

Ending the HIV Epidemic in DC: 2017 Progress Report



Tracking the Goals, Tasks and Impact
of the 90/90/90/50 Plan

December 2017



DC APPLESEED
Solving DC Problems

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Acknowledgements

The 90/90/90/50 Plan was released one year ago on December 1, 2016. It was created through a public-private partnership between the DC Appleseed Center, the Washington AIDS Partnership, Mayor Muriel Bowser, and D.C. Department of Health Director Dr. LaQuandra Nesbitt and her staff in the HIV/AIDS, Hepatitis, STD and TB Administration (HAHSTA) led by Senior Deputy Director Michael Kharfen. DC Appleseed continues to be impressed and encouraged by the talent and dedication of our public partners, and thanks them for their ongoing collaboration.

The work of the 90/90/90/50 Plan and this progress report were generously supported by the Washington AIDS Partnership under the direction of Channing Wickham. They have been steadfast partners for over a decade and we are deeply grateful. We also thank the Consumer Health Foundation for its support of this project and for advancing a racial equity lens in policymaking in the region. We also thank our long-time supporters at the Morris & Gwendolyn Cafritz Foundation, and Eugene and Agnes E. Meyer Foundation.

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In the process of compiling this progress report, the staff at HAHSTA provided a great deal of information. We also consulted with experts at Department of Health Care Finance, the Office of the State Superintendent for Education, DC Public Schools and the DC Public Charter School Board, as well as staff at the DC Council. We interviewed many healthcare providers and representatives of community-based organizations, who shared their experiences with us. We also collected input from DC residents through an online survey during the summer of 2017. We thank all of these groups and individuals for sharing their perspectives and insights.

This report's cover art was created by David Zydd.

And lastly, but not least, we thank the intrepid DC Appleseed staff and Board of Directors, as well as our impressive intern Anne Lombardi, for their persistence and commitment to creating a healthier District of Columbia.

“We must stand together and make a clear commitment to human dignity.”

Elizabeth Taylor, AIDS Activist

Executive Summary

"If we all make this commitment and follow through with this new plan, lives will be saved and the District will be stronger."

Channing Wickham
Executive Director
Washington AIDS Partnership
June 27, 2016

About the 90/90/90/50 Plan and this Progress Report

The District of Columbia's new strategic plan for "ending the epidemic," was released on World AIDS Day, December 1, 2016. The plan was developed through a public-private partnership between Mayor Muriel Bowser, Dr. LaQuandra Nesbitt of the DC Department of Health (DOH) and staff within the HIV/AIDS, Hepatitis, STD and TB Administration (HAHSTA), the DC Applesseed Center for Law & Justice, and the Washington AIDS Partnership. The "90/90/90/50 Plan" was named for its four banner goals: By 2020, 90% of all District residents with HIV will know their HIV status, 90% of District residents living with HIV will be in sustained treatment, 90% of those in treatment will reach viral suppression, and, ultimately, DC will achieve a 50% reduction of new HIV cases by 2020.

These ambitious goals were set after the partners studied data on HIV/AIDS in DC, consulted community stakeholders, and academic partners created detailed models outlining what could be achieved if certain efforts were scaled up. Those efforts are included among the 42 tasks in the 90/90/90/50 Plan as the groundwork necessary to achieve our goals. Most of the activities and interventions that are designed to link and maintain HIV-positive individuals in care are also effective

approaches to help keep individuals HIV-negative. The plan relies on two important clinical advances to catalyze further progress: so-called "treatment as prevention" and Pre-exposure Prophylaxis (PrEP). First, research has now demonstrated that sustained anti-retroviral treatment (ART) can prevent those who have HIV from passing it on to others.¹ Second, PrEP is a modified regimen of ART which can prevent infection for those who are HIV-negative but at elevated risk, such as people in sexual relationships with HIV-positive partners.

Ending the epidemic will also require tackling a range of social and health factors, many of which fall outside the traditional purview of the Department of Health, such as mental health, substance use treatment, housing stability, economic opportunity, and stigma. Furthermore, groups that have been historically underserved or alienated from the healthcare system need to be engaged in care in culturally competent settings. Data on the HIV epidemic in DC offer insight into where efforts should be focused. Stubborn racial disparities persist when it comes to HIV; black men and women in the District carry a disproportionate burden of the disease. Further, new infections are trending young, with the largest share of new cases among 20-29-year-olds. Therefore, the tasks in the plan are often tailored to reach particular groups, ensuring interventions are safe, inclusive, and culturally responsive.

To implement the tasks and goals of the 90/90/90/50 Plan by 2020, the District government will draw on its established capacity, resources and relationships to take its work to the next level. DC Applesseed and other community partners will continue to support these efforts, especially through ongoing research, advocacy and monitoring.

This progress report is produced by DC Applesseed – the first in a series of annual assessments. In this document, we will review and evaluate the progress to-date on the 90/90/90/50 goals and Plan tasks. We received tremendous support from HASHTA's staff in the process of compiling this report, especially

1. Anthony S. Fauci & Hilary D. Marston, Ending the HIV/AIDS Pandemic – Follow the Science, 373 New Eng. J. Med. 2197, 2197-2199 (2015), <http://www.nejm.org/doi/full/10.1056/NEJMp1502020#t=article>.

those who volunteered to participate in the 90/90/90/50 working groups. The working groups were convened for the first time through the fall to assess internal progress on the plan's four goals and the tasks within each goal, and will continue to meet regularly through 2020 to track relevant projects across HAHSTA's divisions. We also spoke with other governmental agencies and policymakers, as well as several community-based organizations to solicit their views on the District's progress.

Progress on the 90/90/90/50 Goals

Goal 1: 90% of all District residents with HIV will know their HIV status

The first step of HIV treatment is timely diagnosis. The Plan called for increased and targeted HIV testing, as well as more active engagement among residents and healthcare providers. In 2015, DOH estimated that 86% of HIV-positive individuals were aware of their HIV status. The 2016 epidemiological report HAHSTA released in June 2017 did not include an updated estimate of the percentage of HIV-positive individuals who knew their status. Without a new estimate, it is not possible to assess whether we are on the right trajectory for this goal, though HAHSTA's 2015 estimate was already approaching the final goal of 90%. Improved data collection proposed in the Plan may allow for better measurement of the progress toward this goal.

Goal 2: 90% of District residents living with HIV will be in sustained treatment

Upon diagnosis, it is critical to link patients with medical treatment and anti-retroviral therapy (ART). When individuals adhere to treatment, there is effectively zero risk that they will pass on the virus. To meet the goal of 90% of HIV-positive District residents in treatment, the Plan examines how to improve linkage and adherence to treatment, while ensuring the care provided is evidence-based and culturally appropriate. The Plan also conceptualizes new policies to improve data sharing, and to help providers connect with patients who have fallen out of care. DOH estimated that 73% of DC residents diagnosed with HIV were engaged in care during 2015. The 2016 epidemiological report estimated that 76% of residents living with HIV were engaged in treatment. While the 2016 data defined "engagement in care" as having attended one or more medical visit, the emphasis with Goal 2 is actually on adherence to anti-retroviral therapy. This definitional discrepancy between "in care" and "on treatment" must be reconciled to most accurately measure progress.

Goal 3: 90% of those in treatment will reach viral suppression

Successful ART treatment leads to viral suppression, or an undetectable level of the HIV virus in the body. This improves health outcomes for people living with HIV (PLWH) and reduces the risk of transmitting the virus. To assure 90% of District residents in treatment reach viral suppression, the Plan envisioned enhanced support for patients, and examined ways to provide services more effectively. DOH estimated that 78% of those in treatment were maintaining viral suppression in 2015, which was the baseline used

Goals of the 90/90/90/50 Plan

Goal 1: 90% of HIV-positive District residents know their status.

Goal 2: 90% of District residents diagnosed with HIV are in treatment.

Goal 3: 90% of District residents living with HIV who are in treatment reach viral load suppression.

Goal 4: 50% reduction in new HIV infections.

for the Plan. According to the 2016 epidemiological report, 82% of individuals in treatment were virally suppressed at their last visit in 2016.

Goal 4: 50% reduction of new HIV cases

The District aims to achieve a 50% reduction in new HIV cases by 2020. The 90/90/90/50 Plan details policies that will enhance prevention efforts through increased access to PrEP and post-exposure prophylaxis (PEP), especially for the groups at the highest risk, and improve youth education and expanded funding for successful syringe access programs. When the Mayor kicked off the 90/90/90/50 Plan development process in June 2015, the most recent surveillance data available were from 2013. During that year, 520 HIV cases were newly diagnosed. Cutting that number in half means we aim to see only 260 new infections in 2020. The 2016 data reveal 347 new infections total, a 33% reduction from the 2013 number. We are very encouraged by the continued progress we see in the 2016 numbers.

Of the 42 tasks outlined in the 90/90/90/50 Plan, four have been implemented, 32 are in progress, and there are six tasks with no progress over the last year. We believe – based on the most recent data – that the 90/90/90/50 goals are achievable, if the activities upon which the goals were modeled is fully implemented as soon as possible.

Recommendations

Based on our assessment of each task's status, we offer concrete recommendations for 2018 within seven categories: Data, Stigma & Public Education, the Social Conditions of Health, Other Activities within DOH, Work with DHCF, DC Appleseed's Role, and Funding. These are summarized below.

DATA

- We have flagged issues with the measurement and definitions of the 90/90/90/50 goals, and suggest HAHSTA produce an update of the estimate for Goal 1 and determine a more concrete and relevant definition of "in treatment" for Goal 2.
- Several tasks in the 90/90/90/50 Plan relate to improving HAHSTA's data systems and its "retention blitzes" which help providers identify and connect with patients who are out of care. Work next year should include implementing an expanded patient consent form to enable more sharing among covered providers, and integrating more sources of data on patient treatment into a single "data-to-care" system.
- DOH committed to producing a web-based application of its current surveillance data. DOH and DC Appleseed also planned to develop a data dashboard to specifically track the Plan's implementation and goals. Neither were accomplished in 2017 and should be given renewed attention in 2018.

STIGMA & PUBLIC EDUCATION

- DOH have a strong record of effectively using social media, social marketing and public awareness campaigns to spread information about HIV prevention and care. We are glad to see these vital efforts continue. In addition, we encourage HAHSTA to more explicitly take on the stigma and persistent myths surrounding HIV among the public and health providers.
- The people and communities who remain vulnerable to HIV are often those who've historically been shut out or underserved by healthcare and political institutions. DOH, providers and institutions should dedicate attention to clinical settings are respectful and culturally appropriate for all patients.
- New HIV infections are trending younger. It is mission critical to equip young people with accurate information and opportunities to build skills to protect their health. We commend OSSE for its commitment to use data from assessments in public and charter schools to improve utility for educators while also increasing transparency about school performance for the public. Overall, DC Appleseed is concerned that sexual health education is not uniformly implemented across all schools, particularly independent charter schools, and call for increased oversight and renewed commitment from all stakeholders to reach all young people, no matter where they attend school.

THE SOCIAL CONDITIONS OF HEALTH

- Disease prevention and treatment adherence require the right conditions for success. Chief among the socio-economic factors that influence health are stable, safe and affordable housing. The

2017 Progress on the 90/90/90/50 Plan

Goal 1	86%	90%
	2015	2016
Goal 2	73%	90%
	2015	2016
Goal 3	78%	90%
	2015	2016
Goal 4		50% reduction
	2013	2016

90/90/90/50 Plan dedicated five tasks to improving housing conditions for PLWH in DC, including, for example, redesigning local implementation of the federal Housing Opportunities for Persons with AIDS (HOPWA) program, and adopting a detailed policy for short-term shelters to provide reasonable accommodations to PLWH. These tasks are largely cross-sector, cross-agency endeavors that HAHSTA must shepherd. Without more progress in the year ahead, we will quickly fall behind on these tasks.

OTHER ACTIVITIES WITHIN DOH

- The HAHSTA working groups have done a great deal of work in a short period to assess the status of each Plan task. We look forward to this work continuing in earnest through 2018.
- We note an opportunity for DOH to improve communication with providers. This is especially important to ensure smooth roll-out and successful implementation of the Plan's initiatives.
- DOH would like to require provider reporting of ART initiation, which can improve data analysis capabilities and support patient reengagement efforts. The necessary conversations should happen as soon as possible, and, in the meantime, providers are encouraged to report voluntarily.
- The provision of and local support for syringe exchange services continues to be critical to reducing new HIV infections. In addition to sustained support, we encourage HAHSTA to assess if current funding meets the true need.
- Other tasks need to be given special attention in 2018 if they are to make an impact by 2020, including, but not limited to: expanding locations, hours and the possible settings for care; increasing access to prescription data to discern patients' treatment adherence; and standing up telemedicine programs for treatment adherence and PrEP.

WORK WITH DHCF

- DOH and the Department of Health Care Finance have separate but interconnected roles, and can continue to find ways to meet the needs of District residents to achieve good health outcomes. The agencies should focus on areas for collaboration in the next year, among them the adoption of performance measures related to testing and care through DC Medicaid contracts to drive improvements in clinical practice, and consistent coverage of PrEP medication and associated care.

DC APPLESEED'S ROLE

- DC Appleseed will continue to be in communication with HAHSTA staff and the working groups to engage in the work of implementation and monitoring.
- We are committed to issuing a progress report every year on the anniversary of the Plan's release, World AIDS Day, December 1.
- We take responsibility for several tasks in the Plan which require research, policy change or advocacy which is outside of DOH's purview. For example, DC Appleseed will follow the efforts to

revise DC Alliance enrollment policies. DC Appleseed will also advocate for appropriate funding in District budget, especially for public health insurance, syringe exchange services, and programs like community health workers.

FUNDING

- The 90/90/90/50 Plan proposed a cost-effectiveness analysis of the proposed tasks to inform ongoing budget planning. In 2018, DC Appleseed and DOH should reconvene to discuss the necessity and scope of this analysis, identify potential researchers to employ, and establish a timeframe for the effort. Similarly, we encourage DOH to assess its funding categories and map what is needed to meet the needs for the tasks at hand.

Conclusion

We congratulate the District government and its community partners for a busy year and many areas of progress. Overall, the District appears to be on the right track to meet the 90/90/90/50 goals by 2020. However, some activities require renewed energy and focus in order to have an impact by 2020. We have detailed the progress and opportunities within this progress report. We have also attempted to distill the key themes and issues where special attention is required. Here and in the work ahead, we aim to be both specific and comprehensive, to simultaneously drill down into each activity while remaining attune to broader community needs. We believe the 90/90/90/50 Plan has the potential to address all aspects of a complicated disease while also serving the whole person.

DC Appleseed is honored to be part of this partnership, and is prepared to continue the work ahead. We do not take where we are today for granted; we must continue to be protective of those conditions upon which our progress toward ending the HIV epidemic is built. In the next year, the District government – and the community – must sustain its investments and continue to pursue big ideas.

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	2017 Progress			Page Number
Goal 1: 90% of HIV-positive District residents know their status.	86% 2015	 86% 2016	90% 2020	17
Task 1.1: Use geospatial and demographic data to increase targeted testing, and require providers receiving testing grants to utilize evidence-based programs that target social networks where new infections are most likely.	In Progress			17
Task 1.2: Continue media campaigns and medical provider education to ensure new and ongoing HIV testing approaches.	Implemented			18
Task 1.3: Identify those who test negative but are at elevated risk and engage counseling for prevention strategies—including counseling for Pre-Exposure Prophylaxis (PrEP).	In Progress			19
Task 1.4: Adopt and implement HIV-testing performance measures and thresholds for Managed Care Organizations (MCOs).	In Progress			20
Goal 2: 90% of District residents diagnosed with HIV are in treatment.	73% 2015	 76% 2016	90% 2020	21
Task 2.1: Reduce the time from initial diagnosis to initiation of ART through a relaunch of the Red Carpet Entry Program.	No Progress			21
Task 2.2: Examine the feasibility of requiring all providers in DC to report treatment of a new patient with HIV and when a patient begins ART to DOH.	In Progress			22
Task 2.3: Expand access to treatment and related services, targeting demographics and geographic areas where populations are at higher risk.	In Progress			24
Task 2.4: Develop a standard consent form for HIV care that allows DOH and providers to share information that could improve treatment while respecting patient confidentiality.	In Progress			24
Task 2.5: Expand the use of community health workers as a component of HIV care and treatment.	In Progress			25
Task 2.6: Use peer navigators to engage with African-American and Latino men who have sex with men and transgender people of color.	In Progress			26
Task 2.7: Reconsider the six-month in-person re-registration for the DC Healthcare Alliance.	In Progress			27
Task 2.8: Identify opportunities to enhance culturally competent HIV treatment.	In Progress			28
Task 2.9: Examine the feasibility of leveraging a Health Information Exchange to improve HIV care and treatment.	No Progress			28
Goal 3: 90% of District residents living with HIV who are in treatment reach viral load suppression.	78% 2015	 82% 2016	90% 2020	30
Task 3.1: Provide more accessible, healthcare services by hours, locations and providers.	In Progress			30
Task 3.2: Partner with other DC government agencies to address the social support needs of clients that may influence treatment-seeking and adherence.	In Progress			31
Task 3.3: Assume direct responsibility for improving clinical quality and health data among all providers in the District.	In Progress			32
Task 3.4: Implement a data-to-care program to increase levels of engagement in care.	In Progress			32
Task 3.5: Work with pharmacies and Pharmacy Benefits Managers around to increase access to prescriptions and improve better track medication treatment adherence.	No Progress			33

Task 3.6: Promote policies to enable and encourage pharmacists to assist in ART adherence.	In Progress	33
Task 3.7: Promote telemedicine approaches for adherence support.	In Progress	34
Task 3.8: Examine adding performance measures to future contracts with MCOs to enhance treatment adherence, viral load suppression, and funding for support services— especially housing.	In Progress	34
Task 3.9: Retool the Ryan White Program to improve District and regional healthcare and supportive services.	Implemented	35
Task 3.10: Redesign the HOPWA program to support persons toward self-sufficiency.	In Progress	36
Task 3.11: Examine opportunities to provide more housing options for persons in the metropolitan area.	In Progress	37
Task 3.12: Examine the need for expanded funding for affordable housing for people living with HIV.	No Progress	37
Task 3.13: Promote use of HOPWA funding for capital development to create new units of affordable housing that are available for people living with HIV.	In Progress	38
Task 3.14: Ensure that people living with HIV who access low-barrier shelters in DC receive accommodations that will allow them to manage their condition.	In Progress	39
Goal 4: The District's rate of new HIV infections in reduced by 50%.		40
Task 4.1: Expand the network of prescribers of PrEP through increased knowledge and capacity of private medical providers.	In Progress	41
Task 4.2: Make PrEP starter packs available at the DC Health and Wellness Center.	Implemented	42
Task 4.3: Develop PrEP-specific telemedicine program.	No Progress	42
Task 4.4: Recruit peer navigators for African-American and Latino men who have sex with men and transgender people of color to promote knowledge of PrEP.	In Progress	43
Task 4.5: Work with Medicaid, MCOs, and private health plans in order to ensure insurance coverage of PrEP treatment and related clinically recommended laboratory monitoring.	No Progress	43
Task 4.6: Monitor the need for a co-payment assistance program for PrEP and gaps in insurance coverage for PrEP and fund PrEP assistance.	In Progress	43
Task 4.7: Expand access and availability of Post-Exposure Prophylaxis (PEP).	In Progress	44
Task 4.8: Develop public education campaigns to raise awareness of prevention strategies, in particular PrEP and PEP.	In Progress	44
Task 4.9: Improve timely notice to DOH of all new HIV diagnoses.	In Progress	44
Task 4.10: Establish programs to eliminate stigma and educate the community about HIV.	In Progress	45
Task 4.11: Promote model programs for persons to take control of their healthcare and improve their well-being.	In Progress	47
Task 4.12: Maintain and adjust funding for syringe exchange services to reach injection drug users in DC.	In Progress	47
Task 4.13: Promote healthy decision-making and increase the availability of sexual health information for young people.	Implemented	48
Task 4.14: Ensure that DC Public Schools and public charter schools provide appropriate HIV and STI-prevention education to all DC students and that students' understanding is assessed regularly.	In Progress	50
Task 4.15: Ensure that all DC schools meet their sexual health education obligations under the Healthy Schools Act.	In Progress	52

*Data Source: DC Department of Health Annual Epidemiology and Surveillance Report (2016)

Introduction & Background

"I'm pleased to say we have made considerable progress, but I don't have to tell you there is more work to do."

Mayor Muriel Bowser,
June 27, 2016

"This disease is not likely to be eradicated, but with the commitment and public support of District leaders, we can reduce its terrible toll." This is how the DC Appleseed Center assessed the state of the HIV epidemic in 2005, in our report [HIV/AIDS in the Nation's Capital](#).² At that time, there were approximately 11,517 people living with HIV in the District—nearly 3% of the adult and adolescent population—with 929 District residents newly diagnosed in that year alone.³ An epidemic is defined as a prevalence rate above 1% of the population, and the HIV epidemic in the District was believed to be the worst in the country.⁴ DC Appleseed's report detailed the District's lack of effective leadership, poor coordination of services, ineffective funding, inadequate data collection and analysis, and inability to meet the needs of special populations. We called for decisive action in a time of great need. Every year afterward, we issued report cards to grade the District's work on tackling the epidemic.

By 2015, the District had seen a 72% decrease in new infections. This progress was tremendous, but the surveillance data showed that we still had a problem. Of particular concern were disparities in the data by age, race, gender identity and ward that were obscured by an average decrease in new cases.

At this ten-year milestone, we stood with Mayor Muriel Bowser and Dr. LaQuandra Nesbitt, Director of the DC Department of Health, to announce the District's commitment to finally end the HIV epidemic in DC. The "90/90/90/50 Plan" was released on World AIDS Day, December 1, 2016. It is named for its four main goals: 90% of all District residents with HIV will know their HIV status, 90% of District residents living with HIV will be in sustained treatment, 90% of those in treatment will reach viral suppression, and a 50% reduction of new HIV cases will be achieved. All by 2020. As Dr. Anthony Fauci from the National Institutes of Health describes, with these gains, "the mathematical model tells you that the epidemic is going to burn itself out."

The work outlined in the 42 tasks in the 90/90/90/50 Plan is underway. These tasks are the strategies and groundwork necessary to realize the measurable outcomes of 90/90/90/50. This progress report will review and assess the progress to date on the goals and tasks. Below is a brief overview of the how the Plan was developed, the rationale and roadmap of the four banner goals and the 42 tasks, and the vision for ongoing reporting and monitoring.

THE PLAN: A partnership and an ambitious idea

The 90/90/90/50 Plan is the product of a public-private partnership coalescing around an ambitious idea. The Mayor, The HIV/AIDS, Hepatitis, STD and TB Administration (HAHSTA) within the DC Department of Health (DOH), DC Appleseed and the Washington AIDS Partnership combined forces in 2015 to explore the possibility of ending the HIV/AIDS epidemic in the city. We were inspired by the federal Office of National AIDS Policy and a few jurisdictions around the country that were charting plans to "end AIDS" or "get to zero."

The District had the capacity and local resources for such an initiative, and was supported by two important clinical advances to catalyze further progress. First, researchers have shown that rapidly initiated and

2. DC Appleseed, *HIV/AIDS in the Nation's Capital: Improving the District Of Columbia's Response To A Public Health Crisis*, August 2005. <http://www.dcappleseed.com/wp-content/uploads/2013/09/HIV2.pdf>

3. D.C. Dep't of Health, HIV/AIDS, Hepatitis, STD, & TB Admin., *Annual Epidemiology & Surveillance Report: Surveillance Data Through December 2015* (2016), <http://www.doh.dc.gov/hahsta>.

4. Paul Denning & Elizabeth DiNenno, Ctrs. for Disease Control and Prevention, *Communities in Crisis: Is There a Generalized HIV Epidemic in Impoverished Urban Areas of the United States?* (2015).

sustained anti-retroviral treatment (ART) can prevent those who have HIV from passing it on.⁵ This is known as “treatment as prevention.” Second, a new modified regimen of ART for those who are at risk, but do not have HIV, can prevent transmission of the virus at very high rates when taken consistently and under proper supervision. This new tool is called Pre-exposure Prophylaxis, or PrEP. If the District effectively leveraged treatment as prevention and PrEP, we could bow the downward trend of new infections even more precipitously. We also knew that ending the epidemic would require more than clinical advances; it would also require tackling a range of health issues and social factors, many of which fall outside of the Department of Health’s traditional purview, such as behavioral health (including mental health and substance use), housing stability, economic opportunity, and stigma and discrimination. Success would depend on engaging the entire community.

In researching and writing the plan, the project team from HAHSTA, led by Senior Deputy Director Michael Kharfen, and DC Appleseed relied on several academic experts at The George Washington University, Howard University and Johns Hopkins University. DOH also drew on its involvement in the DC Partnership for HIV/AIDS Progress (DC PFAP) with the National Institutes of Health (NIH), the DC Center for AIDS Research (DC CFAR), a unique collaboration among academic and medical institutions in the District, and the DC Cohort, which is the largest single-jurisdiction research study of people living with HIV conducted by NIH.

Based on the data and the detailed modeling conducted by academic partners, the project team set ambitious but achievable goals. Our baseline parameters were informed by DC’s HIV disease surveillance and grant-making activities, as well as data collected on the subset of the HIV-positive population receiving services through the federal Ryan White Program. Additionally, we drew from peer-reviewed research on patterns in HIV transmission and the efficacy and impact of scaling up HIV care and prevention activities.

Community engagement and input was a key component of the development process. Qualitative and quantitative data collected from questionnaires, town halls, and focus groups was integrated into the Plan. We had in-depth conversations with government officials who had developed similar plans in New York State, San Francisco and Washington State to learn from their process. DC Appleseed also conducted key interviews with community stakeholders and subject matter experts.

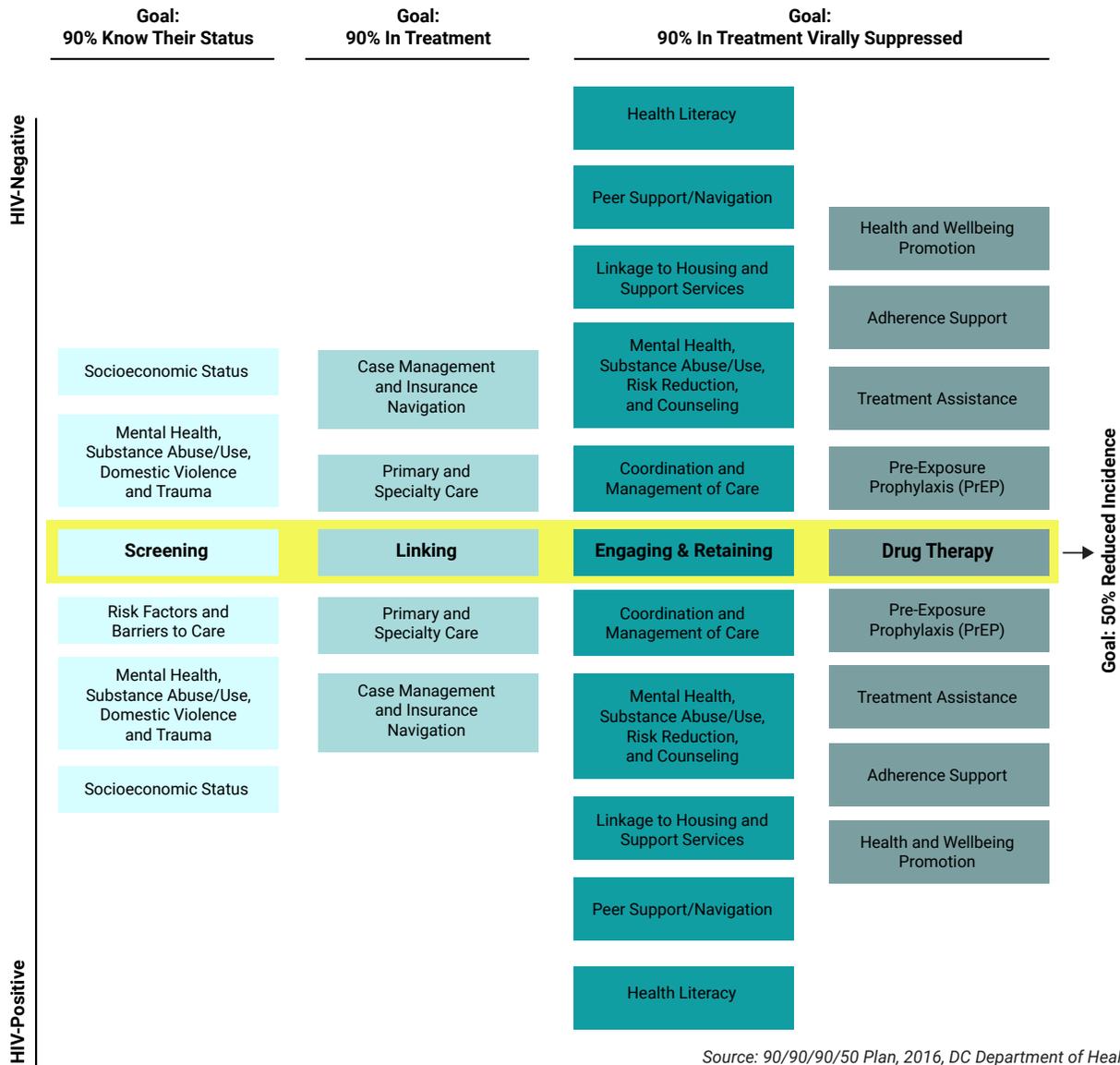
THE GOALS: How we will measure an end to the epidemic

The 90/90/90/50 Plan is framed around the HIV Care Continuum, or treatment cascade, which is widely used by public health agencies and experts. The traditional continuum outlines the stages from testing to achieving viral suppression for individuals living with HIV, recognizing that all steps along the way are fluid and interlinked. The District also uses a Prevention Continuum to describe the steps of decreasing HIV acquisition and transmission. Together, the Prevention and Care Continuum illustrate the stages of HIV prevention and care including screening, linking, retaining and engaging, and drug therapy. Most of the activities and interventions designed to link and maintain HIV-positive individuals in care are also effective approaches to help keep individuals HIV-negative.

Most metrics in the Plan relate directly or indirectly to one important baseline measure: the number of diagnosed infections in DC, measured from the baseline year of 2015, which was the most recent data when the Plan was published. In 2015, an estimated 13,391 individuals diagnosed with HIV lived in the District. This estimate was a revision of a previous number based only on a diagnosis within DC, regardless of current residence of the person living with HIV (PLWH). The new way of counting PLWH is based on the residential address documented on the laboratory results reported to DOH in the past five years.

5. Anthony S. Fauci & Hilary D. Marston, Ending the HIV-AIDS Pandemic – Follow the Science, 373 *New Eng. J. Med.* 2197, 2197-2199 (2015), <http://www.nejm.org/doi/full/10.1056/NEJMp1502020#t=article>.

District of Columbia HIV Prevention and Care Continuum – May 2016



Source: 90/90/90/50 Plan, 2016, DC Department of Health

GOAL 1: 90% of HIV-positive District residents know their status

The first step of HIV treatment is timely diagnosis. To meet the goal of 90% of District residents knowing their HIV status, the Plan calls for increases in targeted HIV testing, in addition to the established routine testing program, as well as more active engagement among residents and healthcare providers. In 2015, DOH estimated that 86% of HIV-positive individuals were aware of their HIV status.

The number or proportion of people are HIV-positive but are not yet diagnosed cannot be precisely counted because they are, by definition, not identified. However, there are several statistical methods that can estimate the percentage of the HIV-positive population unaware of their status. DOH used a model developed by researchers at the University of Washington and statistics consulting firm Fellows Statistics.⁶ The model uses the date of an individual's positive test and the date of that individual's last negative test to define the window of time during which the individual could have become infected; when a negative test is not recorded, a conservative estimate of the earliest possible time that the individual could have been infected is used. The probabilities from these time windows for all individuals are averaged to derive an estimate of the "distribution of time from infection to diagnosis" for the population and an estimated number of people who have HIV but remain undiagnosed at that point. The resulting "undiagnosed percentage" is the number of estimated undiagnosed cases divided by the total number of persons living with HIV in the jurisdiction.

6. Ian E. Fellows et al., A New Method for Estimating the Number of Undiagnosed HIV Infected Based on HIV Testing History, with an Application to Men Who Have Sex with Men in Seattle/King County, WA (2015), <http://journals.plos.org/plosone/article/asset?id=10.1371/journal.pone.0129551.PDF>.

The model estimated that 9% to 14% of actual HIV cases were undiagnosed within the District in 2015. With surveillance data at that time showing that 13,391 people were diagnosed with HIV and living in the District, the upper-bound estimate of 14% undiagnosed yielded a total of 15,571 individuals living with HIV in the District in 2015. Therefore, DOH estimated that 86% of HIV-positive individuals were aware of their HIV status.

GOAL 2: 90% of District residents diagnosed with HIV are in treatment

Until there is a cure for HIV, patients must adhere to medical treatment and anti-retroviral therapy to stay healthy. Further, when HIV-positive individuals adhere to their prescribed treatment regimen and maintain viral suppression – that is, when the number of copies of the virus in the blood stays below 200 per microliter – there is effectively zero risk that the individual will pass on the virus. To meet the goal of 90% of HIV-positive District residents engaged in treatment, the Plan examined how to improve linkage and adherence to treatment, as well as ways to expand and protect access to care, while ensuring that the care provided was evidence-based and culturally appropriate. The Plan also conceptualizes new policies to improve data sharing, and to help providers connect with patients who have fallen out of care. The Department of Health’s best estimate was that 73% of DC residents diagnosed with HIV were in care in 2015.

The estimate for percentage of PLWH on treatment is based on incomplete data, because it cannot currently track whether everyone diagnosed is actively taking ART. Not everyone who accesses care has been prescribed or actively takes ART, and DOH does not have data on ART prescriptions among those diagnosed with HIV. DOH does have complete data for ART uptake among those who access Ryan White-funded providers; in that group, 90% of clients with at least one documented medical visit in 2015 were prescribed ART. The baseline figure used in the plan is that 73% of the total population diagnosed with HIV are retained in care, though DOH estimates that only 66% of all PLWH are actually treated with ART. In order to more precisely count this metric in the future, the Plan outlines policies to give DOH more exact data on ART uptake.

GOAL 3: 90% of District residents diagnosed with HIV who are in treatment reach viral load suppression

Achieving viral suppression, also known as an “undetectable” viral load, through drug therapy improves health outcomes for PLWH and reduces risk of transmitting the virus. To meet the goal of 90% of District residents in treatment reaching viral suppression, the Plan includes strategies to enhance support for people to maintain treatment, address socio-economic conditions that may cause lapses in treatment, and examine how federal Ryan White funding can be used more effectively. DOH estimated that 78% of those in treatment had achieved viral suppression in 2015.

Currently, DOH receives all lab results showing viral load for HIV-positive District residents. However, because of the difficulty of counting the number of HIV-positive District residents who are on ART (described above), it is impossible to precisely determine the percentage of those on treatment who have reached viral suppression. Therefore, the model for the Plan used the rate of viral suppression among those who accessed care in any way—not just those actively taking ART—as indicated by a lab test. That figure was 78%, which was consistent with other reports that found that 80% of individuals on ART achieve viral suppression.

GOAL 4: 50% reduction in new HIV infections overall

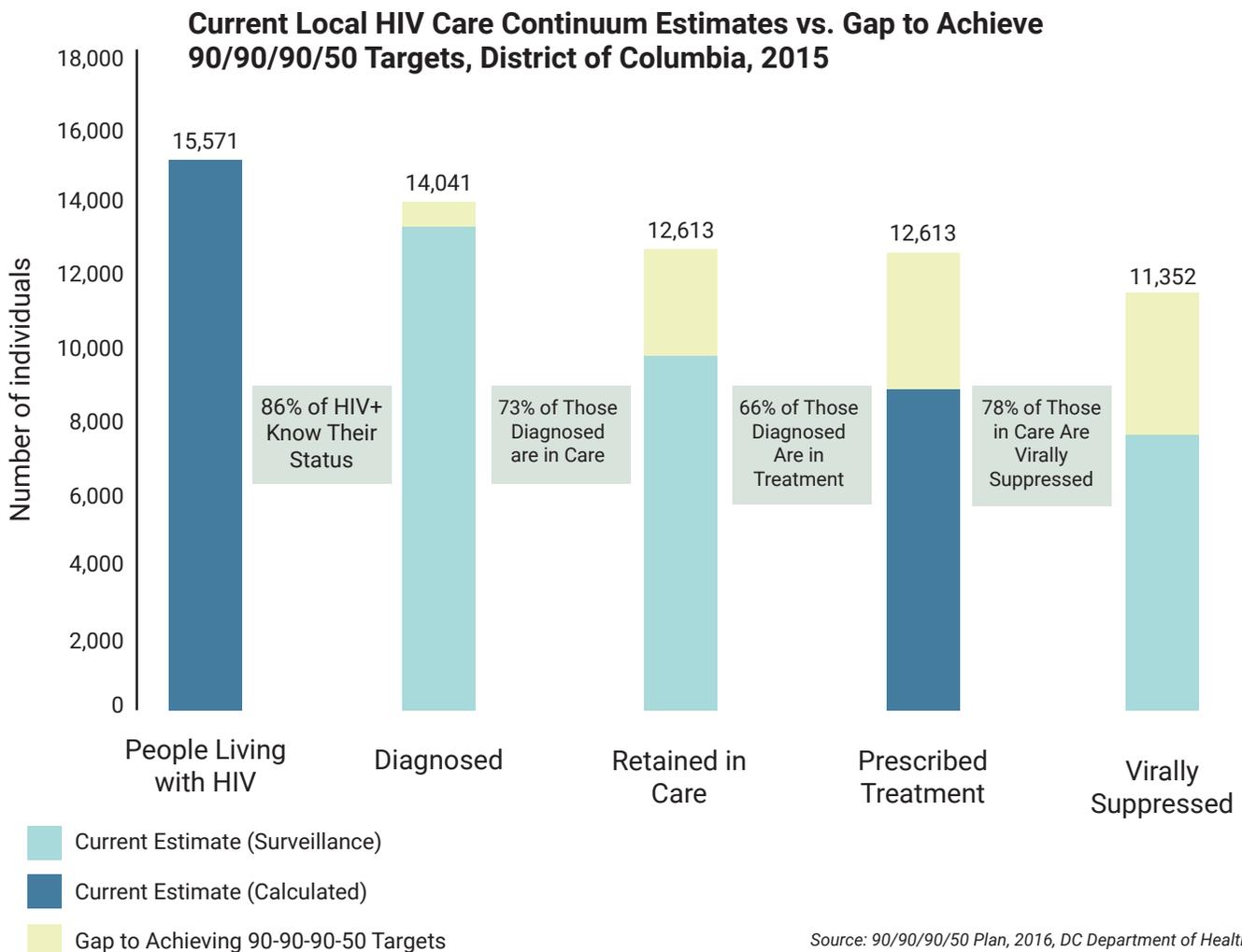
The Plan follows the cascade of the HIV Continuum; as more District residents know they have HIV, more are likely to be engaged in care. As more are in care, more are likely to reach viral load suppression. When more reach viral load suppression, not only will their own health be improved, but fewer will transmit the virus to others, leading to a decrease in the number of new infections over time. Therefore, the District aims to achieve a 50% reduction in new HIV cases by 2020. The Plan includes policies that will increase access to PrEP and post-exposure prophylaxis (PEP), especially for people who have high risk behaviors, in addition to improvements in youth education and expanded funding for successful syringe access programs.

When the development of the 90/90/90/50 Plan was announced by Mayor Bowser, the most recent surveillance data available were from 2013. In that year, the District documented 520 newly diagnosed HIV cases. Cutting it in half means we aim to see only 260 new infections in 2020. Models produced for DOH predict that a decrease of about 56% is actually possible, meaning only 227 new infections in 2020, if the

District (1) continues the effective policies that have been implemented over the last 10 years, (2) meets the 90/90/90 targets described above, and (3) increases the number of District residents taking advantage of preventive interventions—especially PrEP therapy. When the Plan was released in December 2016, data for 2015 showed 371 new HIV diagnoses, marking a 29% decrease over just two years.

PrEP has been shown to be up to 90% effective in preventing transmission of HIV when used consistently and correctly. Some studies reported zero new infections among HIV-negative individuals on PrEP.⁷ The efficacy of the regimen depends on individual adherence. The modeling guiding the Plan assumed an 86% efficacy rate for PrEP in preventing HIV transmission in DC. By incorporating efforts to increase the utilization of PrEP among focus populations, such as men who have sex with men and high-risk heterosexual women, DOH anticipates that the number of newly diagnosed HIV cases in 2020 can be reduced by up to approximately 56% from 2013. The model developed for DOH by The George Washington University and Howard University assumed that approximately 8,000 District residents would need to be on PrEP consistently; the best estimate in 2015 was that only about 2,000 residents have ever been prescribed PrEP. Therefore, in order to meet the 50% reduction target, the District must increase the number of PrEP prescriptions by 6,000 at-risk individuals.

As with the number of prescriptions of PrEP, several supporting targets must be met or exceeded in order to achieve the four banner goals described above. These metrics assume consistent or expanded activities and proliferation of materials in the community by 2020. These targets will be detailed further within this report and are laid out in the table below, including: the percentage of individuals from certain demographic groups who are tested within the year, the number of condoms distributed, and the percentage of injection drug users who report sharing needles among others.



7. Sheena McCormack et al., Pre-exposure Prophylaxis to Prevent the Acquisition of HIV-1 Infection (PROUD): Effectiveness Results from the Pilot Phase of a Pragmatic Open-label Randomised Trial, 387 Lancet 53, 53-60 (2015); Jean-Michel Molina et al., On-Demand Preexposure Prophylaxis in Men at High Risk for HIV-1 Infection, 373 N Engl J Med. 2237-46 (2015).

THE TASKS: The work necessary to achieve the 90/90/90/50 goals

Within the Plan, the project team outlined 42 detailed and specific tasks that would need to be accomplished in order to realize the ambitious goals. The rationale and particulars of these tasks made up the bulk of the 90/90/90/50 Plan. The Plan also included six proposed demonstration projects and four public calls to action.

Most of the work is planned by and delegated to HAHSTA. Several tasks relate to DOH's work to support these models of care through its work and funding to community-based organizations such as reimbursements for services or grants for programs like community health workers. However, due to the broad and holistic nature of the Plan, several tasks fall within the purview of other entities and agencies. For example, the Plan calls for an examination of the DC Healthcare Alliance's requirement that participants recertify eligibility every six months, as providers noted that in practice this regulation caused eligible patients to lose insurance and fall out of care. Similarly, the Plan recommends increased access to housing for people living with HIV, as this critical factor assures the stability, safety and capacity to manage one's health and medication adherence. When a task falls outside of the purview of the Department of Health, DC Appleseed takes primary responsibility for the research, advocacy, and follow-up to achieve the task. Further, there are several tasks that DC Appleseed and DOH staff will undertake together.

The HASHTA staff has organized working groups for the implementation of the tasks, beginning with an assessment of the various activities underway. The groups were first convened in September 2017. The groups are broken out to focus on each of the Plan's four goals and organized so that at least one representative from each division within the agency is included in each group. Volunteers within the group serve as facilitators, coordinators and documenters for group activities. They meet as needed; the recommendation is to meet twice per month. DC Appleseed staff members have been invited to participate. The HAHSTA staff consulted colleagues and documented actions on each task to support this progress report.

While the banner 90/90/90/50 goals will remain fixed, it is possible that the tasks within the Plan may change, evolve or be revised over the four years of Plan implementation. In that way, the Plan is a living document. By design, the Plan did not include exhaustive details about measures and timelines. These details will be determined by the appropriate parties through the course of the project.

Data will be vital to planning, implementing and tracking initiatives related to the Plan. In fact, several tasks relate to enhancing and expanding the systems by which the District collects and utilizes data, including testing, treatment, STD infections, PrEP use, and needle sharing. Although some of this information is currently available for subsets of the HIV-positive population, it is not available for all DC residents living with HIV. For example, providers who treat clients through the Ryan White Program are required to provide DOH with detailed information about clients' treatment. Gathering similar information on the broader high-risk HIV-negative and HIV-positive populations will improve the ability to target interventions and monitor progress. It will also facilitate the tracking of services at an individual level in order to more effectively identify those who need follow-up, which will help to increase the number of HIV-positive District residents in effective treatment. In recent years, DOH has established data-sharing agreements with the DC Departments of Health Care Finance and Behavioral Health to support routine data exchange. DOH has also partnered with health insurance plans in the District to discuss sharing data on healthcare measures to support the goals of the Plan.

Lastly, the development of the 90/90/90/50 Plan coincided with federal planning requirements for DOH. In 2015, the Centers for Disease Control and Prevention (CDC) and the Health Resources and Services Administration (HRSA) issued a joint requirement for jurisdictions to prepare a coordinated plan (merging separate requirements under the HIV Prevention Cooperative Agreement for a Jurisdictional HIV Prevention Plan and the Ryan White CARE Program for a Comprehensive Care Plan). Therefore, the Ryan White Planning Council and the HIV Prevention Planning Group formed a joint working group to prepare the [2017-2021 District of Columbia Eligible Metropolitan Area Integrated HIV/AIDS Prevention and Care Plan](#) ("the Integrated Plan"). The Integrated Plan covers activities related to federal funding throughout the entire Eligible Metropolitan Area (EMA) as defined by HRSA, which includes five counties in suburban Maryland, 11 counties and six independent cities in northern Virginia, and two counties in West Virginia. The 90/90/90/50 Plan informed the Integrated Plan's development, and the 90/90/90/50 goals are echoed in the Integrated Plan. However, there is no complete overlap between the Plan and the Integrated Plan's goals and tasks, due to the requirements,

scope and demographic reach of the Integrated Plan. Each plan follows a four-year timeframe, although work toward the 90/90/90/50 Plan began in 2016, one year before the Integrated Plan. The 90/90/90/50 Plan's working groups within HAHSTA have prepared crosswalks of the Plan's work compared to the Integrated Plan, identifying which activities satisfy both plans and which activities are unique to each document. Cross-referencing the goals and tasks of the Plan and the Integrated Plan will be an ongoing exercise for HAHSTA.

THIS PROGRESS REPORT: Checking in on the work

The plan for reaching the 90/90/90/50 goals anticipated not only the steps needed to reach the goals, but also the method for a transparent, cooperative, and ongoing implementation and monitoring.

Every year on World AIDS Day, DC Appleseed will publish a public report on the activities undertaken in the previous year to achieve the goals of the 90/90/90/50 Plan. This marks a new chapter in our long engagement in the effort to tackle the HIV epidemic in DC, which began in 2005 with a call for a serious overhaul of nearly every aspect of the District government's response to the HIV crisis. Subsequently, DC Appleseed spent the next nine years issuing periodic report cards on the steps taken by the District government and other stakeholders to address the crisis.⁸ By the time of our last report card in December 2014, many local policymakers and advocates asked for the report every year. In fact, many District officials said they were motivated to earn a higher grade throughout the year. Although our role has shifted with the 90/90/90/50 Plan – from watchdog to co-author – we will continue our tradition of monitoring and inclusive community conversation in that process.

This progress report is the first in which we will reflect on the latest HIV statistics, assess the District's work to complete each of the 42 tasks, and analyze the overall trajectory of ending the epidemic by 2020. The progress report attempts to foster the transparency and accountability which have been such essential elements of our progress to date. It is also an opportunity to give residents and advocates a bird's eye view of the District-wide, cross-sector endeavors underway.

This report tracks the movement of the banner goals—90/90/90/50—and assigns each task one of three status categories – Implemented, In Progress, or No Progress. To the extent that activities need to be sustained until 2020 and beyond, the status of “implemented” is not a fixed end point and may be moved back to “in progress” in future years as necessary. The 90/90/90/50 Plan also included public calls to action, which we restate in the report and offer resources for further engagement. We conclude our discussion of the tasks with concrete recommendations for the year ahead.

During the development of the Plan, Washington AIDS Partnership Executive Director Channing Wickham reminded us that “now is not the time to slow down.”⁹ In fact, now is the time for stronger action than ever before, because the potential for change is so great and the stakes so high. Through continued leadership, ambitious thinking, and implementation of the tools and the steps that underpin the 90/90/90/50 goals, the District can bring about greater decreases in new HIV infections and, eventually, end the epidemic in DC.

8. DC Appleseed, Report Cards 1-9 (2006-2014), available at <http://www.dcappleseed.com/projects/health-and-environment/hivaid/>.

9. Morgan Baskin, The Cost of Living, Part 2, Wash. City Paper, Mar. 4, 2016, <http://www.washingtoncitypaper.com/news/article/13047642/the-cost-of-living-part-2-hiv-aids-dc>.

Data Overview:

The Most Recent Numbers on HIV/AIDS in DC

In June 2017, HAHSTA released the [Epidemiology and Surveillance Report](#) with data on HIV for 2016.¹⁰ The six-month turnaround for the epidemiological report's data was half that of previous years. (Note: while the most recently available and complete data that is referenced in this report is for the year 2016, the activities described took place during 2017. The true impact of efforts described herein should be more apparent when complete data for 2017 is released.) The two key measures of the HIV epidemic are prevalence – the number of people diagnosed at any time and currently living with HIV in the District – and the total number of new diagnoses by year. The prevalence data identify those in need of treatment and care interventions, and the number of newly diagnosed cases point to where prevention and testing efforts should be focused.

An estimated 12,964 individuals diagnosed with HIV were presumed to be living in the District at the end of 2016. Thus, about 1.9% of the population of DC is living with HIV. These numbers have been refined from previous years through a new method for counting the people living in the District versus those diagnosed here. The 2016 data show that a total of 16,949 HIV/AIDS cases had been diagnosed in DC to date. Of this total, approximately 6,247 individuals diagnosed in the District have since moved out of the District, and approximately 2,262 individuals initially diagnosed with HIV outside the jurisdiction have moved into the District. As a result, DOH estimates a net loss of 3,985 cases from previous calculations.

The epidemiological report provides prevalence by demographic group, which shows which communities are especially burdened by HIV. By age, the number of diagnosed 13-19 year olds and 20-29 year olds decreased from 2015, while ages 50-59 years and 60 or older increased. District residents between 40 and 49 years of age and 50 and 59 years of age have the highest rates of HIV—approximately 3.7% of residents 40-49 years and 5.2% of residents 50-59 years are living with HIV. This high prevalence in older adults can be explained, in part, by the increased life expectancy of a large group of PLWH diagnosed in past years.

At the end of 2016, 3.1% of black District residents were living with HIV—the hardest hit demographic in the District—with the highest burden of disease among black men (4.4%). Comparatively, 1.2% of Hispanic/Latino residents and 0.9% of white residents were living with HIV in 2016. Less than half (46.7%) of the DC population is black, yet 75% of all HIV cases are among black residents. Among women, black women accounted for 94.1% of HIV cases in DC. In addition, nearly 84% of transgender people living with HIV were black. The persistence of these racial disparities, which have remained stable over several years, necessitates renewed attention and tailored investment. We also observed disparities by neighborhood and gender identity in the data: Census tracts with the highest rates of HIV include wards 5, 6, 7 and 8. Men make up the majority of PLWH in the District (71%).

In 2016, 347 new cases of HIV were diagnosed, representing a 12% decrease from 2015 and a 73% decrease from the height of 1,333 cases reported in 2007. In general, the 2016 data reflects a downward trajectory similar to 2015, and 2016 was the ninth consecutive year the number of new cases declined. Sexual contact was the leading identified mode of transmission, although mode of transmission was “unknown” for more than one-fifth of diagnoses. Another year of decrease in new infections occurred among injection drug users (IDU), with only 7 new HIV cases. New data mirror the racial disparities in the total prevalence; over 73% of newly diagnosed cases were among black residents. Lastly, while the age in the total population of PLWH in DC skews older, the rates of new infections among young people continue to alarm. Young adults ages 20-29 comprise one-third of all new infections, with 115 new cases in 2016. Rates of new infection are especially high among young black men who have sex with men.

10. DC Department of Health HIV/AIDS, Hepatitis, STD, and TB Administration, Annual Epidemiology & Surveillance Report: Data through December 2016 11 (2017). https://doh.dc.gov/sites/default/files/dc/sites/doh/page_content/attachments/2016%20HAHSTA%20Annual%20Report%20-%20final.pdf.

2017 Progress:

The Status of 90/90/90/50 Goals and Tasks

Goal 1

90% of HIV-positive District residents know their status

The first step of HIV treatment is timely diagnosis. In 2015, DOH estimated that 86% of HIV-positive individuals were aware of their HIV status. This figure is the baseline for Goal 1. The 2016 epidemiological report did not include an updated estimate of the percentage of HIV-positive individuals who know their status.



HAHSTA's 2015 estimate—produced for inclusion in the 90/90/90/50 Plan—was already close to the final goal of 90%. Because a new estimate was not calculated, it is not possible to assess whether we are on the right track for this goal. Although other measures exist, they are not apples-to-apples comparisons in methodology or timeframe. For example, National HIV Behavioral Surveillance data from 2013-2015 show that about three-quarters of those surveyed in the District reportedly knew their HIV status. HAHSTA also states in the epidemiological report that “baseline data by subpopulation indicates that residents are on their way to reaching planned goals.”¹¹ However, without an estimate for 2016 derived from the same methodology used in 2015, it is impossible for us to evaluate true progress.

To meet the goal of 90% of District residents knowing their HIV status, the Plan calls for increased targeted HIV testing over and above the routine testing program already in place, as well as more active engagement among residents and all healthcare providers. And, implementation of various data collection strategies included in the Plan may improve measurement of progress on this goal. HAHSTA should promptly revisit its 2015 estimate in order to better gauge progress on this important goal.

Progress on Goal 1's Tasks

Task 1.1: Use geospatial and demographic data to increase targeted testing, and require providers receiving testing grants to utilize evidence-based programs that target social networks where new infections are most likely.

2017 Status: In Progress

Over the last decade, DOH has greatly expanded testing programs throughout the District through a dual approach: promoting routine, opt-out testing when residents visit medical providers, and providing testing in hospital emergency rooms, community-based settings, and at the Department of Motor Vehicles offices. Recently, researchers at The George Washington University showed that in DC, testing directed to populations at higher risk of HIV infection is much more likely to identify new cases of HIV and is more cost-effective than broad efforts to reach the general population.¹² Therefore, the 90/90/90/50 Plan reimagined the mix of testing strat-

11. Epi Report, 2016

12. Amanda D. Castel et al., Comparing Cost-Effectiveness of HIV Testing Strategies: Targeted and Routine Testing in Washington, DC (2015), <http://journals.plos.org/plosone/article/asset?id=10.1371/journal.pone.0139605.pdf>.

egies: The most successful current testing programs—those with positivity rates of 1% or more, such as testing in hospital emergency departments—were to continue, with some funding redirected to new, more targeted testing programs. This task involved identifying geographic “hot spots” for testing and prevention efforts. Over the last year, HAHSTA has conducted research and analysis to inform these targeted programs.

HAHSTA continues to produce maps documenting geospatial patterns of HIV, sexually transmitted infections (STIs), and hepatitis diagnoses across the District as part of the annual epidemiology and surveillance report. While these maps provide a baseline for evaluating geographic patterns of infection, HAHSTA has directed attention toward the utilization of statistical methods for assessing the spatial clustering of HIV and STI diagnoses at the census tract level. HAHSTA has also analyzed these spatial distributions over time, and examined associations between these geographic patterns of infection and demographic characteristics. The acquisition, assessment, and “cleaning” of the data for these analyses has been time-consuming; however, the results of these analyses are currently being developed or are under review. Effort has also been directed toward completing a resource allocation map, which will document the location of prevention and care services across the District. The Strategic Information Division and the Prevention Division within HAHSTA are currently outlining how the results of these analyses can inform testing priorities.

DOH also proposed requiring providers to target high-risk social networks as a condition of grants. DC had implemented “social networking screening” (SNS) as part of a CDC demonstration project in 2005-2006, and the SNS model was implemented as a fee-for-service contract in 2015. DOH discontinued the latest SNS program in August 2017 due to poor performance and low fidelity to the model among providers. In reviewing the SNS program, DOH staff determined that changes in the monitoring and evaluation procedures were necessary, as were provision of appropriate supports, to enable community providers to more successfully comply with the model. Discussions are underway to revise the program—and possibly to include PrEP and PEP. However, no implementation date has been set.

Over the next year, HASHTA staff will continue to meet to specify target HIV testing areas and focus populations. This task will be considered implemented upon the completion of two crucial analyses: the location-allocation analysis to determine optimal prevention and care service locations, and prevention and care resource allocation mapping. Establishing an improved model for DOH targeted testing grants should be part of these activities. Upon implementation, assessment of positivity rates across target areas and populations will need to be evaluated to determine whether the strategies were effective in increasing efficiency of testing programs.

Task 1.2: Continue media campaigns and medical provider education to ensure new and ongoing HIV testing approaches.

2017 Status: Implemented

DOH has launched several successful media campaigns to promote routine testing and advertise available services, the continuation of which is a foundational element of the Plan’s testing and prevention efforts. DOH also plans to continue outreach and education campaigns to individual providers, as well as hospitals and primary care clinics. Given that the assigned task was to “continue” efforts from 2016, this task has been implemented in 2017.

The current high-visibility media campaigns related to prevention and testing include, among others, “[DC Takes on HIV](#),” “[Ask for the Test](#),” “[Rubber Revolution](#),” “[DC Takes on STDs](#),” “[Do It Right DC](#),” “[PrEP for Her](#),” and “[Sex Is...](#)”. DC is also part of the national “[U=U \(Undetectable Equals Untransmittable\)](#)” campaign. Many of the active campaigns are tailored for specific demographic groups; for example, Do It Right DC is designed for gay men. DOH also hosts an online survey to gain feedback on social marketing campaigns as part of “DC Takes on HIV.” Two campaigns ended in 2017: “DC Does It” and “DC Show Off.” Written materials such as information cards are also produced to help the public navigate issues such as accessing care rapidly upon diagnosis. HAHSTA is also developing a new, comprehensive multi-media sexual health campaign for 2019 that will integrate routine screening, prevention options and treatment.

Efforts geared toward provider education include several HAHSTA-prepared handbooks and pamphlets related to routine testing, testing during pregnancy, and PrEP. HAHSTA posts HIV-related continuing education recommendations on the DOH [website](#). Going forward, HAHSTA would like to increase coordination with the department's Health Regulation and Licensing Administration to ensure that up-to-date information on testing techniques is included in medical provider education.

HAHSTA has identified a need for a plan and resources to monitor and evaluate the reach and efficacy of these materials, including efforts to gather feedback from providers and community members, to identify measurable outcomes from the dissemination of this information, and to examine the community impact of its efforts. Staff members also envision creating a repository and coordinated marketing plan for all media campaigns, including those that have been created by community providers through grant funding.

This task is considered implemented. DOH must sustain effective campaigns over the course of the next three years to maintain progress. Evaluation and coordinated plans for the many active campaigns may increase effectiveness and efficiency. Maintaining and enhancing provider education will be especially critical to increasing testing.

Task 1.3: Identify those who test negative but are at elevated risk and engage counseling for prevention strategies—including counseling for Pre-Exposure Prophylaxis (PrEP).

2017 Status: In Progress

In the HIV care continuum, a positive test leads to rapid engagement with treatment, but a negative test often does not lead to any particular action and becomes a missed opportunity to avert future infections. For example, someone who tests negative but is with an HIV-positive partner may be an ideal candidate for PrEP. Likewise, a person who tests negative for HIV but positive for one or more other sexually transmitted infections is at increased risk for HIV infection, and should be counseled on HIV prevention and PrEP. A sexually transmitted infection thus, someone diagnosed with an STI should. To assure these opportunities are not missed, DOH set out to engage certain patients with negative results in prevention strategies, such as counseling for PrEP. In 2017, the practice was implemented at certain sites through dedicated funding, though broader requirements are not yet in effect.

Currently, DOH expects participating testing sites to interview patients regarding their sexual histories to identify high-risk individuals, and report actions to DOH such as treatment of STIs and whether a provider offered PrEP or Expedited Partner Therapy for individuals with chlamydia to obtain treatment for their sexual partners.

Since 2014, HAHSTA has focused on a PrEP navigation program and non-medical assessment for “high-risk negatives” through its “IMPACT DMV” project, funded through the THRIVE Demonstration Project grant from the CDC. Now in its third year, IMPACT DMV is a community-led collaboration that develops and provides holistic health and wellness for men who have sex with men and transgender individuals of color in the region (DC, Prince George's and Montgomery Counties in Maryland, and northern Virginia). In partnership with the DC Health and Wellness Center, candidates for PrEP are identified. As a result of counseling and the assessment process, these candidates can elect to access their initial 30-day prescription of PrEP with navigational and support services. As of October 2017, over 200 persons have been connected to PrEP via the DCHWC. This program can serve as a model for other providers.

Some community providers have also established practices to identify candidates for prevention interventions. For example, at Whitman-Walker Health, everyone who is tested for HIV is offered a conversation about PrEP with a designated “PrEP navigator.” Whitman-Walker reports starting about 50 patients a month on PrEP, totaling more than 900 patients as of November 2017.

Although there are successful models at several sites in the District to further engage patients following a negative HIV test, it is possible that compliance indicators or more stringent grant requirements are needed to change provider practices. Staff at HAHSTA has identified the need for additional analysis to provide up-

to-date results on the risk for HIV acquisition among individuals with elevated risk, such as those diagnosed with an STI infection, to inform the next steps in this effort. This task is currently in progress; DOH will need to determine how to enforce measures or requirements across all testing grantees for this task to be considered implemented.

Task 1.4: Adopt and implement HIV-testing performance measures and thresholds for Managed Care Organizations (MCOs).

2017 Status: In Progress

The Healthcare Effectiveness Data and Information Set (HEDIS) was developed by the non-profit National Committee for Quality Assurance to measure performance on important dimensions of healthcare in the United States. There are 81 measures related to delivery of care, from flu vaccinations to antidepressant medication management. These measures are used by more than 90% of health plans nationally, including Medicare and Medicaid. The District's Department of Health Care Finance (DHCF) uses HEDIS measures to assess the performance of Medicaid managed care organizations in DC. However, there are no current HEDIS measures related to HIV. Therefore, DOH committed to develop and implement a performance measure on HIV testing for the DC Medicaid program to help increase the number of District residents who receive annual testing as part of their healthcare. DC Appleseed volunteered to facilitate research into potential model measures for this initiative. This initial research was completed in 2017.

Research into these measures was conducted by DC Appleseed's pro bono partners at Hogan Lovells US LLP. They surveyed World Health Organization measures, measures considered by the U.S. Department of Defense and Veterans Affairs, ran general searches to try to capture State Department programs where there might be measures, reviewed all HIV-related National Quality Forum measures, and examined other federal sources, including the CDC and the Health Resources and Services Administration (HRSA). Surprisingly, there are not many performance measures related to HIV testing from these sources.

In the end, this research yielded two possibilities related to HIV testing from HRSA. One measure from HRSA's HIV/AIDS Bureau considers the percentage of HIV positive tests among all HIV tests conducted in a 12-month period.¹³ Another from the HRSA Quality Toolkit measures the percentage of pregnant women who were screened for HIV infection during the first or second prenatal care visit.¹⁴

Now that the research has yielded a small number of possible models, HAHSTA's work on developing and implementing measures with DHCF can begin. This task will be considered implemented when one or more HIV-testing performance measures—or measures that achieve the same desired effect—are implemented by DHCF for managed care organizations.

13. HRSA, HIV/AIDS Bureau Performance Measures Portfolio. Available at <https://hab.hrsa.gov/sites/default/files/hab/clinical-quality-management/systemlevelmeasures.pdf> The HIV/AIDS Bureau's complete list of measures related to HIV/AIDS is available at: <https://hab.hrsa.gov/clinical-quality-management/performance-measure-portfolio> (accessed November 17, 2017).

14. HRSA, Quality Measure: HIV Screening for Pregnant Women, available at <https://www.hrsa.gov/sites/default/files/quality/toolbox/508pdfs/hivscreeningpregnantwomen.pdf> (accessed November 17, 2017).

Goal 2

90% of District residents diagnosed with HIV are in treatment

Upon diagnosis, it is critical for patients to be linked with medical treatment and anti-retroviral therapy in order for them to stay healthy. In addition, when individuals adhere to treatment and maintain viral suppression, there is effectively zero risk that they will pass on the virus. The Department of Health estimated that 73% of DC residents diagnosed with HIV had received one or more laboratory tests—an indicator of engagement in care—during 2015. This is the baseline used in the Plan. The 2016 epidemiological report estimated that 76% of residents living with HIV were actively engaged in treatment, a 3% increase toward the 90% goal.



An increase in proportion of diagnosed individuals retained in any care is a step in the right direction. However, while the 2016 data measure engagement in any care (at least one completed lab test), the emphasis with this goal is on treatment (prescription and adherence.) Because not all patients who attend appointments necessarily adhere to daily ART regimens, that number would be lower. (In the Plan, an estimate is ventured that 66% of all people diagnosed with HIV are on treatment.) It is drug therapy that improves health and lowers transmission risk. Yet, the data measures the broader definition. This discrepancy between “care” and “treatment” must be reconciled in order to most accurately measure progress.

The epidemiological report highlighted some disparities in the 2016 care data. Individuals between 30-39 years old were least likely to be engaged in care. Women and transgender individuals were more likely to be retained in care compared to men. By mode of transmission, injection drug users had lower rates of linkage to care. The 2016 report also presents figures of linkage to care within three months of diagnosis from 2011-2015 (81%), which can guide interventions related to rapid linkage to care.

To meet the goal of 90% of HIV-positive District residents being in treatment, the plan examines how to improve linkage and adherence to treatment, as well as ways to expand and protect access to care, while ensuring the care provided is grounded in evidence-based and culturally appropriate practices. The Plan also conceptualizes new policies to improve data sharing, and to help providers connect with patients who have fallen out of care. Alongside these efforts, HAHSTA should define the measure related to this goal more clearly: since the 90/90/90/50 Plan emphasized the importance of treatment adherence beyond connection to a provider, we believe this should be the measurement going forward. This may be more difficult to achieve and measure, but HAHSTA’s tasks outlined in the Plan support this more ambitious characterization of Goal 2.

Progress on Goal 2’s Tasks

Task 2.1: Reduce the time from initial diagnosis to initiation of ART through a relaunch of the Red Carpet Entry Program.

2017 Status: No Progress

As a result of recent research demonstrating that early initiation of HIV therapy reduces mortality and morbidity in HIV-positive individuals, the CDC updated its guidance to recommend immediate initiation of ART. Timely linkage to care, therefore, became a significant focus of the 90/90/90/50 Plan. Goal 2 included a task

15. U.S. Department of Health and Human Services. Panel on Antiretroviral Guidelines for Adults and Adolescents, Guidelines for the Use of Antiretroviral Agents in HIV-1-Infected Adults and Adolescents E-1 (2016), <https://aidsinfo.nih.gov/contentfiles/lvguidelines/adultandadolescentgl.pdf>.

to revamp and expand the Red Carpet Entry program in DC, which had seen previous success in linkage and navigation efforts to “anchor” patients into care with a medical home, where they received comprehensive and continuous medical care. The expansion of the Red Carpet program included establishing a project manager to oversee case managers or peer navigators who help establish and maintain linkage with care. However, the work imagined in the 2016 Plan depended on grant funding, and while HAHSTA applied for such funding, it ultimately did not receive an award in 2017. There was, however, continued investment in linkage activities through other programs, as well as a change in payment delivery to HAHSTA grantees for such services.

The current and ongoing practice is for any patient who is newly diagnosed with HIV to directly start HIV treatment through their provider or is connected to an HIV provider. HAHSTA does follow up with all newly diagnosed persons to ensure or support their linkage to care, offer confidential notification of their partners, and help with other needs like insurance or social services.

Up through this year, linkages or Red Carpet Entry services were outlined in annual grant agreements between HAHSTA and its community providers and monitored through monthly reports of data and service delivery details. HAHSTA is in the early stages of changing the way grants for service provision are administered, from annual grants to a fee-for-service model. Under this new payment arrangement, providers will invoice HAHSTA for services, and HAHSTA will audit and track services and issue payments. HAHSTA expects that the linkage data collected will be even more detailed than the monthly reports.

The Youth Reach program is designed to provide an intensive set of care and support services for high-need young people of color. This year, the federal Ryan White Part A program has funded seven service providers within the Washington, DC Eligible Metropolitan Area (EMA) to provide medical and support services to young people of color between the ages of 13-30, including African-American women, African-American/Hispanic/Latino men who have sex with men, African-American heterosexual men, and African-American/Hispanic/Latino transgender women. The goal is to provide a seamless transition for youth of color from prevention and testing programs into care, and to offer a one-stop shop with experienced, diverse, youth-serving staff. In line with the expectations of a medical home, the program provides comprehensive services including mental health and substance abuse care, early intervention services, medical case management, and outpatient ambulatory health services. As of October 2017, the program included four providers in the District of Columbia, two in suburban Maryland and one in northern Virginia. DOH receives monthly reports on progress in the program. The program will end in spring of 2018, but can be extended for two optional years.

While there was no formalized re-launch of the Red Carpet Entry program, other more narrow activities are underway. HAHSTA will review how a connection to a HIV specialist and the rapid initiation of ART can be improved outside of the original plan. In the year ahead, HAHSTA must determine whether current programs and payment systems are sufficient to reduce the time from diagnosis to treatment across the District. As there is no progress on the task as written in the 90/90/90/50 Plan, the team at HAHSTA may reassess whether the goal needs to be rewritten to meet the realities of programmatic funding in the year ahead.

Task 2.2: Examine the feasibility of requiring all providers in DC to report treatment of a new patient with HIV and when a patient begins ART to DOH.

2017 Status: In Progress

Throughout the 90/90/90/50 Plan, DOH highlighted opportunities to improve data collection, including more precise accounting of who is engaged in drug therapy. Currently, there is no mandate for providers to report to DOH when they establish antiretroviral treatment for a patient. This leaves the District and providers with an incomplete picture of who is in treatment. Requiring healthcare providers in DC to report to DOH is a feasible strategy and should be an integral part of the District’s plans to improve outcomes and conditions for PLWH. DC Appleseed and pro bono partners at Hogan Lovells US LLP conducted research over the last year on the feasibility of instituting such a requirement.

Since 2008, DOH conducts regular “retention blitzes,” when providers reach out to DOH about specific patients who have dropped out of care in order to ascertain whether they are receiving treatment from other providers. DOH then consults records from across the District to identify patient treatment status, gaps, and connections for providers. Tracking patients’ antiretroviral treatments is essential for helping patients manage their illness and keeping their viral loads low, so as to minimize the risk of HIV transmission to uninfected people. However, DC requires the submission of only limited types of data, such as positive HIV test results. It does not require reporting when a patient begins or resumes ART, which would be helpful information for tracking patient status and District-wide treatment adherence.

The District has several tools at its disposal to initiate a new reporting requirement. DC law authorizes the Mayor to issue rules to prevent and control the spread of communicable diseases, such as HIV. Information collected under the relevant provisions is limited to statistical and public health purposes only; identifying information may not be disclosed without written consent unless doing so is essential to safeguard the physical health of others. Moreover, because DC receives federal funding under the Ryan White CARE Act program, DC must already submit monitoring data for providers, clients, and certain drug treatment programs on its progress. Although the Health Insurance Portability and Accountability Act of 1996, amendments, and implementing regulations (HIPAA) limit the disclosure of individual health information without individual consent, the District’s use of such information to track patient treatments falls within a public health authority exception. Other jurisdictions, including the states of California and New York and the city of Baltimore, already require treatment reporting in different forms.

The District’s need for cross-border cooperation with Maryland and Virginia should not present a challenge. Nonetheless, an effort to standardize data entry and collection across both states and the District would make collaboration more efficient.

This legal research has been presented to HAHSTA. Several providers have expressed willingness to share such information with DOH voluntarily or otherwise, so long as the administrative burden is not cumbersome. The next step is for HAHSTA to consult providers directly to further examine the feasibility of such reporting. This task will be considered implemented when these conversations have taken place and the HAHSTA staff reach a conclusion about creating a reporting requirements.

Public Call to Action 1: Providers should voluntarily report (a) when they begin treating a new patient with HIV who is not a new diagnosis and (b) when patients begin ART.

As noted in Task 2.2 and elsewhere, there is no requirement for providers to report to DOH when they establish antiretroviral treatment for a patient, beyond some isolated programs that may include this as part of their grant requirements. As noted in Task 2.2 above, DOH facilitates “retention blitzes” to share information with providers about gaps in care and connections to other providers, allowing practices to focus their re-engagement efforts on those patients who are truly out of care. In addition, when providers report treating a person for the first time, DOH can pass that information along to other providers. This voluntary reporting could potentially save hours of time and work for providers and CBOs, as well as help the District track this important information more precisely. As DOH continues to explore the possibility of institutionalizing treatment reporting, providers can provide the information voluntarily. This may require further discussion with DOH staff about the best way to facilitate this sharing. As noted above, providers in the community expressed willingness to report treatment initiation, as long as it did not present too much administrative burden.

Task 2.3: Expand access to treatment and related services, targeting demographics and geographic areas where populations are at higher risk.

2017 Status: In Progress

As noted on page 17, under Task 1.1, DOH is working to identify geographic “hot spots” where new HIV and STI diagnoses are concentrated in order to determine where resources are most needed. In the Plan, DOH also envisioned assessing the geographic clustering of lower rates of retention in care and viral suppression, and increasing understanding of the influence of social factors on HIV status, such as education, employment, income, transportation, and housing. As with other activities in the Plan, DOH wanted to use more precise analytic tools to tailor interventions efficiently and effectively. Over the last year, several initiatives aimed to expand access to services for high-risk populations.

As described in Task 2.1 on page 21, the Ryan White Part A program has funded seven DC-area providers to offer extensive care and support services to youth of color between the ages of 13-30. Additionally, the Ryan White Part B program funded two organizations in DC to provide outreach and enrollment services to increase minority participation in the AIDS Drug Assistance Program (ADAP) and other medical assistance programs. People of African, Latino/Hispanic, Asian, and/or Arab descent, as well as those who have impaired hearing, have been identified as targeted sub-populations through this funding effort. Through this program, community health workers (CHWs) will conduct presentations, distribute educational tools, conduct one-on-one educational sessions, make appropriate referrals to address identified barriers and needs, and assist eligible individuals with applying for pharmacy assistance programs for medication coverage. Services began through two providers on October 1, 2017 and will end March 31, 2018, with an option to extend the program by one year. The expectation is that the strategies used in this program will continue to increase the District’s capacity to reach and retain traditionally marginalized populations.

DOH is also conducting a needs assessment to inform programming and funding through the Ryan White program. The preliminary results of the District’s Ryan White Planning Council Needs Assessment suggest that respondents were engaged in care, received Outpatient/Ambulatory Health Services (OAHS) on a timely basis, had high rates of ART utilization, and reported very low rates of unmet need. In-depth analysis, such as by ward, has not yet been possible. The data were incorporated into the council’s 2017 Priority Setting and Resource Allocation process in August 2017. Data collection for Needs Assessment will continue through August 2018.

The strategic targeting of interventions—especially those geared toward helping residents overcome barriers and gain access to treatment—are essential for all services in the District, not just those funded through the Ryan White program. As the current programs and data analysis continue through 2018, we hope to see the data inform new initiatives across all District-funded programs.

Task 2.4: Develop a standard consent form for HIV care that allows DOH and providers to share information that could improve treatment while respecting patient confidentiality.

2017 Status: In Progress

During “retention blitzes,” DOH staff members identify patients who may have fallen out of care and inform providers whether they are receiving treatment elsewhere. Currently, DOH can share only whether a patient is in treatment with another provider—not which provider is currently seeing a patient. Task 2.4 envisions a mechanism to increase the patient information DOH collects and shares with other providers. DC Appleseed and its pro bono partners at Hogan Lovells US LLP committed to undertaking research on best practices and potential concerns, and help DOH draft a consent form for patients to allow this kind of information sharing. This initial

research was completed in 2017 and findings are described below.

Based on DC's public health laws, physicians, laboratories, and other entities are required to report an HIV diagnosis to the Department of Health. To ensure that District residents living with HIV are in treatment, HAHSTA collects information relating to blood lab tests, which helps HAHSTA to gauge the level of viral suppression experienced by the patient. When a tested blood sample reveals HIV/AIDS status, this information must be reported to DOH. If a patient falls out of care or changes physicians, the patient's previous physician must update DOH. The reports received are used to inform the District about the overall picture of the epidemic in DC and providers about their individual patients. However, under DC law, DOH cannot release identifying information about the patient to certain providers without the patient's consent.

Providers typically ask patients to complete a form that allows the provider to conduct various medical actions such as screenings, examinations, laboratory tests, and other procedures. Under the Health Insurance Portability and Accountability Act of 1996, amendments, and implementing regulations (HIPAA), providers are permitted to disclose patient health information to other providers for treatment purposes and to state health authorities for public health activities, without a specific authorization for the disclosure. However, under DC law, HAHSTA or any other District agency or service provider disclosing health information to another agency or provider covered under the law must obtain the individual's written consent prior to disclosure. If patients have given prior written consent, DOH may share additional information with covered providers to improve care or help reengage patients who have fallen out of care, while also respecting patients' privacy. Because the DC law requiring written consent does not include specific content requirements, DOH can examine other states' patient authorization forms and consider HIPAA standards and general best practices to adopt in order to protect residents' privacy.

These findings and recommendations have been shared with HAHSTA leadership. An internal workgroup will be established at DOH to review the findings and explore implementing the draft consent form across relevant programs by the end of 2017. This task will be considered "implemented" when a consent form is finalized, distributed and used by providers in the community, especially those serving high volumes of PLWH. Project managers at HAHSTA anticipate implementation in early 2018.

Task 2.5: Expand the use of community health workers as a component of HIV care and treatment.

2017 Status: In Progress

A community health worker (CHW) is a frontline public health worker who is a trusted member of and/or has a close understanding of the community served, and serves as a link between health and social services providers and the community. CHWs not only facilitate linkage and supports for individuals, but can also improve the quality and cultural competence of service delivery. CHWs are especially important when working to engage with more vulnerable populations who have long been underserved, face many barriers to care, and/or have been alienated from the medical system. In order to invest in this model of peer navigation, the Plan tasked DOH with working with other government partners, such as DHCF and the University of the District of Columbia, as well as community partners, to establish an optimal and sustainable CHW program District-wide. This would involve aspects related to training, certification, credentialing, and integration of CHWs into healthcare and non-healthcare settings. This work began within HAHSTA in 2017, with several next steps planned for early 2018.

A CHW workgroup has been formed under the auspices of the already-established Early Identification of Individuals with HIV/AIDS (EIIHA) Committee within HAHSTA. Members of this committee include staff from the different divisions of HAHSTA. The EIIHA Committee was already working on a number of tasks related to CHWs from the EIIHA Workplan, which were developed apart from, but align with, the 90/90/90/50 task. These efforts involve convening and gathering information from CHWs and other stakeholders, which will then inform

standardization of a CHW credentialing process.

The activities undertaken by the workgroup include creating a web-based resource guide for CHWs and front-line services providers, which should be complete in March 2018. The workgroup is also planning to develop standardized operating procedures, performance measures, and an intake form for post-test counseling, intake, linkage-to-care, and reporting of newly diagnosed clients to HAHSTA, which will be discussed and revised through 2017. The workgroup also plans to conduct an online survey for CHWs and providers. A roundtable of CHWs, providers, regional jurisdictional health department staff, and others should be convened in 2018 to learn more about current CHW implementation, needs, and ideas for revision of the CHW implementation process. Additionally, provider meetings with the CHWs are planned to receive feedback from frontline workers and, in turn, offer resources, training and technical assistance. Finally, and with all of the aforementioned feedback gathered, the Committee plans to standardize a CHW certification or credentialing process, beginning in early 2018.

To the extent that a standardized certification or credentialing process spreads the utilization of community health workers in healthcare settings, this task is on its way to implementation. In addition to these efforts, we hope to see expansion of funding for providers to hire and maintain CHWs where HIV services are provided. At present, CHWs can be part of the care team providing a range of services through Ryan White, but there is no other particular mechanism for funding. We also want to ensure that members of vulnerable populations are not boxed out of paid CHW positions due to certification or credentialing requirements, and would like to see discussion of this concern reflected through the EIIHA committee's deliberations. This task will be considered implemented when a plan is finalized, with participation of other government and community groups, for integrating CHWs into more healthcare settings.

Task 2.6: Use peer navigators to engage with African-American and Latino men who have sex with men and transgender people of color.

2017 Status: In Progress

The Improve Measurable Participation and Access to Care and Treatment in the District, Maryland, and Virginia program (IMPACT DMV)—also discussed on page 19—is a collaboration among DOH, Maryland and Virginia health departments, and community partners, to create a regional system of care for both HIV-negative and HIV-positive men who have sex with men and transgender individuals of color. DOH is in the third year of a four-year CDC grant for IMPACT. The project aims to address the contextual circumstances that relate to improved health outcomes, such as education, employment, housing, and overall wellness to enhance self-efficacy. A large proportion of programs participating in IMPACT have experience successfully serving men of color who have sex with men of color and transgender people. In an initial approach to integrate economic opportunity and engagement in the health system, DOH planned to create new peer counseling positions called Health Impact Specialists (HIS) to help with outreach to persons at risk of HIV and living with HIV, and assist in connecting people to community resources and services. This task is currently ongoing.

As of 2017, 24 trained Health Impact Specialists were embedded at community partner sites. Some have “graduated” to become full-time employees at these sites. Currently, three cohorts of HIS have been engaged. Plans are in process for the engagement of the fourth cohort to be recruited and assigned to organizations. These navigators are members of affected communities and relate to clients based on shared experiences, and assist with routine screening for, linkage to, and navigation of behavioral health and social service needs. The services offered by peer navigators are more limited than those offered by community health workers. Plans to complete this demonstration project coincide with the conclusion of the IMPACT DMV Project at the end of the 2019 fiscal year.

The work under Task 2.6 was designed to align directly with the funded IMPACT grant. In the Plan, DOH committed to expand this opportunity for more participants, assess its effectiveness, and determine whether this

model can be used to engage other focus populations in care. The work is in progress, and will be considered implemented when the Health Impact Specialist component of the IMPACT demonstration project is assessed and DOH determines whether the project should be expanded.

Task 2.7: Reconsider the six-month in-person re-registration for the DC Healthcare Alliance.

2017 Status: In Progress

The DC Healthcare Alliance is a locally funded public insurance program that offers coverage to low-income District residents who are ineligible for Medicaid or other programs. The Alliance is an important resource for approximately 15,000 District residents, especially immigrants.¹⁶ In 2012, the Department of Health Care Finance (DHCF) began to require patient re-enrollment every six months instead of every 12 months, a measure aimed to control the costs of the program by screening out non-residents. The process requires an in-person interview to recertify residency.¹⁷ This has created a significant burden for enrollees, who encounter long wait times or insufficient language assistance, and often cannot enroll on the first attempt. In 2015, DHCF data showed that up to 71% of enrollees did not re-enroll on schedule, causing lapses in coverage and leading residents to fall out of care.¹⁸ The District's work to ensure all PLWH are engaged in ongoing care is only possible to the extent that the population can access treatment. The 90/90/90/50 Plan stated that the recertification process "should be reconsidered so that District residents who most need the benefits have reasonable access."

Over the last year, legislative remedies were introduced in the DC Council. First, the DC Healthcare Alliance Program Recertification Simplification Amendment Act of 2017 was introduced by Councilmember Brianne Nadeau in the Committee on Human Services. The bill allows program participants to conduct one biannual re-registration interview by telephone, in lieu of the in-person interview. It would also exempt people who are hospitalized, disabled, elderly—or caring for a household member who is hospitalized, disabled or elderly—from a face-to-face interview. In addition, the bill mandates public reporting on the impact of eligibility procedures on enrollment. The bill was enacted on October 24, and is under congressional review at this time. The law will be effective when the estimated cost of \$5.9 million for Fiscal Year 2018 (\$30.2 million for the four-year financial plan) is allocated in the budget.

Concurrently, Councilmember Vincent Gray introduced the Department of Health Care Finance D.C. Healthcare Alliance Amendment Act of 2017 in the Committee on Health. The bill reverts the re-certification period to 12 months, allows registration at community health centers, and requires DHCF to explore the feasibility of including the Alliance in the DC Health Benefit Exchange online portal. The bill passed the Committee on October 5, and was sent to the whole Council for a future vote. The fiscal impact was estimated to be \$16.9 million in Fiscal Year 2018 and \$105.2 million over the next four years.

In response to testimonies on both bills, the Council's 2018 budget reallocated funding for three full-time employees within the Department of Human Services to enhance capacity for Alliance recertification services.

In 2018, DC Appleseed will advocate for inclusion of adequate funding for the new Recertification Simplification law during the Fiscal Year 2019 budget season, and will engage in the other efforts to improve access and prevent churn in the Alliance program. The task will be considered implemented when that policy change is in effect and adequately funded.

16. U.S. Department of Health and Human Services. Panel on Antiretroviral Guidelines for Adults and Adolescents, Guidelines for the Use of Antiretroviral Agents in HIV-1-Infected Adults and Adolescents E-1 (2016), <https://aidsinfo.nih.gov/contentfiles/lvguidelines/adultandadolescentgl.pdf>.

17. 60 D.C. Reg. 8948-49 (June 14, 2013) (final rulemaking); 58 D.C. Reg. 8388 (Sept. 30, 2011) (emergency and proposed rulemaking effective October 1, 2011).

18. Curt D. Campbell, Carolyn Rumer, and Chelsea Sharon, Testimony Regarding the DC Healthcare Alliance Program Recertification Simplification Amendment Act of 2017 before the District of Columbia Council Committee on Human Services, 33 (April 24, 2017).

Task 2.8: Identify opportunities to enhance culturally competent HIV treatment.

2017 Status: In Progress

When it comes to engagement in medical care and treatment adherence, patients and their providers both have a role to play. Part of the role for healthcare providers is to ensure a sensitive, safe and culturally competent environment that does not alienate or marginalize patients. In the Plan, DOH determined it would identify opportunities to better support providers in this area, including by examining whether existing requirements or resources for HIV-specific education or other medical education were sufficient. In 2017, DOH disseminated implementing regulations for new health provider education requirements in LGBTQ cultural competency, and HAHSTA also plans to start special training on cultural competency for 2018.

In focus groups for the Ryan White Planning Council Needs Assessment, transgender women of color reported the need for increased sensitivity to gender identity, and improved understanding of the connection between gender identity and access to shelters and mental health services. Further responses to this needs assessment will be collected through 2018 to inform DOH about gaps and opportunities.

As outlined in the public call to action below (page 29), DOH encourages providers in DC to independently seek out opportunities to improve their ability to provide care that is respectful of various patients' backgrounds and needs, including sexual orientation, gender identity, age, race/ethnicity, language, nationality, history of substance use and mental health, and returning citizen status, within the context of HIV treatment. DOH is planning culture-affirming training for healthcare professionals in 2018. It is also tracking provider education opportunities that relate to HIV, which include several courses on providing care to particular groups, such as older adults, women, and black and Latino individuals.

This task is considered in progress, as DOH is actively collecting data about patient needs and working toward implementing new provider education requirements. In 2018, work to implement the task fully will include supporting providers and expanding the Department's own offerings in increasing capacity and cultural competency.

Task 2.9: Examine the feasibility of leveraging a Health Information Exchange to improve HIV care and treatment.

2017 Status: No Progress

The District currently has multiple platforms for electronic health information exchange (HIE) among healthcare providers, hospitals, and District agencies that select and implement their own health record systems. However, there is no universally-used mechanism for information to be shared among the systems. The District government formed a health information exchange policy board in 2012 that was designed to either solve existing communication challenges or adopt a new platform that would, among other capabilities, allow providers to submit regular queries to determine whether a particular patient is in care elsewhere. In addition to many functionalities and problems a District-wide HIE would solve, it would eliminate the need for DOH staff to conduct retention blitzes manually.

Separate of the Plan, DOH's Chief Information Officer was tasked with creating a DOH-HIE workgroup. Once established, a representative from HAHSTA will have the opportunity to provide feedback to the workgroup on the Administration's needs toward DOH- and District-wide initiatives. This is a major project which requires intensive resources, and is one over which HAHSTA has only limited control.

There has been no progress on implementing this task—a significant undertaking with enormous potential—in 2017. In 2018, we expect to see the timeline for the HIE workgroup achieving this task set by the DOH Chief Information Officer.

Public Call to Action 2: Healthcare providers in DC should increase their own understanding of culturally competent HIV treatment practices.

Culturally competent practice requires more than just knowledge about HIV pathology and treatment. As a community provider described, every unique patient is made up of “layers of culture” including sexual orientation, gender, race, ethnicity, immigration status, age, language, and socioeconomic status. Further, many patients have a history of trauma, marginalization, incarceration, or co-morbidities such as mental health challenges or substance use. Because these experiences are always present in a provider-patient interaction, the 90/90/90/50 Plan called on healthcare providers to improve their ability to provide care that is respectful of various patients’ backgrounds and needs within the context of HIV treatment.

Since 2012, DC has required completion of three continuing education credits on HIV to maintain licensing for the practice of medicine, registered nursing, practical nursing, nursing assistive personnel, and physician assistants.¹⁹ The Department of Health website has information about [continuing education opportunities and webinars](#). A list of qualifying HIV education events is maintained online by the [Mid-Atlantic AIDS Education and Training Center](#). An accredited three-credit course entitled “[District of Columbia HIV/AIDS Requirement for Healthcare Professionals](#)” is available online at www.continuingeducation.com.

The LGBTQ Cultural Competency Continuing Education Amendment Act was passed by the DC Council and signed by the Mayor in 2016. The law requires that all healthcare providers complete two credit hours of continuing education related to serving patients who “identify as lesbian, gay, bisexual, transgender, gender nonconforming, queer, or question their sexual orientation or gender identity and expression” for renewal of any license, registration, or certification.²⁰ Final regulations were issued by DOH through the summer and fall of 2017 for healthcare professionals including pharmacists, psychologists, social workers, and physicians “to care effectively and respectfully for patients who identify as LGBTQ.”²¹ The Department of Health has also recently released its [Report on the Health of the Lesbian, Gay, Bisexual, and Transgender \(LGBT\) Community in the District of Columbia](#), which includes detailed health data to increase public awareness and improve culturally competent medical practice.

The academic, private, and nonprofit sectors also provide helpful resources for healthcare providers. The District of Columbia Center for AIDS Research (DC-CFAR) distributes a weekly email newsletter which includes a listing of upcoming workshops and conferences, as well as funding, training and mentoring opportunities. Featured events range from webinars and workshops given by local experts to national and global conferences such as the [National Transgender Health Summit](#) and the [HIV and Aging Conference](#). Anyone interested in joining the mailing list should email CFARinDC@gmail.com or visit <https://dccfar.gwu.edu/>.

Because young people in DC have high rates of new HIV and STI infections, it is especially urgent for healthcare providers and others in the community to retool how they interact with youth. Advocates for Youth is a national advocacy organization based in DC that champions efforts that help young people make informed and responsible decisions about their reproductive and sexual health. To this end, research, best practices and curriculum are available on their [website](#) for a variety of audiences. In particular, the resources related to [HIV](#), [Working with Youth](#), and [LGBTQ Issues](#) provide resources for youth ages 15-24 and the adults who work with them.

Many CBOs in the District collaborate with one another to build capacity in culturally competent care, especially CBOs with expertise in serving particular communities. They often share resources and offer education opportunities to other institutions. For example, Whitman-Walker Health offers training and education for providers and the community (including academic institutions, upon request), and is launching a research, education and policy institute in the coming year. Bread for the City has conducted training related to poverty and race for other providers. La Clínica del Pueblo reported that it is in the process of developing a training on Latino sexual health, with funding from DOH, which may offer continuing education credits. In conversations with DC Appleseed on this topic, CBOs underscored the importance of including representatives from impacted communities in the development and delivery of trainings, as well as the importance of paying them for their help. Further, CBOs stressed that openness to patient feedback and flexibility to change are key to ensuring cultural competency in a health setting.

19. DC Code § 3–1205.10(b)(4)(A).

20. DC Code § 3–1205.10(b)(5)(A).

21. Law 21-95, LGBTQ Cultural Competency Continuing Education Amendment Act of 2016, 63 DCR 19 (April 29, 2016).

Goal 3

90% of District residents living with HIV who are in treatment reach viral load suppression

Achieving viral suppression through anti-retroviral therapy (ART) improves health outcomes for PLWH and reduces risk of transmitting infection. DOH estimated that 78% of those in treatment were maintaining viral suppression in 2015, which was the baseline used for the Plan. According to the 2016 epidemiological report, 63% of individuals in treatment were virally suppressed at last known in 2016. This is a 15% decrease over one year.²²



According to the epidemiological report, 63% is of all persons diagnosed (versus those in treatment) were virally suppressed. Using this broader denominator produces a lower number. White and Hispanic/Latino residents had the highest rates of viral suppression in 2016 (each around 66%) Black residents had slightly lower viral suppression rates (62%). There were no notable differences by gender identity or sexual orientation. Residents aged 50-59 years old had the highest proportion of viral suppression (69%), while 20-24 year olds were least likely to be virally suppressed (47.7%) compared to other age groups.

To meet the goal of 90% of District residents in treatment reaching viral suppression, the Plan includes strategies to enhance support for patients in maintaining their treatment, to address socio-economic conditions that may contribute to lapses in treatment, and to examine how federal funding provided through the Ryan White Act can be used more effectively. The slight increase does not reduce the urgency to the tasks outlined in the Plan pertaining to success in viral suppression rates, including enhanced treatment adherence support for individuals and particular groups. Viral suppression must be actively maintained and so must the support and activities wrapping around the patient.

Progress on Goal 3's Tasks

Task 3.1: Provide more accessible healthcare by hours, locations and providers.

2017 Status: In Progress

Most people living with HIV have at least one medical visit per year, often more, especially those who are actively adhering to ART. But there are many reasons some patients might miss appointments, including transportation issues, competing priorities, and forgetting appointments, according to a study conducted by The George Washington University.²³ Participants in the study suggested that flexible appointments, appointment reminders, multiple types of providers co-located in sites and transportation assistance would improve access. The Plan committed to improving the accessibility of healthcare in order to better facilitate patients making their medical appointments and, in turn, successfully adhering to treatment.

22. D.C. Dep't of Health, HIV/AIDS, Hepatitis, STD, & TB Admin., *Annual Epidemiology & Surveillance Report: Surveillance Data Through December 2015* (2016), <http://www.doh.dc.gov/hahsta>.

23. Amanda D. Castel AD, Measuring Engagement and Retention in HIV Care in Washington, DC. Second National CFAR/APC HIV Continuum of Care Working Group Meeting, Washington, DC, presentation, February 3, 2014.

Staff members at HAHSTA are drafting a directory to equip Ryan White providers and clients with a one-stop source of information on service locations, hours, and provider details. The target completion date for the directory is March 2018. The HAHSTA team is also considering compiling information on providers with nontraditional or extended hours of service. Metrics or incentives could be developed to encourage HAHSTA grantees to provide more accessible services. However, difficulties in obtaining funding for the actual provision of such services, like extended hours may remain a barrier.

In 2015, Whitman-Walker Health launched the Mobile Outreach Retention and Engagement (MORE) initiative, supported by funding from DOH and the Washington AIDS Partnership. The MORE mobile medical team provides evaluation, lab tests, and counseling services in patients' homes and at pop-up locations in the community. The project's primary goal is to engage patients who are out-of-care by bringing the services to them. Initial results were encouraging, with increases in re-engagement in treatment and viral suppression among participants. MORE will be evaluated for effectiveness by an independent firm, and it may be scaled up through programs such as Medicaid or Ryan White.

This task is in progress. In the Plan, HAHSTA proposed to work with medical providers and community-based organizations to develop strategies such as shifting available times for appointments to evenings and weekends, creating opportunities for lab testing at more convenient times outside of a medical visit, and examining self-collection approaches to expand the possible settings for treatment-related care. Some providers have launched evening and weekend hours. Meanwhile, the MORE demonstration project is one model we will continue to monitor. While a directory and assessment of locations and hours is important, progress on this task will need to include further development of concrete strategies to extend and redesign services for the task be considered implemented.

Task 3.2: Partner with other DC government agencies to address the social support needs of clients that may influence treatment-seeking and adherence.

2017 Status: In Progress

The need for mental healthcare and substance use treatment presents another barrier to HIV care and treatment adherence for many. The 90/90/90/50 Plan pinpointed both ongoing and new ways DOH can work with other District agencies and providers to address mental and behavioral health needs for PLWH.

Since 2011, a screening tool selected by DOH and the DC Department of Behavioral Health has been available for providers in three service areas: HIV, mental health and substance use. In January 2016, DHCF launched a Medicaid Health Home for people with serious mental illness through a new Medicaid model created under the Affordable Care Act. At the time the 90/90/90/50 Plan was released, DHCF was working on a second Health Home model for Medicaid MCOs that aimed to improve health outcomes through individual-level coordination, such as managing adherence to medications and addressing other acute medical needs. This new multi-disciplinary model was introduced to providers in the summer of 2017 as My Health GPS. Providers District-wide are now using this care-coordination platform with enrolled patients, including providers of HIV services.

HAHSTA will continue to support these initiatives as it identifies new areas for partnerships within each government agency to address patients' social support needs. Mental and behavioral health are common and significant challenges, but there are many other social support needs to address and barriers to mitigate to ensure PLWH have the conditions in place to adhere to their treatment for HIV and all other conditions they are facing.

Task 3.3: Assume direct responsibility for improving clinical quality and health data among all providers in the District.

2017 Status: In Progress

HIV is a complex medical condition, which often co-occurs with other health conditions. While care for PLWH focuses on ART adherence, providers must also attend to other medical needs and treat patients holistically. In the Plan, DOH sketched a design to improving clinical care generally, including the establishment of a clinical quality management team as an ongoing resource to providers and the creation of a learning collaborative to define clinical excellence standards, particularly in addressing co-morbidities associated with HIV. Further, DOH intended to leverage the DC Cohort—the joint longitudinal HIV study between GWU and DOH described on page 10—to develop baselines and goals for other health conditions affecting persons living with HIV, such as diabetes or cancer, and then to assess how providers are meeting goals for the overall health of persons living with HIV.

This task is in progress. HAHSTA has established the clinical quality management team as described in the plan, and hired five staff across clinical and data disciplines. The team currently gets advices from the Strategic Information Division Chief; a new Chief Medical Officer within DOH will likely add to this guidance. HAHSTA has conducted some preliminary brainstorming around possible sources of data, performance measures, and other ongoing provider quality improvement projects to use for this task.

Task 3.4: Implement a data-to-care program to increase levels of engagement in care.

2017 Status: In Progress

“Data-to-care” is a CDC-endorsed public health strategy that uses HIV surveillance data to identify HIV-diagnosed individuals not in care and link them to treatment that will encourage viral suppression. The implementation of a data-to-care program in DC was one of DOH’s central proposals in the Plan. Under a local data-to-care program, DOH would integrate various surveillance and monitoring systems—both internal and external to HAHSTA—to collect information on care and treatment utilization. For example, DOH could use viral suppression rates from reported laboratory test results, or service utilization or prescription information, as a prompt for intervention from both providers and DOH outreach specialists. This concept was successfully tested in 2017, with the IMPACT demonstration project, and further system building is slated for 2018.

Currently, routine data-sharing across HIV surveillance programs in DC, Maryland and Virginia supports the identification of individuals that have moved out of the jurisdiction and/or who are receiving services from out-of-jurisdiction providers. HAHSTA also provides support by reaching out to individuals who are especially hard to reach and disseminating information through regular retention blitzes. Under the Plan, these blitzes would evolve into a more standardized and broad-based data-to-care system. In the first quarter of 2018, HAHSTA plans to finalize efforts to enhance the routine integration of surveillance, Ryan White, and Medicaid data to more accurately assess care engagement. HAHSTA will formalize a process to routinely generate lists of individuals without evidence of care for 12 months or more who were also not virally suppressed, based on their last reported laboratory result, in order to supplement the review and verification of provider-generated lists of patients out of care.

Through 2017, HAHSTA supported a hybrid data-to-care program co-led by providers and DOH under the IMPACT demonstration project. Under this project, a data-to-care coordinator helps organizations target outreach by verifying the status of individuals through laboratory records collected as part of HIV surveillance activities. This has produced results: during the third quarter of 2017 (July-September), 18 men of color who have sex with men were reportedly reengaged in care through the IMPACT demonstration project. HAHSTA staff report-

ed that these efforts will be expanded and incorporated into routine HIV surveillance activities.

As explained above, retaining PLWH in treatment is the key to ending the HIV epidemic, and investment in good data and systems is critical to meeting this end. The important work to develop a robust data-to-care system task is in progress. This task will be considered implemented when all potential internal and external sources of data on patient treatment are integrated into a single platform or program that streamlines and enhances DOH's outreach efforts.

Task 3.5: Work with pharmacies and Pharmacy Benefits Managers around to increase access to prescriptions and improve better track medication treatment adherence.

2017 Status: No Progress

Getting and taking ART medication are the indicators of treatment adherence, yet there is currently no established way to track ART initiation or medication utilization. A proxy for measuring medication adherence is pharmacy dispense and refill information. Every health insurance plan contracts with a third-party Pharmacy Benefit Management system (PBM) for its medication benefits, including Medicaid and AIDS Drug Assistance Program (ADAP). The PBM is primarily responsible for processing and paying prescription drug claims. The PBM that DOH uses to manage ADAP provides regular reporting on prescription dispenses and refills. Through a data-sharing agreement with the DC Medicaid program, DOH can obtain equivalent Medicaid PBM reports. DOH estimates that these two sources cover about half of all PLWH in the District. In order to access prescription data for the other half who are covered under private health insurance plans, DOH initiated a collaboration in 2016 with the major health insurance plans in the District to obtain aggregate data on medication adherence. This effort has been delayed. DOH has identified the primary medication codes that will be shared with the private insurance plans in 2018. DOH requested new funding from CDC under a competitive announcement to establish a pharmacy data project. HAHSTA aims to initiate that project in 2018.

In addition to obtaining data to assess treatment adherence, DOH staff want to work with pharmacies to design a program to monitor medication pick-up and refer patients who do not pick up medications regularly to medication therapy management, conducted by a clinical pharmacist. Candidates for such intervention may be flagged by a prescription not dispensed within 90 days of the date. Anticipated barriers to such an initiative include uncommunicative or uninterested clients, or incomplete or out-of-date contact information.

The task will be considered implemented when DOH expands prescription data collection. Such efforts can better inform interventions in settings outside the doctor's office and, ultimately, improve treatment adherence.

Task 3.6: Promote policies to enable and encourage pharmacists to assist in ART adherence.

2017 Status: In Progress

Tracking medication utilization at a population level, as described in Task 3.5, will provide DOH with helpful information. The next step is to offer support and advice to patients in the pharmacy itself. Pharmacists are highly trained members of the medical care team and are easily accessible to patients; using their skills in this effort is strategic and necessary. There are already several specialty pharmacies in the District, including provider-based pharmacies, which provide medication management and counseling directly. To achieve Goal 3 of the plan, DOH proposed to work with the DC Board of Pharmacy and select pharmacies to expand medication therapy reviews and consults. DOH's 2016 solicitation for the ADAP pharmacy network required awardees to provide adherence counseling and drug utilization review. A new solicitation will open in January 2018, though DOH staff have not

detailed requirements or enhancements related to support for ART adherence.

As outlined in Task 3.5, DOH is also planning a pilot to track medication utilization with ADAP and DC Medicaid to identify people who could benefit from direct engagement with a pharmacist. Meanwhile, to further expand medication management opportunities in the District, the DC Boards of Pharmacy and Medicine need to finalize regulations to allow pharmacists to enter into collaborative practice agreements with physicians, pursuant to a 2012 DC law that has yet to be implemented.²⁴ When this policy is finally in place, DOH may want to offer specific training to pharmacists on ART and HIV issues.

Implementing treatment adherence programs in pharmacies will be an important step to broadening support for PLWH and treatment adherence District-wide. This task is in progress, as the District works through the steps to broaden opportunities for pharmacist involvement. This could be implemented in 2018 if the ADAP solicitation explicitly includes counseling, review, and consult services for patients, and if DOH is active in supporting the new collaborative practice model.

Task 3.7: Promote telemedicine approaches for adherence support.

2017 Status: In Progress

Innovative approaches are needed to increase access and adherence to treatment, especially among hard-to-reach populations. In the Plan, DOH proposed creative strategies to support adherence, including telemedicine-based interventions, such as mobile apps or text message reminders, or “Smart Cap” technology that helps users track their medication usage via a Bluetooth-enabled pill bottle cap. Specifically, DOH planned to allocate funding for a telemedicine demonstration project. In 2017, Clinical Pharmacy Associates, DC ADAP’s HIV/AIDS Drug Advisory Committee contractor, began targeting ADAP beneficiaries ages 18-30 who are non-adherent to their regimen for drug utilization review consulting, using telemedicine communications. These outreach activities are ongoing through spring 2018. Details about the nature of the intervention are being finalized, and the feasibility of other technology-based projects is being explored. This task will be considered implemented when this program is established and in use.

Task 3.8: Examine adding performance measures to future contracts with MCOs to enhance treatment adherence, viral load suppression, and funding for support services—especially housing.

2017 Status: In Progress

As discussed in Task 1.4 on page 20, there are no current Healthcare Effectiveness Data and Information Set (HEDIS) measures related to HIV care and services for use by Medicaid managed care organizations (MCOs). In theory, performance measures related to enhanced adherence and meeting patient needs change provider and MCO behavior by incentivizing priority practices. Therefore, the Plan tasked DOH, DHCF, DC Appleseed, and other relevant partners with developing a set of HIV performance measures, such as frequency of medical visits, medication adherence, and viral load suppression, which could be included in future contracts. When considering this task, we were inspired by models in other parts of the country that channeled funds “upstream” into social support services in order to improve health outcomes. In particular, the AIDS Foundation of Chicago (AFC) was able to demonstrate to MCOs that funded housing and supportive services for clients with HIV would not only improve health outcomes, but also generate cost savings.

In 2017, concurrent with research for Task 1.4, DC Appleseed and Hogan Lovells US LLP researched model perfor-

24. DC Code § 3-1202.08(h)(2).

mance measures related to treatment adherence, viral load suppression, and support services. We identified several potential models from HRSA's HIV/AIDS Bureau which could be added to MCO contracts. These potential measures include: routine HIV medical care visit within three months of HIV diagnosis; prescription of HIV antiretroviral therapy; HIV viral suppression (less than 200 copies/ml at last HIV viral load test); HIV medical visit frequency; and gap in HIV medical visits.²⁵ Guidelines for the "routine medical care visit" measure state that providers should include "an assessment of high-risk behaviors, substance abuse, social support, mental illness, comorbidities, economic factors (e.g., unstable housing), medical insurance status, and adequacy of coverage, and other factors that are known to impair adherence to ART and increase the risk of HIV transmission. Once evaluated, these factors should be managed accordingly."²⁶ However, this is not a stand-alone measure to incentivize MCOs to provide the actual housing or support services, which is a possibility that should be explored further by DHCF and DOH.

In the year ahead, DOH intends to work with DHCF on the feasibility of adding performance measures to contracts with MCOs to encourage treatment adherence, viral load suppression, and funding for support services. The stated task is to "examine" how to add measures, and this will be considered implemented when final measures are selected and recommended to DHCF. DOH staff project this could be accomplished in 2019. At that time, DOH and DC Appleseed may follow up to pursue adoption of the recommendations with DHCF, who has final authority for such a decision.

Task 3.9: Retool the Ryan White Program to improve District and regional healthcare and supportive services.

2017 Status: Implemented

The federal Ryan White CARE Program is operated in DC by DOH and provides an extensive array of medical and non-medical services to PLWH throughout the region. It generally boasts higher rates of treatment adherence and viral suppression than the general PLWH population, due in part to its comprehensiveness. Since insurance coverage through other programs increased in DC under the Affordable Care Act, a burden of payment for clinical care was shifted away from Ryan White funds. This shift encouraged HAHSTA to seek a waiver from the HRSA in 2016 to retool the Ryan White program to provide broader coverage for non-clinical services that support treatment success, such as housing, childcare, emergency financial assistance, and transportation. Accordingly, a redesign of the Ryan White program was rolled out in October 2017 across the entire EMA, including DC and counties in Maryland, Virginia, and West Virginia.

The new program is structured as a fee-for-service payment model and includes reimbursement for services in six categories: Outpatient Ambulatory Health Services, Oral Health, Mental Health, Substance Use, Food and Home Delivered Meals, and Non-Medical Case Management. HAHSTA also added housing services in DC only. The roll-out of the new model was bumpy; DOH encountered delays with the procurement process, and providers have had difficulty understanding the new application process. Further, community providers have complained of a chaotic start, and some fear that the new model will result in loss of funds for vital services. For example, letters sent to providers indicated that the ceiling for reimbursement for certain prevention activities was greatly reduced. Some providers expressed the sense that the changes will actually underfund the relational and supportive services which are necessary for effective medical interventions. Considering the level of concern expressed among some providers, DOH should work to provide more communication, responsiveness and support around the adoption of the new payment system.

This task is considered implemented, as the model is established and will continue through 2020. While there are challenges to work through with providers, the intention of the change was to expand non-clinical services to better target resources toward mitigating barriers to treatment. We will continue to monitor whether this objective is achieved under the new model in the year ahead.

25. HRSA, HIV/AIDS Bureau Performance Measures Portfolio, HRSA. Available at <https://hab.hrsa.gov/clinical-quality-management/performance-measure-portfolio> (accessed November 17, 2017).

26. HRSA, HIV/AIDS Bureau Performance Measures: System-Level Measures, Part 1. Available at <https://hab.hrsa.gov/sites/default/files/hab/clinical-quality-management/systemlevelmeasures-part1.pdf> (accessed November 17, 2017).

Task 3.10: Redesign the HOPWA program to support persons toward self-sufficiency.

2017 Status: In Progress

Housing is a central need for anyone, and is especially important for those managing a complex medical condition. However, housing in DC is increasingly expensive and inaccessible to many low- and middle-income residents. In the Metropolitan Washington Regional Ryan White Planning Council's 2012-2014 Comprehensive HIV Care Plan, housing was the most frequently cited need among PLWH in the DC metro area.²⁷ Because treatment adherence requires stable and safe housing for individuals—and the urgent need for housing support was echoed throughout the community—the 90/90/90/50 Plan dedicated several tasks to improving housing conditions for PLWH in DC. Tasks 3.10-3.14 deal with this issue from a variety of angles, while working within funding limitations, beginning with retooling the use of certain federal funding.

The Housing Opportunities for Persons with AIDS (HOPWA) program is the federal program that supports efforts to connect PLWH with affordable housing in the District and metropolitan area. DOH uses HOPWA to support: tenant-based rental assistance; facility-based housing (supportive housing); short-term rent, mortgage, and utilities services; housing information and referral services; and supportive services such as case management, substance use services, and meals or nutritional services.²⁸ Among HOPWA clients, 93% were retained in care in 2014, while 73% of all DC residents living with HIV were engaged in care.²⁹ This mirrors results around the country and recent studies that have shown that stable housing improves the quality of life for those with chronic illnesses.

The U.S. Office of Housing and Urban Development (HUD) reduced DC's HOPWA funding by almost \$2 million between 2014 and 2015, when supplementary funding for areas with high rates of HIV expired. Since then, HUD funding has remained mostly level.³⁰ This further stressed an already strained model: when Congress established the HOPWA program in 1990, the average life expectancy for a person with HIV was nine to 24 months. Originally, HOPWA was essentially a program for end-of-life housing support. Today, with ART, a person diagnosed at the age of 20 can expect to live to 75 years or more, yet the basic HOPWA program has not been updated to reflect this reality. This led to an impossibly long waiting list for new participants entering the program in DC. Therefore, DOH is working with the District government and other stakeholders to redesign the local use of HOPWA funding to support people to achieve independence from the program. The Plan outlined a design in which recipients of HOPWA funding would develop goals for self-sufficiency, and HOPWA voucher agreements would provide supportive services related to the client's goal, including peer supports when necessary, and specify times at which the agreement would be reviewed. Then, as clients who are able to become self-sufficient no longer need a HOPWA voucher, more people living with HIV would be able to access stable housing through the program. For those who need continued support, HOPWA would work with other DC agencies, when possible, to identify other programs to help clients achieve their housing goals.

Further, a revamped HOPWA program would follow the "housing first" concept, in which those who need housing support are placed immediately, without spending time in a transitional housing program or substance use treatment. DOH was actively piloting a housing-first approach in a rental assistance project with Joseph's House and Jubilee Housing, as well as in a demonstration project for persons living with HIV who are also victims of violence.

At the time the Plan was released, DOH was also developing an employment and housing demonstration project aiming to increase access to economic opportunities, while improving health outcomes. The goal of

27. Metropolitan Washington Regional Ryan White Planning Council, 2012-2014 Comprehensive HIV Care Plan (2014), http://doh.dc.gov/sites/default/files/dc/sites/doh/publication/attachments/Comprehensive%20HIV%20Care%20Plan%202012-2014%20%282%29_0.pdf.

28. D.C. Dep't of Health, Appendix B: HOPWA 5-Year Consolidated Plan, FY2011-2015 and HOPWA FY2011 Action Plan, (Mar. 28 2014), http://dhcd.dc.gov/sites/default/files/dc/sites/dhcd/release_content/attachments/20336/03%20Appendix%20B-HOPWA%20FY1115%20Con%20Plan.pdf.

29. U.S. Dep't of Hous. & Urban Affairs, HOPWA Performance Profile - Formula Grantee: District of Columbia (Mar. 29, 2015), https://www.hudexchange.info/resource/reportmanagement/published/HOPWA_Perf_GrantForm_00_WASH-DC_DC_2013.pdf.

30. *Id.*

the employment and housing demonstration project (EHDP) was to assist 24 program participants in achieving economic and housing stability. In 2017, the EHDP had 11 participant households receiving support services, assistance services and housing, with a moratorium on new intake. HAHSTA is discontinuing this project as the implementation did not meet the aims of the project. However, HAHSTA has identified Ryan White supplemental dollars to stand up a new program partnering with Housing Counseling Services, and aims for the project to be operational in 2018. This program will include a temporary modest subsidy to meet the gap between income and housing costs.

This task is in progress, as demonstration projects detailed in the Plan is redesigned through 2018. However, the plan for an overall redesign of HOPWA is unknown. This task will need to be reviewed further in the year ahead, perhaps in concert with evaluation of the Ryan White redesign, to ensure that funding for housing and support, and assistance services is ultimately increased and PLWH have the conditions in place to be successful in treatment.

Task 3.11: Examine opportunities to provide more housing options for persons in the metropolitan area.

2017 Status: In Progress

As noted above, finding affordable housing is a District-wide challenge. HOPWA asks clients to pay 30% of their monthly income for housing while the program covers the rest of the unit's rent cost. The maximum total rent allowable for a HOPWA-subsidized unit is also capped; for example, the cap for a two-bedroom unit in the DC region in 2016 was \$1,623 per month. This means few units are attainable for participants within the District. DOH stated in the Plan that expanding offerings beyond DC's borders could open up new choices for HOPWA clients.

In October 2017, DOH held an HIV Housing and HOPWA training to provide technical assistance and solicit feedback on services administration in the field. This allowed DOH to identify areas to focus its efforts on increasing housing options throughout the broader HOPWA Eligible Metropolitan Statistical Area (EMSA). Also, quarterly provider meetings foster time to gather data and information, adding to data shared by agencies (providers) for annual reporting. Preliminary meetings are being held between Maryland, DC and Virginia. Additionally, over the last year, DOH reports it has continued to identify opportunities by partnering with other DC government entities and public and private partners, and by using other funding sources where households are eligible.

This task is in progress, and will be implemented when concrete details of expanding housing choices outside of DC are proposed and considered. There is no timeline set for this task. DC Appleseed notes that this is a sensitive issue. While exploring regional options may increase accessibility to housing, it should not replace efforts to increase opportunities within the District.

Task 3.12: Examine the need for expanded funding for affordable housing for people living with HIV.

2017 Status: No Progress

In the Plan, DOH and DC Appleseed pledged to examine additional funding opportunities that could be leveraged to provide access to stable housing for PLWH in DC. Many services are currently funded through DOH. About 300 DC residents living with HIV receive Tenant-Based Rental Assistance and 1,800 eligible households receive Ryan White Part B-funded housing case management. HOPWA allocations in DC are approximately \$3.8 million for tenant-based rental assistance; \$300,000 for short-term rent, mortgage, and utilities services;

\$500,000 for housing, information, referral services; and \$871,000 for temporary housing. A demonstration project serving victims of domestic violence received \$1.3 million over 3 years. An additional \$200,000 from local funding is spent on short-term assistance. DOH also funded a demonstration project for rental assistance for Joseph's House with \$500,000. Other agencies have responsibility for housing services to the general public. An assessment is necessary to determine if the numbers are sufficient for the need. The work on this task will include DOH collaborating with DHCF to investigate the possibility of using Medicaid funds to cover housing-related costs, as part of efforts to achieve better health outcomes. This could potentially involve a payment model that pays providers based on outcomes related to these services. There is no progress on this task in 2017, but together DC Applesseed and DOH can assess the need for and methods to achieve expanded funding in 2018 and beyond.

Task 3.13: Promote use of HOPWA funding for capital development to create new units of affordable housing that are available for people living with HIV.

2017 Status: In Progress

This approach leverages limited HOPWA funds to increase the stock of affordable housing set aside for PLWH. Due to the high cost of housing development, the District government and project sponsors often blend multiple funding sources to make projects viable. The funding sources cover both construction and services for supportive housing. This model has been successfully implemented for projects with a range of funding sources such as the District's Housing Production Trust Fund, federal tax credits, DC Housing Authority vouchers, DC Department of Behavioral Health funds, and DC Department of Human Services' homeless funding. The advantage of the blended funding approach is that no one agency or program carries the full cost. And if there is a funding source dedicated to a certain population or health condition, then the whole unit—regardless of the amount contributed—must be set aside for that eligible occupant. In the Plan, DOH planned to continue its work with the DC Department of Housing and Community Development to encourage developers to design housing financing proposals that would include a portion of HOPWA funds to promote new housing stock and a set-aside of units specifically for PLWH. This task involves working with the Deputy Mayor for Planning and Economic Development to encourage new developments to access this funding where feasible and appropriate, as well as outreach to affordable housing developers to increase their understanding of how HOPWA fits into a development's financing and set-asides.

DOH's HIV housing team continues to analyze its budget allocations to determine how much can be spent on capital investments and projected that it may take three to five years to establish a funding amount for capital investments. HAHSTA has identified a possible target of creating two new units per year. Because of the longer time horizon for this task, DOH should invest time and energy to discussions with partners in 2018 to achieve the goal of creating two units for PLWH by 2020.

Task 3.14: Ensure that people living with HIV who access low-barrier shelters in DC receive accommodations that will allow them to manage their condition.

2017 Status: In Progress

In interviews with advocates over the years, DC Appleseed has consistently heard of the challenges that people experiencing homelessness encounter when trying to manage their health, from ART adherence to avoiding other infections. Therefore, we tasked ourselves with finding ways to mitigate these challenges. Over the last year, we conducted baseline legal research related to this issue.

Although the District of Columbia has provided some housing resources for PLWH, there are significant gaps in coverage, and minimal legal recourse PLWH can take when confronting barriers. As a local government unit providing publicly funded services to individuals experiencing homelessness, the District must provide reasonable accommodations to and refrain from discriminating against individuals with disabilities, including PLWH, under the Americans with Disabilities Act (ADA), the Rehabilitation Act, the Fair Housing Act (FHA), and various municipal regulations. However, the scope of reasonable accommodations the District must make for PLWH is unclear, because the case law is limited due to frequent settlement and because there are exceptions for accommodations that would cause undue hardship to, or fundamentally alter the nature of, the program.

In addition, the District lacks a consistent, clear, or efficient policy for handling housing matters and reasonable accommodation requests from PLWH. HIV-positive individuals need particular accommodations to manage their illness, including a secure storage space for medications, access to bathrooms, hygienic environments where they can avoid people with contagious illnesses, and shelter in adverse weather conditions. Access to emergency shelters is granted on a first-come, first-served basis; homeless individuals who are able to access a shelter on a given night must vacate in the morning and return in the evening to line up for a bed for the next night. Although the Community Partnership for the Prevention for Homelessness provides some procedures for requesting reasonable accommodations, the District's approach is case-by-case, and no standard policy exists. Gaps in coverage are particularly noticeable in the District's efforts to transition individuals experiencing homelessness into permanent housing through Coordinated Assessment and Housing Placement.

The District's failure to expeditiously and adequately provide reasonable accommodations for PLWH has left many in unsafe, unsanitary, and crowded low barrier/emergency shelters, with some opting to sleep on the street or engage in unsafe behaviors as an alternative. Even when an individual is able to request a reasonable accommodation, the process can be long and arduous, and the individual's illness can worsen during the wait. Some healthcare providers offer space for medication storage at their clinics, but this meets only one of many acute needs.

To improve conditions for PLWH who experience homelessness, the Department of Human Services and the Community Partnership for the Prevention for Homelessness should implement a well-researched, clear and detailed policy for shelters to provide reasonable accommodations to PLWH. The District should also expedite transitions to permanent housing for PLWH in order to improve health outcomes and facilitate adherence to medical treatment. In the year ahead, DC Appleseed will continue our investigation, including researching best practices from other jurisdictions, exploring possible legislative and regulatory changes, and engaging with advocates and service providers to identify potential fixes outside of government action.

Goal 4

50% reduction in new HIV infections

The goals of the 90/90/90/50 Plan follow a cascade: as more District residents know they have HIV, more are likely to be engaged in care. As more are in care, more are likely to reach viral load suppression. When more reach viral load suppression, not only will their own health be improved, but fewer will transmit the virus to others, and there will be decreases in the number of new infections over time. Specifically, the District aims to achieve a 50% reduction in new HIV cases by 2020. When Mayor Bowser teed up the development of the 90/90/90/50 Plan in June 2015, the most recent surveillance data available were from 2013. During that year, 520 HIV cases were newly diagnosed. Since the Mayor’s announcement was made based on this number, we use it as the baseline. (Other banner goals use 2015 data.) Cutting that number in half means we aim to see only 260 new infections in 2020. The 2016 data reveal 347 new infections total, a 33% reduction from the 2013 number.



When it comes to reduction of new cases, the District is well on its way. If the District maintains an identical rate of reduction over the next two years, the 2020 number of new infections would be well under the target. We recognize that gains may be more hard-won as the overall numbers and margins decrease.

As noted in the breakdown of the 2016 data on page 16, sexual contact was the leading mode of transmission, though the mode of transmission is “unknown” for more than one-fifth of diagnoses. The largest decrease in new infections occurred among injection drug users, among whom there were only 7 new cases. New data reflect persistent disparities within the epidemic by race: over 73% of newly diagnosed residents were black. Young adults ages 20-29 comprise one-third of all new infections, with 115 new cases in 2016. Rates are high in young black men, especially those who have sex with men.

The 90/90/90/50 Plan details policies that will enhance prevention efforts, such as increased access to PrEP and PEP, especially for the groups at the highest risk, and improvements in youth education and expanded funding of successful syringe access programs. The District’s success with prevention efforts is reflected in nearly a decade of reductions of new cases, due to the adoption of science-driven policies and practices and support of programs based on harm-reduction principles. As examples of this success, 803,596 used syringes were traded through exchange services and six million male and female condoms were distributed in the community in 2016. We are encouraged by the continued progress we see in the 2016 numbers. HAHSTA should maintain its robust portfolio of prevention services and embrace new strategies, such as upscaling PrEP, to ensure the District doesn’t lose momentum.

Task 4.1: Expand the network of prescribers of PrEP through increased knowledge and capacity of private medical providers

2017 Status: In Progress

In 2012, the Food and Drug Administration approved a modified regimen of the drug Truvada, which is widely used for those on ART, to prevent HIV infection among those who are at risk but HIV-negative.³¹ As described throughout this report, this treatment is called Pre-Exposure Prophylaxis, or PrEP. PrEP use involves a daily dosage of a single medication supported by periodic counseling sessions and lab tests. It is 90% effective with consistent use. The modeling done for the 90/90/90/50 Plan anticipated that upscaling PrEP utilization would account for 15% of the expected decrease in HIV diagnoses by 2020. Approximately 8,000 total people who are at high risk for HIV infection need to consistently use PrEP on an annual basis to reach the goal, a huge increase from the current PrEP uptake in DC estimated at about 2,000 people. Expanding the network of medical professionals prescribing PrEP in DC is critical. DOH planned to produce educational materials, utilize contracted clinical educators to private and large-group practices, work with community partners to recruit more prescribers to larger clinical education sessions, and advise clinicians to connect people to the network of DOH-funded community partners that provide counseling and adherence support. This task also included building the capacity of providers to offer appropriate care and information for special populations, such as transgender people of color, in culturally-affirming settings to ensure PrEP uptake in these communities. This is a significant undertaking that is currently in progress.

In concert with the release of the 90/90/90/50 Plan in 2016, the PrEP for Women initiative, a public private partnership between HAHSTA and WAP, awarded grants to Children's National Medical Center, Mary's Center, and Planned Parenthood to conduct provider education as well as prescribe PrEP in their clinics. This initiative is funded through 2019.

In June 2017, Alosa Health was contracted to conduct educational visits at doctors' offices throughout DC using "academic detailing." Using presentations developed in partnership with HAHSTA, the Alosa detailers conducted 173 one-on-one sessions through September, also providing education materials and collecting survey information on knowledge and willingness to prescribe PrEP. Academic detailing aims to reach 500 medical providers by June 2018. Further, in late 2018 Alosa will provide an online module on PrEP education that provides one Continuing Medical Education credit. DOH has also conducted 12 women and PrEP provider education sessions for 82 providers.

The CDC-funded IMPACT DMV demonstration project currently funds 11 organizations to increase the uptake of PrEP among men who have sex with men and transgender persons of color in the DC, northern Virginia, and suburban Maryland area. These activities include PrEP education, referral and linkage to medical providers, treatment adherence, on-site provision of PrEP medication, and provider capacity building.

As of October 2017, six providers have been funded by DOH to provide PrEP services such as education, navigation, and prescription in the District. These providers are Family and Medical Counseling Service, HIPS, La Clínica del Pueblo, Mary's Center, Us Helping Us, and Whitman-Walker Health.

Other organizations that are known to prescribe or refer PrEP include the DC Health & Wellness Center (formerly known as HAHSTA STD Clinic), Andromeda Transcultural Health, Children's National Medical Center, Planned Parenthood, United Medical Center, and Metro Health. A more coordinated effort to collect, share, store, update and disseminate information on providers who are prescribing PrEP is needed. An internal HAHSTA working group will discuss this in the years ahead, likely in 2019.

31. U.S. Food & Drug, FDA Approves First Drug for Reducing the Risk of Sexually Acquired HIV Infection, (July 16, 2012), <http://www.fda.gov/NewsEvents/Newsroom/PressAnnouncements/ucm312210.htm>.

Lastly, DOH has funded the Children’s Research Institute to map adolescent primary care providers—especially those serving female patients who test positive for STIs—for community outreach. They plan to use this list to identify providers who can offer PrEP and related follow up and will host quarterly trainings on sexual health and the use of PrEP among adolescent and young adult women.

Myriad initiatives are underway to expand access to PrEP in the community by building provider capacity. This will lay the foundation for 8,000 eligible District residents to receive prescriptions needed to avert HIV infection and reduce new infections according to the Plan. This task will be considered implemented when more providers, particularly those in private and large-group practices that do not receive special HAHSTA funding, are known to prescribe PrEP.

Task 4.2: Make PrEP starter packs available at the DC Health and Wellness Center.

2017 Status: Implemented

In addition to coordinating the expansion of PrEP prescribers in the community, DOH planned to implement a PrEP program in its new Health and Wellness Center. DOH planned to provide a starter pack of either a 30-day or seven-day supply with follow-up visits and routine lab tests. DOH designated a PrEP adherence specialist position to help participants navigate insurance coverage necessary to access refills and to provide medication counseling. As of 2017, this task is implemented. All patients seen for PrEP leave with a seven- or 30-day supply of PrEP, based on clinician assessment. As of November 2017, 185 patients had received a starter pack at the Wellness Center. This initiative should be continued with adequate funding to serve the demand—which will hopefully continue to increase—through 2020. We will continue to monitor success through the year ahead.

Task 4.3: Develop PrEP-specific telemedicine program.

2017 Status: No Progress

To expand access to PrEP even more broadly, DOH proposed developing a PrEP-specific telemedicine pilot—similar to the telemedicine program outlined in Task 3.7 described on page 34—to engage participants and support PrEP adherence. In such a program, a clinician and adherence specialist would schedule consultation sessions according to individual availability, including non-standard clinical hours. DOH also intended to develop an agreement with a laboratory to allow participants to take lab tests in locations other than the Health and Wellness Center. This task has not yet been initiated. While PrEP and telemedicine activities have been added to agreements with DOH grantees, no programming has commenced for this task. HAHSTA staff have identified a need to develop partnerships with providers that have the capacity to deliver this telemedicine service. The electronic record system used at the Health and Wellness Center, eClinicalWorks, has a video feature that will enable the implementation of PrEP telemedicine when HAHSTA prepares the protocols. These steps should be taken in the year ahead, as with those necessary for implementation of Task 3.7, in order to have an operational program online by 2020.

Task 4.4: Recruit peer navigators for African-American and Latino men who have sex with men and transgender people of color to promote knowledge of PrEP.

2017 Status: In Progress

The use of trusted peer navigators can be the most effective way to engage historically vulnerable populations in healthcare. As described in Task 2.6 on page 26, the IMPACT demonstration project funded by the CDC aims to address contextual circumstances, such as education, employment, housing, and overall wellness to enhance self-efficacy and improve health outcomes. Twenty-four Health Impact Specialists (HIS) help patients access and adhere to HIV treatment, and are also trained to promote knowledge of PrEP and to assist in connecting people with community resources and services. This task is currently in progress. As with Task 2.6, this task will also be considered implemented when the work of HISs under the IMPACT demonstration project is assessed and DOH determines whether the project should be expanded.

Task 4.5: Work with Medicaid, MCOs, and private health plans in order to ensure insurance coverage of PrEP treatment and related clinically recommended laboratory monitoring.

2017 Status: No Progress

To ensure the affordability of PrEP for individuals, DOH planned to work with DHCF and private insurance carriers to cover the intervention. The routine clinical costs include medical visits and laboratory tests related to screening for HIV, hepatitis, and STIs, and tests to determine fit for the medication, including kidney and liver function. While insurance coverage for the drug itself is usually sufficient to enable utilization, in some cases the complementary lab testing is not covered, which can be a barrier to adherence. Co-pays for office visits can add up. Part of the role of providers and navigators supporting PrEP use is helping clients understand their payment options. Gilead—the drug maker—has offered a financial assistance plan called Advancing Access, which can be used by all uninsured and under-insured people. Gilead’s Co-Pay Assistance covers up to \$3,500 per year for people with high insurance deductibles. Once this benefit has been exhausted, if the deductible has not been met, clients are left with a high co-pay. DC Medicaid requires coverage for both medication and labs. (However, some patients report to HAHSTA that participating Managed Care Organizations will cover only the cost of their laboratory test and not their medication. DHCF is reportedly trying to address these challenges.) Clients of the DC Alliance have to use Gilead’s Advancing Access plan because the DC program does not cover any ART treatment. As of November 2017, DOH has identified five private insurers that provide full coverage of PrEP treatment and laboratory tests. While DOH staff are monitoring the situation, there is no plan yet for working with DHCF, MCOs, Alliance or private insurers to change or expand coverage practices. This should be tackled as soon as possible in 2018 so that PrEP is included in formularies when the next coverage year begins.

Task 4.6: Monitor the need for a co-payment assistance program for PrEP and gaps in insurance coverage for PrEP and fund PrEP assistance.

2017 Status: In Progress

PrEP adherence requires follow-up medical visits and testing and the co-pays for these visits may be prohibitive for some. This was anticipated in the Plan as a possible barrier to PrEP uptake and adherence. As described above in Task 4.5, Gilead’s Advancing Access Co-Pay Assistance Program can support individuals with up to \$3,500 in assistance. The ADAP pharmacy contractor, PBM, is set up to support PrEP prescription financially by covering co-pays or co-insurance that exceeds insurance or Gilead coverage, but needs funding. The PrEP module is in the PBM system and HAHSTA has drafted initial protocols. It aims to have a program in place in 2018. As with Task 4.5, this should be a priority area in order to bring 6,000 new patients onto PrEP by 2020.

Task 4.7: Expand access and availability of Post-Exposure Prophylaxis (PEP).

2017 Status: In Progress

Post-exposure prophylaxis (PEP) treatment is a 28-day ART regimen taken after possible exposure to HIV. It is highly effective in preventing the development of HIV infection if started within 72 hours of exposure.³² PEP is most widely used by those who are exposed to HIV in occupational settings, such as nurses or first responders, but it is also effective for patients exposed through unprotected sex with an HIV-positive partner or injection drug use. As part of the effort to decrease new HIV infections detailed in the Plan, the District government planned to expand access to PEP for non-occupational exposures. Prescribing PEP also serves as an opportunity to connect a patient to PrEP. The scale-up of PEP entails some of the elements described for PrEP, including providing PEP in the new Health and Wellness Center, developing provider education materials, monitoring PEP initiation, and assuring insurance coverage. DOH also committed to share data with the community on these measures. Through 2017, HAHSTA furnished PEP to a small number of patients, and provided support to PrEP and PEP education programs to increase usage; for example, PEP services were included in agreements with DOH-funded providers which DOH expects to expand the number of engaged providers. Ongoing barriers include funding and low public awareness about the intervention. HAHSTA staff have identified metrics that may be helpful to collect and share through monthly progress reports collected from providers, including the number of organizations providing PEP, the number of PEP prescriptions supplied annually, and the number of PEP prescriptions completed. This task will be considered implemented when public and private insurance cover PEP, and DOH collects and shares information publicly about availability and utilization in the District.

Task 4.8: Develop public education campaigns to raise awareness of prevention strategies, in particular PrEP and PEP.

2017 Status: In Progress

Building on its successful portfolio of public education campaigns about testing and condoms, DOH committed in the Plan to maintain and revise its campaigns on testing, care and treatment, and prevention (PrEP and condoms). New campaigns would contain several core components: cultural competence and affirmation, practical actions, and the use of appealing media platforms. Since 2016, HAHSTA has conducted several social marketing campaigns on PrEP, including “[Do It Right DC](#)” and the “Dominate” advertisements through the [PrEP for Women](#) initiative with Washington AIDS Partnership. Another initiative debuting in late 2017 is “PrEP Power Hours,” held at the Health and Wellness Clinic for transgender men and women. For these monthly events, HAHSTA will partner with one or more of its CBO partners (e.g. Us Helping Us, The Women’s Collective, NovaSalud, Heart to Hand, etc.) as well as Walgreen’s Pharmacy and/or Gilead. The agenda includes education, promotion, screenings, on-the-spot PrEP startup, and enrollment in assistance plans. There is no active public education campaign yet on PEP; therefore, this task is in progress.

Task 4.9: Improve timely notice to DOH of all new HIV diagnoses.

2017 Status: In Progress

Providers are required to report a positive HIV diagnosis to DOH within 48 hours. This standard allows DOH to notify potentially exposed individuals through its Partner Services team. As HIV testing has advanced to allow for quicker results, and because starting ART as soon as possible speeds up an individual’s ability to reach viral load suppression, timely follow-up and reporting is possible and important. Current DC regulations require a phone call within two hours for a range of diseases, such as anthrax, botulism, and cholera, so there is prece-

32. Dawn K. Smith et al., U.S. Dep’t of Health and Human Servs, Antiretroviral postexposure prophylaxis after sexual, injection-drug use, or other nonoccupational exposure to HIV in the United States: recommendations from the U.S. Department of Health and Human Services, 54 MMWR Recommendations and Rep. 1, 1-20 (Jan. 21, 2005).

dent in DC law for very early reporting of an infectious disease.³³ This task required DOH to consult with practitioners and develop an appropriate time frame and mechanism for earlier reporting of acute HIV infection. The Plan also proposed a Rapid HIV Surveillance and PEP-Plan B demonstration project through which DOH would assess the effectiveness of more timely deployment of Partner Services—including immediate contact with partners with possible on-call distribution of PEP starter packs—as a means of interrupting HIV transmissions. The proposal was to begin in late 2016, but this demonstration project has not yet started. HAHSTA is in the process of restructuring its field surveillance team and considering new staff configurations to conduct more timely engagements. HAHSTA also commissioned the health policy team at The George Washington University to analyze the range of reporting of new diagnoses requirements across the country. HAHSTA is considering proposing regulation changes.

In 2017, HAHSTA created a one-page HIV and STI reporting form for easier completion by clinic sites, and an electronic version of the form will be available by the end of January 2018. HAHSTA staff visited six different clinics to meet with clinic staff and discuss reporting requirements and the importance of reporting within 48 hours. HAHSTA also held three drop-in sessions for clinicians on the required forms and reporting deadlines. Staff will continue to contact clinics and private doctors' offices to raise awareness of reporting requirements in the year ahead. An evaluation will be necessary to determine if these activities have improved reporting time by 2020. This task will be considered implemented when the demonstration project has been developed, in addition to other measures of support for providers, and when an improvement to reporting time is assessed.

Public Call to Action 3: Providers should give more timely notice to DOH of a new HIV diagnosis.

Current regulations require medical providers and laboratories to report an HIV diagnosis within 48 hours. Unfortunately, this time frame is not always followed by practitioners. Further, some providers rely on laboratories to report to the health department which can further delay and complicate reporting to DOH. Timely reporting is especially important so that Partner Services at DOH can contact newly diagnosed people to request information on partners who might have been exposed, and then guide the exposed individual to testing in a sensitive and private manner. Better notification of new diagnoses could initiate the Partner Services intervention sooner and potentially with greater success. Therefore, providers are encouraged to give more timely notice of a new HIV diagnosis directly to DOH.

Task 4.10: Establish programs to eliminate stigma and educate the community about HIV.

2017 Status: In Progress

The 90/90/90/50 Plan called on all District residents and communities to “ensure the city is free of fear, stigma, and discrimination against those with HIV.” Myths, stereotypes and negative attitudes harm and marginalize individuals, as well as perpetuate misinformation about the disease and transmission. The Plan also recognized the need to fight stigma associated with race, ethnicity, immigration status, history of substance use and mental illness, and offender status. Surveys showing negative attitudes toward PLWH underscored the need to proactively work to provide affirming healthcare across the District. For example, 20% of providers surveyed reported wearing double gloves with HIV patients, an unnecessary and potentially stigmatizing precaution, and 25% disagreed or strongly disagreed that women with HIV should have babies.³⁴

While no specific program has been established for addressing stigma in 2017, HAHSTA's approach to expand the provision of HIV information, routine annual HIV screening and emphasis on populations that may need it more often, social marketing, condom distribution, and PrEP all serve as vehicles to reduce stigma or discrimination. HAHSTA staff believe that efforts to normalize these conversations and convey a positive and aspirational message that supports and fosters sexual health well-being and self-efficacy can minimize the stigma

33. Dawn K. Smith et al., U.S. Dep't of Health and Human Servs, Antiretroviral postexposure prophylaxis after sexual, injection-drug use, or other nonoccupational exposure to HIV in the United States: recommendations from the U.S. Department of Health and Human Services, 54 MMWR Recommendations and Rep. 1, 1-20 (Jan. 21, 2005).

34. Howard University Department of Pediatrics & Child Health, HIV Related Stigma in Healthcare Providers: Preliminary Survey Report, 2016, (Not published).

and its harms. The efforts to educate providers, as described throughout this report, will continue to be essential, in concert with public education efforts and school-based sexual health education. HAHSTA also intends to look into the feasibility of a “Stigma Index” tool, or other assessments, across HAHSTA and other programs. In general, community-based providers say the District could use a step back to “retool and reassess” successes and failures related to providing culturally-competent healthcare and a safe community for everyone. This task will be marked as implemented when DOH establishes a stand-alone program to measure and/or battle stigma in the community.

Public Call to Action 4: DC residents and healthcare providers must work to eliminate stigma and educate themselves about HIV. Healthcare providers must educate themselves about new clinical advances to treat and prevent HIV—including PrEP.

DOH has committed to agency-level measures to eliminate stigma and educate the community, as outlined above in Task 4.10. Beyond these governmental efforts, we would like to highlight other resources available to the public related to addressing stigma and to providers about PrEP. (In Public Call to Action #2 on page 29, we provide resources on culturally-competent HIV information for providers.)

Avert, a UK-based HIV education organization, offers free educational resources on their website. The page on [“HIV Stigma and Discrimination”](#) offers easily digestible information on identifying and addressing HIV stigma at a variety of levels, from internal and interpersonal stigma, to governmental and systemic stigma and discrimination, with an extensive list of references for further reading.

In October 2017, UNAIDS released a new report on [“Confronting Discrimination: Overcoming HIV-Related Stigma and Discrimination in Healthcare Settings and Beyond.”](#) The report outlines research on “how stigma and discrimination create barriers across the HIV prevention, testing and treatment cascades and reduce the impact of the AIDS response.” It also presents best practices and resources on confronting stigma and discrimination for organizations, policymakers, healthcare providers, and community members.

The 8th Annual International Conference on Stigma took place at Howard University on November 17, 2017. The agenda included general discussions about fighting stigma locally and nationally and sessions on specific topics, such as addressing stigma for incarcerated women living with HIV/AIDS. Registration is open to the public each year, and a live webcast is also available at www.whocanyoutell.org. Continuing Medical Education credits, Continuing Education Units for social workers, and certificates of attendance are offered.

As noted above, stigma and harmful negative views can be targeted to many aspects of a person’s experience and identity beyond HIV-status, which, among other harms, can lead people to avoid seeking care. CBOs highlighted discrimination related to race, gender expression and identity, and immigration status as potent concerns locally and nationally. One provider lauded how effectively the District upholds and protects human rights, though they noted that stigma regarding immigrants is increasing and a sense of discrimination is “in the air.” DC Appleseed will continue to monitor potential policies, possible community actions and relevant resources to fight stigma, especially related to health status and history, immigration status, race, sexual orientation and gender identity, and other socio-economic factors.

We also heard from providers that healthcare and community services should be delivered via a harm-reduction model—a nonjudgmental approach that meets people “where they are” with drug use or other activities, which is particularly relevant for prevention activities and education.

Lastly, a significant uptake in prescription and use of PrEP is vital to meeting the goal of a 50% reduction in new infections. A lack of knowledge and understanding of the PrEP regimen persists, and the spread of misinformation can contribute to stigmatization of its use. Further, the at-risk populations who are the best candidates for PrEP may be disengaged from care because of problematic interactions with providers in the past. To increase awareness in the community, the MAC AIDS Fund launched the PrEP for Women Initiative with the Washington AIDS Partnership and DOH in conjunction with the announcement of the 90/90/90/50 Plan. This [initiative established grants to DC organizations](#) as well as a [public messaging campaign](#) about PrEP for wom-

en of color in DC. And most recently, Whitman-Walker Health launched a [“Meet PrEP” TV advertisement](#), hotline (202-939-7690), and [informational website](#) for the public, with links to make appointments or connect with a PrEP navigator. For providers, the DOH website also includes links to several PrEP-related continuing education opportunities, including a session called “What You Need to Know About PrEP” conducted by the [DC Center for Rational Prescribing](#). Whitman-Walker Health also offers assistance to providers looking for more information about integrating PrEP screening and prescribing into their practice.

Task 4.11: Promote model programs for persons to take control of their healthcare and improve their well-being.

2017 Status: In Progress

Beyond dissemination of clinical practices and marketing campaigns, DOH planned to promote more models to increase the number of DC residents who take proactive measures to protect their health and prevent HIV infection. Some active initiatives in the vein of empowerment have been described elsewhere, such as the PrEP Power Hours for transgender women and men and the “Sex is...” campaign for DC youth. HAHSTA is also setting up new partnerships with university student health services to increase sexual health services for older youth in 2018.

Community-based peer self-efficacy approaches also have demonstrated effectiveness. For example, DOH funds a model called ManDate, a peer-based approach providing a non-traditional environment for African-American gay men to safely engage in conversations and develop support mechanisms around health and wellness, relationships, and self-identity. The settings are usually members’ homes, where there is a greater comfort level. In 2016, DOH and community partner NovaSalud were developing ManDate models for Latino gay and bisexual men, as well as African-American and Latina transgender women. Additionally, DOH has supported a faith-based initiative for African-American women integrating prevention and wellness into health ministries and other church activities. DOH planned to continue to develop this self-efficacy approach, including for Latina women. DOH has also identified and supported models among young persons and transgender persons. In the 90/90/90/50 Plan, DOH committed to review and promote more models for different communities to support self-actualization and health promotion strategies.

This task is in progress. Full implementation of the task will require specifics about the expansion of the models described above, to new populations and settings. Public education and social marketing campaigns are important to increase awareness in the general population. However, to the extent that peer support is a keystone of self-efficacy, in-person or community-based models should be emphasized.

Task 4.12: Maintain and adjust funding for syringe exchange services to reach injection drug users.

2017 Status: In Progress

In 2005, 163 new cases of HIV were attributable to injection drug use (IDU). Only seven such infections were reported in 2016.³⁵ This precipitous decrease is due to an influx of funding to CBOs for clean needles and other harm-reduction services for people who inject drugs, which occurred after Congress lifted a ban on local spending for needle exchanges in 2008. A study by researchers at The George Washington University estimated that the syringe exchange services (SES) policy change averted 120 new infections in the first two years

35. HAHSTA Epi Report, 2016.

after the ban was lifted and, further, that the \$1.2 million investment in SES over those two years led to \$44.3 million in savings to the DC healthcare system.³⁶ Because of the effectiveness of SES in DC—and as a local and national opioid epidemic increases the risk for transmission by IDU—the Plan pledged to maintain funding for these services in the years ahead.

SES providers—primarily HIPS and Family Medical Counseling Services (FMCS)—served approximately 10,000 people in 2015, representing an estimated three-quarters (77%) of active drug users at the time. SES collected 803,596 needles from the streets in 2016. The harm reduction programs have also facilitated the provision of hundreds of hepatitis C tests. This is significant coverage, but CBOs report that demand often exceeds the resources, and there are still more people to be reached. In 2017, HAHSTA's budget for SES increased by \$100,000 and an enhancement of \$850,000 was added to expand the response to the current opioid crisis. Some of this funding will be disbursed to the SES providers for associated services with dedicated funding for opioid treatment to Bread for the City in 2018.

Due to federal grant restrictions, funding for syringes must remain a local priority. It is possible for DOH to seek a waiver to these restrictions from the federal government, under an emergency designation. The District did apply for this waiver, though the CDC turned it down on technical issues. HAHSTA will be revisiting the waiver application to reapply.

The District has made a significant investment in SES over the last decade, and it has paid dividends. As demand has increased, DOH has increased funding for providers. DC Appleseed will continue to monitor whether funding is adequate to reach all residents requiring SES. This task is in progress until more clarity is gained about the adequacy of the funding landscape to prevent HIV transmission through injection drug use.

Task 4.13: Promote health decision-making and increase the availability of sexual health information for young people.

2017 Status: Implemented

While the number of newly diagnosed HIV cases citywide decreased by 51.8% from 2011 to 2016 for those between the ages of 20 to 29, this age group still leads all ages in terms of number of individuals newly diagnosed.³⁷ There were 52 new infections diagnosed in 2016 within the 20-24 age group, compared to 9 diagnoses for those between ages 13-19, and only one (perinatal transmission) under the age of 13.³⁸ In response, Goal 4 of the Plan aims to educate and empower school-aged children to make better decisions about health in their early adulthood, when new diagnoses are disproportionately high. Additionally, and significantly, preventing infection in teenage years may reduce the number of new diagnoses amongst young adults, given lag time between infection and diagnosis. Therefore, Tasks 4.13-4.15 relate to the importance of sexual education for students in DC.

To respond to the needs of young people, in 2016, DOH, through its Community Health Administration (CHA) and HAHSTA, revamped its youth HIV prevention plan to emphasize “the prevention of unplanned pregnancies, the support for contraceptive choice, the promotion of health literacy, and the integration of health in all relevant policies.”³⁹ The resulting 2016-2020 Youth Sexual Health Plan (YSHP) represents the latest iteration of an ongoing DOH effort to define, coordinate, and promote various resources across the District addressing the HIV epidemic. YSHP's first objective aims to create a “trusted adults model,” which engages and equips caregivers, educators, providers, and other adults to serve as knowledgeable, supportive, and trusted sources of sexual health information for youth.⁴⁰

36. Monica S. Ruiz et al., Impact Evaluation of a Policy Intervention for HIV Prevention in Washington, DC, 20 AIDS and Behavior 22, 2228 (2016).

37. HAHSTA Epi Report, 2016.

38. HAHSTA Epi Report, 2016.

39. 2016-2020 Youth Sexual Health Plan. Department of Health.

40. 2016-2020 Youth Sexual Health Plan. Department of Health.

The new YSHP prioritizes data collection, including evaluating fluctuations in HIV rates and “looking at the social determinants of youth sexual and reproductive health” in the design of sexual education programming.⁴¹ School truancy data, for example, led the DOH to extend its programming to include community-based initiatives that support students absent from in-school sessions, while also moving STI screening exclusively to schools due to low participation rates at pop-up screening tables.

In exploring the reasons why the pop-up screenings were unsuccessful (students cited a lack of privacy, coupled with the negative stigma associated with being tested for STIs), DOH learned the value of first-hand feedback on its initiatives. Accordingly, DOH has reportedly prioritized its youth focus groups to solicit instant feedback on the efficacy of its initiatives, while also maintaining a base of peer outreach advocates. With the assistance of these youth volunteers, to promote events and services, DOH engages the school-aged population through various creative and youth-centered initiatives, such as poetry contests, prizes for participation and volunteering, and a sexual health awareness month in May which utilized and promoted the since-ended “ShowOff” sex-positive social media campaign. DOH included other agencies and stakeholders in the development process for the YSHP and is actively partnering with the broader community to implement the YSHP and increase young people’s access to sexual and reproductive health education, while revising its on-the-ground efforts based on data and feedback on an ongoing basis.

In September 2017 the “Sex Is…” campaign launched, with a website, an event attended by about 100 young people, and social marketing campaign, including social media, digital, print and radio advertisement. The campaign promotes open, honest, judgment-free dialogue between youth, their peers, and trusted adults about sex and relationships. Campaign expansion in the second year will include additional social media engagement, youth events, “pillars of community” buy-in and events, parent engagement events, and resources developed by September 2018. DOH’s social media campaigns—RealTALKDC and Sex Is—have relatively large followings.

Efforts outside of the classroom reach students and non-students in a wide array of settings. Three community-based sites were funded in 2017 for youth peer education: Whitman-Walker, SMYAL and The Women’s Collective. DOH also funded Latin American Youth Center as an STI testing provider. HAHSTA estimates that 12,000 total young people have been served between small- and large-scale events with these four providers. DOH will continue to operate the school-based STI screening program to reach youth; twenty schools participated in the 2016-17 school year. DOH will also work to bring charter schools on board for screening and the Condom Access Program, but current charter school uptake is slow, and DOH has limited resources to expand screening. DOH aims to bring three additional charter schools onto these programs by the end of the 2017-18 school year.

In the 2016-2017 school year, HAHSTA funded over 300 peer educators, reached 84,885 young people in one-on-one sessions and 1,200 in workshops. HAHSTA conducted eight peer trainings, where 133 youth were trained. DOH also hosted or funded 324 small events and 18 large-scale events including Hoops 4 Life, World AIDS Day, and BLACK HIV/AIDS Awareness Day. Staff report that these efforts are great successes but present unique challenges. In the peer educator program, a maximum \$150 stipend is paid monthly to the peer educators, while non-paid educators receive course credit; these are often not enough to incentivize participation. Further, large scale events are burdensome and costly, often including the costs of a DJ, venue, and AV/lighting, which HAHSTA does not reimburse to host organizations.

DOH’s youth engagement and promotion of the “trusted adults” model are active initiatives, and this task is therefore considered to be “implemented.” However, the activities must continue through subsequent years in order to maintain this status.

41. 2016-2020 Youth Sexual Health Plan. Department of Health.

Task 4.14: Ensure that DC Public Schools and public charter schools provide HIV and STI-prevention education to all DC students and that students' understanding is assessed regularly.

2017 Status: In Progress

While efforts described above, to meet youth where they are, will be essential, a baseline of knowledge for all students is set in schools. To assess the landscape related to HIV education for youth in DC, DC Applesseed and the law firm of Paul, Weiss, Rifkind, Wharton & Garrison LLP undertook analysis of testing data, conversations with various stakeholders in the community, and interviews with representatives from relevant agencies, departments, and offices, including the Office of the State Superintendent of Education (OSSE), DC Public Schools (DCPS), the DC Public Charter School Board (DCPCSB), and staff of DC Council. Several District policies—including some that have very recently changed—impact the provision, design and assessment of health education.

The 2016 Health Education Standards issued by OSSE establish criteria for what is appropriate HIV and STI prevention education. These requirements provide a framework for teachers and policymakers to incorporate into lessons, overall curricula, and assessments for progress.⁴² The 2016 standards—the most recent update since the State Board of Education approved the previous standards in 2007—prioritize evidence-based approaches focused on skills, rather than rote knowledge. The new standards shift the emphasis on HIV education from reactive to proactive measures, such as strategies to maintain healthy intimate relationships, delay sexual activity, and engage in safe sex through condom use.⁴³ The standards established for each grade level coincide with the National Health Education Standards (NHES).⁴⁴

OSSE is charged by the 2010 Healthy Schools Act with assessing student knowledge of the NHES. OSSE now uses the annual Partnership for Assessment of Readiness for College and Careers (PARCC) standardized test, which broadly tests DC students' preparation for success in their personal lives, college careers, and professional endeavors. Separately, the Health and Physical Education Assessment (HPEA) presents questions on health development, sexuality, and reproduction; it is administered in the fifth and eighth grades, and throughout high school health classes. One of the categories tested within the HPEA is Human Body & Personal Health. The most recent HPEA data show that, across all grade levels, scores in this category have improved by several percentage points: DC fifth graders jumped from a 74% average score in the 2015-2016 HPEA's Human Body & Personal Health section to 81% in 2016-2017; eighth graders saw an improvement from 69% to 72%; and high school students jumped seven percentage points from 46% to 53%.⁴⁵ However, not all students participate in the HPEA testing; only 60% of eligible high school students, 69% of eighth graders, and 79% of fifth graders took the HPEA.⁴⁶ School participation in HPEA, however, was 93%. Stakeholders conveyed numerous reasons for low participation and general frustration with the HPEA test, though OSSE attributes the disparity to attendance and predicts that student participation will continue to increase with OSSE's own increased activities to address challenges.

Additionally, OSSE looks for trends in the DC components of the Centers for Disease Control and Prevention's (CDC) state and local Youth Risk Behavior Survey (YRBS) to gauge the effectiveness of education in DC schools. YRBS is a comprehensive collection of data that assesses health behaviors among young people, including, for example, frequency of condom use. Low participation in sexual education lessons and testing generally might explain the self-reported data in the most recent YRBS report: condom use amongst middle

42. Office of the State Superintendent of Education, 2016 Health Education Standards. Available at https://osse.dc.gov/sites/default/files/dc/sites/osse/publication/attachments/2016%20Health%20Education%20Standards_0.pdf.

43. OSSE 2016 Health Education Standards.

44. Centers for Disease Control and Prevention, National Health Education Standards, August 18, 2016. <https://www.cdc.gov/healthyschools/sher/standards/index.htm>.

45. Office of the State Superintendent of Education, Addendum to the Healthy Schools Act 2017 Report: Health and Physical Education Assessment 2016-17 District-Level Results, November 2017.

46. OSSE Addendum to the Healthy Schools Act 2017 Report: Health and Physical Education Assessment 2016-17 District-Level Results

school students declined, with statistical significance, from 78.1% in 2007 to 73.0% in 2012 to just 68.8% in 2015.⁴⁷ Alarmingly, YRBS reports that the percentage of students who say they have been taught about HIV/AIDS infection in school dropped precipitously for middle school students from 72.2% in 2007 to 56.5% in 2012 and to just 43.4% in 2015.⁴⁸

One of the most significant challenges related to health education in DC is the bifurcated public school landscape, with about half of students attending DCPS and the other half enrolled in independent charter schools. DCPS can design standard curriculum and practices through all its schools while autonomous charter schools make independent decisions about these matters. For example, while public charter schools do not have a uniform sexual education curriculum that OSSE can track, DCPS employs a standard, K-12 curriculum designed by Advocates for Youth, known as the “[3Rs Curriculum: Rights, Respect, Responsibility](#).” Even a perfect set of standards, curricula, and assessments will fail to be optimally effective if the information and/or testing is not accessible to all DC students in public and public charter schools.

So, while OSSE can provide resources for educators—such as a curriculum library, and a comprehensive [Health and Physical Education Booklist](#) for teachers to consult or incorporate into their sexual education curricula—it finds itself limited in pushing out standardized approaches District-wide. The Public Charter School Board likewise offers support to charter schools and teachers upon request, but it does not mandate any curriculum or practices and has pushed back on whether the Healthy Schools Act legally applies to charter schools.

Another factor cited for low participation in health education and HPEA testing was the limited incentives. Schools noted a long lag between administering HPEA testing and receiving the results, which did not allow time to tailor lessons for the current or next school year. (For the HPEA administered between April and June of 2015, some schools stated that they did not receive results until the following April). Teachers also expressed frustration that they were provided only with results in seven domains, without specifics regarding the subject matter tested. Moving forward, OSSE plans to provide sample questions to schools in order to offer better methods for instruction, but says it cannot release the questions without generating new questions every year, a task that would require unavailable resources.

Since 2016, OSSE has been making significant progress in providing resources and developing lines of communication with schools and educators. In an effort to respond to the expressed concerns, OSSE has committed to continuing the shift toward skills-based health education and testing; disseminating results and analysis from the HPEA to stakeholders more expeditiously (namely by utilizing a new program called Qlik, which provides schools with real-time school-level and student-level completion data and assessment results); pausing the recycling of HPEA questions so that teachers can identify content areas of concern for their specific students; continuing to work with teachers to develop sexual education curricula, draft specific lesson plans and find time within lessons to accommodate sexual education objectives; and releasing specific breakdowns of district-level and school-level data to increase transparency. OSSE also convenes a Youth Advisory Committee (YAC) of students who meet to brainstorm, advise on, and help implement projects for OSSE (much like DOH’s peer outreach advocates, but with more of an internal advisory role.)

To supplement capacity within schools, CBOs provide sexual education training when requested. CBOs have also been instrumental in offering health initiatives outside of the school environment, including after-school sexual education activities, peer youth ambassador programs, condom use seminars, condom distributions, HIV testing, and rewards-based models to incentivize students to attend events and participate in outreach.

DOH is also finding ways to empower educators with information. In addition to the youth plan activities described in Task 4.13, a representative from the HAHSTA youth team attends DCPS and OSSE health and wellness team meetings, training, and YRBS planning meetings to provide feedback. DOH also developed and delivered training at an OSSE conference on integrating PrEP and PEP information into lessons and will be making the resource available online for educators in early 2018.

47. Office of the State Superintendent of Education, District of Columbia Youth Risk Behavior Survey 2015, April 2017.

48. OSSE, District of Columbia Youth Risk Behavior Survey 2015.

There is another new challenge to providing comprehensive, fact-based education in all District schools. Changes in the federal Administration and US Department of Education leadership have resulted in a threatened loss of federal funds for sex education programs as well as rhetoric against comprehensive, evidence-based sex education in favor of a risk-avoidance (i.e., abstinence-only) curriculum. DC Appleseed will continue to monitor the political climate and engage with stakeholders to understand shifting needs for advocacy.

Data and analysis of sexual health knowledge, skills, and trends is critical in responding to the epidemic appropriately. We note that the 2016 and 2017 data are too recent to fully capture the impact of the numerous recent and positive changes in the strategy, implementation, and assessment of sexual education initiatives.

In 2018, DC Appleseed can help connect OSSE with CBOs and other stakeholders in order to facilitate an informed update of OSSE's resource library and curriculum; for example, some stakeholders informed DC Appleseed that the sexual education videos and graphics that teachers use in the classrooms are often almost 30 years old, which distracts students and detracts from the overall message.

This task is in progress. In 2018, DC Appleseed and partners will continue to engage with OSSE and educators to identify areas for improvement, track and respond to gaps in resources and knowledge, advocate for adequate funding, and engage in dialogue about stakeholder experience. We would like to talk more with teachers and students to understand what works. Task 4.14 will be considered implemented when HPEA results show knowledge and skills proficiency among students; when the testing data can be gathered and utilized in a timely and transparent way to best inform and equip educators to address current students' needs in line with the Standards' objectives; and when the YRBS data demonstrates an improvement in healthy behaviors, such as significantly increased condom use, amongst youth.

Task 4.15: Ensure that all DC schools meet their sexual health education obligations under the Healthy Schools Act.

2017 Status: In Progress

The Healthy Schools Act was passed by the DC Council in May 2010 to improve the health of students in the District, from the provision of nutritious meals to the provision of health education. The Act grants OSSE "the authority to verify compliance" with, and mandates that OSSE measure students' knowledge as it relates to its education Standards, including those on health and sexual health education.⁴⁹ OSSE works in concert with local education agencies to comply with the Healthy Schools Act by evaluating health education, as described above in Task 4.14. Based on the research by DC Appleseed and Paul, Weiss, Rifkind, Wharton & Garrison LLP, not all actors appear to be meeting their obligations. Remedying low participation and enthusiasm for health education across all schools is vital to arm students with evidence-based facts and skills that can lead to a reduction in new HIV infections.

Although some charter school teachers obtain OSSE's curriculum training and make use of OSSE's library, without dedicated attention or enforcement from PCSB, the actual implementation and oversight of sexual education in charter schools presents a particular challenge. Accordingly, the DC Council should consider renewed attention to the Healthy Schools Act's implementation across all schools and oversight of compliance by OSSE. For example, the Committee on Education within the DC Council should consider holding a hearing on HIV and sexual health education in DCPS and charter schools. DC Appleseed would also like to talk with schools and educators who are working effectively in their settings, enabled by OSSE's initiative to share school-level data on HPEA performance. Without full mandatory enforcement of the sexual health standards and testing of its progress, students are not being provided with the information they need to be healthy, successful adults in the District of Columbia.

47. Office of the State Superintendent of Education, District of Columbia Youth Risk Behavior Survey 2015, April 2017.

48. OSSE, District of Columbia Youth Risk Behavior Survey 2015.

49. D.C. Code §38-821.01

Task 4.15 will be considered “implemented” when, as with Task 4.14, data show that all schools—that is, public and charter schools—are meeting their sexual health education obligations and, given the requirements of the Healthy Schools Act, schools are equipped to comply with, and do comply with, the Act on an ongoing, day-to-day basis. We note that compliance with the Healthy Schools Act is not limited to the duration of the 90/90/90/50 Plan and must continue even past the Plan’s 2020 goal date.

Recommendations

As we reflect back on the progress made since our first report in 2005—when the situation was best described as dire—to now, we are encouraged. The ambitious and comprehensive activities underway across the District and at DOH to tackle the HIV crisis are considerable. How did the District go from the worst epidemic in the country to a jurisdiction poised to end the epidemic? First, we needed transparency and accountability and leadership willing to face the problem. From there, the District achieved its gains through significant investment of resources, dedication to good data and evidence-based public health practice, support for and partnerships with culturally competent community-based organizations, high rates of insurance coverage, and uptake of clinical best practices.

The District must sustain its investments and continue to follow big ideas.

We do not take where we are today for granted; we must continue to be protective of those conditions which our progress is built upon. The District must sustain its investments and continue to follow-through on big ideas.

Overall, we congratulate the District government and its community partners for a busy year of progress. DC Appleseed is glad to be part of this partnership and is prepared to continue the work ahead. Our recommendations for the next year—and every year until we achieve the 90/90/90/50 goals in 2020—are outlined in the seven categories below: Data, Stigma & Public Education, Social Conditions of Health, Other Activities within DOH, Work with DHCF, DC Appleseed’s Role, and Funding.

DATA

- In measuring our progress toward the 90/90/90/50 Goals, we have flagged a few key issues with data that should be updated or reconciled by the next progress report:
 - **Goal 1:** The latest epidemiological report did not include an updated estimate of the percentage of HIV-positive individuals who knew their status. The measurement of progress on this goal may be improved with implementation of various data collection strategies included in the Plan. HAHSTA should revisit its 2015 estimate in order to gauge progress on this important goal.
 - **Goal 2:** The treatment goal should be defined more precisely—do we want to achieve 90% of those diagnosed in care (attending medical visits) or in treatment (on and adherence to anti-retroviral therapy)? As the research points to antiretroviral therapy being the key to viral suppression and decreased transmission, the ideal definition, in our view, relates to active treatment adherence.
 - **Goal 3:** District residents in treatment reaching viral suppression increased modestly in 2016. Suppressing viral load is the key not only to the health of individuals, but also to preventing transmission. Progress on this goal relies on progress toward—and clarity within—Goal 2.
 - **Goal 4:** We are encouraged by the steady decline we see in numbers of new infections. We look forward to seeing HAHSTA maintain its robust portfolio of prevention services and embrace new strategies, such as upscaling PrEP, to ensure we don’t lose momentum.
- Several tasks in the 90/90/90/50 Plan relate to HAHSTA’s “retention blitzes,” with the goal of improving or replacing the data available and increasing their efficiency. The retention blitzes help providers identify and connect with patients who are out of care. Several activities stand out as critical next steps:
 - DOH identified the need to obtain patient consent in order to share additional information with providers, to improve care or help reengage patients who have fallen out of care, while also respecting patients’ privacy. Legal research determined this is possible, and DC Appleseed’s pro bono partners

at Hogan Lovells US LLP have shared a draft of a potential consent form. DOH should work to finalize and distribute this form to providers in the community, especially those serving high volumes of PLWH. (Task 2.4)

- HAHSTA envisions a more standardized and broad-based “data-to-care” system. Through 2017, HAHSTA supported a smaller-scale hybrid data-to-care program co-led by providers and DOH under the IMPACT DMV demonstration project. This task will be considered implemented when all potential internal and external sources of data on patient treatment is integrated into a single platform or program that streamlines and enhances DOH’s outreach efforts. (Task 3.4)

- In the Next Steps of the 90/90/90/50 Plan, DOH committed to enhancing the functionality of a web-based application to compile its core surveillance data, with the intention of updating data on a quarterly basis. DOH and DC Appleseed also planned to develop a data dashboard to track the progress of the Plan’s implementation and goals. Work on an online data application or a Plan data dashboard has taken a back seat to other activities but should resume in 2018. Further, HAHSTA has started to release surveillance data about every six months rather than quarterly. This is important to the District’s ability to monitor progress.

STIGMA & PUBLIC EDUCATION

- Many tasks in the Plan and other DOH initiatives rely on the use of social media and social marketing campaigns to spread messages about HIV prevention and care. DOH must sustain these effective campaigns over the course of the next three years to maintain progress. Maintaining and enhancing provider education will be especially critical to increasing testing, treatment, and PrEP uptake. (Task 1.2; Task 4.8)
- HAHSTA is engaged in campaigns to normalize conversations around sex and HIV through messages that support and to foster sexual health, well-being, and self-efficacy, which may minimize the surrounding stigma and its harms. However, no specific program has been established. We encourage HAHSTA to look at concrete means to assess and address stigma, such as the use of a “Stigma Index” tool or other stand-alone program in the community. (Task 4.10)
- The provision of sexual health education in public and public charter schools is critical in the effort to reduce HIV infections, especially as 20 to 29-year-olds lead all age groups in new diagnoses. We have treated the matter in some detail in this report:
 - DOH’s youth activities are comprehensive and should receive continued support.
 - For the classroom-based activities and testing, we are encouraged to see that OSSE and other stakeholders are looking at data to drive practice, and that the health standards focus on building skills rather than rote knowledge. OSSE should continue its efforts to share assessment data in the most transparent, useful ways for educators and the public.
 - DC Appleseed is concerned that participation in lessons and assessment is low, and that sexual health education is not uniformly implemented across independent charter schools. We will continue to dialogue with stakeholders to identify opportunities to increase capacity and participation. Meanwhile, the DC Council should consider providing additional oversight of the Healthy Schools Act’s implementation. For example, the Committee on Education within the DC Council may consider holding a hearing on HIV and sexual health education in DCPS and charter schools. Without full enforcement of the sexual health standards and testing of its progress, students are not being provided with the information they need to be healthy, successful adults in the District of Columbia.

SOCIAL CONDITIONS OF HEALTH

- Disease prevention and treatment adherence require the right conditions for success. Chief among the socio-economic factors that influence health are stable and safe housing. As in years past, the need for

housing support was echoed throughout the community, so the 90/90/90/50 Plan dedicated several tasks to improving housing conditions for PLWH in DC. Tasks 3.10-3.14 deal with this issue from a variety of angles. We note several opportunities for action or areas of concern in this area:

- The HOPWA program provides housing assistance and services to PLWH in DC. DOH intends to redesign HOPWA to focus on supporting people to achieve independence from the program; as clients no longer need a HOPWA voucher, more people living with HIV would be able to access stable housing through the program. Within this task, DOH started the employment and housing demonstration project (EHDP) to increase to assist participants in achieving economic and housing stability. The target was to serve 24 households, though the program only served 11 and was discontinued. The results of the EHDP were meant to inform an overall redesign of HOPWA, but the future of redesign efforts will need to be clarified in 2018. (Task 3.10)
- DOH believes that expanding the offering of HOPWA-eligible rental units beyond DC's borders could open up new, affordable choices for HOPWA clients. While a broader area for housing options may increase accessibility to housing, it should not replace efforts to increase opportunities within the District. (Task 3.11)
- In the Plan, DOH and DC Appleseed pledged to examine additional funding opportunities for access to stable housing for PLWH in DC. An assessment is necessary to determine if the current offerings are sufficient for the need. The work on this task included DOH collaborating with DHCF to investigate the possibility of using Medicaid funds to cover housing-related costs, as part of efforts to achieve better health outcomes. Neither of these efforts are underway, but these possibilities should be explored in the year ahead. (Task 3.12)
- Through strategic capital investments and partnerships with other entities, HAHSTA endeavors to create two new affordable rental units per year, set aside for PLWH. Because of the longer time horizon for this task, DOH should invest time and energy to discussions with partners in 2018 to achieve this goal. (Task 3.13)
- To improve conditions for PLWH who experience homelessness, the Department of Human Services and TCP should implement a well-researched, clear, and detailed policy for shelters to provide reasonable accommodations to PLWH. The District should also expedite transitions to permanent housing for PLWH in order to improve health outcomes and facilitate adherence to medical treatment. In the year ahead, DC Appleseed will continue our investigation, including researching best practices from other jurisdictions, exploring possible legislative and regulatory changes, and engaging with advocates and service providers to identify potential fixes outside of government action. (Task 3.14)

OTHER ACTIVITIES WITHIN DOH

- Staff at HAHSTA have formed working groups to track and monitor implementation of the tasks in the 90/90/90/50 Plan. These groups were instrumental in compiling the information on internal activities in this report. We envision these groups as driving the progress on the tasks of the Plan, especially those that might be otherwise overlooked, unassigned, or seem unobtainable. DC Appleseed appreciates the welcome it has received in working group meetings and looks forward to seeing them meet regularly and work effectively.
- In conversations with community-based providers and in analyzing progress on a few notable Plan tasks, we note an opportunity to increase and improve communication with providers. This is especially important to ensure smooth roll-out of and success through initiatives. For example, DOH noted that a recent social networking screening model was discontinued due to poor performance and low fidelity to the model among providers. (Task 1.1) Additionally, some CBOs expressed concerns that HAHSTA's new fee-for-service payment model will result in loss of funds for vital services, and DOH noted that implementation was delayed due to provider difficulty with the application. (Task 3.9) HAHSTA and CBOs generally have strong and supportive relationships, and it will be important for DOH to provide more communication, reassurance, and support around the adoption of the many new initiatives ahead.

- DOH would like to require provider reporting of ART initiation. This is a feasible strategy that could improve data collection and health outcomes. Providers have expressed willingness to share such information with DOH voluntarily or otherwise, so long as it is not burdensome. This may require further discussion with DOH staff about the best way to facilitate this sharing. As DOH continues to explore the possibility of institutionalizing treatment reporting, providers can provide the information voluntarily. (Task 2.2)
- The 90/90/90/50 Plan detailed how expanding locations, hours and the possible settings for care would mitigate barriers for many PLWH. While a directory of locations and hours is an important step, HAHSTA's work will also need to include more development of concrete strategies to extend and redesign services. (Task 3.1)
- DOH plans to do more to promote programs and models that increase the self-efficacy of DC residents to protect their own health. We would like to see specifics about the expansion of the models underway to new populations and settings. DOH should emphasize in-person, peer-led and community-based models. (Task 4.11)
- The implementation of and local support for syringe exchange services continue to be critical to reducing new HIV infections. This support must continue. We also encourage HAHSTA to assess if current funding meets the community need and to reapply for a waiver from restrictions on federal funds. (Task 4.12)
- In order to access ART prescription data for the half of patients who are covered under private health insurance plans, in 2016, DOH initiated a collaboration with the major health insurance plans in the District to obtain aggregate data on medication adherence. We would like to know more about the status of this effort. (Task 3.5)
- Two telemedicine initiatives were proposed in the Plan, one to support treatment adherence and another to support use of PrEP. These tasks are promising, but neither has been initiated. HAHSTA staff identified the need to develop partnerships with providers that have the capacity to deliver these services. These initial steps should be taken in 2018 in order to have an operational program online by 2020. (Task 3.7; Task 4.3)

WORK WITH DHCF

- Performance measures for insurance plans and providers can drive the uptake of clinical practice and improvement of quality in medical settings. A few potential model measures have been identified related to testing and care which could be used by DC Medicaid MCOs. DOH and DHCF should collaborate to select and implement one or more performance measures in MCO contracts for the next plan year. (Task 1.4; Task 3.8)
- DHCF and DOH can continue to find ways to meet the needs of shared clients. For example, many HIV providers use DHCF recently-launched My Health GPS platform for patients with chronic conditions. There are many other needs to address and barriers to mitigate in order to ensure PLWH have the conditions in place to achieve good health outcomes. We hope DOH and DHCF will, for example, explore the possibility of integrating payment for housing and/or social services in contracts with MCOs. (Task 3.2; Task 3.12)
- To assure the affordability of PrEP for eligible individuals, DOH planned to work with DHCF and private insurance carriers to cover the intervention. Reportedly, some MCOs participating in DC Medicaid will cover only the cost of laboratory tests and not the medication, and DC Alliance clients have to use Gilead's Advancing Access plan because the DC program does not cover ART treatments. While DOH staff are monitoring the situation, there is no plan yet for working with DHCF, MCOs, Alliance or private insurers to change coverage practices. This should be tackled as soon as possible. (Task 4.5)

DC APPLESEED'S ROLE

- As an outside party but an engaged partner, DC Appleseed is committed to supporting the work described in this report. As part of this engagement, we will continue participating in working groups, where appropriate, to provide feedback, report progress on our own work, and continue the monitoring necessary for these progress reports.
- We are committed to producing progress reports on an annual basis to assess the movement toward the 90/90/90/50 goals and implementation of Plan tasks. We plan to release this document every year on the anniversary of the Plan's release, World AIDS Day, December 1.
- Several tasks in the Plan require research or policy change which lands outside of DOH's purview. We have initiated work or monitored progress on these tasks, and have noted our next steps in this report. For example, DC Appleseed will follow the legislative and agency-level efforts to revise policies on DC Alliance enrollment to ensure all residents have access to reliable insurance coverage. We will also continue our investigation into and engagement with the issue of sexual health education in DC schools.
- DC Appleseed will advocate for appropriate funding in the District budget, especially for public health coverage through Medicaid and DC Alliance, syringe exchange services, and programs like community health workers.

FUNDING

- The 90/90/90/50 plan proposed a cost-effectiveness analysis of the proposed tasks within six months of issuing this plan. DC Appleseed and DOH were to prepare this study of cost-effectiveness, which would inform the ongoing budget planning. (As with the data dashboard, this supplemental activity was not pursued.) In 2018, we should reconvene our partners to discuss the necessity and scope of this analysis, identify potential researchers to employ, and establish a timeframe for the effort.
- We note that within the narrative of several tasks in this report, funding was considered a challenge or potential obstacle for implementation. Therefore, we encourage DOH to do an overall assessment of its funding categories and map what is needed to bridge the gaps and meet the needs for the tasks at hand. This could be part of or separate from the cost-effectiveness analysis described above.

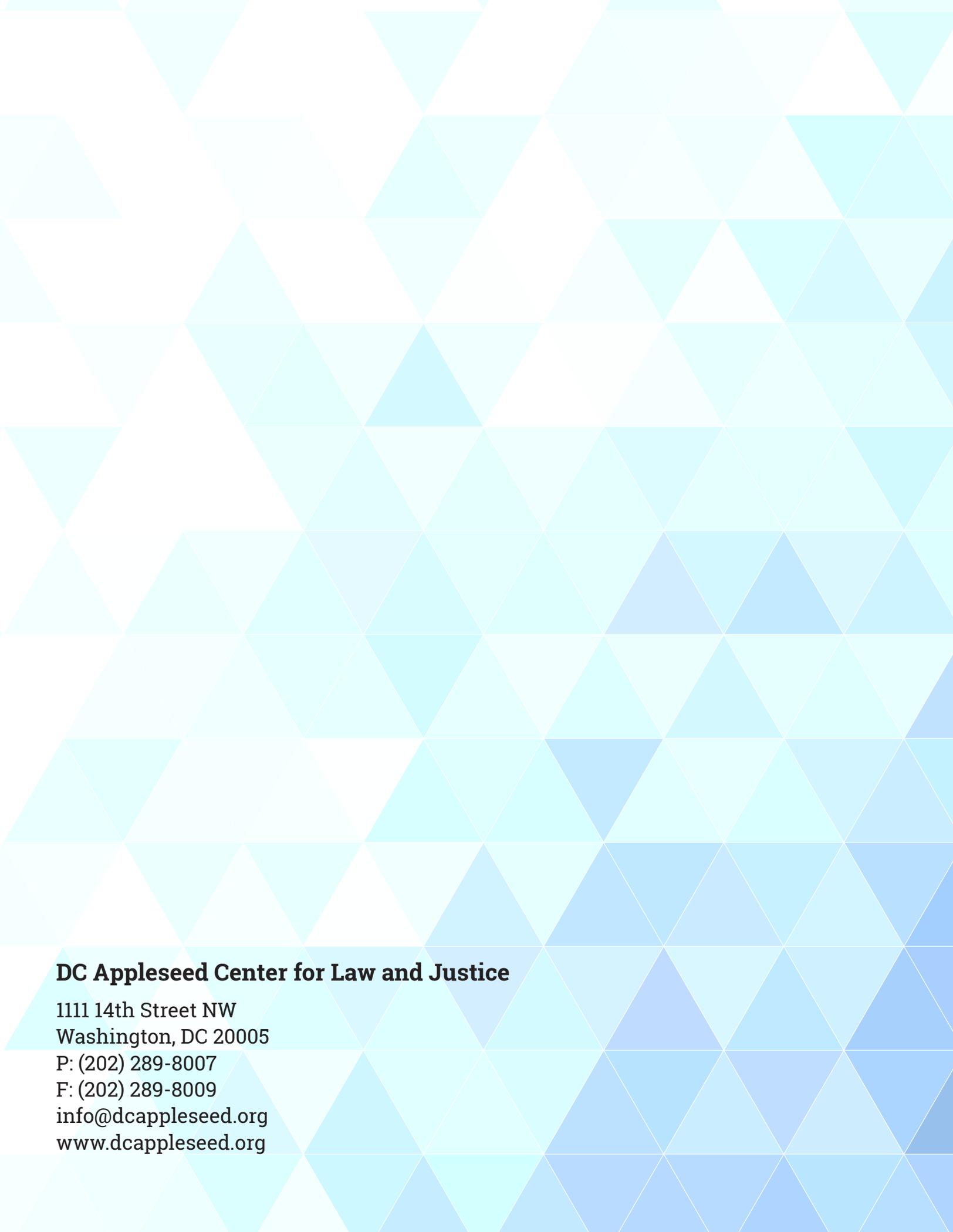
Conclusion

As we celebrate the progress of the last decade—and the last year—toward ending the HIV epidemic in DC, we have noted many areas that need special attention, reinvigorated efforts, or diligent monitoring to succeed. The briefest summary of our assessment is that progress must continue toward robust prevention efforts, while focusing intensely on increasing treatment adherence and viral suppression activities, which are often more complicated undertakings.

The District has been strong on the science - our rates of death and infection have so improved over the decade because of our ability to address the whole disease in many phases and stages. To keep moving the needle, we must tackle all the barriers that keep patients from the doctor's office or the factors that interfere with treatment adherence like housing, self-efficacy and stigma. Rates of infection are decreasing in the District, but those who remain vulnerable are often those who've historically been shut out or underserved by healthcare and political institutions, especially black residents, transgender people and young people. Trust-building, education and engagement—especially through community-based programs—are vital for a person-centered response to the epidemic and critical to keep nudging us forward toward our goals.

This work will require an unprecedented effort at cross-sector work and cross-agency collaboration to address issues like housing, education, and insurance coverage. The more progress we make, the harder worn future progress would be – there is no more low-hanging fruit. However, the District has faced tough battles in the past. Through the same ambition, dedication and partnerships that enabled our tremendous progress in the fight against HIV over the last decade, we can achieve our goals to finally end the epidemic in DC.

**This will require
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