

Mayor Muriel Bowser

DC ENDS HIV

Ending the HIV Epidemic in the District
of Columbia for All Communities by 2030

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MURIEL BOWSER, MAYOR



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EXECUTIVE SUMMARY

This report was submitted to the Centers for Disease Control and Prevention (CDC) on December 31, 2020.

In June 1983, the first-known diagnosis of HIV was recorded in Washington, DC. During the first decade of the epidemic in the nation's capital, this first person was joined by 10,000 more residents, with 4,000 people dead — overall, 14,000 DC residents have died with HIV — and the idea of ending the epidemic seemed unattainable. Fast forward to 2020 and the audacious goal of ending the HIV epidemic now seems achievable. The federal Ending the HIV Epidemic: A Plan for America (EHE) offers a new opportunity to accelerate key strategies and promote innovative approaches. The District of Columbia is grateful for the support from the US Centers for Disease Control and Prevention (CDC) Notice of Funding Opportunity (NOFO) PS19-1906 to conduct robust community engagement activities to inform the DC Ends HIV plan. On December 4, 2020, DC Mayor Muriel Bowser announced the release of the District's updated ending the HIV epidemic plan and the new community platform DCEndsHIV.org. The DC Ends HIV plan was developed as a public-private partnership among the DC Department of Health (DC Health), the DC Appleseed Center, and the Washington AIDS Partnership.

The DC Ends HIV plan has a goal of fewer than 130 new HIV diagnoses a year by 2030.

DC's first plan to end the HIV epidemic, known as the 90/90/90/50 Plan, had four goals: 90% of people with HIV knowing their status; 90% of people diagnosed with HIV being on treatment; 90% of people with HIV on treatment achieving viral suppression; and a 50% reduction in new diagnoses by the year 2020.

For this updated plan, Washington, DC has raised the floor to a new minimum of 95% of people knowing their HIV status, 95% of people diagnosed with HIV being on treatment, and



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95% of people with HIV on treatment reaching viral suppression. Through its community engagement, DC learned that the percentage decrease was more challenging to understand with numbers changing from year to year. To respond to that input, DC is setting an ambitious but achievable number of new HIV diagnoses that represents ending the epidemic. The number represents that the District has maximized all the strategies and tools available to end the epidemic. It is not zero, because there is not yet a cure or vaccine. However, the number means DC is making new HIV diagnoses as rare as possible. Further, to achieve fewer than 130 new diagnoses per year, DC has to increase uptake and use of pre-exposure prophylaxis (PrEP). DC has set a goal of more than 13,000 people on PrEP.

The DC Ends HIV plan follows the four pillars of the federal Ending the HIV Epidemic initiative: Diagnose, Treat, Prevent, and Respond. The plan values health equity and recognizes structural barriers, such as racism and stigma, to optimal health outcomes and individual success. It also centers people's life experiences, including social determinants of health. To reflect these critical factors, the DC Ends HIV plan adds a fifth pillar: Engage. DC Health held nearly 50 sessions with more than 750 culturally diverse people from all parts of the city, including people living with HIV, to understand their challenges and strengths. These conversations informed the key strategies summarized here:

1. **DIAGNOSE.** Increase access to HIV testing through programs such as the new at-home and walk-in testing program, GetCheckedDC.org, and advance policy and process approaches for routine HIV and STD screening.
2. **TREAT.** Start HIV treatment rapidly, such as the day a person is diagnosed, and prioritize Undetectable Equals Untransmittable (U=U) to promote staying on treatment.
3. **PREVENT.** Increase access and support for PrEP and post-exposure prophylaxis (PEP), expand harm-reduction programs for people who use drugs, and promote U=U because people who are virally suppressed cannot transmit HIV to a sexual partner.
4. **RESPOND.** Connect with people who have been newly diagnosed with HIV faster to intervene in clusters, among social networks, and connect individuals to care or prevention.
5. **ENGAGE.** Launch new wellness services to address the stress residents expressed as a barrier for prioritizing HIV health and advance approaches to reduce stigma, support stable housing and economic opportunity, ensure cultural humility is integral to services, and promote accurate information.

The DC Ends HIV plan includes 23 preliminary metrics by the Diagnose, Treat, Prevent, and Respond pillars to measure the productivity and effectiveness of the strategies. DC Health is developing measures for its Engage pillar and anticipates additional metrics for the other pillars. DC Health will be collecting and reporting data by focus populations, where available, including Black men, Black women, Latino gay men, young Black gay men, transgender

individuals, and people who use drugs. Complementing [DCEndsHIV.org](https://dcehiv.org), DC Health is establishing a partnership with the City University of New York Institute for Implementation Science in Population Health (ISPH). ISPH will develop a DC EHE Data Dashboard, which will contain data visualizations on key indicators of the District's HIV epidemic and the strategies to end it along with social media dissemination features to engage community members. DC Health will develop a regular schedule for updating the data measures.

While meeting the requirement under PS19-1906 to submit a written plan to CDC, DC has created an interactive plan site with [DCEndsHIV.org](https://dcehiv.org) to sustain regular community engagement. The website is designed to be updated regularly with community-informed approaches and new developments in the HIV field, such as the anticipated availability of long-acting HIV treatment and PrEP. In addition to DC Health-sponsored engagement activities, [DCEndsHIV.org](https://dcehiv.org) contains resources for communities to conduct their own discussions to share. The new DC EHE Data Dashboard will engage community residents through the promotion of data points. DC Health intends for both websites to be active and ongoing planning tools to advance data-driven, up-to-date strategies. The DC Ends HIV plan belongs to everyone in DC, including District government, medical providers, community-based organizations, residents living with HIV, HIV-negative residents from all backgrounds, and academic institutions. Together DC can achieve a vision of an ended HIV epidemic supporting the best and most equitable health outcomes for all communities in DC.





INTRODUCTION

The DC Ends HIV plan has defined a vision, mission statement, and goals as follows:

Vision: The HIV epidemic has ended for all communities, resources are equitably available, and optimal health outcomes are attainable for everyone in the District of Columbia.

Mission: By providing prevention and treatment services that are safe for people to access, supported by the latest science and data, and responsive to the well-being and needs of communities and individuals, DC will end the HIV epidemic in the nation's capital.

Goals:

- By 2030, DC will have **fewer than 130 new diagnoses of HIV** per year.
- People living with HIV will be able **to easily and safely maintain optimal integrated health.**
- DC acknowledges and aspires to address **the impact of stigma and structural racism** on sexual health and HIV outcomes.

In 2016, DC issued the 90/90/90/50 Plan to end the HIV epidemic in DC by 2020, developed through a public-private collaboration among the DC Department of Health, DC Appleseed, and the Washington AIDS Partnership. The 90/90/90/50 plan was named for its goals: 90% of DC residents with HIV knowing their status; 90% of people diagnosed with HIV being on treatment; and 90% of people with HIV on treatment achieving viral suppression. Through these and other activities, the District aimed to see a 50% reduction in new diagnoses by 2020. The plan consisted of 42 tasks, six demonstration projects, and four public calls to action within a key programmatic framework of linkage, reengagement, and retention; treatment initiation; Data to Care; and biomedical prevention, primarily PrEP. It recognized that social determinants of health, policy changes, community engagement, education, stigma, and data capacity were crucial drivers and strategies to address inequities. DC Health with academic partners prepared statistical models to calculate program activities and attribution to meet the plan's goals. The models demonstrated that meeting the 90/90/90 goals would achieve most of the aim to reduce new infections by 50% with PrEP contributing the remaining portion.

The District has made significant advances: a 79% decrease in new cases from 1,374 in 2007 to 282 in 2019. In 2019, 81% of newly diagnosed people were linked to care within 30 days — 62% within seven days. And among all people living with HIV, 69% achieved viral suppression, an increase of more than 40% a decade ago. Among individuals diagnosed with

HIV presumed to currently be living in the District, 80% have laboratory evidence of receiving care with 87% of those in care virally suppressed. The proportion of newly diagnosed individuals achieving viral suppression within 90 days increased significantly from 45% in 2018 to 59% in 2019. DC was the second public health department in the nation to endorse the Undetectable Equals Untransmittable (U=U) consensus statement. PrEP initiations by DC Health-funded community partners increased from around 500 in 2016 to more than 2,000 in 2019. The following table reports on the District's progress:

	2015	2016	2017	2018	2019	2020 Goal
Goal #1: 90% of HIV-positive District residents know their status	86%	86%	87%	88%	90%	90%
Goal #2: 90% of District residents living with HIV are in treatment	73%	76%	77%	77%	80%	90%
Goal #3: 90% of District residents living with HIV in treatment reach viral suppression	78%	82%	84%	85%	87%	90%
Goal# 4: 50% reduction in new HIV diagnoses	399	379	371	335	282	196

The success of the DC Ends HIV plan will depend on meaningful and ongoing community engagement in the ownership and implementation of the strategies; enhancing critical, multisector partnerships with community providers, academic and research institutions, federal grantors, adjoining jurisdictions, foundations, industry, advocates, and stakeholders; and maintaining leadership support from public officials, community planning bodies, and opinion-makers. The District honors a commitment to an authentic and credible process of implementation and continued planning guided by community participation.

The development of the DC Ends HIV plan started in October 2019, two months before the novel coronavirus, SARS-CoV-2, was discovered that would affect nearly 80 million people globally, nearly 20 million in the US, and more than 27,000 DC residents by the end of 2020. COVID-19 has become the third-leading cause of death in the US. The pandemic has significantly altered the delivery of routine healthcare and community services universally. In Washington, DC, most medical and community providers transitioned to telehealth for clinical services and nonclinical services. As evidence, in January 2020, 0.3% of Medicaid claims for 0.8% of beneficiaries were for telehealth care. From April to September 2020,

21% of claims covering 31% of beneficiaries were under telehealth. The pandemic hastened the development and implementation of new service models. DC Health launched a new at-home testing program called GetCheckedDC.org. In June 2020, DC Health started sending an oral rapid HIV test kit to residents. To date, more than 1,200 kits have been sent. In September 2020, DC Health added home STD tests, which has enabled more than 600 residents to obtain three-site STD screening. DC Health also launched a novel walk-in testing program where residents can request HIV, STD, and/or hepatitis testing through the GetCheckedDC.org portal and visit any LabCorp office to receive the tests. With the arrival of COVID-19 vaccines, there is new encouragement that DC will succeed in moving past the pandemic. The lessons from the pandemic will continue to inform and adapt HIV health and support services.





SECTION I

Engagement Process

Community engagement is an integral part of DC's EHE plan to learn as much from the community as possible from epidemiological data. The only way public health prevention and treatment tools can be effective is if there is equitable access to those tools. To plan and coordinate community engagement activities for EHE planning, DC Health formed an internal "1906 work group" consisting of DC Health program, surveillance, capacity building and planning staff, as well as members from the Washington, DC Regional Planning Commission on Health and HIV (COHAH), the DC region's integrated prevention and care planning body.

DC Health acknowledges that to support people with or without HIV to stay healthy there was a need to pause from focusing solely on HIV, or even sexual health, and start with people's daily lived experiences. DC Health heard from people with HIV that the competing needs of daily life often take priority over managing their HIV. With that in mind, DC Health community engagement conversations were initially guided by four central questions:

- What's going on in the lives of people in your community?
- What are the major concerns of your community?
- What are strengths of your community?
- How do we use these strengths to continue to support the lives of the people in your community?

After initial community feedback and thematic documentation of overall community strengths and concerns, community conversations pivoted to topics of sexual health and HIV.

DC Health launched community engagement activities in October 2019. However, in March 2020, DC Health paused engagement to enact COVID-19 prevention measures. In May 2020, DC Health resumed conducting engagement activities through virtual platforms. Although virtual sessions worked for many of the groups, DC Health acknowledges that it missed some engagement opportunities because virtual platforms were not appropriate for all communities.

To date, community engagement activities have included the voices of around 740 diverse community members, inclusive of HIV status, population, and employment. DC Health was intentional in reaching people not traditionally part of engagement efforts or meetings.

Engagement sessions were conducted in several formats, depending on the community: breakfasts, casual chat and conversation gatherings, focus groups, dinners, and large-scale social events. These sessions were held in safe, casual, familiar spaces to encourage open conversations and decrease the feeling of business or government formalities. Documentation on community engagement is submitted as an attachment to this document. Summaries appear below.

Existing local prevention and care integrated planning bodies. The COHAH was included in all levels of HIV planning and provided feedback on engagement plans, as well as communities to engage. DC Health presented the EHE update initiative before beginning accelerated community engagement. COHAH staff members were members of the 1906 planning work group while work group staff attended COHAH committee meetings. The COHAH's Community Engagement and Education Committee provided guidance and connected community engagement efforts between DC Health staff and people living with HIV. In February 2020, COHAH members participated in a half-day engagement session brainstorming regionally relevant ideas per federal pillar. The following summarizes COHAH recommendations:

- **OVERALL:** More effective feedback loops; include the community at every level; share results of research (especially any comorbidities); engage the first cohort in discussions of aging and HIV; and use more widely used platforms for dissemination of information.
- **DIAGNOSE:** Increase testing; work with trust issues in historically marginalized communities; decrease stigma; increase access to testing.
- **PREVENT:** Focus on populations with the greatest need; PrEP education and awareness; U=U; holistic approach; and social determinants of health.
- **TREAT:** Full access to care and education about access; provider education; rapid antiretroviral therapy (ART) education; continuity of care; and U=U to reduce stigma.
- **RESPOND:** Youth focused; better data sharing; and better reporting.

Local community partners. DC Health has strong community partnerships that consistently provide feedback and programming and planning efforts. However, for the updated plan, there was intentional outreach to cast a wider net for new voices in different as well as known communities. Led by data from DC's 2019 annual surveillance report, the expanded community engagement included focus populations not traditionally connected to DC Health providers or community-based organizations, including Black women, Black gay or bisexual men, Latinas, Latino gay men, returning citizens, Black heterosexual men, faith-based communities, transgender people, social networks, and regional partners.

Local service provider partners. Most provider sessions were conducted virtually due to COVID-19 restrictions. Initially, DC Health engaged health department staff in four virtual sessions guided by staff who identified essential populations and providers of substance use, senior/aging, mental health, and PrEP. DC Health also engaged providers who work with

the Latinx community, wellness providers, providers working with returning citizens, middle management direct service providers, and youth providers. Most of these provider groups had multiple opportunities to participate and continued outreach will occur during Phase 2 of community engagement.

These conversations raised themes of resilience and barriers to accessing resources. Although many unique experiences were shared during population-specific sessions, there were emerging themes that were raised across communities.

EMERGING THEMES FROM COMMUNITY ENGAGEMENT

Cross-Community Themes	Components
Stress	<ul style="list-style-type: none"> • Work-life balance • Generational trauma • Super Woman Syndrome • Violence
Connection	<ul style="list-style-type: none"> • Finding partners • Communal spaces • Peer and support groups
Culture	<ul style="list-style-type: none"> • Stigma, shame, and fear • Misinformation • Perception of risk • Family and gender roles
Identity	<ul style="list-style-type: none"> • Gay • Transgender • Gender • Nationality
Structural issues	<ul style="list-style-type: none"> • Healthcare access • Mental health • Language
Social determinants	<ul style="list-style-type: none"> • Socioeconomic status • Education • Returning citizen status

DC Health commits to continued community engagement and will launch Phase 2 of community engagement in January 2021. Phase 2 of community engagement will follow a three-tiered approach: (1) return to those communities previously engaged; (2) focus efforts on communities not previously reached; and (3) develop and implement a routine community feedback loop process to leverage national observances, such as population-based awareness days, National HIV Testing Day, Transgender Day of Remembrance, and World AIDS Day.

DC Health also plans to partner with the District of Columbia Center for AIDS Research (DC CFAR) Community Advisory Board to coordinate a community research conference where the community, researchers, providers, and other stakeholders can meet and share various forms of data for feedback and dissemination.



Reengagement	New Engagement
Transgender individuals and gender-nonconforming individuals	College students
Young Black gay men	African-born individuals
Faith-based LGBTQ+ individuals	Reentry network providers
Black Women	Older Black men
Middle management providers	Older individuals
Returning citizens	Fraternities and sororities
Faith-based community	Individuals experiencing homelessness
Latinas	Housing providers
Substance users	Wellness community
Direct service providers — mental health and wellness community	Sex workers
Direct service providers — substance users	
Research community	
Black Women and DC Health staff	
Latino/a/x general population	
Planning body	
Direct service providers — Latino/a/x community	
Direct service providers — reentry network	
Black heterosexual men	
Health department staff/regional	
Latino/x men who have sex with men	
Wellness providers	

SECTION II

Epidemiological Profile

An estimated 1.8% (n=12,408) of the resident population in the District of Columbia is living with HIV. This estimate is based on case report and laboratory data collected as part of routine disease surveillance activities. With an estimated 10% of individuals living with HIV in the District unaware of their HIV status, the true burden of HIV in the jurisdiction is even higher than that documented by surveillance data.

Although the magnitude of declines has varied over the past decade, a reduction in the annual number of newly diagnosed HIV cases in the District continues to be observed. In 2019, 282 individuals were newly diagnosed with HIV in the District, marking a 29% decrease from the number of newly diagnosed HIV cases documented in 2015 (n=399). Unfortunately, such declines have not been consistent across all populations, contributing to persistent demographic disparities in the risk and burden of HIV within the District. A 42% decline in the number of newly diagnosed HIV cases was observed within the white population over the past five years, compared with 24% and 37% declines over the same period documented within the Black and Latinx communities, respectively. Overall, Black men who have sex with men (31%) and Black women (21%) accounted for the largest proportion of newly diagnosed HIV cases in the District from 2015 through 2019 (n=1,766), followed by white (9%) and Latino (9%) men who have sex with men. Although most likely underestimated due to the limitations of surveillance data, around 3% of newly diagnosed HIV cases in the District from 2015 through 2019 occurred within the transgender community. Slightly more than 50% of all individuals living in the District diagnosed with HIV are 50 or older. However, newly



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diagnosed HIV cases tend to occur within younger age cohorts. From 2015 through 2019, around 34% of newly diagnosed HIV cases in the District occurred among those ages 20 to 29, with individuals ages 30 to 39 (28%) accounting for the second-largest proportion of newly diagnosed HIV cases. Geographically, the highest HIV burden and rates of new infection are observed in the eastern region of the District, comprising Wards 5, 6, 7, and 8.



Of those diagnosed with HIV living in the District, around 80% have evidence of being engaged in HIV care (≥ 1 CD4 or Viral Load laboratory report) in 2019, with 87% of those engaged in care having an undetectable viral load (< 200 copies/mL) based on their last laboratory report during the year. With regards to newly diagnosed HIV cases ($n=1,766$) from 2015 through 2019, 88% were linked to care within 30 days of diagnosis and 60% had evidence of achieving viral suppression within 90 days of diagnosis. There is evidence of some variation in HIV care engagement across demographic groups. However, more substantial disparities are apparent with regards to viral suppression among those engaged in care. Notably, 95% of white individuals living

in the District diagnosed with HIV that were engaged in HIV care in 2019 had evidence of being virally suppressed based on their last documented laboratory report, compared with 72% of Black individuals and 68% of Latinx individuals. A similar disparity is also observed with regards to age. Around 90% of individuals living in the District diagnosed with HIV ages 40 and over that were engaged in HIV care in 2019 had evidence of being virally suppressed based on their last documented laboratory report, compared with 79% of individuals age 39 and younger.

Although the total number of deaths among individuals living in the District diagnosed with HIV declined slightly between 2016 ($n=314$) and 2018 ($n=277$), the proportion of deaths attributable to HIV has remained relatively stable. Less than 30% of the deaths occurring from 2016 through 2018 among individuals diagnosed with HIV living in the District had HIV documented as the primary cause of death. The most prevalent documented primary causes of death among individuals living with HIV in the District are cancer, cardiovascular disease, and accidental death.

Positive epidemiologic trends in HIV diagnosis, care engagement, viral suppression, and mortality continue to be documented within the District. However, challenges remain with regards to reducing inequities across the population in the risk and burden of infection.



SECTION III

Situational Analysis

The District is well positioned to end the HIV epidemic in the next 10 years. Multiple strengths support this goal. The District contains an extensive network of clinical and nonclinical providers with well-developed partnerships among them. The District has a unique academic-government-community collaboration through the DC CFAR to develop and study innovative approaches and promising practices supported and guided by the National Institutes of Health (NIH) HIV research framework. Its health department compiles, analyzes, and disseminates data to drive policy and program directions. It has an integrated HIV care and prevention planning group, which develops relevant service standards and conducts comprehensive needs assessments. The District has both a comprehensive Integrated HIV Care and Prevention plan and an initial EHE plan (90/90/90/50 Plan). There is a robust collaboration among regional health departments to coordinate program approaches and optimize resource allocations. A recent example of health department joint collaboration is the development of a regional early intervention services program initiative. The initiative defined a status-neutral approach that supports early engagement with individuals across the metropolitan area in care or prevention services. This innovative design reduces the silos of HIV care and prevention services that often miss people in need of connection and a person-centered provider home. As a jurisdiction, Washington, DC values health equity and recognizes structural barriers, such as racism, to optimal health outcomes and individual success. The District has fashioned a civil society that legally bars discrimination, established a strong human rights ethic, recognized sexual and gender minorities, and designed standards and curriculum with age-appropriate sexual health education. These HIV health infrastructure components and social factors, among others, provide a context to the strategies that will accelerate reducing new HIV diagnoses and ensuring successful health outcomes for people living with HIV.

Although the strengths described offer the foundation for a successful EHE goal, some challenges can detract from or derail effective plans. First, there are fundamental social threats: structural racism, stigma, and inequity. The negative impact of racism on health is widely recognized, and ongoing systemic, structural change is needed to improve health outcomes in historically marginalized communities. It is no small task, and meaningful change requires respect, cultural humility, and affinity while addressing ways to undo the systems that hold damaging policies in place. As part of this plan and an intentional part of all future

functions, DC Health acknowledges and will attempt to address the impact of structural racism on sexual health and HIV outcomes. DC Health is developing a framework for promoting social justice in its work, centering the voices and lives of Black and Latinx people, and creating principles and dedicating resources to erode racism and inequity. Internally, DC Health will begin by intentionally looking at race and racism. This work must be done mindfully, fully taking into account the diverse populations served, the diverse population that works within DC Health, and the larger context in which DC Health delivers programs and develops policies. DC Health will:

- Create spaces to discuss racism in internalized, interpersonal, institutional, and structural levels and how these levels of racism affect work.
- Agree upon a framework and strategies to address racism within DC Health, as well as in policies and programs.
- Define internal guiding principles for addressing racism.
- Agree upon metrics to measure progress on becoming an antiracist organization.

With acknowledging and addressing structural racism, it is fundamental to ensure equity when it comes to access to resources and opportunities to all racial, ethnic, gender, and sexual identities and experiences. DC Health has developed programs on drug-user health, sexual positivity, social and emotional well-being, and addressing issues such as employment, fellowship, and housing. It has also aimed to not assign risk to people based on their identities, instead defining risk in terms of behavior (for example, not wearing condoms, not knowing the status of a partner) to lessen the stigma people might feel. All have aimed for diversity, equity, and inclusion of many populations often left at the margins, as well as to decrease the stigma connected to some of these populations. Additional ongoing initiatives that help increase equity and reduce stigma are:

- **Undetectable Equals Untransmittable (U=U).** DC Health was the second health department in the nation to endorse the U=U consensus statement as a significant message to emphasize treatment adherence, reduce stigma for people living with HIV, and prevent new HIV transmissions. DC Health expects the integration of U=U into clinical and support services. DC Health supports this integration by pairing U=U messaging with other sexual health education



campaigns, translating messaging into Spanish, and including it as a main strategy in planning efforts.

- **Health Impact Specialists.** In 2015, DC Health received a four-year demonstration grant from the CDC focused on creating a system of care for men who have sex with men and transgender people of color. A program was developed to hire individuals from the community affected by HIV, providing an opportunity for economic growth while simultaneously putting health resources into the same community. It is a model for activating social justice and empowerment.
- **Rapid Peer Responders.** Rapid Peer Responders address the health of people who use drugs through a harm reduction approach. Similar to the Health Impact Specialists, opportunities are provided to individuals who are from the community they serve, and who have identified employment challenges, such as recent incarceration experience, or limited work experience in the formal economy.
- **Status-Neutral and Regional Early Intervention Services.** DC Health has developed a status-neutral approach, responding to individual sexual health needs wherever they are on the HIV prevention and treatment continuum. This status-neutral approach is delivered using the “Hi-V (high five) model,” which consists of five pillars — “find ’em, teach ’em, test ’em, link ’em, and keep ’em” — of client-centered services that promote equity, whole-person health, and eliminate barriers (e.g., behavioral health, employment, housing) to prevention and/or treatment services. These services are delivered to focus populations that are at very high risk of HIV infection, have demonstrated high HIV prevalence, have inconsistent engagement in care and treatment, and/or are at increased risk of falling out of care and treatment.

Second, there are local challenges that reflect geography and life priorities as expressed by residents during community engagement sessions. One challenge is how to end the HIV epidemic in the District when it is a small jurisdiction in an area within a large and complex metropolitan area inclusive of other jurisdictions. People live, work, play, and access health services irrespective of jurisdictional lines. The metropolitan area covers counties in Maryland, Virginia, and West Virginia, and the District. Two Phase One EHE jurisdictions — Montgomery County and Prince George’s County — directly border the District. The city of Baltimore, another Phase One jurisdiction, is 30 miles from Washington.

Another challenge is how HIV factors in the lives of focus populations. As described in the engagement section, DC Health initiated community conversations with a nuanced question to elicit multilayered responses to “What’s going on in the lives of each population?” Subsequent questions were asked about resiliency and effects on the population, what is the role of sexual health, what needs would support overall health, among others. Among diverse community members, HIV health was not among the top concerns.

The following sections will present the needs assessment, current activities by pillar, and additional strategies that DC is including in this plan.

Needs Assessment. Data from the Washington, DC Regional Planning Commission on Health and HIV (COHAH), which serves as the Ryan White Planning Council and HIV Prevention Planning Group, needs assessment shows that, overall, people living with HIV were engaged in care, received outpatient ambulatory health services on a timely basis, had high rates of antiretroviral medication use, and used those medications as prescribed. Regarding service needs, focus group and interview data identified the importance of mental health services, psychosocial support, and assistance with additional housing services in the DC eligible metropolitan area (EMA). Psychosocial and emotional factors were one of the most consistently reported barriers to linking with HIV care across communities. Additionally, the cost of housing, the availability of housing, and discrimination in housing were all identified as barriers to using and adhering to HIV care and treatment, particularly in DC and Maryland.

To address some of these, DC is working toward formal certification for community health workers (CHW) and expanding the CHW and peer navigator model to reduce barriers to linkage and retention in care, particularly for minority populations. CHWs have access to and the trust of communities, making them an integral part of linkage and retention efforts, particularly for those who feel marginalized, have been lost to care, or are newly diagnosed. Housing is being addressed through a housing navigator program. The housing service category in the Ryan White Part A Program has been updated to include housing navigation and referral services, as well as transitional, short-term, or emergency housing assistance to enable people living with HIV to gain or maintain outpatient/ambulatory health services and treatment. A wellness support service category is being developed to provide additional services to support holistic well-being that complements mental health and psychosocial support services. The Regional Early Intervention Services initiative is a status-neutral approach toward prevention and care services and is described below in more detail.

COVID-19 interrupted 2020 needs assessment efforts, so a comprehensive needs assessment will be conducted in 2021. There will be an emphasis on reaching people who are out of care or recently reengaged in care. The needs assessment will also incorporate people who are HIV negative to understand HIV prevention needs.

Snapshot by Pillar

Using a health equity- and trauma-informed framework, plan strategies include testing, U=U, PrEP/PEP, rapid ART, and accelerated responses to new diagnoses. These focus areas will align with the four federal pillars; the additional DC-specific pillar, Engage; and ongoing work at DC Health assuring programs are accessible and responsive to the diverse communities, as well as the unique intersectional needs of this diversity.

Several initiatives at DC Health are informing planning on these areas of focus. DC Health continues to leverage and engage existing working partnerships across government, jurisdictions, academic and research, community providers, education, and consumer and stakeholder groups to inform and develop planning and programs. Funding through HRSA

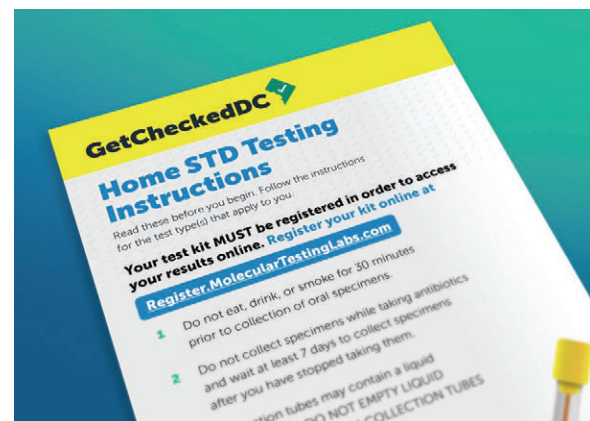
20-078 and CDC PS20-2010 enables DC Health to expand access to programs supporting the availability of innovative and effective medical, support services, and prevention services to people living with HIV and people who are HIV negative. Under HRSA 20-078, the funding will also engage people who previously were not eligible to receive Ryan White program services. In addition, DC Health was awarded NIH supplements on ending the epidemic for planning new approaches on PrEP, molecular surveillance, and rapid ART.

DC Health has adopted a status-neutral approach through the Regional Early Intervention Services model to create innovative and culturally appropriate services, either within specific stages or along the full continuum of HIV prevention, testing, care, and treatment. The goal is to improve access to and use of high-quality, client-centered services for individuals living in the DC eligible metropolitan area (EMA) most affected by the HIV epidemic.

DC Health continues its commitment to the regional DC, Maryland, and Virginia (DMV) collaborative, innovative and expanded Data to Care, and the intersection of HIV and opioid use, while recognizing the impact of COVID-19 within systems of power and privilege, to address health inequities in communities.

DIAGNOSE. DC Health has maintained its contracting relationship with 19 clinical and nonclinical community-based organizations to provide HIV testing and linkage to care services. These partnerships have supported the sustainability of large and small organizations to provide either lab-based or point-of-care rapid HIV screenings. Even though COVID-19 has interrupted services, an unexpected success has been the necessity to create new protocols to safely continue to offer HIV screening to clients in this environment. Programs have developed various models that are tailored to their respective structures. DC Health has facilitated meetings between HIV screening providers and community COVID-19 testing sites to learn specific approaches and workflows.

DC Health responded to COVID pandemic-related closures and reductions in healthcare services, particularly HIV testing, by designing and implementing an at-home testing program. At the end of June 2020, DC Health launched GetCheckedDC.org, a website portal for requesting at-home HIV test kits. Using the OraQuick test kit, DC Health sends the kit and a questionnaire 14 days afterward to ask about the person's results and experience with the program. Data from the program indicates that it is being met with success in terms of the



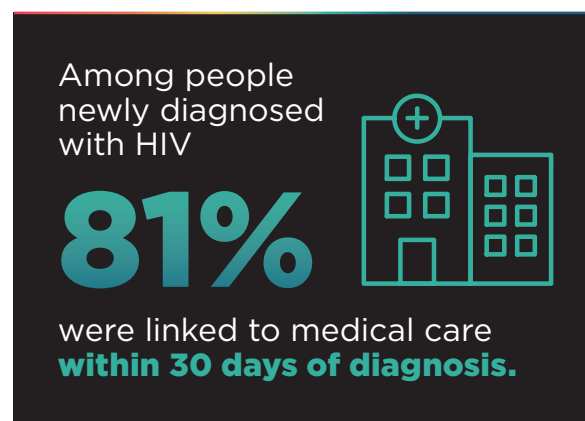
DC Health responded to COVID pandemic-related closures and reductions in healthcare services by designing and implementing an **at-home testing program.**

number of test kits distributed, the satisfaction of residents who have received a test kit, and filling gaps that were created by pandemic-related closures and fears. In September 2020, DC Health added two new components of the program: at-home STD test kits and walk-in HIV, STD, and hepatitis testing.

Since the launch of the at-home HIV testing program [GetCheckedDC.org](https://getcheckeddc.org), more than 1,200 residents have ordered tests. More than half of participants indicated use of the program due to “effects of the COVID pandemic,” followed by the benefit of convenience. Almost 40% of participants last received an HIV test “more than 12 months ago” and nearly 7% indicated that they had “never been tested for HIV.” DC Health will increase the program’s outreach, particularly among focus populations, in 2021 by partnering test kit distribution through community-based providers.

TREAT. DC Health’s 2019 Annual Surveillance Report cites that 12,408 current residents of the District, or 1.8% of the population, are living with HIV. Among people newly diagnosed with HIV, 62% were linked to medical care within seven days of diagnosis and 81% within 30 days. Viral suppression among all people living with HIV in DC remained at 69% overall and 87% among people with an indication of engagement in care. Community providers continued their linkage to care approach under the DC Red Carpet Entry protocol of confirming a linkage to care appointment within 72 hours of diagnosis.

To enhance linkages to care, DC Health launched LinkU, an online resource and referral platform for internal and external partners and community members. The website linkudmv.org contains the full range of community providers in the DC metropolitan area. One feature of LinkU is the ability to make appointments directly with providers, which also enables providers to track and evaluate referrals and outcomes related to linkages. Additional features, such as specialty tabs for specific subpopulations (e.g., HIV-positive mothers), were added. Search tabs were adjusted based on feedback from providers and community members.



DC Health’s Youth Reach is a Minority AIDS Initiative program focused on serving youth and young adults of color ages 13 to 30 in the following subpopulations: Black women, Black and Latino men who have sex with men, Black heterosexual men, and Black or Latina transgender women. Youths and young adults are shown to have low rates of viral suppression. To address these health outcomes, services provided are consistent with ongoing consumer engagement, culturally and linguistically appropriate, and encompass a wide referral and linkage network that is readily able to address the varying needs of this population. Entities funded under the Youth Reach program provide a cadre of services to youths. The programs are designed to facilitate a seamless transition from prevention and testing programs into care and from pediatric to adult care through a coordinated cluster of services.

The DC Adhere app was officially rolled out to pharmacies, providers, and clients associated with the AIDS Drug Assistance Program (ADAP) administered by DC Health. This app is designed to track prescription pickup (point of sale); send alerts and reminders to clients concerning prescriptions and ADAP enrollment; track daily prescription use (voluntary); and generate client and population-level reports. Pharmacy and physician providers received training as part of the rollout process, providing an overview of use requirements and end-user procedures.

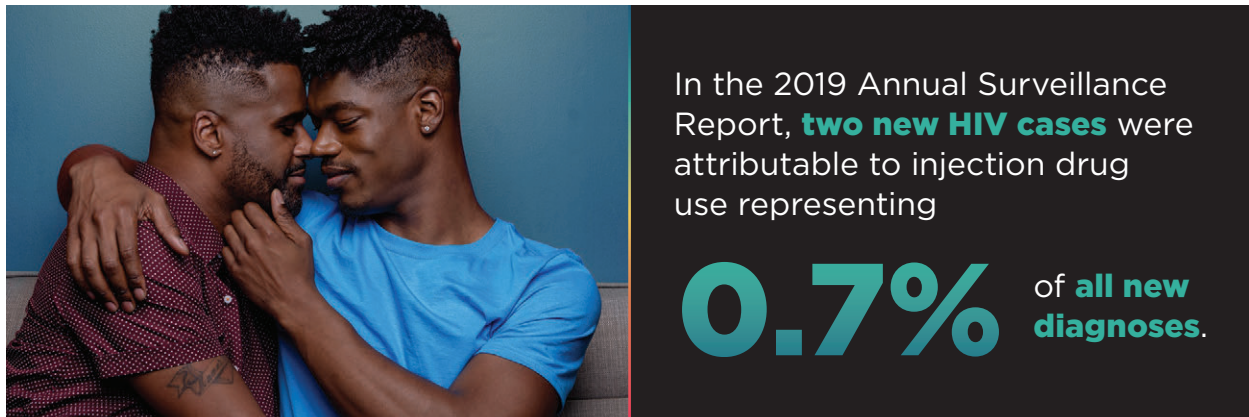
As part of HRSA 20-078 funding, DC will be able to expand services to more people living with HIV, as well as provide new innovative initiatives. DC will implement three program initiatives: (1) integration of clinical care coordinators into private provider care systems; (2) integrated health and wellness; and (3) community disease intervention specialist (DIS) project with enhanced data to action. With more than half of DC residents with HIV receiving care by private providers, the proposal will address gaps in support to ensure engagement in care and treatment adherence. The integrated health approach will address the barriers to care engagement by reducing chronic conditions and stress factors that reduce treatment effectiveness. A new approach to build trust with newly diagnosed individuals will result in timely engagement of partners to people with HIV and reduced infections.

PREVENT. DC Health continues to work to increase capacity for comprehensive preventive health services including support for providers to offer PrEP services, outreach and wellness activities, linkages to STD and hepatitis C screening, condom distribution, and behavioral interventions. Based on data reported by DC Health-funded PrEP providers, 69% of HIV-negative clients received a PrEP assessment and 14% of those individuals received a clinical visit for PrEP. Of those assessed, 93% received a prescription for PrEP medication. DC Health has been participating in the NIH-funded DC CFAR supplement on a citywide scale-up of PrEP. Through the project, DC Health will be examining strategies to increase acceptability and sustained use of PrEP among focus populations: Black gay men, Latinx people, adolescents and young adults, Black women, and people who use drugs. DC Health aims to launch its PEP initiative in early 2021 to increase accessibility while developing new messages and engagement strategies to increase condom distribution and promotion. DC Health maintained its public sector condom distribution program, which comprises more than 300 community and business distribution sites and a direct mail component to DC residents. In 2019, DC Health distributed more than 4 million condoms.

Many prevention activities are being delivered through virtual and telehealth modalities to conduct individual-, group-, and community-level interventions. Harm reduction services, such as syringe service programs and condom distribution, have continued on a limited basis. Community partners providing in-person services have employed best practices in minimizing COVID-19 exposure.

DC Health has expanded harm reduction and opioid-related services into programming. This included the expansion of hepatitis C screening and treatment, medication-assisted therapy

(MAT) services, syringe exchange, and harm-reduction activities that include wraparound services for people living with HIV. DC Health currently supports four syringe service providers, serving around 10,000 people who use drugs. In the 2019 Annual Surveillance Report, two new HIV cases were attributable to injection drug use representing 0.7% of all new diagnoses, an 80% decrease from 10 cases in 2018, and a 99% decrease from 150 cases in 2007.



Harm reduction serves a critical role in a continuum of services for people who use drugs. DC Health acknowledges that socioeconomic conditions, trauma, social isolation, discrimination, stigma, and other inequities are factors in the lives of people who use drugs, and DC Health works with providers to incorporate them in harm-reduction approaches. DC Health has integrated overdose prevention into syringe exchange programs and increased naloxone distribution. DC Health has also implemented a Rapid Peer Responder program to link individuals with active opiate use disorder at high risk for overdose to buprenorphine-based MAT, including screening and potential linkage to care. These peer referral specialists serve as rapid responders to those recently experiencing overdose and are trained in the SBIRT (Screening, Brief Intervention and Referral to Treatment) intervention model. Linkage occurs through a web-based appointment system linking individuals in need of rapid engagement into treatment to clinicians trained to provide buprenorphine. DC Health continues to work with current syringe service providers to increase capacity to provide comprehensive preventive health services and increase linkage to care of HIV and hepatitis C.

RESPOND. Each month, genetic sequences are analyzed via Secure HIV-TRACE to pinpoint clusters for investigation. Cluster members are then prioritized based on last-known viral load and manually searched in the STD surveillance and partner services database, DC Public Health Information System (DC PHIS). Named partners of cluster members identified after HIV diagnosis are incorporated into the cluster profiles. Case information gathered from HIV and STD surveillance and partner services programs are outlined in a dataset for review. Each case is then assigned a disposition for follow-up. Cluster investigations begin with contacting the last-known provider or residential jurisdiction of the member. Based on the information

found through that contact, the member may then be recommended for reengagement and linkage to care activities. Due to the COVID-19 pandemic, DC Health has maintained as much of the core functions of cluster investigations as possible, and all field services have been conducted via telephone.



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

ENGAGE. DC Health has added a fifth pillar. The purpose of this pillar is to pilot and integrate strategies to address the structural and individual challenges to uptake of health activities. These include structural racism, stigma, equity, and wellness. DC Health has laid the groundwork for some of these conditions, with more needed. To reduce stigma, DC Health has adopted a visibility approach. It has centered sexual well-being in its social marketing programs composed of two components: (1) general and focus populations and (2) youths and young adults. DC Health maintains the Sexual Being campaign for its general population program. The program featured directed action messages on HIV testing, PrEP, HIV treatment, and U=U. Bienestar DC, which means

“well-being,” is a new campaign for the Latinx community and has been launched to provide information on general sexual health, as well as STD- and HIV-related information. Mi Gente, DC Health’s Latinx working group, conducted community engagement on messages that would be most effective for Latinx people. DC Health continues its youth- and young adult- (ages 12 to 24) focused program, called Sex is..., and also launched a Spanish version, Sexo es..., with a website and promotional materials.

DC Health redesigned its funding process for community-based organizations to make funding more equitable. It eliminated a requirement for a long written narrative application, which disadvantaged smaller, population-focused organizations without skilled grant-writing staff or resources. It added a decisional site visit to enable smaller organizations to demonstrate their cultural humility and competency, staff expertise, and the infrastructure

to administer the funding. These changes resulted in first-time funding for a transgender-led organization, a small Latinx community-based provider, and non-HIV-focused organizations with wellness and behavioral health expertise. DC Health is currently conducting a Lean Six Sigma examination of its funding processes to further streamline equity opportunities and efficiencies.

DC Health launched an internal initiative to examine its opportunity as an HIV-focused administration to contribute to addressing structural racism. This process recognizes that DC Health approaches this important condition with humility. The DC Ends HIV plan recognizes structural racism as a challenge to achieving the goal of reduced new HIV diagnoses and optimal well-being for people living with HIV.





SECTION IV

EHE Planning

To achieve the goal of ending the HIV epidemic in DC, the plan will be framed using the federal strategies of the four pillars: Diagnose, Prevent, Treat, and Respond, with a fifth pillar unique to DC, Engage. The Engage pillar represents the commitment that the community will continue to be fully engaged in the planning process and will represent new and innovative initiatives that develop from this engagement. Specific strategies per pillar are described below and have been informed by regional planning activities, community engagement, and health department initiatives.

Care Continuum Goal Modeling

To define the DC Ends HIV plan goal, DC Health developed a predictive model for estimating the planned impact of scaling up plan strategies. DC Health needed to determine starting points or baseline values for several parameters: the number of people living with HIV; the number of people diagnosed with HIV knowing their status; the number of people diagnosed with HIV who are “in treatment,” defined here to mean on antiretroviral therapy (ART); and the number of people with HIV on treatment who are virally suppressed. Those parameters are known as the “HIV care continuum.” DC Health attributes most of its goal of 130 new diagnoses by the year 2030 to increasing the numbers of the care continuum. However, reaching the goal will also require the expansion of PrEP. Given gaps in certain data, establishing baseline model inputs required the estimation of several parameters.

Undiagnosed model estimates. Through the Fellows model¹, DC Health estimates that 11% to 17.7% of HIV cases within the District were undiagnosed. DC Health is using 11%, the more conservative (base bound) estimate, for its reported estimates of total HIV infection (Figure 1).

Care continuum estimates. To measure the progress of the DC Ends HIV plan and to achieve its goal by 2030, DC Health calculated its baseline for several parameters. DC Health used a data-driven model² that uses local surveillance data to project care continuum targets

¹ Fellows IE, Morris M, Birnbaum JK, 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. *PLoS ONE*. 2015;10(7):1-11. doi:10.1371/journal.pone.0129551.

² Bradley H, Rosenberg ES, Holtgrave DR. Data-Driven Goals for Curbing the U.S. HIV Epidemic by 2030. *AIDS and Behavior*. 2019;23(0123456789):557-563. doi:10.1007/s10461-019-02442-7.

for each year. The model calibrated predicted incidence estimates from HAHSTA’s Annual Epidemiology & Surveillance Report³ for the years 2015–2019 by scaling predicted values using the following formula:

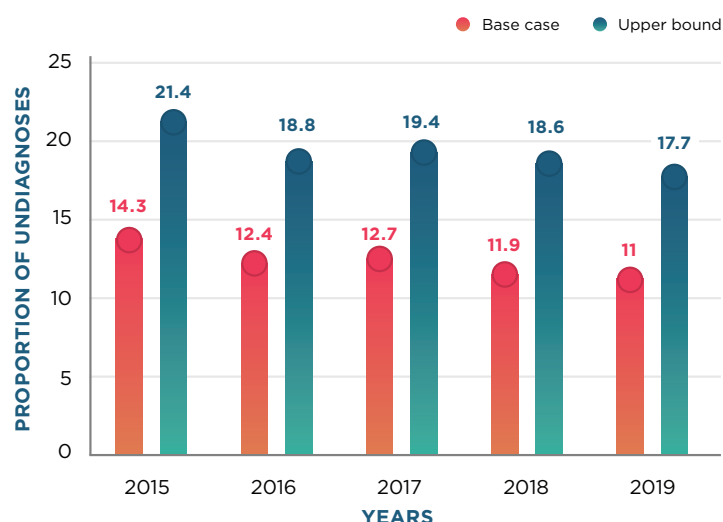
$$\frac{\text{care continuum outcome of year } x + (\text{difference in care continuum input years})}{n-1},$$

where “x” is the year in question and “n” is the number of years. To bring the latest surveillance estimates to the year 2020, the model assumed that care continuum parameters of percent diagnosed, on treatment, and virally suppressed continued to improve at a linear rate since last observed. After 2020, these parameters formed the basis of intervention scenarios. The denominator remained n - 1 for the years after 2020 as well.

DC Health changed the model and assumed the mortality rate continued at a 0.97% annual decline observed during 2015–2019. After 2019, the model projected the end goal by achieving 95% of people diagnosed, 95% on treatment, and 95% virally suppressed by 2030, with 20% of new diagnoses averted by PrEP. The scenario in which 20% of diagnoses are averted by PrEP roughly corresponds to the AIDSVu estimate of PrEP use for DC.⁴

The current number of people diagnosed and residing in DC is 12,408 (89%). Retention to care, which is based on laboratory visits reported to DC Health, was 9,745 (78.5%) in 2019. The number of people virally suppressed and retained in HIV care at the end of 2019 was 8,495 (87.2%). The model estimated 12,202 (95%) diagnosed, 11,592 (95%) retained, and 11,012 (95%) virally suppressed (Figure 2) in 2030. DC Health used the model to estimate the goal amount of new HIV diagnoses (130) by 2030 (Figure 3). The number of death estimates includes all deaths, not just deaths related to HIV.

FIGURE 1 — PROPORTION OF UNDIAGNOSED - FELLOW’S MODEL



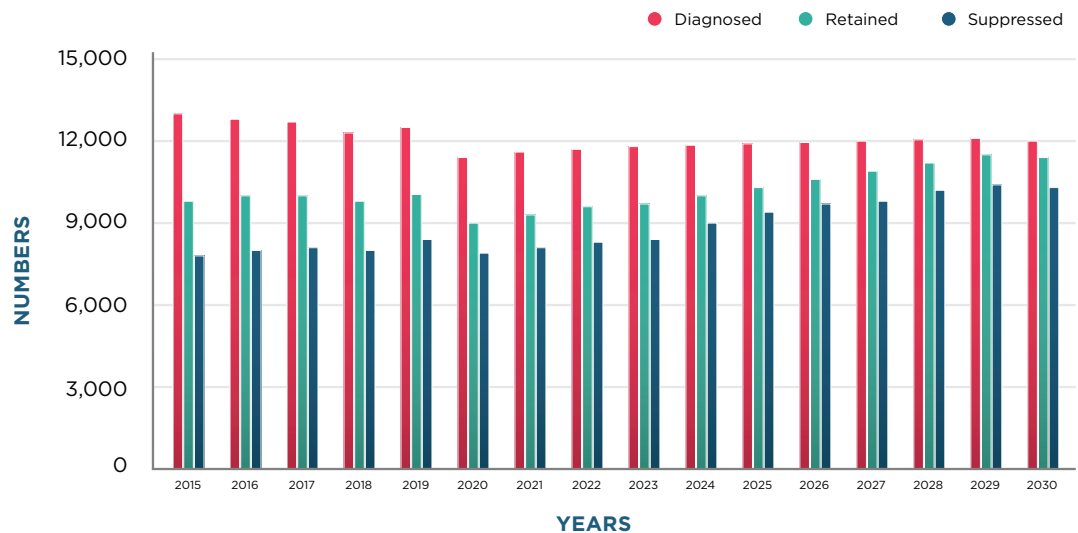
³ HAHSTA. Annual Epidemiology & Surveillance Report; 2019.

⁴ AIDSVu. All States PrEP Data Sets. Retrieved from <https://aidsvu.org/resources/#/>.

FIGURE 2

CARE CONTINUUM TARGETS

95-95-95 achieved by 2030 with 20% new infections averted by Pre-Exposure Prophylaxis



CARE CONTINUUM TARGETS

95-95-95 achieved by 2030 with 20% new infections averted by Pre-Exposure Prophylaxis

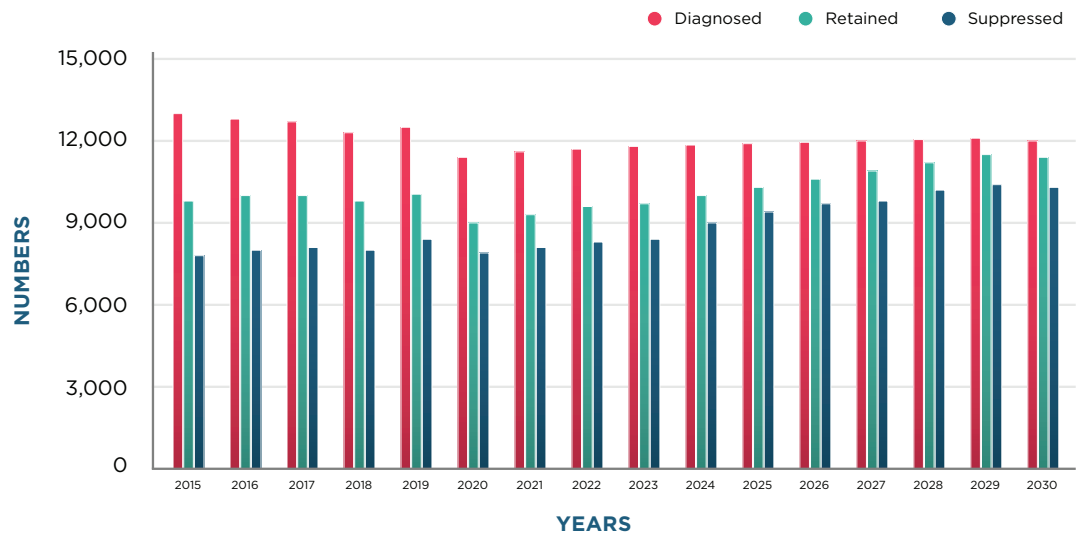
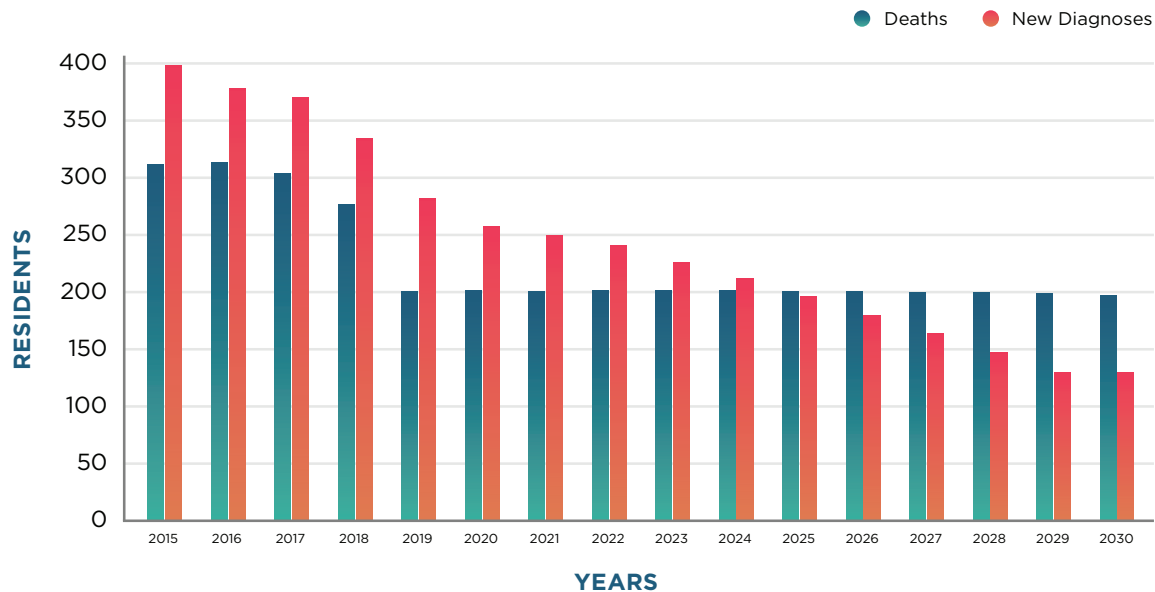


FIGURE 3 — NEW DIAGNOSES AND DEATHS PER YEAR, 2015-2030



Development of Local PrEP Utilization Targets

Effectively monitoring progress in maximizing the benefits of PrEP in the prevention of HIV at the population level is in part dependent on an accurate assessment of optimal targets for utilization coverage. Such information is essential for not only understanding the total number of individuals that can potentially benefit from PrEP use, but it is also integral in defining the key populations for PrEP awareness, linkage, and adherence support programs. Modeled after a previous analysis done by the CDC,^{5 6} a multiplier method was applied to local demographic and HIV surveillance data to ascertain estimates regarding the number of individuals living in the District with indications for PrEP use. To facilitate a focused assessment of local PrEP coverage needs, estimates were stratified by four key HIV risk exposure categories: men who have sex with men, heterosexually active men, heterosexually active women, and people who inject drugs.

Although inadequate information regarding risk behavior patterns within the HIV-negative population limits the ability to conduct a direct assessment of PrEP need, an estimation can be derived through extrapolating information from national and local survey and disease surveillance data. Information available from the 2019 American Community Survey (ACS) 5-Year Estimate Data Profile documents an adult (i.e., ≥ 18 years of age) male population

5 Smith DK, Van Handel M, Wolitski RJ, Stryker JE, Hall HI, Prejean J, et al. Vital Signs: Estimated percentages and numbers of adults with indications for pre-exposure prophylaxis to prevent HIV acquisition—United States, 2015. *MMWR Morb Mortal Wkly Rep* 2015;64(46):1291-5.

6 Smith DK, Van Handel M, Grey J. Estimates of adults with indications for HIV pre-exposure prophylaxis by jurisdiction, transmission risk group, and race/ethnicity, United States, 2015. *Annals of Epidemiology* 2018; 28:850-857.

in the District of 266,022. Using this number as a base, there are around 40,701 men who have sex with men living in the District, assuming previous estimates (15.3% of adult male population) derived from the ACS and National Health and Nutrition Examination Survey (NHANES).⁷ Based on local surveillance data, there were 6,081 men who have sex with men diagnosed with HIV living in the District in 2019. Subtracting the number of men who have sex with men diagnosed with HIV from the total number of men who have sex with men population produces a local HIV-negative men who have sex with men population estimate of 34,620. Nationally, it is estimated that 24.7% of HIV-negative men who have sex with men have indications for PrEP based on an assessment of NHANES data documenting the number of individuals reporting sex with two or more men and any sex without condoms or STDs within 12 months.⁸ Applying this percentage to the local HIV-negative men who have sex with men population produces an estimate of 8,551 men who have sex with men in the District with indications for PrEP.

Consistent with previous analysis,⁹ there is a similar assumption of the ratio of the number of the other focus populations (i.e., heterosexual men, heterosexual women, and people who inject drugs) with indications for PrEP relative to the proportion of new HIV diagnoses attributable to their populations based on the men who have sex with men calculation. By multiplying the latter ratios by the number of men who have sex with men in the District with indications for PrEP, estimates regarding the number of individuals with PrEP indications can be derived for each of the additional focus populations. Of the 1,766 new HIV diagnoses

Of the 1,766 new HIV diagnoses documented in the District between 2015 and 2019:

53% were accounted for by men who have sex with men

17% heterosexual women

11% heterosexual men

2% people who inject drugs

documented in the District between 2015 and 2019, 53% were accounted for by men who have sex with men, 17% heterosexual women, 11% heterosexual men, and 2% people who

7 Grey JA, Bernstein KT, Sullivan PS, Purcell DW, Chesson HW, Gift TI, et al. Estimating the population sizes of men who have sex with men in US states and counties using data from the American Community Survey. *JIMR Public Health Surveill* 2016; 2(1):e14.

8 Smith, Van Handel, et al. *Vital Signs: Estimated percentages and numbers of adults with indications for pre-exposure prophylaxis to prevent HIV acquisition.*

9 Smith, Van Handel, et al. *Estimates of adults with indications for HIV pre-exposure prophylaxis by jurisdiction, transmission risk group, and race/ethnicity.*

inject drugs. Using these percentages, the ratio of the proportion of new HIV diagnoses attributable to focus populations relative to the proportion of new HIV diagnoses attributable to the men who have sex with men population is 0.32 (i.e., ratio = 17/53) for heterosexual women, 0.21 (i.e., ratio = 11/53) for heterosexual men, and 0.04 (i.e., ratio = 2/53) for the people who inject drugs. Based on applying these ratios to the estimated number of men who have sex with men (n = 8,551) with indications for PrEP, there are around 2,743 heterosexual women, 1,775 heterosexual men, and 323 people who inject drugs with indications for PrEP in the District.

Similar to previously published assessments,¹⁰ DC Health estimates that 13,392 individuals have indications for PrEP in the District, based on analysis using the most current demographic and HIV surveillance data. As additional information becomes available and more robust modeling methodologies are developed, estimates will be updated to reflect evolving knowledge of local HIV epidemic characteristics.

As additional data and information are available, the model will be updated to reflect the evolving knowledge of the characteristics of the HIV epidemic within the District and the efficacy of intervention strategies within the local population.

EHE Pillars. Following the PS19-1906 program guidance, the following section highlights a key goal for each of the EHE pillars and the added DC pillar using the recommended plan structure template. The planning website DCEndsHIV.org contains other key goals, which are summarized here by pillar. It is important to repeat that goals, strategies, activities, and outcomes in implementation will reflect cultural diversity and focus populations of Black men, Black women, Latino gay men, young Black gay men, transgender individuals, and people who use drugs.

PILLAR 1: DIAGNOSE

HIV Testing

Goal 1: To achieve 95% of people living with HIV knowing their status.

Key Activities and Strategies:

- Expand convenience-based HIV and STD testing through GetCheckedDC.org by evaluating a pilot of HIV home-testing kits, expanding community partnerships to increase the availability of kits, promoting walk-in testing through a partnership with LabCorp, and initiating telemedicine testing.
- Develop and train new rapid testing partners in underserved communities.

¹⁰ *Ibid.*

- Augment services for youth and young adults by training peers and peer-based organizations to conduct HIV and STD testing, expanding testing hours (evenings and weekends), and supporting HIV and STD testing at college and university health centers.
- Refresh medical provider education on routine HIV screening by compiling a list of reporting providers, obtaining Medicaid data on screening rates by provider, and conducting outreach.
- Develop new outreach for specific populations, including individuals experiencing homelessness and older adults.
- Modify existing policies that are barriers to screening and diagnosis, including adding HIV and STD testing to the DC Health Universal Health Certificate and refraining from sending explanation of benefits notifications for HIV and STD screening for young adults.

Key Partners: Federally qualified health centers, community-based providers, hospital-based and private practices, youth-focused community organizations, the DC Health and Wellness Center (operated by DC Health), Department of Health Care Finance, Department of Insurance, and healthcare and medical provider associations.

Potential Funding Resources: Medicaid, private health insurance, CDC HIV Prevention and Surveillance Program, CDC EHE Implementation funding, HRSA EHE Implementation funding, CDC STD Program, CDC Division of Adolescent and School Health, state and local funding, foundation grant-making, and private funding.

Estimated Funding Allocation: \$4.76 million (public health funds only)

Outcomes:

- Percentage of DC residents receiving an HIV test in the past 12 months.
- Number of people who test positive in HIV testing programs.
- Number of new HIV diagnoses with a simultaneous Stage 3 (AIDS) diagnosis.
- Percentage of people in a syringe service program tested for HIV.

Monitoring Data Source: Surveillance data, CDC testing data, at-home testing program data, Department of Healthcare Finance testing data, EvaluationWeb, syringe service program reporting.



Workforce Needs: Hiring peers to promote and conduct HIV testing, community-based rapid testing partners, training and educating medical providers on HIV testing, hiring of epidemiology and data staff, and capacity building for community-based providers

PILLAR 2: TREAT

Rapid ART

Goal: To reduce the time between HIV diagnosis and HIV treatment to seven days.

Key Activities and Strategies:

- Update Red Carpet Entry citywide protocol for implementing rapid linkage to HIV care and ART initiation, including U=U messaging as the standard of care and transportation assistance.
- Study how factors such as communication, health literacy, systemic racism, intersectional stigma and discrimination, and mental health affect the acceptance of rapid linkage to HIV care and ART initiation.
- Pilot clinical care coordination in private health settings to implement rapid ART and sustain viral suppression.
- Expand provider community of practice for local clinicians to implement rapid ART initiation and learn from DC Health and their peers.
- Work with the Department of Health Care Finance and the Department of Insurance, Securities and Banking to promote healthcare coverage policies that support rapid HIV care and treatment initiation.
- Conduct a detailed epidemiological analysis to understand which demographic groups have not benefited from rapid linkage to HIV care and treatment initiation.

Key Partners: Regional health departments, clinicians and providers of HIV services, community-based providers, Department of Health Care Finance, Department of Insurance, Securities and Banking.

Potential Funding Resources: Medicaid, private health insurance, CDC HIV Prevention and Surveillance Program, Ryan White (HIV/AIDS) program, CDC EHE Implementation funding, HRSA EHE Implementation funding, state and local funding, foundation grant-making, and private funding.

Estimated Funding Allocation: \$32.2 million (public health funds only)

Outcomes:

- Percentage of people newly diagnosed with HIV starting HIV medication within seven days.

- Percentage of people newly diagnosed with HIV linked to medical care within one month.
- Percentage of people newly diagnosed with HIV reaching viral suppression within three months.
- Percentage of people with HIV with sustained viral suppression within the past two years.
- Percentage of people with HIV missing two prescription refills within 90 days.
- Percentage of young people (ages 13–30) with HIV missing two prescription refills within 90 days.

Monitoring Data Source: CareWare, eHARS, pharmaceutical data clearinghouse, Chesapeake Regional Information System for our Patients (CRISP), Medicaid provider claims database, DC Health-funded community provider program reports, DC Public Health Information System, electronic health record data system.

Workforce Needs: Staff for academic detailing with medical providers on rapid ART, hiring of epidemiology and data staff.

Additional Goal: Integrate U=U as the standard of care in the status-neutral approach for HIV care and prevention services by providing training to medical and community-based providers and increasing social marketing. DC Health will assess population-level and provider-level knowledge of U=U to assess education efforts and prescription refills and viral suppression on treatment adherence impact. More information on this strategy can be found at dcendshiv.org/key-strategies/u-u.

PILLAR 3: PREVENT

Goal: To increase to more than 13,000 individuals on PrEP by 2030.¹¹

Key Activities and Strategies:

- Expand PrEP social marketing and educational materials in a diversity of media platforms and formats.

¹¹ *An integrative approach seeks to combine traditional medical care with a broader understanding of the whole person. People are emotional, mental, social, spiritual, as well as physical beings. An integrative approach can be a useful mechanism for many who experience health challenges or stressors learn wellness tools that can help with handling competing needs of the whole person. Wellness approaches have been shown to improve both physical and mental health by supporting healing from physical and emotional trauma, psychological distress, assisting with pain management, improving sleep, improving health related quality of life, improving body strength, and positive social and emotional outcomes.*



- Expand PrEP telehealth, including home-based and walk-in laboratory testing and e-prescribing.
- Recruit diverse and culturally affirming peer navigators to educate and connect individuals with PrEP services to address individual risk perception and address perceived stigma and safety concerns.
- Develop and implement a status-neutral wellness program to increase PrEP uptake through enhanced self-efficacy and reduced internalized stigma.
- Develop and implement PrEP Housing Pilot to provide temporary housing and case management to address social determinant needs of young men who have sex with men of color using PrEP.
- Develop an on-demand PrEP pilot program.
- Build capacity of the DC Health and Wellness Center, hire a case manager to assess individuals using PrEP and PEP for adherence, and assist with scheduling visits for those who missed appointments.

Key Partners: Federally qualified health centers, community-based providers, hospital-based and private practices, youth-focused community organizations, healthcare associations, the DC Health and Wellness Center (operated by DC Health).

Potential Funding Resources: Medicaid, private health insurance, CDC HIV Prevention and Surveillance Program, CDC EHE Implementation funding, HRSA EHE Implementation funding, CDC STD Program, Substance Abuse and Mental Health Services Administration (SAMHSA) funding, state and local funding, patient assistance programs, foundation grant-making, and private funding.

Estimated Funding Allocation: \$3.4 million (public health funds only)

Outcomes:

- Number of people prescribed PrEP.
- Number of family medicine and internal medicine physicians with at least two PrEP prescriptions covered by Medicaid.
- Number of HIV-negative Medicaid enrollees filling at least one PrEP prescription within the year.
- Number of syringe service program clients starting PrEP.
- Percentage of men with new syphilis diagnoses while on PrEP.
- Number of HIV-negative individuals receiving housing assistance starting PrEP and remaining adherent for up to one year.

Monitoring Data Source: Pharmaceutical data clearinghouse, Chesapeake Regional Information System for our Patients (CRISP), AIDSvu, Medicaid provider claims database, DC Health-funded community provider program reports, syringe service program reports, DC Public Health Information System.

Workforce Needs: Hiring of peer navigators, training medical providers on sexual health assessments and PrEP provision, hiring of epidemiology and data staff, and capacity-building for community-based providers on effective, culturally affirming PrEP approaches.

Additional Goals: The DC Ends HIV plan includes several additional goals for the Prevent pillar: to make PEP available 24/7, to enhance integrated harm reduction services, and to promote and routinize U=U in prevention approaches. These goals are summarized as follows:

- **PEP Initiative** — Establish a 24/7 PEP hotline and access program with immediate prescription availability and increase the number of providers prescribing PEP. DC Health will measure the number of PEP prescriptions (source pharmaceutical databases) and the number of PEP prescriptions covered by Medicaid. More information on this strategy can be found at dcendshiv.org/key-strategies/prep-and-pep.
- **Harm Reduction** — Enhance integrated syringe service programs by increasing the number of community partners using harm reduction approaches (including peer led), building capacity to address polysubstance use, and combination HIV prevention (including PrEP) and opioid treatment. DC Health will measure the number of clients using syringe service programs. More information on this strategy can be found at dcendshiv.org/key-strategies/harm-reduction.
- **U=U or Undetectable = Untransmittable** — Integrate U=U as the standard of care in the status-neutral approach for HIV care and prevention services by providing training to medical and community-based providers and increasing social marketing. DC Health will assess population-level and provider-level knowledge of U=U to assess education and promotion efforts. More information on this strategy can be found at dcendshiv.org/key-strategies/u-u.

PILLAR 4: RESPOND

Goal: To increase the timeliness and completeness of cluster investigations to link individuals to HIV care or prevention services.

Key Activities and Strategies:

- Establish new protocols for HIV diagnoses, with a new time frame to process the diagnosis and issue a field record within seven days.
- Use continuous quality improvement techniques to improve the timeliness of molecular

cluster detection by addressing lab-related delays in receipt of molecular HIV sequences and delays in internal processing of molecular HIV sequences.

- Establish a Cluster Response Committee to review cluster data and make plans to tailor HIV prevention, testing, and care and treatment messages and services based on the findings.
- Increase staff capacity to respond to cluster with the direct service team and community-based disease intervention specialists, using evidence-based interventions.
- Collaborate with the Maryland Department of Health, Virginia Department of Health, Montgomery County, and Prince George's County to evaluate and enhance the regional approach to HIV cluster detection and response.

Key Partners: Regional health departments, COHAH, medical providers, laboratories, and community-based providers.

Potential Funding Resources: CDC HIV Prevention and Surveillance Program, Ryan White (HIV/AIDS) program, CDC STD Program, CDC EHE Implementation funding, HRSA EHE Implementation funding, and state and local funding.

Estimated Funding Allocation: \$2.77 million (public health funds only)

Outcomes:

- Percentage of people with HIV interviewed by DC Health within 30 days of diagnosis.
- Percentage of people with HIV in an HIV transmission cluster achieving viral suppression within six months.

Monitoring Data Source: DC Public Health Information System, eHARS.

Workforce Needs: Hiring of new direct service staff for the response team, hiring of epidemiology and data staff, training to DC Health staff on new processes and procedures, and capacity building for community-based providers on partner services.

Additional Goal: The DC Ends HIV plan includes Data to Prevention to enhance the use of STD surveillance data to deliver HIV prevention services, namely PrEP and PEP. DC will be measuring the percentage of HIV-negative people with two or more STDs starting PrEP. More on this strategy is at dcendshiv.org/key-strategies/data-to-prevention.

PILLAR 5: ENGAGE

Goal: To develop a network of wellness services guided by an HIV status-neutral approach.

Key Activities and Strategies:

- Develop a new service standard for wellness support services.

- Establish a pilot wellness program using a status-neutral approach, including linkage to mental health support services.
- Increase PrEP and PEP uptake to reduce new transmissions and HIV treatment adherence to increase viral suppression and improve overall health outcomes.

Key Partners: Wellness services providers, federally qualified health centers, health service providers, and community-based providers.

Potential Funding Resources: Medicaid, private health insurance, CDC HIV Prevention and Surveillance Program, Ryan White (HIV/AIDS) program, CDC EHE Implementation funding, HRSA EHE Implementation funding, SAMHSA funding, state and local funding, foundation grant-making, and private funding.

Estimated Funding Allocation: \$200,000 (initial pilot program funding from CDC and HRSA EHE Implementation)

Outcomes:

- Number of clients served.
- Number of individuals starting PrEP.
- Number of individuals maintaining viral suppression.
- Number of clients indicating reduced stress and/or self-efficacy measures.
- Pre- and post-test assessment on program effectiveness.

Monitoring Data Source: Wellness service program data.

Workforce Needs: Capacity building for wellness service providers on HIV care and prevention.

Additional Goals: The DC Ends HIV plan recognizes that there are multiple social determinants of health and structural barriers that need to be addressed to achieve its goals. These social determinants include stigma, trauma (individual, community-level, and historical), education, housing, employment, and language access. The DC Ends HIV plan centers structural barriers of racism, homophobia, transphobia, and legal status. DC Health, DC Appleseed, and the Washington AIDS Partnership are collaborating to develop position papers for greater community-level strategies and measurements. Through its ongoing community engagement, DC Health will obtain input on specific strategies for public health implementation and broader policies. The DCEndsHIV.org planning website, community voices, and key strategies will be informed and updated by community recommendations.

REACHING PLANNING BODY CONCURRENCE



DC Health presented and elicited feedback on the Ending the Epidemic funding initiative and required accelerated community engagement to the COHAH in October 2019. Throughout the planning year, there was cross membership on work groups and COHAH committees when coordinating and conducting engagement activities. The COHAH received regular updates on community engagement and how strategies were being informed and developed from engagement data. DC Health presented a version of the developing plan to the COHAH for feedback in October 2020. The final version was presented in November 2020 and received concurrence from the COHAH. The letter of concurrence is included with this submission.





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