needs as possible while keeping the survey a manageable length was a challenge. Survey designers were intentional about only collecting pertinent information for DC Health to act upon, but future surveys may require additional trimming of survey questions to improve response rates.

Finally, this consumer needs assessment is subject to the same limitations inherent in any consumer needs assessment: 1) self-reporting bias, 2) selection bias, and 3) recall bias. Respondents who have not

been diagnosed with HIV—or one of the other physical or behavioral health conditions asked in the survey—will likely not report that they need certain services because they are unaware of their need. Self-report bias is a common problem in most observational research study designs. Respondents may not always know what they need and thus cannot express those needs.

Like self-reporting bias, selection bias may have underestimated consumer needs in the DC EMA because the needs assessment recruited participants directly from provider clinics. Respondents who are engaged in care likely have different needs than those who are not engaged in care. Consequently, the consumer needs assessment may have not captured the needs of potential respondents who did not go to a provider clinic or seek care during the study.

Recall bias may have occurred since several survey questions asked respondents to recall past events or experiences. Respondents may have erroneously responded depending on their ability to recall the information. Recall bias may have occurred on questions relating to the length of the recall period (e.g. 12 months, more than a year) and perception of past experiences (e.g. service utilization, barriers to medication adherence).

CONCLUSION

Despite the challenges in fielding the survey, the 2022-2023 DC EMA Consumer Status Neutral Needs Assessment reinforced many of the needs and priority populations identified by surveillance data and prioritized by the DC EMA Integrated Plan. The cross-jurisdictional consumer needs 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. While not explicitly prioritized, aging services and models of care for older adults are needed considerations to ensure that people are not just living longer with HIV but are living better. The survey findings provide a part of the HIV DC EMA landscape but in combination with surveillance data, the HIV epidemic in the DC EMA is 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.

Ultimately, the 2022-2023 DC EMA Consumer Needs Assessment has established a solid framework, both for addressing needs in the DC EMA and fielding future needs assessments.

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