2017-2021 District of Columbia
Eligible Metropolitan Area
Integrated HIV/AIDS Prevention and Care Plan

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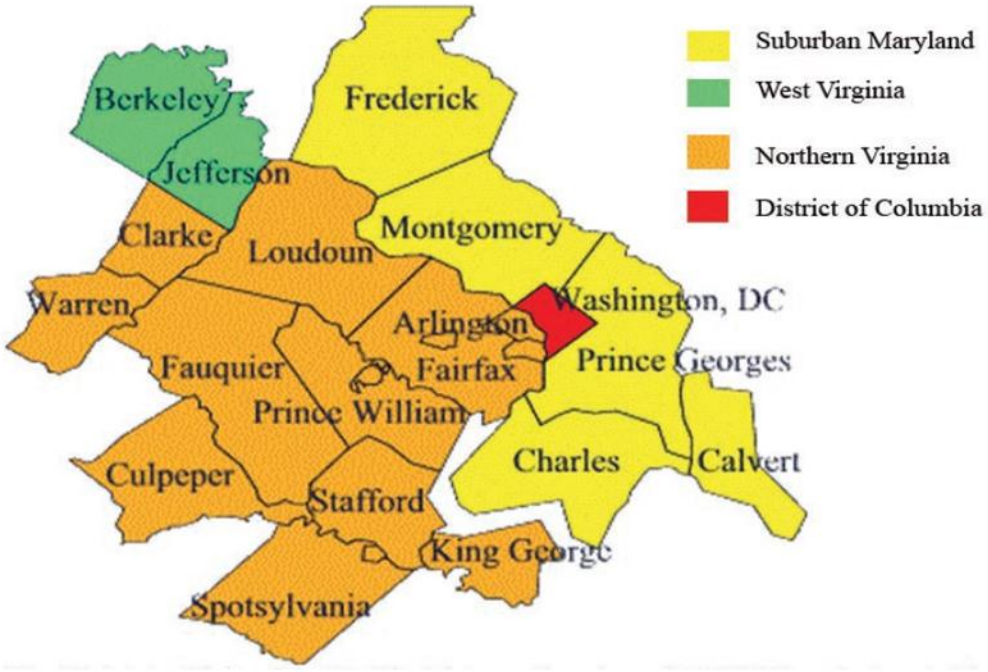
Integrated HIV/AIDS Prevention and Care Plan

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

2017-2021 INTEGRATED HIV PREVENTION AND CARE PLAN
Including the Statewide Coordinated Statement of Need
District of Columbia Eligible Metropolitan Area

SECTION 1: Statewide Coordinated Statement of Need/Needs Assessment



The map above represents the District of Columbia Eligible Metropolitan Area (DC EMA) as designated by the United States Department of Health and Human Services, Health Resources and Services Administration (HRSA). It spans a wide metropolitan region of 6,922 square miles, comprising five counties in suburban Maryland, 11 counties and six independent cities in Northern Virginia, and two counties in West Virginia. The EMA is home to 6,162,244 people, according to 2013 estimates from the US Census Bureau. Ryan White (RW) funds are critical to maintaining a robust continuum of high quality HIV care, treatment, and support services for persons across the region. Sub-recipients/providers throughout the DC EMA receive funding from the Ryan White HIV/AIDS Treatment Extension Act of 2009 through one or more of the RW Parts (A, B, C, D, and F) which support specific types of programs and target specific activities. Sub-recipients include health departments, hospitals, federally qualified health centers, community-based organizations, and training centers.

While RW funding covers the EMA, the Centers for Disease Control and Prevention (CDC) funds the region's jurisdictions separately. The DC Department of Health (DOH) receives Centers for

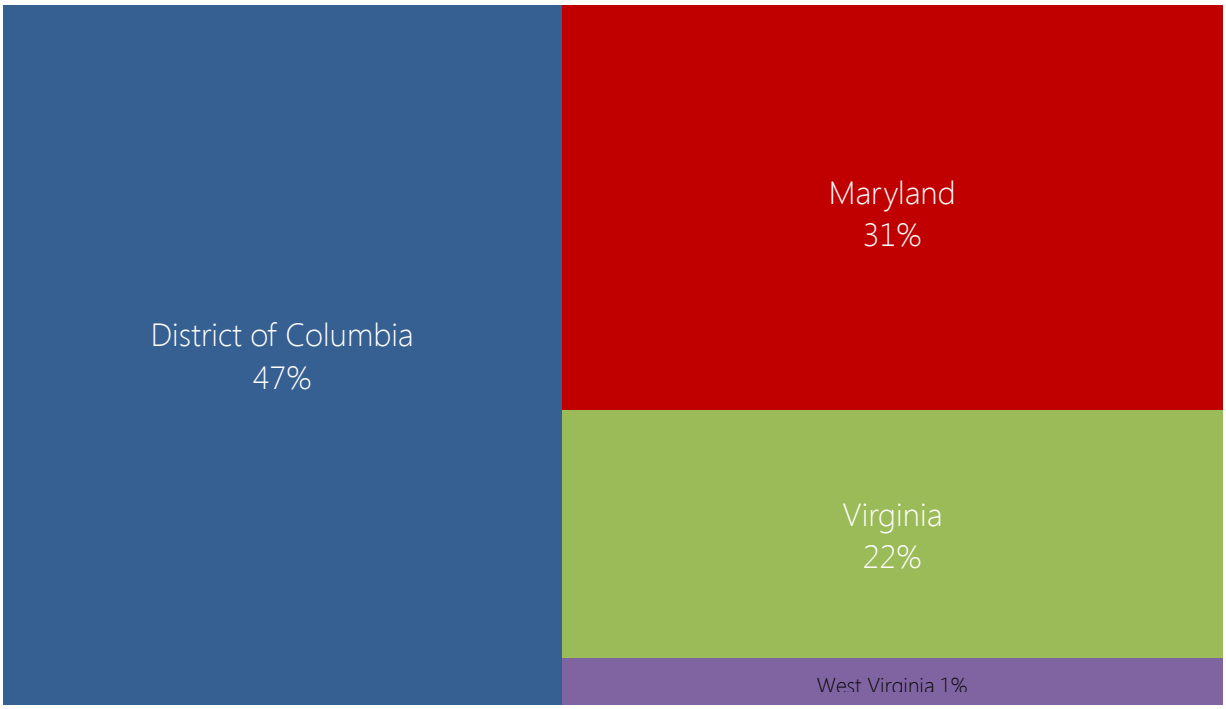
Disease Control (CDC) funding for HIV prevention efforts. Throughout the years of prevention efforts, there has been increased physiological understanding of the virus, improved sensitivity and specificity in screenings, and advancements in effective treatment protocols that achieve virologic control,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

Due to the way HIV prevention and care has evolved as a result of these advances, health departments and planning bodies are integrating prevention and care service planning in order to design a more coordinated, effective, regional response to the epidemic. Prevention and care planning bodies and providers will consult on decisions in areas of shared responsibility, work together to maximize testing, entry, and retention in care, and create a shared workgroup for combined planning. DC DOH supports initiatives directly in line with the tenets of integration and has developed an Integrated Prevention and Care Plan to be implemented from 2017-2021.

I-A. Epidemiologic Overview and Profile

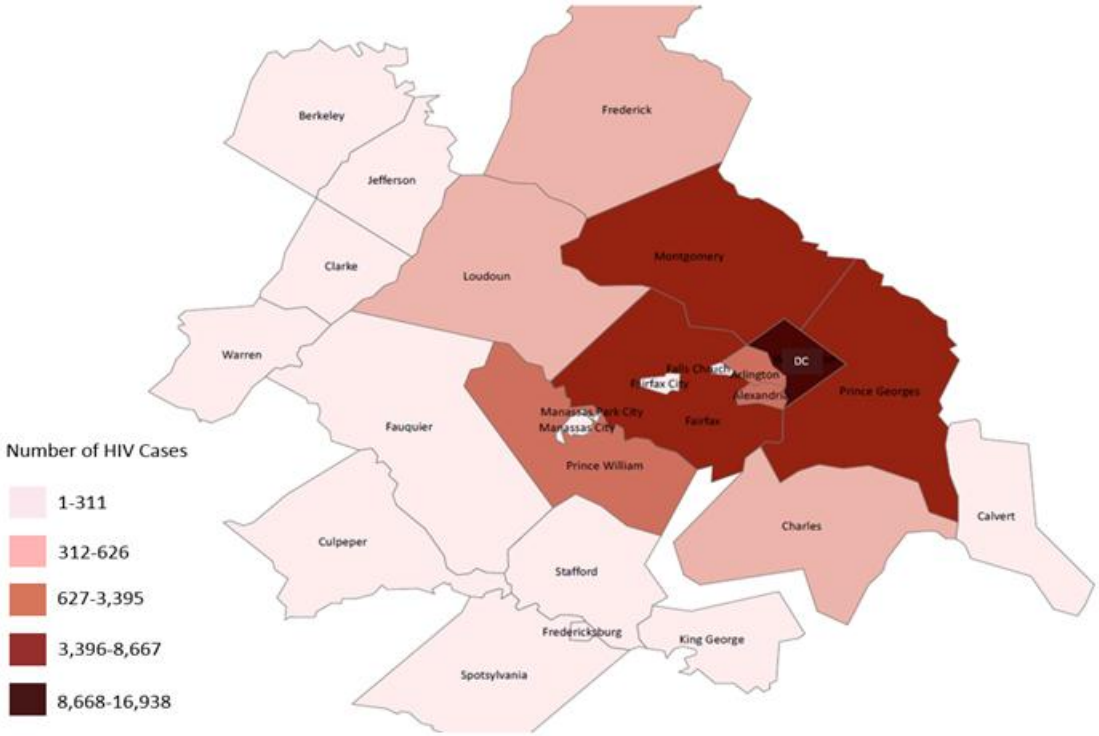
The DC EMA is one of nine EMAs/TGAs that cross state boundaries and the only one that includes counties and independent municipalities spanning four jurisdictions. Its main city is Washington, DC, which has one of the highest rates of HIV in the country. Although all four jurisdictions comprising the DC EMA border each other, they each have unique and substantial variations in population characteristics and public policies that impact HIV service planning and delivery. Each also addresses health and social service needs of its residents in a different way. Two percent of residents in Washington, DC, are diagnosed and reported with HIV.[1] The estimated prevalence rate in the Nation's Capital is twice as high as the established guidelines of 1%**,** a criterion that defines a generalized epidemic among residents of a specific geographic area,[2] established by the United Nations Joint Program on HIV/AIDS and the CDC. A generalized epidemic requires a multilayered approach to alleviate its overall impact. The overall prevalence of people living with HIV (PLWH) for the EMA at the end of 2014 (0.6 %) is nearly twice the national estimated prevalence rate of 0.4% for diagnoses of HIV.[3] The epicenter of the EMA is the District of Columbia, which is 10.7% of the EMA population, but 46.6% of all EMA HIV cases. At the end of 2014, there were a total of 36,369 people living with HIV in the DC EMA.

[1] District of Columbia HIV/AIDS, Epidemiology Annual Report 2012.
[2] Ibid.
[3] Center for Disease Control and Prevention, HIV Surveillance Report 2008, Vol. 20, 2010.



Geographic Distribution of the Number of People living with HIV in the DC EMA by County, 2014

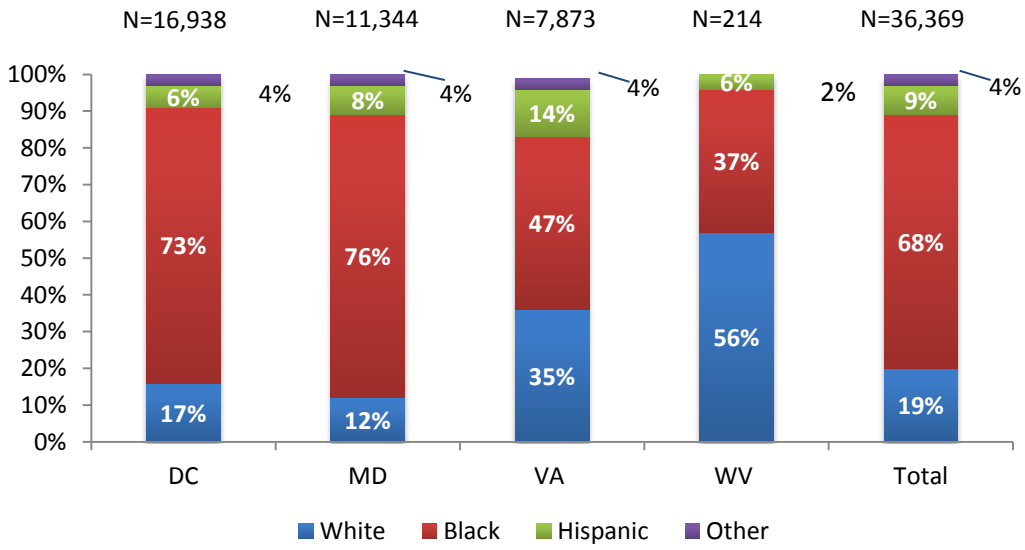
N= 36,369



The majority of living HIV cases in the DC EMA were: black (68%), male (71%), over 40 years old (74%), age 40-59 (58%) and 20-39 (60%) at diagnosis, and had sexual contact as mode of transmission (66%). The graphs below display socio-demographic information of people living with HIV in the DC EMA by race/ethnicity, gender, age, and mode of transmission.

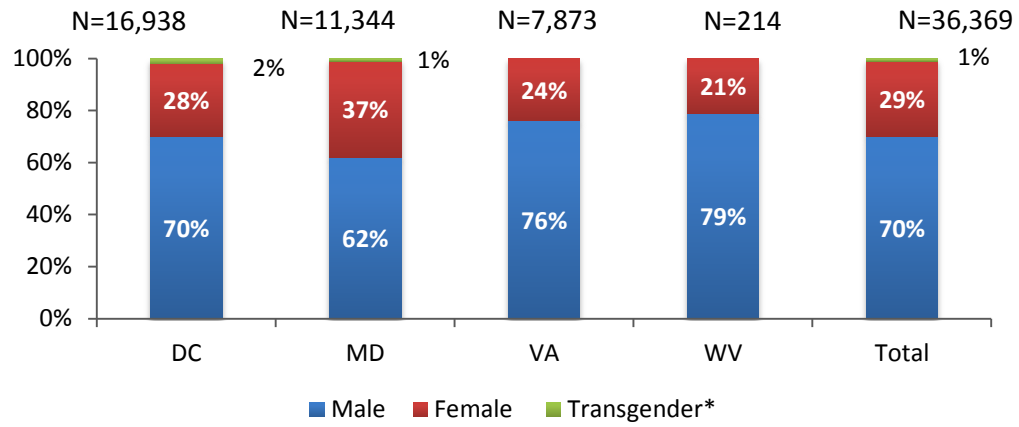
Living HIV/AIDS Cases by Race/Ethnicity. The HIV epidemic continues to impact communities of color in the DC EMA. People of color account for approximately half of the EMA population, but over 80% of the estimated number of people living with HIV. Blacks account for the majority of cases at 68%; whites, 19 %; Hispanics, 9 %; Asian/Pacific Islanders, 1 %; and "other/ unknown," 4%. With the exception of West Virginia, blacks are the largest proportion of the estimated number of PLWH in all jurisdictions. In West Virginia, blacks account for approximately 34% compared to 56% for whites. Virginia has the highest proportion of Hispanics living with HIV (14%), almost double that of other jurisdictions.

Race/Ethnicity and Jurisdiction, DC EMA 2014



Living HIV/AIDS Cases by Gender and Jurisdiction In all jurisdictions, the majority of living HIV cases were men, with Maryland having the highest proportion of cases among women at 37%.

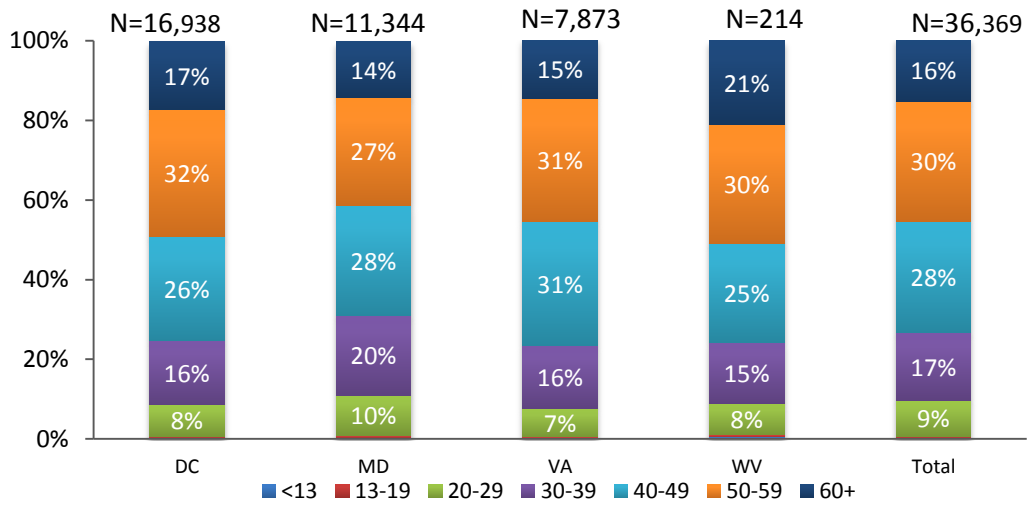
Gender and Jurisdiction, DC EMA 2014



* Not all jurisdictions collect data for transgender individuals

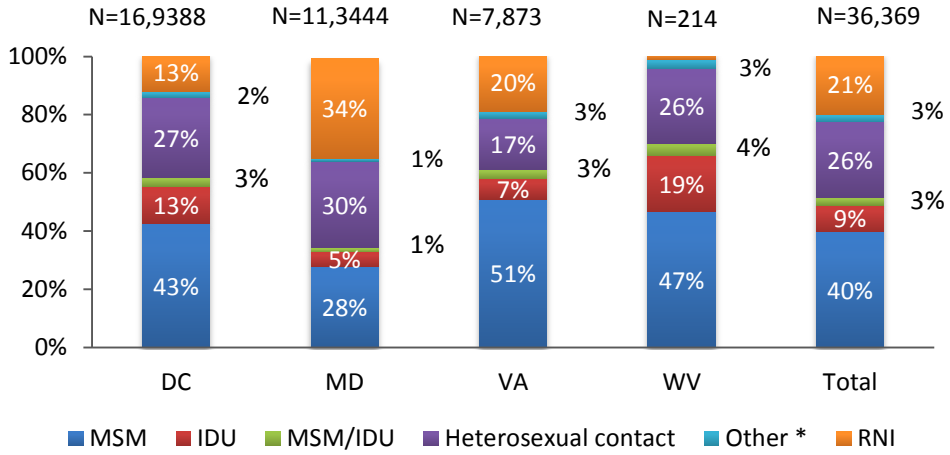
Living HIV/AIDS Cases by Age and Jurisdiction Of the estimated cases living with HIV in the EMA, over three-quarters (84.1%) were aged 20–49 years at diagnosis and 57.7 % were between the ages of 40–59 years or older at the end of 2014. Advances in antiretroviral medications mean that individuals are living longer across the region.

Current Age and Jurisdiction, DC EMA, 2014



Living HIV/AIDS Cases by Exposure Category and Jurisdiction. Overall, men who have sex with men accounted for the majority of people living with HIV in the EMA. This trend remained consistent by jurisdiction, with the exception of Maryland (28%), ranging from 43% in DC to 51% in Virginia. Maryland had the highest proportion of people living with HIV transmitted through heterosexual contact (30%) as well as those whose risk was no identified. West Virginia had the highest proportion of people living with HIV transmitted through injection drug use at 19%. A significant number of cases in the EMA (21%) are reported without any identifiable risk category. Pediatric cases account for 1 % of the estimated number of people living with HIV.

Mode of Transmission and Jurisdiction, DC EMA 2014



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

Newly Diagnosed HIV Cases: In 2014, Maryland had the highest number of newly diagnosed (594) and Virginia the lowest (259). The highest new diagnosis rates are among black non-Hispanic men between 20-39 years old and with sexual contact as the mode of transmission. Maryland has the highest amount of newly diagnosed women more than doubling the other jurisdictions. Maryland also had the highest number of Hispanics (84) newly diagnosed, and Virginia had the highest number of white non-Hispanics (87) who were newly diagnosed in 2014. Sexual contact was the primary mode of transmission across jurisdictions, but a large portion of people newly infected with HIV had no known or identified risk.

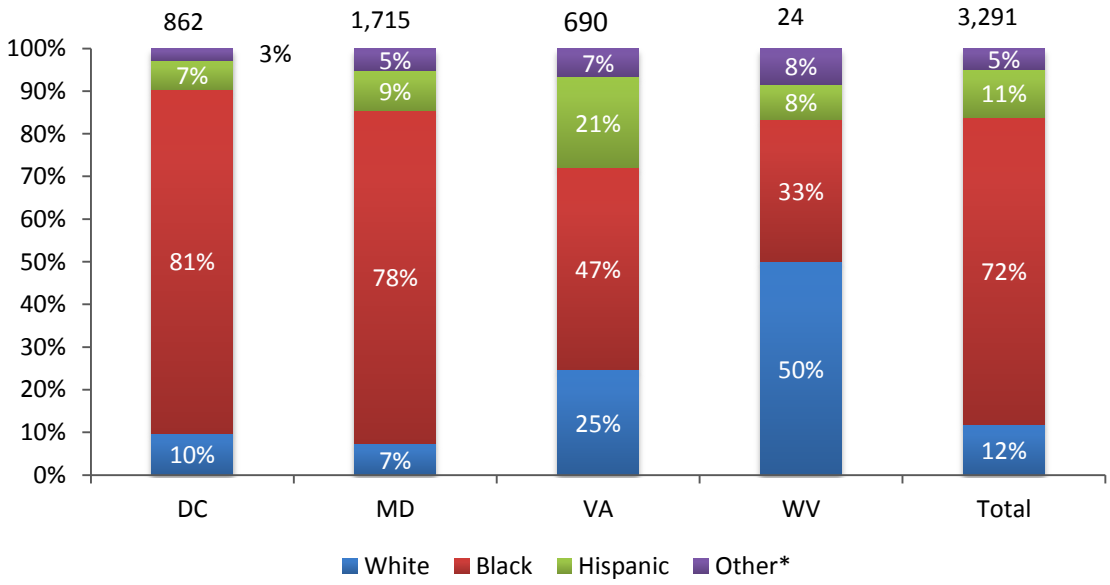
Washington DC EMA 2014	DC		Virginia		Maryland	
Sex at Birth	**N**	**%**	**N**	**%**	**N**	**%**
Male	334	78.8	198	76.4	404	68.0
Female	75	17.7	61	23.6	186	31.3
Race/Ethnicity						
Black, non-Hispanic	302	71.2	102	39.4	425	71.5
White, non-Hispanic	68	16.0	87	33.6	65	10.9
Hispanic (all races)	36	8.5	53	20.5	84	14.1
Asian	*	*	12	4.6	*	*
Multi-race/ Unknown	*	*	5	1.9	*	*
Age at Diagnosis						
<13	0	0	4	1.5	3	0.5
13 - 19	16	3.8	7	2.7	21	3.5
20 - 29	140	33.1	75	29.0	194	32.7
30 - 39	109	25.7	68	26.3	149	25.1
40 - 49	76	17.9	57	22.0	126	21.2
50 - 59	56	13.2	34	13.1	70	11.8
60+	27	6.4	14	5.4	31	5.2
Transmission Risk						
Sexual Contact	249	58.7	170	65.7	385	64.8
Injection drug use (IDU)	11	2.6	4	1.5	3	0.5
MSM & IDU	6	1.4	5	1.9	3	0.5

Pediatric	*	*	6	2.3	3	0.5
No risk factor reported or identified (NRR/NIR)	158	37.3	74	28.6	200	33.7
Total	**424**	**100**	**259**	**100**	**594**	**100**

Newly Diagnosed Stage 3 (AIDS) Cases. For the three-year period of Jan. 1, 2012–Dec. 31, 2014, a total of 3,284 Stage 3 (AIDS) diagnoses were reported in the EMA. Overall, the number of new cases for each subsequent year has declined, but the proportion of new cases by race/ethnicity has remained relatively constant across the three years. Consistent with living HIV cases, newly diagnosed Stage 3 (AIDS) cases were predominantly among people of color, men, and those diagnosed between the ages of 20–49 and attributed to MSM transmission.

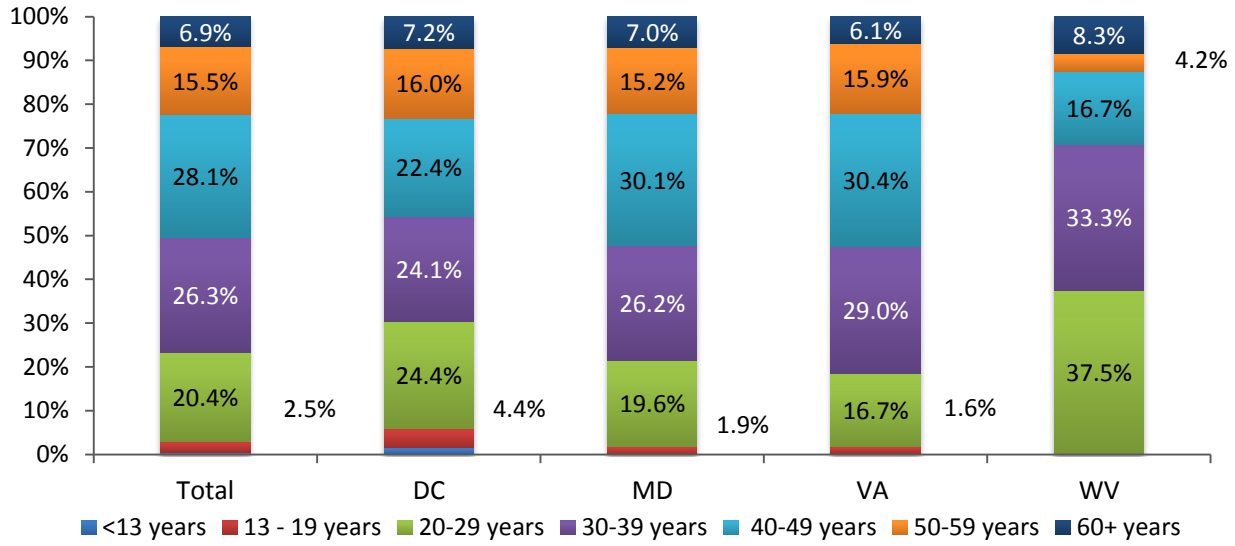
The majority of newly diagnosed Stage 3 (AIDS) diagnoses were among black non-Hispanics in the EMA. With the exception of West Virginia, this is also true by jurisdiction. Half of all newly diagnosed AIDS cases in West Virginia were white non-Hispanic.

Newly Diagnosed Stage 3 (AIDS) by Race/Ethnicity and Jurisdiction, DC EMA 2012-2014



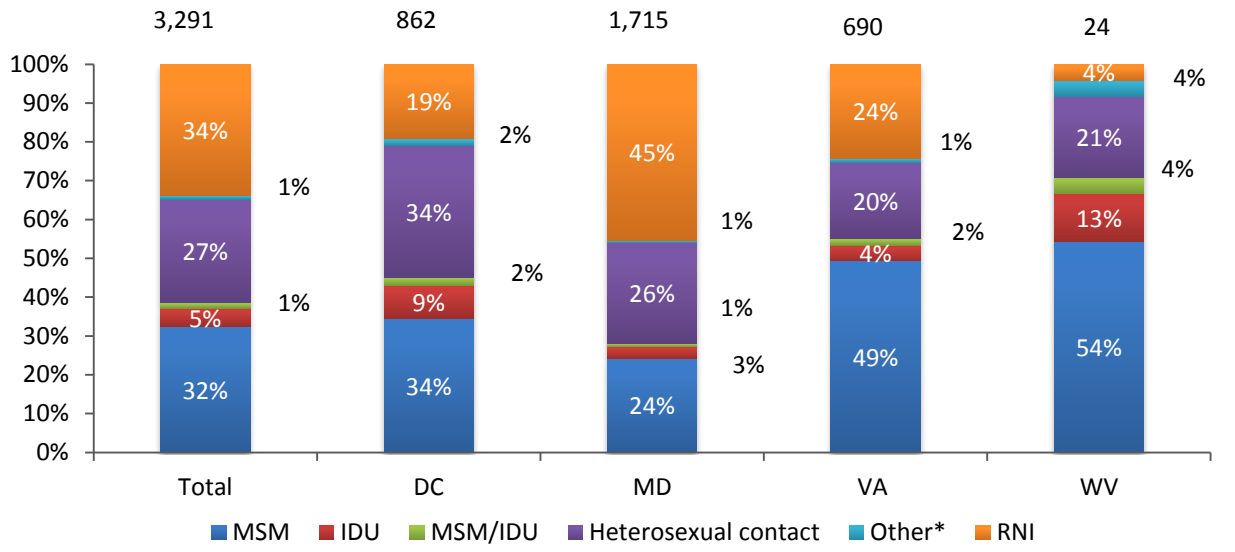
Overall, the majority of newly diagnosed Stage 3 (AIDS) cases were among residents age 40-49, 30-39 and 20-29 in the EMA. This is similar among all jurisdictions with the exception of West Virginia, where the majority were aged 20-29 at diagnosis

Newly Diagnosed Stage 3 (AIDS) by Age at Diagnosis and Jurisdiction, DC EMA 2012-2014



New diagnoses of Stage 3 (AIDS) cases by mode of HIV transmission varied by jurisdiction. With the exception of Maryland, the highest mode of transmission was MSM followed by heterosexual contact. Those who had no identified risk (RNI) varied from 4% of those diagnosed in West Virginia to 45% of those diagnosed in Maryland.

Newly Diagnosed Stage 3 (AIDS) by Mode of Transmission and Jurisdiction, DC EMA 2012-2014



CDC HIV Testing program data

The DC DOH has 39 testing programs that are currently funded, through either direct funding from the CDC or local funds, to provide HIV testing. The majority of testing occurs in clinical settings (hospitals and other healthcare facilities) but other locations that provide testing include community based organizations, faith based organizations, mobile testing facilities, and

organizations that serve populations at high risk, including men who have sex with men, African-American men, Latinos, commercial sex workers, and transgender persons. In 2014, through the CDC testing program in DC, 833 people tested positive for HIV. Nearly a quarter (25%) of those were between the ages of 20-29, 21.49% were 30-39 years old, 19.69% were 40-49 years old, and 32.77% were 50 years old and over. A large proportion of those who tested positive identified as Black or African American (85.71%), with 5.16% identifying as White. Most were men (63.87%), 32.53% were women and 3.36% identified as transgender women. The most common identified mode of transmission was sexual contact among men who have sex with men; however, a large percentage (52.34%) had no identified risk.

Early Identification of Individuals with HIV/AIDS

DC DOH formed an interdisciplinary, internal work group of staff from across care, prevention, and strategic information divisions to conduct a thorough review of the epidemiological data available for the DC EMA, HIV testing reports, and an analysis of several subpopulations, including the FY 2015 special populations. Through this analysis, the work group identified these new special populations, primarily based on proportionately high rates of previously unaware and new diagnoses: youth (ages 13–24), men who have sex with men, and transgender women. Strategies and activities directed toward these populations focused on early intervention services (EIS), new testing strategies such as social network approaches, treatment adherence, and retention in care.

Early Identification of Individuals with HIV/AIDS (EIIHA): Newly and Previously Diagnosed

EEIHA Data, 01/01/2015–06/30/2015*			
Subpopulations	**MSM**	**Youth (ages 13–24)**	**Transgender Women**
NEWLY DIAGNOSED:			
Number of test events	6,953	25,895	282
Number of newly diagnosed positive test events	180	97	6
Number of newly diagnosed positive test events	108	52	2
WITH client linked to HIV medical care			
Number of newly diagnosed confirmed positive test events	146	71	1
Number of newly diagnosed confirmed positive test events WITH client interviewed for partner services	82	37	0
Number of newly diagnosed confirmed positive test events WITH client referred to prevention services	111	53	1
Total # of newly diagnosed confirmed positive test events who received CD4 cell count and viral load testing	NA	NA	NA
PREVIOUSLY DIAGNOSED:			
Number of test events	6,953	25,895	282
Number of previously diagnosed positive test events	35	19	11
Number of previously diagnosed positive test events WITH client reengaged in HIV medical care	18	6	8
Number of previously diagnosed confirmed positive test events	24	14	4

Number of previously diagnosed confirmed positive test events WITH client interviewed for partner services	7	1	1
Number of previously diagnosed confirmed positive test events WITH client referred to prevention services	11	4	3
Total # of previously diagnosed confirmed positive test events linked to and accessed to CD4 cell count and viral load testing	NA	NA	NA

*Data only shown for DC and Virginia

Socioeconomic Data for People living with HIV Receiving RW Services in the DC EMA

The socioeconomic data presented below is the poverty level and medical insurance status for Ryan White consumers in the DC EMA for grant year 2015 (March 2015-February 2016). Nearly half of Ryan White consumers in the EMA live <100% of the federal poverty level with DC residents representing the largest proportion (56%) of those living <100% of FPL.

POVERTY LEVEL	DC	%	MD	%	VA	%	WV	%	EMA	%
<100% of FPL	3,652	56.24%	1,221	51.05%	560	28.15%	62	37.80%	5,495	49.78%
100 - 138% of FPL	244	3.76%	270	11.29%	193	9.70%	35	21.34%	742	6.72%
139 - 200% of FPL	642	9.89%	309	12.92%	212	10.66%	20	12.20%	1,183	10.72%
201 - 250% of FPL	85	1.31%	121	5.06%	116	5.83%	19	11.59%	341	3.09%
251 - 400% of FPL	338	5.20%	161	6.73%	174	8.75%	13	7.93%	686	6.21%
401 - 500% of FPL	18	0.28%	42	1.76%	3	0.15%	4	2.44%	67	0.61%
500+% of FPL	24	0.37%	24	1.00%	1	0.05%	1	0.61%	50	0.45%
Missing	1,491	22.96%	244	10.20%	730	36.70%	10	6.10%	2,475	22.42%
Grand Total	**6,494**	**100.00%**	**2,392**	**100.00%**	**1,989**	**100.00%**	**164**	**100.00%**	**11,039**	**100.00%**

Data on medical insurance status for the entire EMA shows that a good portion of Ryan White consumers have some type of medical insurance coverage with 36.6% covered by Medicaid, 12.5% by Medicare, and 13.4% with private insurance. However, 20.5% of people living with HIV in the EMA do not have insurance, and a large number of those without insurance live in Virginia. Of people living with HIV in Virginia, 46.5% have no insurance compared to 12.2% in DC and 22.8% in Maryland.

MEDICAL INSURANCE	DC	%	MD	%	VA	%	WV	%	EMA	%
Private - Employer	71	1.09%	217	8.36%	142	7.14%	19	9.05%	449	3.98%
Private - Individual	260	4.00%	357	13.75%	443	22.27%	8	3.81%	1068	9.46%
Medicare	804	12.38%	316	12.17%	253	12.72%	42	20.00%	1415	12.53%
Medicaid, CHIP or other public	2,915	44.89%	959	36.94%	202	10.16%	62	29.52%	4138	36.66%
VA, Tricare & other military	0	0.00%	0	0.00%	2	0.10%	37	17.62%	39	0.35%
Indian Health Service	0	0.00%	0	0.00%	0	0.00%	0	0.00%	0	0.00%
Other Plans	381	5.87%	155	5.97%	23	1.16%	34	16.19%	593	5.25%
No insurance/uninsured	792	12.20%	592	22.80%	924	46.46%	8	3.81%	2316	20.52%
Missing	1,271	19.57%	0	0.00%	0	0.00%	0	0.00%	1271	11.26%
Grand Total	**6,494**	**100.00%**	**2596**	**100.00%**	**1989**	**100.00%**	**210**	**100.00%**	**11289**	**100.00%**

Disproportionate Impact of HIV on Certain Populations.

All Minority Communities. People of color continue to be disproportionately impacted by HIV, representing 80.2% percent of estimated HIV diagnoses in the EMA, even though they comprise

about half (51%) of its total population. This diversity demonstrates a need for broader cultural competency among providers.

African-Americans (Blacks). HIV continues to have a disproportionate impact on the black community in the DC EMA. Blacks comprised nearly three-quarters (72.8%) of the newly diagnosed AIDS cases in 2014, and more than two-thirds (68.3%) of the people estimated to be living with HIV in the EMA, yet they account for about one-quarter (24.8%) of the population of the EMA. In further investigating black cases by sex and mode of transmission, it was found that among the 36,369 diagnosed and reported cases in the EMA, 24% of all cases were black women and 19.5% were among black men who have sex with men, which constitutes nearly half (43.6 percent) of all diagnosed cases in the EMA. By jurisdiction, black women and black men who have sex with men account for 49% of all diagnosed cases in DC, 49% of cases in suburban Maryland, 33 % of diagnosed and reported cases in Virginia, and 21.5% of cases in West Virginia.

Immigrants. Throughout this document, the DOH defines immigrants as individuals who are foreign-born and residing in the EMA, regardless of their legal status. In the EMA, there are an increasing number of immigrants, particularly those from African, Caribbean, and Latin American countries. Immigrants face a variety of unique service delivery challenges, including cultural and linguistic barriers when attempting to access HIV services throughout the continuum of care. This is especially problematic in the DC EMA because 26.7% of the total population in the EMA is foreign-born, nearly double the national average of 12.1 %. This population speaks more than 141 languages and more than 28% speak English “less than very well.” One in four residents in the Washington Metropolitan Area speaks a primary language other than English. The immigrant population is unique and rapidly growing across the EMA. Northern Virginia has a large number of Latino immigrants; Maryland has more African immigrants than any other immigrant group. At the Dennis Avenue Clinic in Montgomery County, Maryland, Africans make up 52% of the current clients and account for 40% of all new-to-care clients.

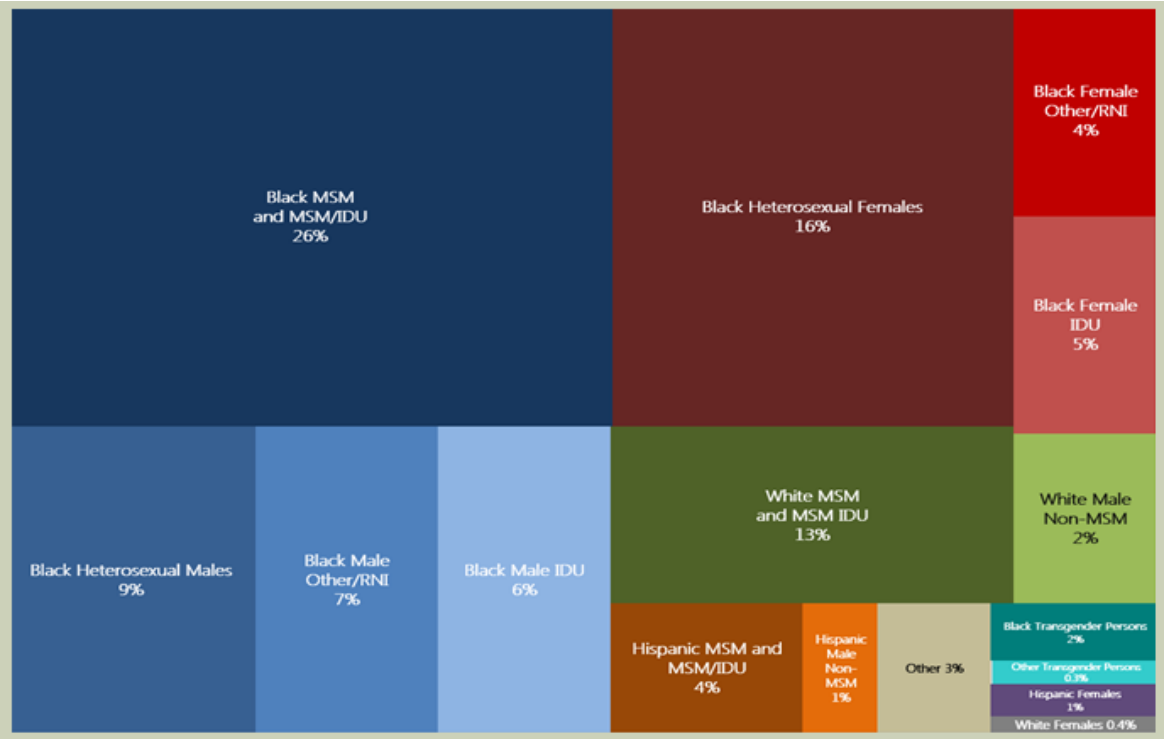
PLWH who are Homeless or Struggle with Housing Costs. Housing costs in the DC EMA are rising at a faster pace than incomes, resulting in a still-too-high proportion of individuals facing housing instability or homelessness. A 2014 report by The Commonwealth Institute for Fiscal Analysis used the Economic Policy Institute’s family budget calculator to find that the region’s two-parent, two-child households would need between $81,900 and $89,600 to be able to comfortably pay for basic living expenses. However, some good news is found in the May 2015 report, *Homelessness in Metropolitan Washington*, by the Metropolitan Washington Council of Governments: The region reported a 2.7% annual decrease in the total number of persons experiencing homelessness. According to a recent epidemiological profile of the DC EMA, an estimated 15.3% of people living with HIV in the EMA are homeless or have experienced a history of homelessness, complicating care and making it difficult to achieve durable viral suppression.

African-American Women. Black women were the highest proportion of cases among the disproportionately impacted populations in the EMA, accounting for 24% of the total HIV cases, 23.3% of living AIDS cases, and 24.8% of HIV (non AIDS) cases as of Dec. 31, 2014. Among new Stage 3 (AIDS) diagnosed cases in 2014, black women represented the highest proportion of cases among the disproportionately impacted populations at 26.1%. Black women accounted for 24.7% of all diagnosed cases with HIV in DC, 31.3% in suburban Maryland, 16.9% in Virginia, and 9.8% in West Virginia.

Black Men Who have Sex with Men (MSM). MSM continue to be the leading reported mode of transmission for HIV. In the DC EMA, black MSM in particular are significantly impacted, accounting for 19.5 % of all cases diagnosed with HIV at the end of 2014 and 19.6 % of all living AIDS cases. Black MSM are 24 % of all diagnosed cases in DC, 18.1% in suburban Maryland, 16.1% in Virginia, and 11.7 % in West Virginia. DOH conducted a CDC-funded behavior study among MSM as part of the National HIV Behavior Surveillance (NHBS) study, which also found older men and men of color had HIV-positive rates nearly three times higher than younger men and white men; and men of color 30 years or older had the highest rates of HIV, with an overall positivity as high as 25% compared to 8% of white males.

Proportion of Cases Living in DC by Race/Ethnicity, Gender Identity, and Mode of Transmission

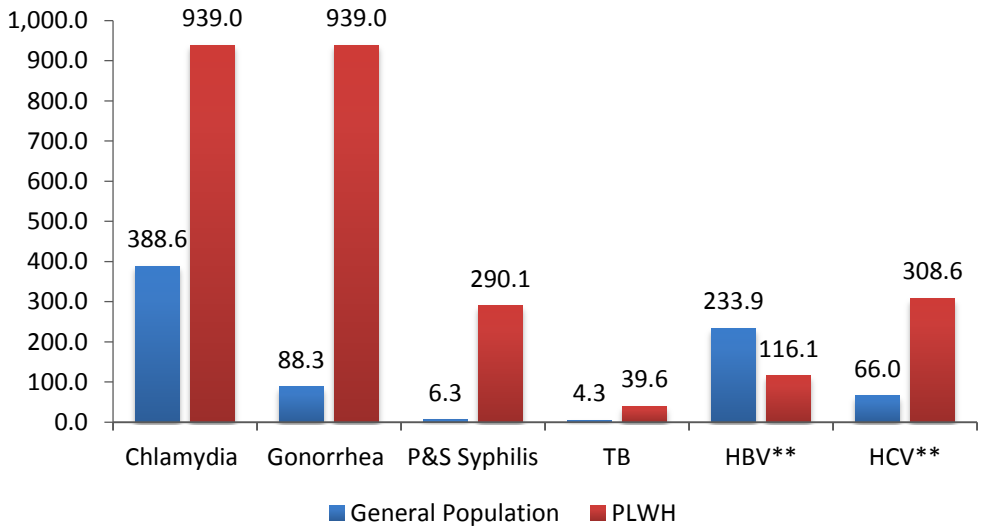
The graph below displays the intersecting characteristics of people living with HIV in DC and the disproportionate impact on certain populations.



Co-morbidities affecting People living with HIV in the DC EMA. Co-morbidities among people living with HIV in the DC EMA are characterized as ever being diagnosed with HIV and a

diagnosis of another disease. The rates presented here are for 2014 and represent diagnosis of a sexually transmitted disease, Hepatitis, or tuberculosis among people living with HIV compared to the general population. With the exception of hepatitis B, people living with HIV have higher rates of sexually transmitted diseases, Hepatitis, and tuberculosis compared to the general population.

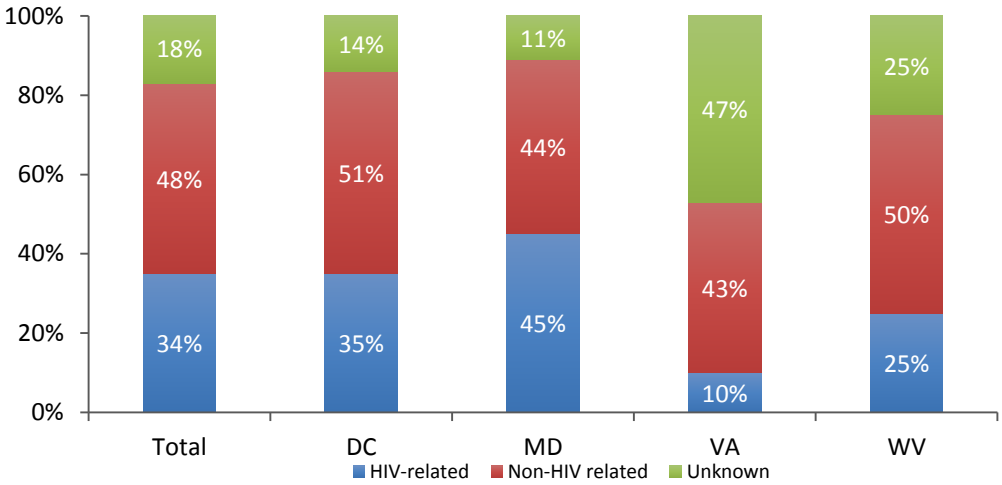
Co-morbidities among the General Population and PLWHA, per 100,000 persons, DC EMA 2014



** Data for Hepatitis B and C used information from 2013

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

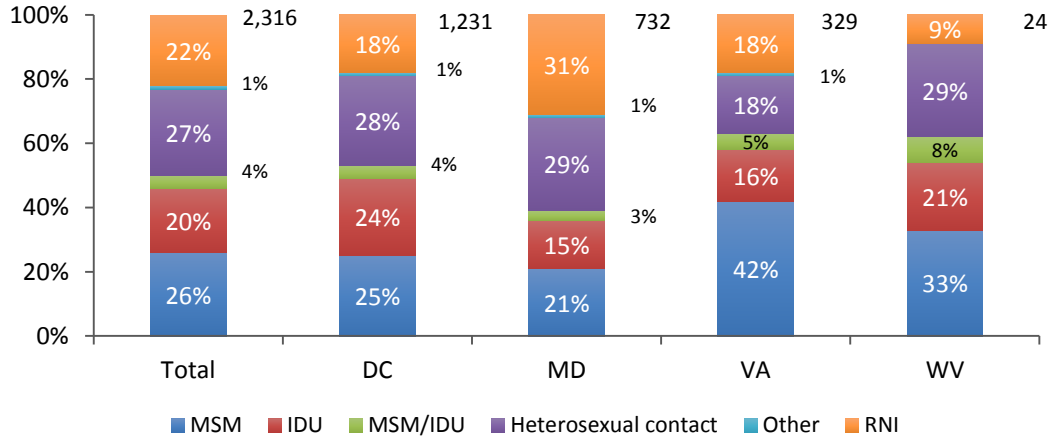
Cause of Death by Jurisdiction, DC EMA, 2010-2014



The rate of death among people living with HIV by gender looks similar to the rate of infection across jurisdiction with most deaths among men (68% for the DC EMA). For age at death, both

overall and by jurisdiction, the highest proportion is among those age 50-59 (37%), followed by those 60 years of age and older (26%), and then those between 40-49 years of age (25%). Though deaths by mode of transmission were similar across the DC EMA, deaths did vary somewhat by jurisdiction. Virginia (42%) and West Virginia (33%) had the highest proportions of deaths among residents with a mode of transmission of men who have sex with men. In Maryland, compared to other jurisdictions, there were a high number of deaths that did not have an identified risk (31%).

Deaths by Mode of Transmission and Jurisdiction, DC EMA, 2010-2014



Ryan White Services Report, GY 2015. While the data presented above represent 2014 surveillance data for the entire DC EMA, the following data describes those who received Ryan White services in the DC EMA for 2015. A total of 11,039 people living with HIV received Ryan White services from March 2015-February 2016. Of those 11,039 clients, 59% reside in DC (6,494), 22% in Maryland (2,392), 18% in Virginia (1,989), and 1% in West Virginia (164). The majority of Ryan White consumers are men (62%) while women represent 35%, and transgender persons represent about 2% of the population, the majority of whom are transgender women. However, among women, the rate increased by 10 percentage points from the previous year's distribution. Clients aged less than 24 years make up about 7% of the total population of Ryan White consumers in the DC EMA. Consumers between 25 – 44 years old make up about 38% while those aged 45 and older represent the largest proportion (55%). Black or African Americans constitute the majority of the client population across the DC EMA. The highest proportions of Black or African Americans are found in Suburban Maryland (81%) while DC has the second highest at 77%. Among the White population, the highest proportion is found in West Virginia, while it also has the lowest proportion of Black or African Americans. About 10% of Ryan White consumers in the DC EMA identify as Hispanic; of this, 21% reside in Virginia and 10% in Maryland. DC and West Virginia account for 10% of the total Hispanic population among RW clients in the EMA. Mode of HIV transmission for those who are Ryan White consumers in the DC EMA appears below. Heterosexual contact is the most common mode of transmission across all jurisdictions (42.2%), followed by men who have sex with men (30%).

Indicators of Risk: Ryan White HIV/AIDS Services Report

HIV RISK FACTOR	DC	%	MD	%	NV	%	WV	%	EMA	%
MSM	2,008	30.92%	614	25.67%	637	32.03%	57	34.76%	3316	30.04%
IDU	222	3.42%	52	2.17%	110	5.53%	2	1.22%	386	3.50%
Hemo/Coag Disorder	5	0.08%	0	0.00%	2	0.10%	1	0.61%	8	0.07%
Heterosexual Contact	2,267	34.91%	1,278	53.43%	1,065	53.54%	70	42.68%	4680	42.40%
Rec'd Bld Trans/Comp/Tissue	24	0.37%	40	1.67%	47	2.36%	0	0.00%	111	1.01%
Perinatal	107	1.65%	133	5.56%	30	1.51%	3	1.83%	273	2.47%
Risk Not Identified/Reported	1,841	28.35%	268	11.20%	92	4.63%	2	1.22%	2203	19.96%
Missing	20	0.31%	7	0.29%	6	0.30%	29	17.68%	62	0.56%
Grand Total	**6,494**	**100.00%**	**2,392**	**100.00%**	**1,989**	**100.00%**	**164**	**100.00%**	**11,039**	**100.00%**

*NV=Northern Virginia

Below is a list of the most utilized Ryan White service categories in the DC EMA for 2015. These data were based on the number of people that have used the service and projected to the total number of people in the EMA. In DC, the most utilized core service category was Outpatient/Ambulatory Care; however, in Maryland, Virginia, and West Virginia, Medical Case Management was the most utilized service category. Among support service categories, treatment adherence was the most utilized in DC, non-medical case management was the most utilized in Maryland, medical transportation was the support service most utilized in Virginia, and emergency financial assistance was the support service category most utilized in West Virginia.

DC EMA Top 10 Utilized Service Categories, 2015

Rank	Service Category	Percent of Total
1	Outpatient/Ambulatory Medical Care	77%
2	Medical Case Management	58%
3	Mental Health	24%
4	Oral Health Care	21%
5	Medical Transportation	14%
6	Emergency Financial Assistance	12%
7	Treatment Adherence	10%
8	Substance Abuse Services (outpatient)	7.5%
9	Medical Nutrition Therapy	7.3%
10	Food Bank/Home Delivered Meals	6%

AIDS Drug Assistance Program. This chart illustrates the total number of clients served in calendar year 2015 by the AIDS Drug Assistance Program (ADAP) in Washington DC, Virginia, Maryland, and two counties in West Virginia, in addition to a breakdown of the services provided and the client's demographic profile. A total of 15,346 clients were served within these areas in calendar year 2015 by ADAP. An average of 36% of clients in all the jurisdictions were within 0-100% of the federal poverty level (FPL). The remaining 64% of clients earn between 100%-500% of the FPL. As the payer of last resort, this underscores the point that a significant number of HIV infected individuals rely on the ADAP program to provide their HIV medications and assist with paying their health care premiums. With the implementation of the Affordable Care Act (ACA), HIV positive persons were able to obtain quality healthcare coverage because insurance carriers could no longer deny a person with a pre-existing health condition from securing health insurance. With that the number of individuals that the ADAP program has been able to provide premium and copay assistance has increased exponentially over the past few years. In 2015, an average of 39% of ADAP clients within Washington DC, Virginia, and Maryland received premium assistance. This is significant because comprehensive healthcare is important to reaching and maintaining optimal health outcomes for PLWH and not just drug purchasing assistance.

2015 ADAP Clients for Washington DC Metropolitan Area*

	DC	DC % of Total Served	VA**	VA % of Total Served	MD***	MD % of Total Served	WV	WV % of Total Served
Total Clients Served	1,426		6,834		7,045		41	
Race Breakdown								
Black Clients	969	69%	4,266	60%	5,262	79%	9	22%
White Clients	412	30%	2,643	37%	1,299	20%	32	78%
Other Race	20	1%	185	3%	94	1%	0	0%
Gender								
Male	1,062	74%	4,921	72%	4,812	66%	35	85%
Female	354	25%	1,843	27%	2,456	34%	6	15%
Transgender	10	1%	70	1%	23	0%	n/a	
Income Level								
below 100% FPL	728	49%	3,968	58%	2,791	38%	0	0%
between 101-500% FPL	698	51%	2,846	42%	4,500	62%	41	100%
Received Insurance Assistance								
Full Premium Payment	191	34%	3,724	49%	2,251	34%	n/a	n/a
Partial Premium Payment	0	0%	0	0%	0	0%	n/a	n/a
Co-pay/deductible	378	66%	3,867	51%	4,342	66%	n/a	n/a

**This chart includes the following jurisdictions: Washington DC, Virginia, Maryland, and two counties in West Virginia*
***This represents every county in Virginia*
****This represents every county in Maryland*

Community Health Center Data

In 2015 274,062 patients received services from Federally Qualified Health Centers (FQHCs) in the EMA. This geographic area is served by eight clinics in the District of Columbia, four in Suburban Maryland, three in Northern Virginia, and one in Berkeley County West Virginia. Overall, patients accessing care at FQHCs and FQHC look-alikes tend to be racial and/or ethnic minorities and have higher rates of un-insurance, lower incomes, and higher rates of HIV than the general population.

Jurisdiction	Racial/Ethnic Minority	Uninsured %	<200% FPL	HIV Diagnosis
DC	95.24%	19.46%	92.71%	4.43%
MD	94.40%	36.61%	98.29%	1.25%
VA	86.70%	55.88%	96.27%	0.67%
WV	27.49%	13.05%	87.89%	0.38%

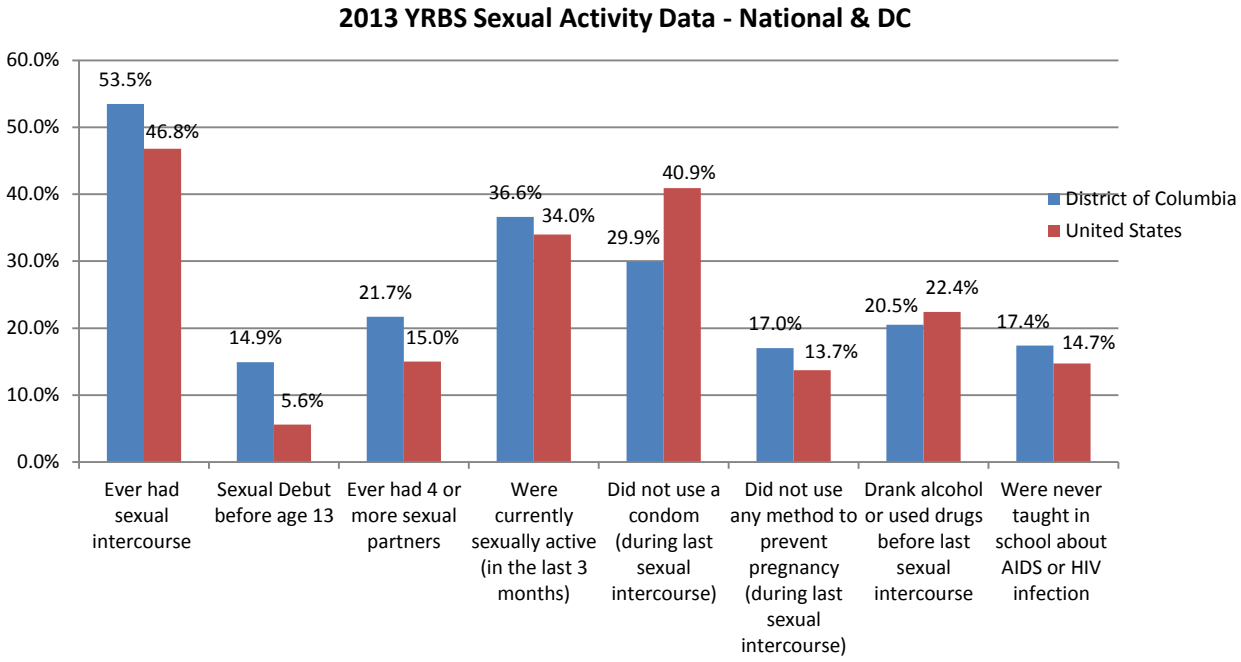
Data from www.**udsmapper**.org/

Behavioral Surveillance

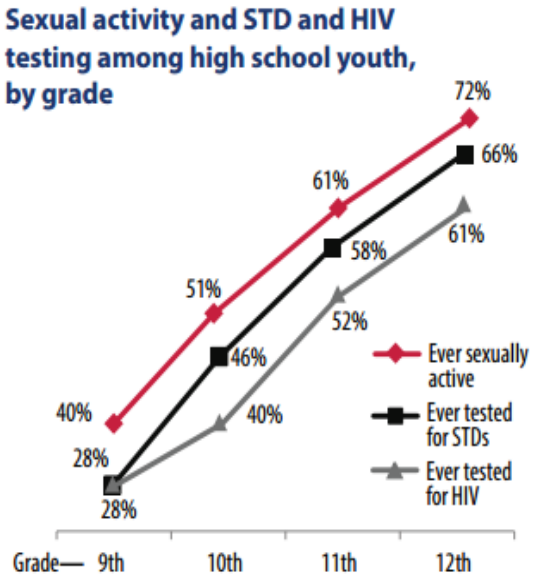
Most of the behavioral survey data presented below pertains to DC only and not the entire EMA. In addition, behavior survey data are not collected every year. However, included below are data summaries from the most recent Youth Risk Behavior Surveillance System and the National HIV Behavioral Surveillance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

Youth Risk Behavior Surveillance (YRBS). In the District of Columbia in 2013, youth ages 14 to 24 comprise 15.7% of the population. As the table below illustrates, DC youth disproportionately engage in sexual behaviors that increase the risk for sexually transmitted infections (STIs), including HIV, as well as unintended pregnancy, compared with youth nationally. Across DC, in 2012, 16% of male students and 3% of female students reported initiation of sexual intercourse by age 11, while 25% of male students and 6% of female students reported initiation by age 13. Additionally, 19% of high school students had a recent sexual partner who was three or more years older. At the end of 2014, HIV prevalence among youth ages 13–24 was 0.6%, and young men who have sex with men and transgender youth are showing significant increases in HIV infection.[4]

[4] *HIV among Transgender Persons in the District of Columbia HIV/AIDS, Hepatitis, STD, and TB Data through 2014*, District of Columbia Department of Health, p.36.



DC 2012 YRBS Report: Sexual Activity, STD, and HIV testing Among High School Aged Youth by Grade



This table displays that as youth get older, their sexual activity increases, but STD and HIV testing also increase at similar rates. However, by 12th grade, 72% of youth are sexually active, but only 61% have ever been tested for HIV. STD and HIV testing among sexually active youth remains particularly critical. However, high school-aged youth reported higher rates of condom use than the national average, and 78% of males, compared to 62% of females reported using condoms during their last sexual intercourse.

National HIV Behavioral Surveillance (NHBS). For the National HIV Behavioral Surveillance system, the CDC identified three target populations with significant risk and behaviors associated with HIV infection: heterosexuals at high risk of HIV infection, men who have sex with men and injecting drug users. DOH contracted with the George Washington University School of Public Health and Health Services, Department of Epidemiology and Biostatistics (GWU) to conduct the study for DC and named the local version as the DC HIV Behavioral Study Series.

Men who have sex with Men 2011. Major findings from this sample of men who have sex with men revealed that: 23% of HIV positive individuals were unaware of their status prior to the

study; rates of HIV were higher among men of color compared to white men; and among HIV positive men under 30 years old, nearly all were men of color. Most men in the study had been to a health care provider in the previous 12 months (83%), but only 55.3% were offered an HIV test at a provider visit and half of those newly diagnosed had seen a health care provider in the previous 12 months.

Condom use was not consistent, and only 50% used condoms at last sex with a male partner with men of color more likely to report using condoms than white men. More than one-third of participants reported seven or more partners in the previous 12 months. About half of the men reported having sex with other partners and about half believed their last partner had sex with other partners as well. More than 60% expressed interest in using PrEP and 80% would be willing to use PEP if they had unprotected sex. Most participants reported that they would still practice safe sex if they used PrEP Approximately half of the study participants (46.5%) reported non-injection drug use with marijuana having the highest utilization rate at 75.6% followed by poppers (45.3%) and powdered cocaine (32.1%). Use of party drugs was also reported with 17.9% using ecstasy, 12.0% using crystal meth, 7.7% using GHB, and 4.7% using Special K/ketamine.

Injection Drug Users 2012. The majority of the participants in the study were long-time injection drug users; the average time from start of injection drug use was 30.9 years. Nearly 60% were 50 years old and older, but many participants started injection drug use at an average age of 22 years old. Overall, 41% reported sharing needles in the previous 12 months, women were more likely to share needles than men. More than two-thirds of study participants reported not using condoms during their last sexual encounter, and 13% were HIV positive with 22% of those reporting being unaware of their diagnosis prior to the study. Among those newly diagnosed, 73% had seen a health care provider at least once in the past 12 months and had not been diagnosed by that provider. Overall, 89% had seen a medical provider in the last year with 57% being offered an HIV test. Recommendations were: increasing the availability of free needles and targeted outreach to younger and new injection drug users.

High Risk Heterosexuals 2013. Overall, 3.7% of high risk heterosexuals (HET) in DC tested positive for HIV in the 2013 NHBS with women (7.6%) nearly two times more likely to be positive than men (4.0%). Over 70% of participants reported knowing their current HIV status, and 59.3% knew the status of their last sex partner. Most participants reported seeing a health care provider in the previous 12 months, and 71.3% were offered an HIV test by the health care provider. More women (93.9%) than men (71%) had seen a health care provider in the previous 12 months, yet a lower proportion of women (67.4%) were offered an HIV test compared to men (76.1%).

Over a third (35.7&) of participants reported discussing condoms at last sexual encounter, of which 32.4% reported that only they wanted to use condoms, 2.8% said only their partner wanted to use condom and 64.3% reported that both they and their partner wanted to use condoms at last sex. Nearly a third (32.6%) of participants reported actual condom use at last sex. When asked the number of times participants used a condom in the last 10 sexual

encounters, majority reported 0 times, and nearly a third reported 7 or more times. Participants in the study provided reason for not using a condom at last sex including a low-risk partner (31.5%), considered themselves low-risk (12.2%), condoms decreased sexual pleasure (8.4%), and 6.7% reported that condoms were not available. Finally, over 20% of participants (21.6%) reported that there was no particular reason for the lack of condom use at last sexual encounter. Based on low condom usage and high rates of interactions with a health care provider, although many are offered an HIV test at a provider visit, it is a missed opportunity when an HIV test is not offered, particularly for females.

Non-injection drug use in the past 12 months was reported by 61.3% of all study participants. Marijuana (56.6%) was the most commonly used drug followed by ecstasy (20.2%) and pain killers (16%).

HIV in the DC EMA: Key Points

In the DC EMA, which incorporates Washington DC, Northern Virginia, suburban Maryland and two counties in West Virginia, DC has the highest proportion (47%) of people living with HIV in the region. A majority of people living with HIV are Black, men, between 40-59 years old, and had sexual contact as a mode of transmission. Most new Stage 3 (AIDS) diagnoses were among African Americans, men, between the ages of 30-49 and a mode of transmission of MSM or heterosexual contact. Those newly diagnosed with HIV in the EMA were black, men, between 20-29 years of age with sexual contact as the mode of transmission, although there are still a large amount of newly diagnosed people living with HIV who have no identified risk factor. Among RW consumers, most lived <100% below the federal poverty level, but rates and type of medical insurance varied based on state of residence.

Overall, living HIV cases in the EMA are experiencing co-infections, with higher rates of disease than the general public. What is noteworthy is that STD co-infections are being diagnosed after a person already received an HIV diagnosis, which indicates that PLWH are engaging in high-risk behaviors. The majority of deaths among people diagnosed with HIV in the EMA between 2010 and 2014 were non-HIV related, and much like surveillance data, the majority of deaths were among black, males, between the ages 50-59. For death rates by mode of HIV transmission, proportions were almost evenly spread between MSM, heterosexual contact and IDU.

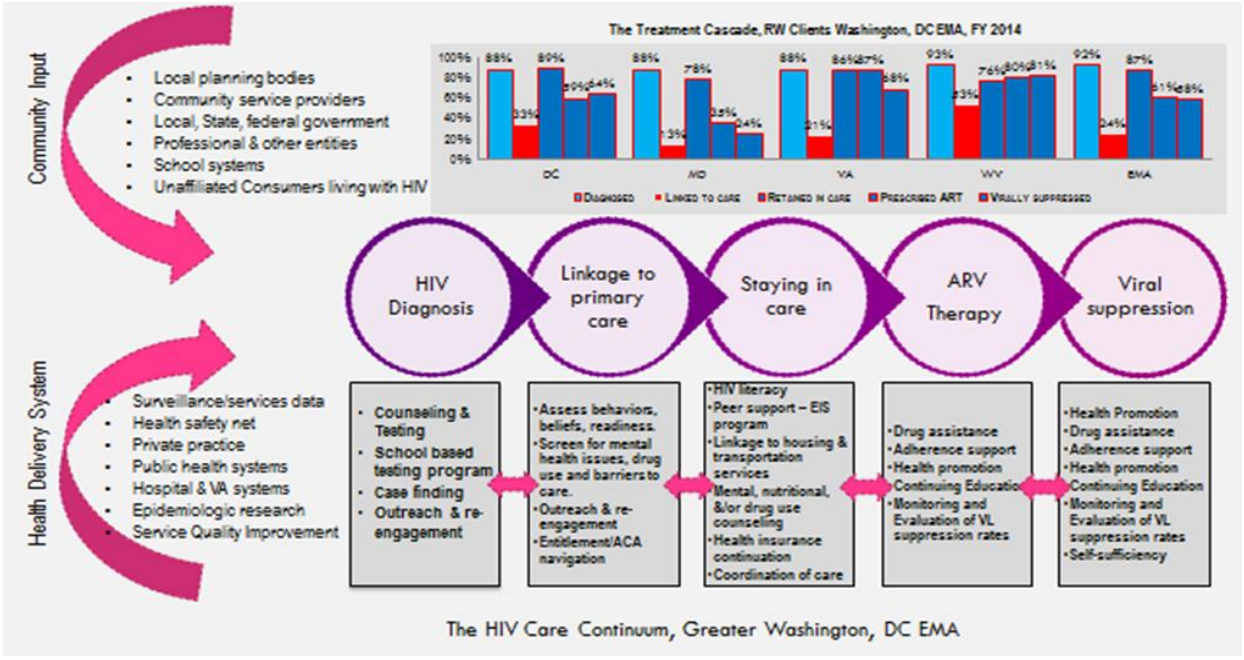
Behavioral data reveal that condom use remains sporadic among the groups identified by the CDC for the NHBS system. Interestingly, according the results from the YRBS report, sexual active youth may use condoms more often, although rates are still not very high. Regarding HIV testing in these populations, there are missed opportunities for testing among all groups, but particularly females, who regularly see health care providers but are offered HIV tests less often compared to males.

I-B: HIV Care Continuum

HIV Care Continuum Graph with Five Main Stages of Diagnosis.

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

- **Community input –** Involving a wide array of entities, including local, state, and federal entities, professional groups, the school system, and unaffiliated HIV consumers that together provide guidance and influence how the continuum will be used to track progress of people living with HIV in the different stages of the treatment cascade.
- **Health Delivery System –** A set of health care institutions, professional practitioners, and public health systems, epidemiologic research bodies, disease surveillance units, and others that directly impact the continuum of care. These entities provide the components of HIV care and ensure that standards of care are executed to achieve viral suppression among clients.



Using the 2014 RW Service Report (RSR), an EMA-wide continuum was generated by using consolidated data sets from each of the jurisdictional regions. The total number of diagnosed cases in the EMA is 36,369. The caseload for each jurisdiction reflects the burden of HIV disease, with DC having almost 45 percent of total EMA cases. Maryland is second and has similar population characteristics to DC. Virginia, the largest in land area and demographically diverse, had about 21 percent of the cases in the EMA. Berkeley and

Jefferson counties, West Virginia, have about 1 percent of the caseload. Regarding the continuum in all four jurisdictions, it is important to note the following:

- **Diagnosed:** The EMA has an estimated 41,303 cases living with HIV disease; of these 36,393 or 92 percent are reported and diagnosed. Approximately 12 percent are unaware that they are HIV- positive. In each of the jurisdictions, about 88 percent (total number of reported and diagnosed HIV, including Stage 3) of cases are reported and diagnosed with HIV disease.
- **Linked to Care:** Using the requisite definition of linked to care, 24 percent of the EMA's diagnosed cases are in RW care; DC has 33 percent of its cases linked to care, Maryland is 13 percent, Virginia is 21 percent, and West Virginia is 53 percent.
- **Retained in Care:** Following the requisite definition of retained in care, 87 percent of the EMA's RW clients are retained in care. DC, Maryland, Virginia, and West Virginia jurisdictions indicate that 89 percent, 78 percent, 86 percent, 76 percent are retained in care, respectively.
- **Prescribed ART:** As required, the proportion of EMA clients prescribed Anti-Retroviral Therapy is 61 percent, above the national average of 37 percent. The continuum indicates that Virginia has the highest proportion (87 percent) of its HIV medical care clients prescribed ART; West Virginia is at 80 percent, DC is at 59 percent, and Maryland is at 35 percent.
- **Viral Suppression:** The National Continuum indicates that of those people living with HIV in medical care, about 30 percent are virally suppressed. The EMA's Continuum indicates 58 percent are virally suppressed; West Virginia has the highest proportion (81 percent) of PLWHA who are virally suppressed; DC and Virginia have 64 and 68 percent respectively. Maryland reports 24 percent.

The continuum shows the focus and direction of planning HIV prevention and care services. In each stage of the continuum, a set of prevention and care services, including counseling and testing and early intervention programs, are implemented to ensure that outcomes along each stage are realized. These services/programs are best described as the integration of HIV prevention and care of people living with HIV. In the first stage, the expected result of the increase in the number of newly diagnosed cases is conservatively projected at about 3.5 percent. Increased access and referral to medical care and other services are strategies that enable clients to progress from diagnosis to viral suppression.

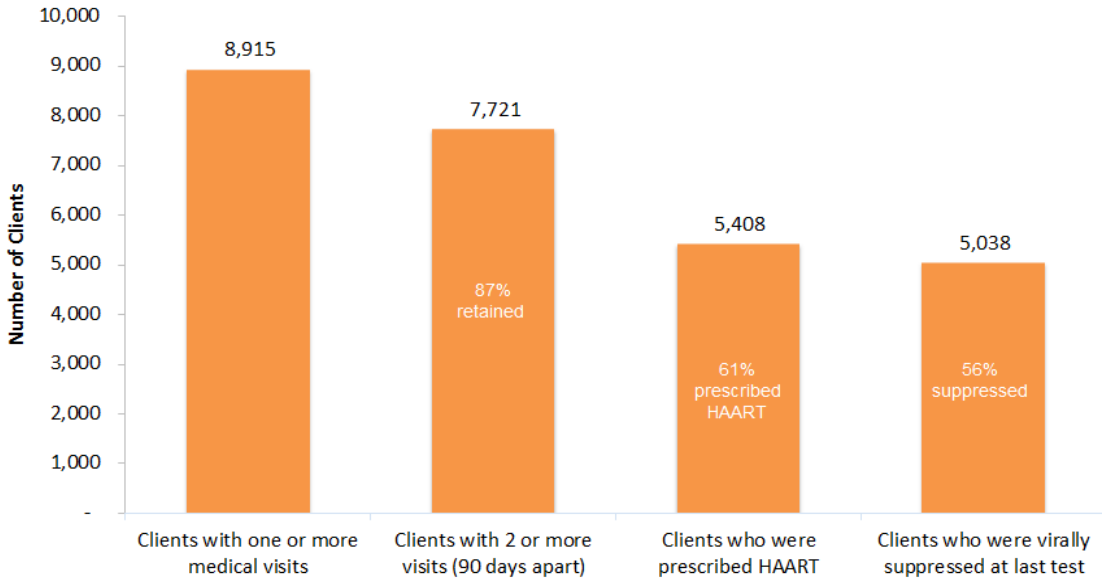
In the next stage, HIV primary medical care and medical case management possess key intervention roles. Using Public Health Service guidelines for primary care, a person living with HIV will complete all required medical assessments and diagnostic screens for comorbid conditions like sexually transmitted infections, substance use, mental health, oral health, and other health conditions. A treatment plan is devised with components such as prescription of

antiretroviral medications, risk-reduction counseling and education, and appropriate referrals to other services like oral health and nutrition therapy. Follow-up visits are also incorporated.

HIV Care Continuum: EMA and by Jurisdiction

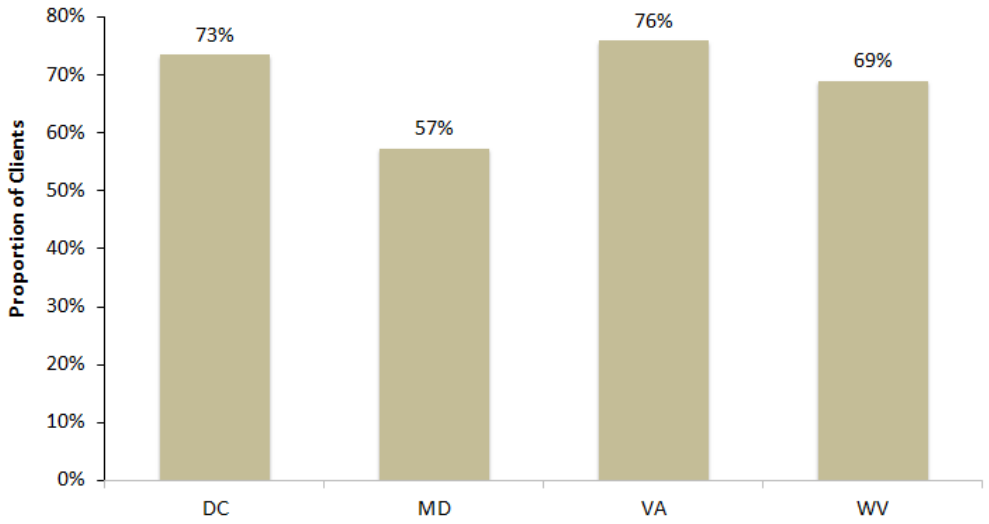
Of the 8,915 RW clients with at least one medical visit in 2014, 87% of were considered retained in care, 61% were prescribed ART, and 56% were virally suppressed. Though the traditional continuum looks at all clients as the denominator, data from CAREWare for RW consumers uses clients who had at least one primary care visit as a denominator because not all clients used RW primary care services.

HIV Continuum of Care among Ryan White Clients in the EMA, 2014



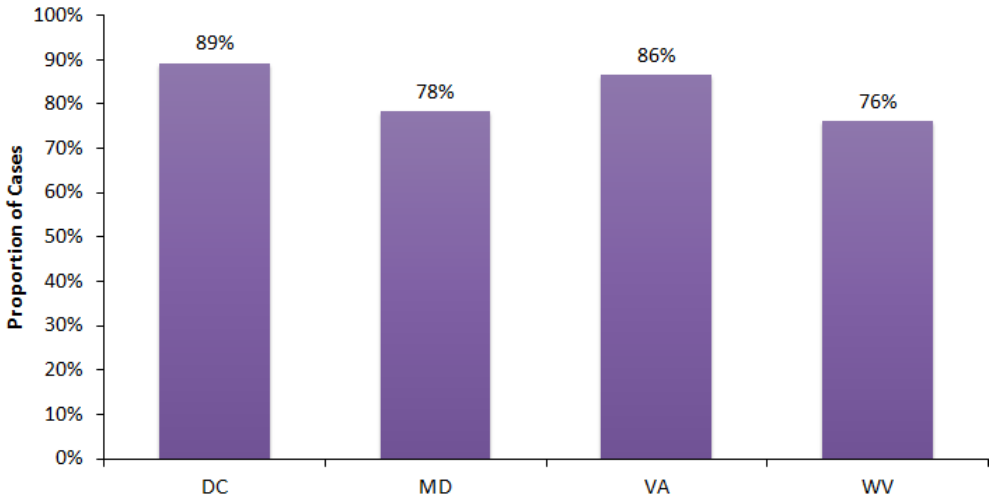
Proportion of RW Clients Receiving Services Who had 1 or More Primary Care Visits by Jurisdiction, 2014

A majority of Ryan White clients who were receiving any type of services had at least one primary care visit in 2014. The highest proportion of RW consumers receiving primary HIV care was in Virginia (76%) and the lowest proportion RW consumers receiving primary HIV care was in Maryland (57%).



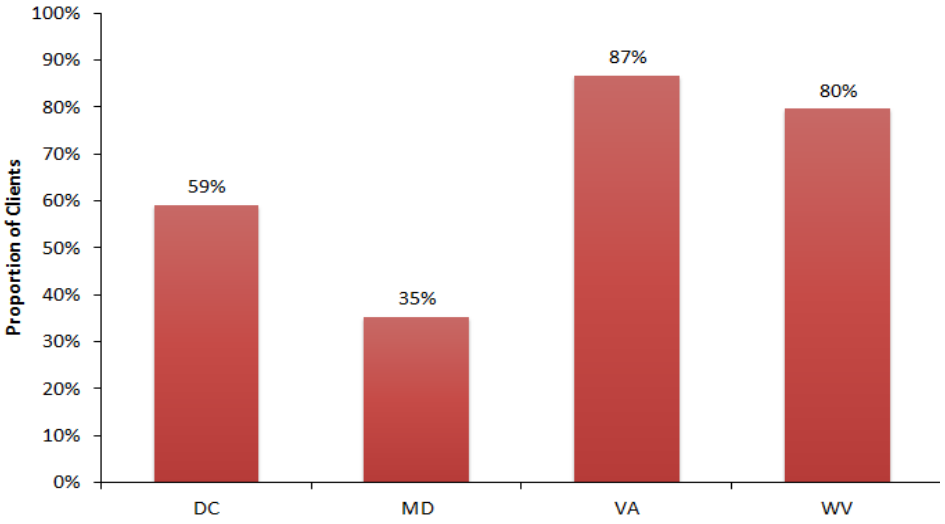
Proportion of RW Clients Receiving Services who had 2 or More Primary Care Visits at Least 90 Days Apart by Jurisdiction, 2014

Rates of retention in care among RW consumers were similar across jurisdictions. The rate of retention in care ranged from 76% in West Virginia to 89% in DC.

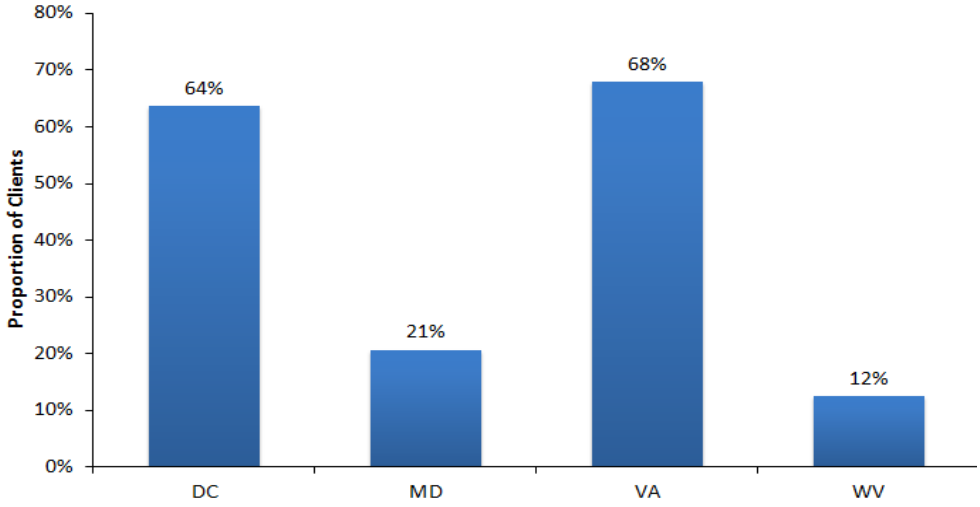


Proportion of RW Clients Receiving Services Who were Prescribed ART by Jurisdiction, 2014

RW consumers who were prescribed ART varied by jurisdiction. The rate of being prescribed ART ranged from 35% in Maryland to 78% in Virginia.



Proportion of RW Clients Receiving Services Who were Virally Suppressed by Jurisdiction, 2014
Viral suppression varied considerably among RW consumers throughout the EMA. Over two-thirds of RW consumers in Virginia were virally suppressed compared to 12% in West Virginia.



HIV Care Continuum: Planning. The HIV Care continuum for the EMA is utilized in planning and prioritization through a process known as priority setting and resource allocation (PSRA). Led by the Ryan White Planning Council, this process is a participative and cooperative and aims to identify needs at all levels; namely, providers, people living with HIV, stakeholders in the community, jurisdictional agencies, and nonaffiliated consumers. In the 2015 PSRA process, for instance, presentation of the HIV Care Continuum led to additional resource set-asides to targeted early intervention services to three specific populations—Latinos, African-American, and young MSM—to reach, identify, and link them to care and treatment.

No single set of services can effectively address the needs of a wide range of races, ethnicities, social identities, risk behaviors, clinical statuses, and service expectations throughout the

EMA. The aim is for a service delivery system that establishes and maintains a continuum to ensure access, retention, and coordination of all required care and support services. This is characterized by:

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

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

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

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

HIV Care Continuum among Ryan White Clients in the EMA, by Demographics, 2014
Below is a chart of the demographic breakdown at the different stages of the continuum of care for all RW clients in 2014. The continuums of care rates by gender are similar across all stages of the continuum. RW clients age 13-34 had the lowest rates across the continuum and

clients aged 55 and older had significantly higher rates of being engaged in care and virally suppressed. However, part of this may be just an outcome of more years living with HIV. By race, Asian, Pacific Islander, Native Hawaiian, American Indian, and Native Alaskan had the lowest rates of engagement across the continuum, with viral suppression as low as 34%. However, the total number of persons is very low, which affects the rate calculation. Whites and African Americans living with HIV have similar rates of retention in care, but Whites were prescribed ART at a higher rate and have higher viral suppression rates than Black RW consumers. Hispanic RW Consumers had higher rates of being prescribed ART and virally suppressed compared to non-Hispanics.

	In Medical Care	Retained in care		Prescribed ART		Virally suppressed	
	N	N	%	N	%	N	%
Gender Identity							
Male	5,368	4,840	90.2	3,437	64.0	3,203	59.7
Female	3,090	2,716	87.9	1,860	60.2	1,722	55.7
Transgender	187	165	88.2	111	59.4	113	60.4
Total	**8,915**	**7,721**	**86.6**	**5,408**	**60.7**	**5,038**	**56.5**
Current Age							
0-12	13	3	23.1	0	0	0	0
13-24	413	325	78.7	177	42.9	141	34.1
25-34	1,640	1,379	84.1	919	56.0	820	50.0
35 - 44	2,035	1,742	85.6	1,279	62.9	1,140	56.0
45 - 54	2,781	2,449	88.1	1,755	63.1	1,640	59.0
55 - 64	1,686	1,518	90.0	1,053	62.5	1,050	62.3
65+	344	305	88.7	225	65.4	247	71.8
Total	**8,915**	**7,721**	**86.6**	**5,408**	**60.7**	**5,038**	**56.5**
Race**							
White	1,572	1,357	86.3	1,210	77.0	981	62.4
Black	6,505	5,641	86.7	3,809	58.6	3,340	51.3
Asian	159	103	64.8	94	59.1	80	50.3
NH/PI/NA/AI	38	22	57.9	17	44.7	13	34.2
Missing	694	598	86.2	278	40.1	624	89.9
Total	**8,968**	**7,721**	**86.1**	**5,408**	**60.3**	**5,038**	**56.2**
Ethnicity							
Hispanic	1,035	860	83.1	714	69.0	674	65.1
Non-Hispanic	7,880	6,861	87.1	4,694	59.6	4,364	55.4
Total	**8,915**	**7,721**	**86.6**	**5,408**	**60.7**	**5,038**	**56.5**
HIV Risk Exposure**							
MSM	2,653	2,482	93.6	1,755	66.2	1,476	55.6
IDU	336	311	92.6	221	65.8	174	51.8
Heterosexual contact	4,038	3,700	91.6	2,862	70.9	2,203	54.6
Other*	219	168	76.7	127	58.0	72	32.9
RNI/Missing**	1,758	1,060	60.3	476	27.1	1,113	63.3
Total	**9,004**	**7,721**	**85.8**	**5,441**	**60.4**	**5,038**	**56.0**

*Other HIV risk exposures includes hemophilia, blood transfusion, occupational exposure (healthcare workers), and perinatal exposure
**Discrepancy in data due to the exclusion of data from four providers

HIV Care Continuum: Approaches to Address Other Barriers or Unique Challenges. The unique challenges identified at the jurisdictional level are addressed locally:

- Data transfer and collection for the EMA is at various stages of maturity; two of the four jurisdictions have implemented CAREWare. Virginia and West Virginia implemented CAREWare three years ago. DC and Maryland implemented CAREWare in 2014. In DC and Maryland, where there are significantly lower proportions of documented ART prescription and viral suppression rates, several measures were adopted to improve data inputs for the Care Continuum.
- A Data Improvement Project is needed EMA wide to address quality measures and establish a feedback process for providers to utilize viral load, medical visits, ART prescriptions, and patient outcomes data to improve the care continuum.
- To address various medical insurance and ADAP policies that may pose as a barrier to accessing ART, Virginia was designated by the PC to implement an EMA-wide local pharmaceutical assistance.
- With the expansion of Medicaid in three of the four EMA jurisdictions, obtaining Medicaid utilization data will better illustrate care dynamics to improve the care continuum. DC implemented a data-sharing agreement between DC Medicaid and HAHSTA.
- Provider education is critical to the success of the continuum of care; there is a need for ongoing cultural competency training.
- To increase access to care, enhance continuity and sustainability of care provision, and improve accountability, the current reimbursement method of funding for RW providers was assessed in 2015. The planning for an alternative method of service delivery payments that is equitable and accessible to people living with HIV is underway. The plan will adopt a phase-in approach to ensure it is beneficial for PLWHA and their providers.

The care continuum is a vital tool that reveals the state of HIV care in a region using data from the first appointment with a primary medical service provider to, ideally, viral suppression. Though there are limitations in the data, the care continuum assists in the evaluation of cases through the course of care for effective planning purposes. Overall, RW consumers who had at least one medical visit in 2014 had high rates of retention in care, 87% of clients who had at least medical visit being retained in care at the end of 2014. However, prescription of ART and viral suppression varied considerably and reveal that particularly racial minorities and young people living with HIV could benefit from focused strategic service efforts to improve engagement and retention in care leading to increased viral suppression among people living with HIV who are RW consumers.

For 2017 planning, there have been improvements in Continuum of Care measures in 2016, including increased testing, reduced late testing, increased entry into care within 90 days, and improved viral outcomes, as well as data improvement projects.

I-C. Financial and Human Resources Inventory

Within the DC EMA, a range of service providers, both inside and outside the RW system, offer prevention and care services to people living with HIV and those at risk of infection. Funding for the services and providers is offered through RW and a range of other sources listed in the financial inventory. [See Appendix – Expanded Financial Inventory]

Financial Inventory Overview

The following table is an HIV resource inventory which includes the available public and private funding sources for HIV prevention, care, and treatment services in the EMA, the dollar amount of available funds from that source in FY2016, the services those funds deliver, the agencies that deliver those services, and the HIV Care Continuum Step(s) that are impacted. Where 2016 data are not available, but the funding source is known to still be in place, earlier data are provided. See the notes column in [Appendix - Expanded Financial Inventory] for further details on each section.

As detailed in the Appendix, Medicaid is the largest source of funding for HIV services in the EMA, but precise figures on Medicaid spending can be difficult to obtain. As the section on gaps and needs discusses further below, this chart reflects Medicaid expenditures for DC and Maryland, but not Virginia and West Virginia, though rough estimates for those states are included in [Appendix – Expanded Financial Inventory]. The Appendix also includes estimated Medicare expenditures for the EMA, but the figure is not included in the total below.

Funding Source	Funding Amount ($) from FY16	Services Delivered Using	Agencies Providing	HIV Care Continuum Step(s) Impacted	Data Source(s)
Grant Funding					
Ryan White Part A					
EMA Total	$23,706,958	Outpatient Ambulatory Medical Care, Medical Case Management, Mental Health Services, Medical Nutrition Therapy, Early Intervention Services, Home & Community-Based Health Svcs, Substance Abuse Services - Outpatient, Medical Transportation Services, Treatment Adherence Counseling, Outreach Services, Psychosocial Support Services, Emergency Financial Assistance, Food Bank/Home-Delivered Meals, Oral Health Services, Early Intervention Services (EMA), Linguistics Services, Legal Services, Non-Medical Case Management, AIDS Pharmaceutical Assistance (local), Health Insurance Premium & Cost Sharing, Child Care Services, Housing Services.	30 Providers	Diagnosis, Linkage to Care, Retention in Care, Antiretroviral Use, Viral Load Suppression	See Appendix
Ryan White Part B					
EMA Total	$24,963,164	Medical Case Management, Medical Nutrition Therapy, Food Bank/Home-Delivered Meals, Health Insurance Premium & Cost Sharing, Early Intervention Services, Medical	13 Providers	Diagnosis, Linkage to Care, Retention in Care, Antiretroviral Use, Viral Load Suppression	See Appendix

		Transportation Services, Outreach Services, Mental Health Services, Psychosocial Support Services, Treatment Adherence Counseling, OAMC(Specialty), Oral Health, Non-Medical Case Management, EFA Food, ADAP, Co-insurance and ADAP insurance premiums, and nutrition food vouchers. The total award also includes NVRC Admin Dollars.			
Ryan White Part C					
EMA Total	$2,661,109	Primary Medical Care, Medical Case Management, Oral Health, Mental Health, Substance Abuse.	10 Providers	Diagnosis, Linkage to Care, Retention in Care, Antiretroviral Use, Viral Load Suppression	See Appendix
Ryan White Part D					
EMA Total	$542,049	Primary Medical Care, Medical Case Management, Oral Health, Mental Health, Substance Abuse, and Transportation	2 Providers		See Appendix
Ryan White Part F - Dental					
EMA Total	$0				See Appendix
CDC HIV Prevention					
EMA Total	$8,221,108	Condom distribution, HIV prevention for high-risk negatives, Full-Range clinical support for positives (treatment adherence, HIV screening, and linkages to care), Prevention, HIV Testing, Outreach testing, CTR/recertification, educational presentation, partner services.	10 Providers	Prevention, Diagnosis, Linkage to Care	See Appendix
CDC HIV Testing					
EMA Total	$1,568,000	Routine HIV Screening is conducted in clinical settings in addition to linking HIV positive individuals into care and testing.	7 Providers	Diagnosis, Linkage to Care	See Appendix
CDC HIV Surveillance					
EMA total	$2,431,112				See Appendix
CDC HIV CBOs					
EMA Total	$1,750,000	PS15-1502: Comprehensive High-Impact HIV Prevention Projects for Community-Based Organizations	6 Providers	Prevention	See Appendix
CDC HIV School Health					
EMA Total	$757,699	Collect and report Youth Risk Behavior Survey (YRBS) and School Health Profiles data. Deliver exemplary sexual health education emphasizing HIV and other STD prevention (ESHE); increase adolescent access to key sexual health services (SHS); and establish safe and supportive environments for students and staff (SSE); Cooperative Agreements to Promote Adolescent Health through School-Based HIV/STD Prevention and School-Based Surveillance		Prevention, Diagnosis, Linkage to Care	See Appendix
SAMHSA HIV AIDS Grants					
EMA Total	$1,683,448	Student peer educator (SPE) model designed to raise awareness and educate about the risk and protective	5 Providers	Prevention, Diagnosis, Linkage to Care, Retention in Care,	See Appendix

		factors associated with HIV/AIDS, Substance Abuse (SA), and HCV ; Peer educator program to implement a multifaceted HIV/AIDS and substance abuse prevention; Substance abuse, HIV and viral hepatitis prevention services for high-risk and HIV positive immigrant Latino young adults.; Residential substance abuse treatment; HIV/AIDS care; emergency and transitional housing; nutritional counseling; and out-patient primary medical care; Substance use, HIV, and HVC prevention education and services will be provided to minority college students at BSU youth, ages 18-24, in communities neighboring the campus disproportionately affected by HIV		Antiretroviral Use, Viral Load Suppression	
SAMHSA SUBSTANCE ABUSE PREVENTION AND TREATMENT Block Grant					
EMA Total	$777,165	HIV Early Intervention services and sexual health in recovery plus testing		Prevention, Diagnosis	See Appendix
HOPWA Formula					
EMA Total	$12,421,735	Permanent housing in facilities, permanent housing placement, short term or transitional housing facilities, Short Term Rent Mortgage and Utility Assistance (STRMU), Supportive Services, Tenant Based Rental Assistance, Housing Information and Referral Services, Capital Investment, Tenant-based rental asst. , Short-term rent, mortgage and utilities, Tenant-based rental asst. , Short-term rent, mortgage and utilities, first month's rent/security deposit, Housing Info, Housing Case-Management, Job Training and Transportation. The Total award also includes NVRC Admin Dollars	19 Providers	Retention in Care, Viral Load Suppression	See Appendix
HOPWA/VAWA					
EMA Total	$1,297,520	Housing Assistance (Permanent Housing Placement Assistance, Housing Information Services, Other HUD-Approved Activities), Resource Identification.	2 Providers	Retention in Care, Viral Load Suppression	See Appendix
HRSA Bureau of Primary Health Care					
EMA Total	$1,692,406.55		9 Providers	Prevention, Diagnosis, Linkage to Care, Retention in Care, Antiretroviral Use, Viral Load Suppression	See Appendix
HHS Office of Minority Health					
EMA Total	$374,993	Employs evidence-based disease management and preventive health program and supportive services to: Reduce the transmission of HIV; Address gaps and fragmentation of HIV/AIDS treatment; Reduce HIV/AIDS	2 Providers	Prevention, Diagnosis, Linkage to Care, Retention in Care, Antiretroviral Use, Viral Load Suppression	See Appendix

		stigma and barriers to culturally and linguistically appropriate care; Address social determinants of health that impede treatment adherence; Prevent opportunistic infections; and Improve clinical outcomes of MSM and young minority males living with HIV or at high risk for HIV infections.			
HHS Office of Population Affairs					
EMA Total	$473,000	High-impact HIV prevention services integrated with Title X Family Planning Services	1 Provider	Prevention	See Appendix
Administration for Children and Families					
EMA Total	$899,322		1 Provider		See Appendix
Washington AIDS Partnership					
EMA Total	$1,934,218	Broad range; see link in data sources column for further details and Retention in care	19 Providers	Prevention, Diagnosis, Linkage to Care, Retention in Care, Antiretroviral Use, Viral Load Suppression	See Appendix
Private Virginia Funds					
EMA Total	$189,830	Home & Community Based Support, OAHS, Drug Assistance, Interpreter, Food Bank, Admin/Other	3 Providers	Retention in Care, Antiretroviral Use, Viral Load Suppression	See Appendix
Total Grant Funding	$88,344,836.61				
State Funding					
Local DC Funds					
Total local DC funds	$500,000	Integrated Housing, nursing, and support services for homeless people with late-stage AIDS or terminal cancer	1 Provider	Retention in Care, Viral Load Suppression	See Appendix
Maryland State Funds					
Total MD state funds	$840,625	Meal delivery for counties in EMA	1 Provider	Retention in Care, Viral Load Suppression	See Appendix
Virginia State Funds					
Total VA state funds	$16,410,502	SPAP, ADAP, Insurance payment assistance, HIV Early Intervention Services, OAHS, Food Bank, Transportation.	3 Providers	Prevention, Diagnosis, Linkage to Care, Retention in Care, Antiretroviral Use, Viral Load Suppression	See Appendix
West Virginia State Funds					
Total WV State Funds	$14,200			Diagnosis	See Appendix
TOTAL STATE FUNDING	$17,765,327				
Insurance and VHA Expenditures					
Medicaid					
EMA Total	$306,872,139			Prevention, Diagnosis, Linkage to Care, Retention in Care, Antiretroviral Use,	See Appendix

				Viral Load Suppression	
Medicare					
EMA Total	$295,175,042			Prevention, Diagnosis, Linkage to Care, Retention in Care, Antiretroviral Use, Viral Load Suppression	See Appendix
DC Alliance					
EMA Total	$7,076,419			Prevention, Diagnosis, Linkage to Care, Retention in Care, Antiretroviral Use, Viral Load Suppression	See Appendix
Veterans Health Administration					
EMA Total	$40,645,945.34			Prevention, Diagnosis, Linkage to Care, Retention in Care, Antiretroviral Use, Viral Load Suppression	See Appendix
Private Insurance					
EMA Total	$0				See Appendix
TOTAL INSURANCE FUNDING	$354,594,503.79				
TOTAL FUNDING	**$460,704,667.40**				

Overview of RW Part A Funded Providers

The chart below depicts the number of Part A-funded providers in each jurisdiction of the EMA.[5] As discussed further in this section, additional providers exist that do not receive Part A funding. Many providers work across multiple service categories and therefore are counted in multiple rows.

Service Category	DC	MD	VA	WV
Outpatient Ambulatory Medical Care	10	6	3	1
Medical Case Management	18	7	4	1
Non-Medical Case Management	0	6	5	0
Mental Health Services	9	3	5	1
Medical Nutrition Therapy	6	5	3	1
Early Intervention	6	3	1	0
Substance Abuse Services – Outpatient	7	3	3	0

[5] HAHSTA Internal Data, 7/29/16 Excel file

Medical Transportation Services	7	4	8	1
Psychosocial Support Services	6	0	0	0
Food Bank/Home Delivered Meals	4	3	3	1
Home and Community-Based Health Services	2	0	0	0
Treatment Adherence Counseling	7	0	0	0
Oral Health Services	3	4	2	0
Linguistic Services	1	1	4	0
Outreach Services	2	1	5	1
Legal Services	1	0	1	0

Inventory of Clinical Service Providers

The RW-funded sites (Parts A, B, and/or C) served a range of patient populations, and varied significantly in the scope of the RW population served. The current set of RW funded providers in DC are:

AIDS Healthcare Foundation
Andromeda Transcultural Health
Casa Ruby
Children's National Medical Center
Community Family Life Services
Damien Ministries
DC Care Consortium
Family & Medical Counseling Services
Food and Friends
Helping Individuals Prostitutes Survive (HIPS)
Homes for Hope
Howard University (CIDMAR)
Howard University and Washington Hospital Center Department of Oral & Maxillofacial Surgery
Howard University Hospital (HUHCARES)
Howard University, Inc
Institute for Public Health Innovation
La Clinica del Pueblo
Metro Health
Providence Health Foundation, Inc
Terrific, Inc.

The Women's Collective
United Medical Center
Unity Health Care
Us Helping Us
Whitman-Walker Health

In the MD counties, the RW-funded providers are:

AIDS Healthcare Foundation
Charles County Department of Health
Children's National Medical Center
Frederick County Health Department
Greater Baden Medical Services, Inc.
Heart to Hand
MedStar Health Research Institute
Montgomery County DHHS
Prince George's County FHS

In the VA counties, the RW-funded providers are:

AIDS Response Effort
Food and Friends
Fredericksburg Area HIV/AIDS Support Services
INOVA Healthcare Services
INOVA Juniper Program
Institute for Public Health Innovation
Legal Services of Northern Virginia
Mary Washington Healthcare
Neighborhood Health
Northern Virginia Regional Commission
NovaSalud
Virginia Health Options

In West Virginia, Shenandoah Valley Medical System, Inc. operates Shenandoah Community Health Center in Martinsburg, receiving Part A and C funds to provide HIV care. The AIDS Task Force and WV ADAP also receive Part B funds from RW, which serve patients in the 2 counties in the EMA. Many of these sites also see non-RW clients who are living with HIV.

Profiles of some of the larger clinics demonstrate the breadth of care available. For example, Whitman-Walker Health was historically an HIV-dedicated clinic. It is now a FQHC, with HIV expertise; all of its clinicians provide HIV care. Unity Health Care is a multi-site system of

community health centers, with HIV specialists who travel among the sites to serve patients in high-prevalence neighborhoods. Family and Medical Counseling Service is a FQHC in DC's highest-prevalence neighborhood and has staff physicians with HIV expertise. Some of the sites with smaller patient loads are serving specific populations; for example, Regional Addiction Prevention provides services for PLWH who are also experiencing substance use disorder.

Among the hospitals in the District, Children's National Medical Center focuses on children and adolescents, with providers specializing in physical and mental health services for youth with HIV. MedStar Washington Hospital Center has an HIV program directed by ID physicians. Howard University Medical Center has an infectious diseases clinic as well as an early intervention clinic.

In the suburbs, Prince George's County Health has two sites with dedicated HIV clinics. Greater Baden Medical Services is an FQHC with three sites that offer HIV care. Montgomery County Health Department has a central dedicated HIV clinic, and also pays health insurance premiums for patients seen in private settings. Inova Juniper has an HIV-dedicated clinic administered by a hospital but located in the Northern Virginia community. The Alexandria City Health Department has a clinic co-managed with a community health center.
Other medical systems and hospitals outside of the Ryan White program serve large numbers of PLWH in the EMA. With regard to non-RW providers:

- The VA Medical system reports that 1,103 people living with HIV accessed care at a VA facility in DC in 2013. Data on PLWH at the Military Medical Center are not available.
- The Kaiser Permanente system has patients in care in Virginia, Maryland and DC locations.
- Georgetown University Medical Center and George Washington University Medical Center each have dedicated HIV clinics.

As for private physicians, a 2013 analysis by Dr. David Wheeler identified five practices in Northwest DC that served an estimated total of 2,500 PLWH. They are infectious disease or internal health clinics, some focused on gay men's health. In Northeast DC, one private practice and one hospital-based infectious disease clinic served a total of approximately 600 PLWH. In Maryland, Prince George's County has three private practitioners with a total of approximately 700 PLWH in care, and Dimensions Health Care, a hospital-based HIV/infectious disease clinic, serves approximately 100 PLWH. In Montgomery County, four group infectious disease practices serve approximately 1,500 PLWH. And in Northern Virginia, 4 group ID practices serve a total of 1,450 PLWH, and six solo ID practices serve a total of 600.

Community Health Workers

The EMA also benefits from the work of HIV-focused community health workers (CHWs). In the District, a network of trained CHWs help link and retain people in care by helping them navigate

the medical system and by addressing social factors impacting their health.[6] The CHWs operate from a range of clinical and nonclinical settings, including AmeriHealth DC (a Medicaid managed care organization), Andromeda Transcultural Health, the AIDS Healthcare Foundation's Blair Underwood Clinic, Family & Medical Counseling Services, HIPS, Unity Health Care, Whitman-Walker Health, and The Women's Collective (see text box for further information).

From the Institute for Public Health Innovation [1][Might have lost this cite in formatting]:

The HIV/AIDS Early Intervention and Retention in Care: Using a Community Health Worker Model to Improve HIV Medical Care Systems

IPHI's linkage to and retention in care programs aim to:

- Link people who are not in medical care to a medical home;
- Increase the frequency of medical visits for all people living with HIV/AIDS to meet the recommended guidelines for HIV care.
- Increase the likelihood that people living with HIV will stay in medical care for a lifetime by connecting them to resources to address barriers to utilizing care, increasing HIV literacy, and creating treatment self-efficacy and a self-value of staying in care.

Beginning in 2011, IPHI has developed and is managing a number of broad-scale CHW initiatives focused on increasing HIV care utilization throughout the District of Columbia, Northern and Northwest Virginia, West Virginia and Prince George's County, Maryland. Through these interventions, IPHI is systematizing the use of CHWs as integral members of medical and HIV care teams across the region.

IPHI's model is to partner with community-based organizations, managed care organizations, and medical sites, which include hospitals, community clinics, Federally Qualified Health Centers (FQHCs), and health departments, which are closely connected to the communities most affected by the epidemic. IPHI works with partner sites to recruit, train, and integrate CHWs and then support the sites and CHWs to effectively identify, link, and retain persons in care.

CHWs work at their employing or host organizations and in the community to identify individuals who are HIV positive and not receiving HIV medical care in order to build trust and inform them about living with HIV, provide personalized assistance to help them enter medical care, and support them throughout the early part of their care until they are fully involved.

[6] http://www.institutephi.org/our-work-in-action/community-health-worker-initiatives/hiv-aids-early-interventions-retention-care/positive-pathways/

CHWs are expected to work closely with clinical and case management staff. This allows them to effectively identify eligible clients and to coordinate CHW support services with case managers, nurses or physicians, and other staff. Some CHWs may cover non-clinical points of entry, including testing sites and various community-based organizations. WeConnect is IPHI's Ryan White Part A-funded project that seeks to increase accessibility to Early Intervention services, Psychosocial, and Medical Transportation Services to PLWH throughout the entire EMA of Washington, DC through the following strategies:

- Recruiting, training, and placing 6-8 Community Health Workers (CHWs) at clinical and community-based host sites across the EMA;
- Interconnecting with IPHI's existing CHW initiatives in DC, Northern Virginia, and Prince George's County to create an integrated regional system;
- Concentrating new CHWs in areas with unmet need, unique barriers to care, and limited existing EIS resources;
- Creating a broad regional network of providers; and
- Integrating group-based psychosocial support and transportation services in strategic locations and for key populations.

WeConnect CHWs work with clients at the following sites across the EMA:

- MedStar Washington Hospital Center (Washington, DC)
- Prince George's County Health Department, Maryland (through referral from Heart to Hand)
- AIDS Healthcare Foundation (Washington, DC and Prince George's County)
- Montgomery County Health Department, Maryland
- Heart to Hand Prince George's County MD)
- Providence Hospital (Washington, DC)
- Nova Salud (Northern Virginia)
- AIDS Response Effort serving Northwest Virginia and West Virginia
- Pending: United Medical Center (Washington, DC)

The EMA project is integrated into IPHI's existing HIV linkage and retention in care activities.

In addition to CHWs working under the auspices of IPHI, CHWs formerly trained by IPHI are currently working at The Women's Collective, Unity Healthcare, HIPS, Whitman-Walker Health,

and Family and Medical Counseling Services.[7] There are also CHWs on the staff of Us Helping Us.[8]

Testing Providers

In the District of Columbia, a broad range of entities offer tests across the city: eight in Northwest DC, five in Northeast, eight in Southeast, and two in Southwest. Routine testing is also offered in emergency departments of five DC hospitals. The Maryland and Virginia portion of the EMA have 13 and six testing sites, respectively, and the West Virginia portion of the EMA has four.

As the Financial Inventory chart demonstrates, the set of financial resources allocated to the Washington DC EMA form a complex web. Public and private funding goes to and through four states, dozens of counties and cities, and scores of service providers. Coordination across geographic and political boundaries is complex but crucial, given that people in the region live, work, and seek healthcare across state and county lines every day. For people at risk of HIV and those living with the virus, it is vital to understand how resources are distributed across the region to ensure that prevention, treatment, care and support needs are met across the whole EMA.

The following discussion, drawing on narrative provided in the EMA's most recent Part A application, explains the processes that allow DC DOH and other stakeholders to appropriately allocate and integrate funding streams across the EMA.

Interaction of Ryan White Funding Streams

Each year the Metropolitan Washington Regional RW Planning Council (PC) takes the lead in carrying out priority setting and resource allocations (PSRA) for Ryan White funding for the Washington Regional EMA, with careful coordination across all affected jurisdictions. As expected by HAB, the PSRA effort follows a written, PC-approved process, as described below. The DC EMA's PSRA process is a joint effort involving the Part A grantee DC DOH; administrative agents for suburban Maryland and Northern Virginia and their state health department epidemiologists; consumers; providers; and PC support staff and contractors.

The PSRA process includes the following components:

- **Community/PLWH input:** Each year the PC seeks input on service needs, barriers, and priorities from the community, with a strong focus on PLWH.
- **Determination of funds for each jurisdiction:** The EMA allocates some funds for DC EMA–wide services and then divides remaining funds among the four jurisdictions based on their percentage of the DC EMA's total living HIV cases. With less than 1 percent of cases, two WV counties receive a set amount.

[7] Correspondence with IPHI staff, August 29, 2016.
[8] Correspondence with IPHI staff, August 29, 2016.

- **Priority setting:** The PC prioritizes approved core medical–related and support services for the entire DC EMA, but allows jurisdictions to modify those priorities based on their unique needs.
- **Resource allocations:** Although the PC makes the final decisions about allocations, it delegates the development of recommended allocations to the four jurisdictions. The PC reviews a "roll up" that includes both regular Part A and Part A Minority AIDS Initiative (MAI) funding, by jurisdiction and by OTT funds.
- **Directives:** The PC provides directives to the grantee on how best to meet established priorities. Directives arise throughout the year as part of committee work and at PLWH town halls. Before they are brought to the full PC for approval, directives require analysis in relation to importance, feasibility, and cost implications.

The PC used living HIV cases from each of the jurisdictions to guide the allocation of funds. It adopted this approach after a relatively modest allocation for services without respect to area of residence within the DC EMA. The DC EMA's formula balances consistency with the federal formula and locally determined need. This creates a unique opportunity for the PC to target funding and be responsive. Indicators of local need for service may include the following factors: Cases among jurisdictions, cases in rural areas, cases of "unmet need," cases unaware of HIV infection, low-income populations, emerging populations in need of services, "Medicaid gaps," (variations in Medicaid) and in other health care system investments.

As part of PSRA, the PC also considered Medicaid and ADAP, and the variable rates of Medicaid expansion. The PC is aware of the varying state and local government financial contributions to HIV care services in the DC EMA. A formula that relies on federal funds to aid jurisdictions could create a disincentive for local contributions. Finally, the PC considered methods to calculate the number of individuals unaware of their HIV status across the EMA and the extent to which increased portability of services may benefit mobile clients but adversely impact those with limited access to transportation and other resources.

The PC uses information from other federally funded HIV programs—including all other CARE Act Part programs, CDC HIV Prevention Programs, SAMHSA, and HOPWA—to set priorities. These data are used to support funding priorities, resource allocation, and support determination of service needs.

Interaction among Prevention and Care Dollars

Members of the HPPG and PC established a workgroup focused on the Integrated HIV Prevention and Care plan. Along with the HIV planners from the health departments in the EMA and other stakeholders, this group provided input to define and create goals to roadmap how to meet prevention, care, and treatment in the EMA.

In planning the continuum of care services and prioritizing and allocating Part A funds, consideration was given for non-Part A services funded by other sources. A decentralized

approach streamlines coordination of services among Part A and other funding streams in each jurisdiction. This year, when setting priorities and allocations for the Part A continuum of HIV care, the PC considered the impact of the following issues:

- **ACA.** The implementation of ACA in the DC EMA varies among jurisdictions, and coordinating services and service delivery integration is an ongoing challenge and need.
- **Medicaid.** The various changes occurring in Medicaid programs in each of the jurisdictions, and the impact of health care reform, heavily determined the priorities for the Part A continuum of care. DC, Maryland, and WV all expanded Medicaid—DC to individuals with incomes of up to 200 percent of the federal poverty level (FPL); Maryland and West Virginia to those within 183 percent of FPL and also to childless adults. Virginia has not expanded Medicaid, and so the EMA has to pay for coinsurance and copays for primary care visits and medications there. Gaps in Medicaid across the EMA increases demand on Part A-funded services.
- **Medicare, including Medicare Part D.** Many individuals who have Medicare Part D face challenges with the coverage gap ("doughnut hole") and their copays. Local funds are used to close the gap. CARE Act Part A and B funds cover client copays and insurance premiums.
- **Women, Infants, and Children (WIC).** In 2015 there were 44 WIC sites throughout the EMA. Of these, 16 are co-located with Part A service providers, making it easier for women with children to access HIV services and for clients of HIV service providers to access WIC.
- **Veterans Affairs (VA).** Many DC EMA veterans reside in West Virginia. HIV service providers work closely with the Martinsburg VA to screen every client for eligibility for VA services. Veterans report the following common service gaps: dental care, specialty outpatient medical care, housing, emergency financial assistance, and transportation. These are covered through Part A funds allocated to West Virginia.
- **Housing Opportunities for Persons with AIDS Programs (HOPWA).** HOPWA is available throughout the EMA although the eligible area is different than the DC EMA boundaries, creating care coordination challenges. Funding for housing subsidies is a highly ranked need of PLWH, and requests for Part A funds to cover housing costs have therefore increased.
- **CDC Funds.** The CDC's enhanced strategy for prevention, including counseling, testing, and referral services, has increased the EMA's ability to use innovative strategies to link newly identified PLWH. The EMA's strategies emphasize the importance of pairing HIV testing and prevention with linkage to care and providing testing in traditional and nontraditional site locations. The Maryland Department of Health and Mental Hygiene received the CDC and HRSA Partnership for Care (P4C), which also included funding for one FQHC in Prince George's County. The two programs help to enhance counseling, testing, and referral services and has increased the EMA's ability to help suburban Maryland Prince George's County link newly identified PLWH to care, testing, and services.

- **Local and Federal Funds for Substance Abuse and Mental Health Treatment Services.** In FY 2013, DC expanded inpatient and outpatient substance use services through a Medicaid State Plan Amendment. The lack of inpatient substance abuse treatment is a major challenge in Maryland. The state received a set-aside through their SAMHSA Block Grant for behavioral health services and HIV. Suburban Maryland's four health departments received funding for training and implementation of sexual health in recovery, which helps PLWH cope with addiction and mental health.
- **Other CARE Act HIV Program Funding.** The PC examines funding from local and county sources. With the expanded Medicaid program and the DC Healthcare Alliance Program, most PLWHs have some medical insurance. More Part A/MAI funds will be needed to underwrite the costs of support services such as treatment adherence, nonmedical case management, and housing services. The DC Healthcare Alliance Program does not cover the costs of mental health, substance abuse, or vision services. Part A funds cover the costs of these services.

Part B funds in VA provide most dental services and food vouchers but are coordinated with Part A to provide a comprehensive package of services. Virginia's Department of Health (the Part B grantee) keeps current on Part A spending/service delivery through the Metro DC RW PC's Fiscal Oversight and Allocations Committee (FOAC) conference calls. The NoVA HIV Consortium, advisory body to the Veterans Affairs administrative agent on Part A receives monthly updates from VDH about Part B spending, the condition of the ADAP program, and new funds that may be available for award. Two service providers receive Part C funding directly from HRSA. One provider also receives Part D funding. These amounts and their use are discussed by the PC.

Suburban Maryland is working with the DC EMA and the Maryland DHMH Center for HIV Surveillance and Epidemiology (CHSE) to produce the Maryland Cascade of HIV Engagement and increase consumer and provider understanding of the HIV Cascade. In addition, providers will be made aware of available CDC, HRSA, SAMHSA, and Housing and Urban Development funding for HIV/AIDS care and treatment.

Interaction between Ryan White Funding and Public and Private Insurance

While at this point the data are not available to provide most of the specific insurance funding levels for PLWH for each state in the EMA, DC DOH does have a clear sense of the varied insurance resources available in each jurisdiction. A majority of clients in the EMA (70 percent) had some form of insurance. DC and Maryland clients benefit most from increased availability of Medicaid. There was a mix of health insurance coverage among Virginia and West Virginia RW clients.

Payment, or coordination with other entities for payment of premium assistance and copays, also varies within the EMA. DC does not allocate Part A funds for premium and copay assistance as most clients receive Medicaid. Maryland and West Virginia each set aside a small amount of funding for copays. With Virginia's limited Medicaid, copay assistance is

more critical. Unexpectedly, this funding was mostly unused as clients may be reaching insurance out-of-pocket maximums with only copays/coinsurance for their HIV drugs (i.e., costs usually borne by VDH).

Maryland and Virginia state health departments purchase insurance plans as one way to cover a portion of state ADAP clients. Maryland underwrites a platinum plan and silver plans; Virginia underwrites some silver plans for clients eligible for subsidies and bronze plans for those below 138 percent FPL and those with incomes between 251–400 percent FPL. VDH pays plan premiums and medication copays, with Virginia Part A covering other out-of pocket costs such as doctor visit copays. VDH was serving 1,161 Northern Virginia ADAP clients with insurance purchased as of Oct. 1, 2015.

DC DOH is working with several entities to create a coordinated and concentrated effort to prevent HIV, STDs, tuberculosis, and hepatitis transmission and ensure care is provided to people with these conditions. These partnerships cross program and community sector, including but not limited to District government agencies for housing (Department of Housing and Community Development), health insurance (Department of Health Care Finance/Medicaid and Health Benefit Exchange Authority), mental health and substance use (Department of Behavioral Health), workforce development (Department of Employment Services, Office of Disability Services), regional prevention services and planning groups, RW Parts B and C, HOPWA programs, local community-based organizations, and The George Washington University (GWU). District Mayor Muriel Bowser announced a public–private collaboration to develop a plan to "end" the epidemic. The District established the goals of 90/90/90/50 by the year 2020. The District will aim to achieve 90 percent of persons with HIV to know their status, 90 percent engaged in HIV care and treatment, 90 percent of persons with viral load suppression, and a 50 percent decrease in new diagnoses of HIV. As health departments throughout the DC EMA create goals/plans to end the epidemic, the EIIHA team, regional RW PC, and DC DOH will work collaboratively incorporate strategies and ensure a regional approach.

Identifying needed resources and/or services in the jurisdiction which are not being provided, and steps taken to secure them. Please see Section D, Assessing Needs, Gaps, and Barriers, for a detailed discussion of needed resources and services in Washington, DC and the surrounding areas, and current plans to align resources to meet those needs. In the specific context of the Financial and Human Resources Inventory conducted, DC DOH identified several major needs. First, a theme that arose throughout the research was the lack of data available from some of the most significant sources of funding in the EMA. These include:

Insurance Enrollment Data from CAREWare: By comparing CAREWare insurance coverage data with actual DC Medicaid expenditure and enrollment data for PLWH, DC DOH have determined that CAREWare data does not capture all enrollment information. Given the important role of insurance coverage for PLWH in the EMA, DC DOH will develop an approach to address this gap.

Medicaid: While DC DOH has a recently-established agreement to share Medicaid data with the DC Department of Health Care Finance, allowing precise calculations and analyses of

expenditures for PLWH. However, none of the other states in the EMA has such an agreement, making it difficult to assess the role Medicaid plays for PLWH in the rest of the EMA. Maryland and Virginia are both in the process of establishing data-sharing agreements with Medicaid, but they are not yet in place. In the meantime, as noted in the chart, the Medicaid funding for those states can only be approximated: for Maryland, capitated rate information was used instead of actual expenditures. For Virginia and West Virginia, DC DOH relied on Kaiser Family Foundation reports of CMS estimates of total Medicaid spending by state, and allocated a portion to the EMA based on prevalence (see http://kff.org/hivaids/state-indicator/enrollment-spending-on-hiv). The CMS data are from FY11, and the prevalence approach to allocation yields an extremely rough estimate. DC DOH looks forward to improved expenditure data from both the DC data sharing agreement and future agreements in Maryland and Virginia.

Private Insurance: A large proportion of people living with HIV in the EMA have private insurance, but DC DOH has no data sharing agreement at present with any private issuers. DC DOH is currently working with certain private insurers to obtain aggregate data on HIV care and medication, as well as health practices (annual screening) and HIV prevention practice (Pre-Exposure Prophylaxis or PrEP).

Medicare: DC DOH was unable to identify any data on Medicare expenditures for PLWH by state, let alone by county in a way that would allow us to identify funds specific to the EMA. The Kaiser Family Foundation receives information directly from CMS on annual national Medicare expenditures (see Table 2 at http://kff.org/global-health-policy/fact-sheet/u-s-federal-funding-for-hivaids-trends-over-time/). An estimate for the EMA is included in the Appendix, but is not included in the financial inventory above because it is rough. Because of the enormous role that Medicare plays in funding HIV care in the DC EMA and nationwide, it would be very helpful if HRSA could work with CMS to make available Medicare expenditure data for PLWH, at least at the state level.

HIV Workforce

On the workforce side, reported gaps persist for specific populations and regions. As described in the discussion in the most recent Part A application, across the EMA, these gaps include:

- Not enough providers with services that engage and meet the needs of young people aging out of pediatric programs, or other young PLWH, including African-American MSM.
- More services needed to meet the needs of both newly diagnosed older adults and longtime survivors; there are few geriatric social workers or clinicians trained to address the intersection of health care issues related to HIV and aging.
- Not enough peer community health workers to assist newly diagnosed PLWH as well as individuals who have been out of care.
- Inadequate numbers of peers and use of peers in too few service categories.

- Supports groups often run by medical providers and access is often limited to their medical clients – individual providers typically offer only a few groups, which do not meet all needs.
- Need for peer-led focus groups with appropriate supervision as well as professionally-led groups.
- Care not covered by RW funds is very difficult to obtain, particularly for specialists not available at safety net clinics such as CHCs/FQHCs.
- Shortage of resources for mental health services, particularly for psychiatrists – often too expensive to hire and limited referrals available.
- Combination of residential and out-patient services to address the needs of some long-time addicts, for whom most programs are too limited or short-term; intensive programs funded by other public and private sources are hard to access.

In DC, the availability of oral healthcare services is reported to be an ongoing concern. In suburban Maryland, some counties have very few safety net providers, whether CHCs/FQHCs or free clinics, which means that affordable non-HIV-related medical care is difficult to obtain. Mental health providers for immigrants are also inadequate in suburban Maryland, with some long waits for services, and few multilingual clinicians. In Northern Virginia, it is difficult to find providers who have the expertise and willingness to work effectively with individuals who are transgender and HIV positive; in addition, mental health services are limited. In West Virginia, lack of peer support groups and lack of diverse providers able to treat communities of color and immigrants were reported concerns.

DC DOH plans to conduct a detailed inventory of specific providers by category at all RW-funded sites, based on the most recent application information. DC DOH will additionally explore how to update Dr. Wheeler's findings regarding capacity at non-RW-funded providers, and determine if it can gather FTE information for those providers as well.

I-D: Assessing Needs, Gaps, and Barriers

In this section of the integrated plan, several sources of data are used to assess the needs, gaps, and barriers that will inform improved alignment and access to HIV prevention, care, and treatment services. Most of the data here are from a 2014 Consumer Survey of the Washington DC Part A Eligible Metropolitan Area and will precede a more comprehensive needs assessment that will be conducted at DC DOH in 2017. Also included in this section are the results of four EMA-wide 2016 Ryan White Planning Council town hall meetings. Since the town hall data are more recent, they are presented first.

2016 Town Halls

In June 2016, the PC conducted four town halls (Maryland residents, Virginia residents, District of Columbia residents, and all EMA residents) in the DC EMA for the purpose of determining need and improving RW services for people living with HIV. A total of 64 people living with HIV, primarily RW consumers, participated and were asked questions about: 1. utilization and medication; 2. barriers to getting health care or other services; 3. what services work well and which need improving; and 4. identifying new needs or services not currently available. Although there were some jurisdiction-specific issues and suggestions, several themes emerged that were shared between the jurisdictions. These themes represent areas of perceived need, as well as participant recommendations for services that should be developed, maintained, or increased in order to improve care and treatment.

Housing

Housing was mentioned often as a service need, as well as a recommendation for improving health outcomes. The cost of housing, the availability of housing, and discrimination in housing were all identified as barriers to utilizing and adhering to care and treatment, particularly in DC and Maryland. When housing is among the competing needs of people living with HIV, retention and adherence to care or treatment becomes secondary. Older adults and transgender individuals were identified by participants as most likely to have housing needs. In addition, availability and affordability of housing in DC becomes increasingly strained as residents of Maryland and Virginia move into DC where services and resources are more widely available.

Outreach

Another EMA-wide theme was the success of community health workers (CHW) and peers, who were described by many as the go-to person on a care team. CHWs and peers have access to the communities and trust of the community, making them an integral part of prevention, linkage, and retention efforts, particularly for those who feel marginalized (vulnerable groups), have been lost to care, or are newly diagnosed. A staff member in one jurisdiction reported that clinic services increased dramatically with the addition of four community outreach workers to their care team. They are often seen as advocates for the community. Recommendation: Increase the number of community health workers and peers at every level of HIV prevention and care and make sure they properly represent the populations in greatest need by age, race/ethnicity, gender identity and sexual orientation.

Mental Health/Psychosocial Support

According to the 2014 DC EMA Consumer Survey, mental health issues are the most common co-occurring condition for people living with HIV. However, mental health services continue to be reported as a need across the EMA. This need goes well beyond seeing a psychiatrist and getting medications, as participants suggested that psychosocial support should exist from individuals at all levels of HIV care. Recommendations include: 1. increase availability of support groups and counseling opportunities, particularly for substance users and specific target populations; 2. family support groups consisting of an initial intake between the family and a counselor before entering into a support group setting; 3. couples and partner counseling/support groups to involve partners in HIV care and prevention; 4. Counseling and education on medication/medical regimens; 5. Counseling and education on health care system navigation for newly diagnosed or those lost to care; and 6. an immediate link to an appropriate support group at diagnosis.

Coordinated and Compassionate Service Delivery

Many town hall participants spoke of positive experiences and services, particularly in the context of wrap around care when available. However, in terms of need, several concepts were mentioned around better coordination of care and more compassionate care. Participants spoke of issues with provider response times to requests of information or appointments, as well as not enough time with providers at their visits. Finding specialists, particularly those willing to treat people living with HIV, was mentioned as an EMA-wide issue of availability but may be even more of a barrier for special populations in some jurisdictions. Co-occurring conditions that are not considered HIV related are not covered by RW and co-payments can be large and burdensome. Additionally, there were reports that non-HIV related health issues are usually not addressed during appointments with a primary provider.

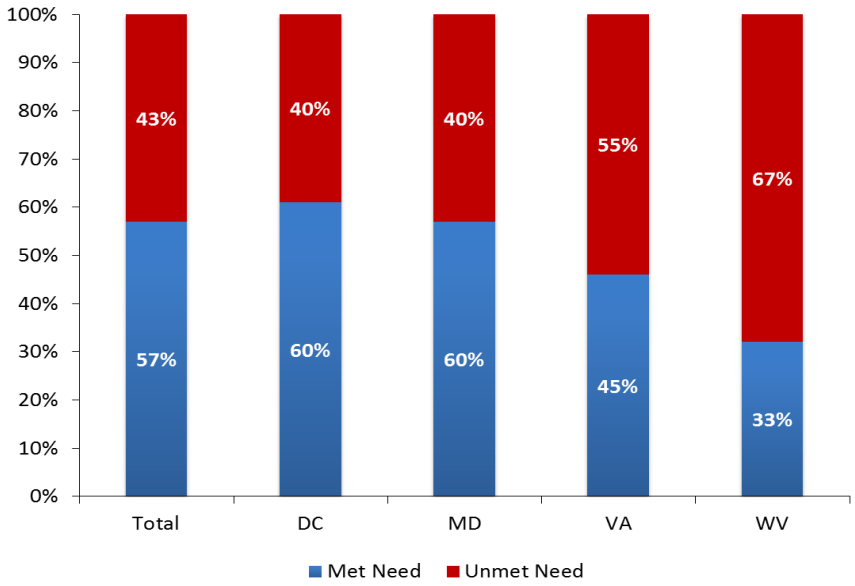
Coordination of care between specialists, physicians, case managers, and other critical HIV care team members within the EMA, and within an agency, would also assist with patient trust and comfort, increasing retention and ultimately, viral suppression. Recommendations include: 1. conduct required EMA-wide meeting of providers at least twice a year; 2. educational trainings for HIV care teams to keep providers abreast on what services are available elsewhere in the EMA for better referrals and patient care; 3. advocate for recognition of more comorbidities related to accelerated aging among people living with HIV; 4. financial assistance with co-payments for non-HIV related specialty care; 5. provider training for jurisdiction-specific special populations; and 6. eligibility workers to help people living with HIV settle bills and navigate insurance

<u>Unmet Need: 2014 Consumer Survey Overview</u>

HRSA defines “unmet need” as the proportion of persons who aware of their HIV-positive status but are not receiving primary medical care. Primary medical care is further defined as evidence of receipt of a CD4, viral load, or use of antiretroviral medications during the specified period, which is usually a 12-month period. The estimate of unmet need in the EMA was completed using data available at the time of this plan. Each jurisdiction in the EMA

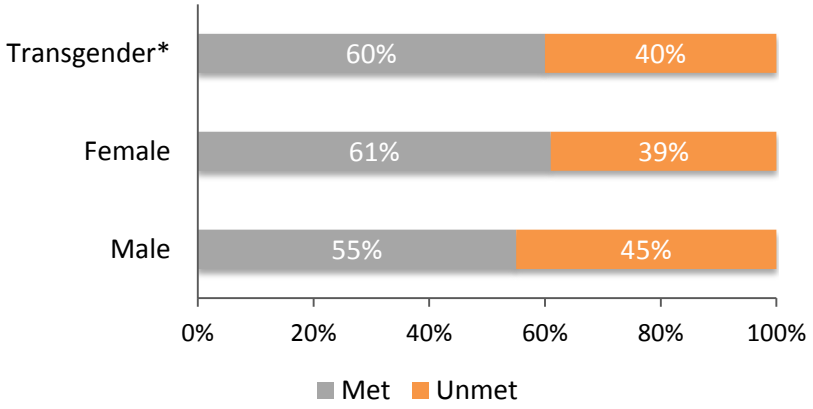
independently reported met and unmet need using disparate data sets, each of which has unique limitations.

Unmet Need Estimates, by Jurisdiction, DC EMA 2014, N=36,369



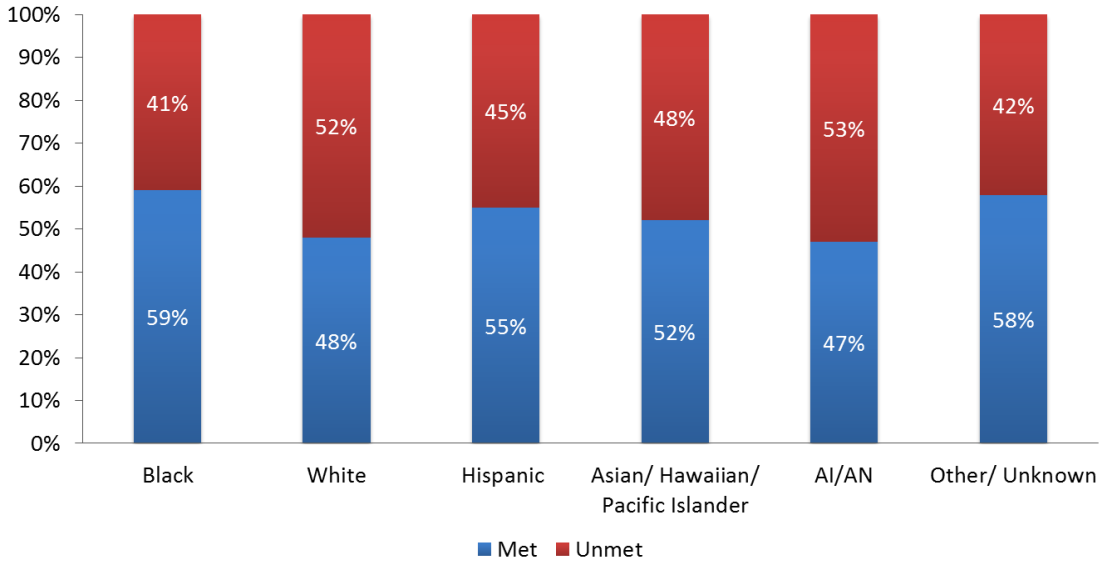
Overall unmet need for the DC EMA was 43% among cases diagnosed in the EMA. By jurisdiction, unmet need ranges from 40-67% with West Virginia representing the largest amount of unmet need in the EMA.

Estimated Unmet Need in the DC EMA by sex/gender, 2014, N=36,369



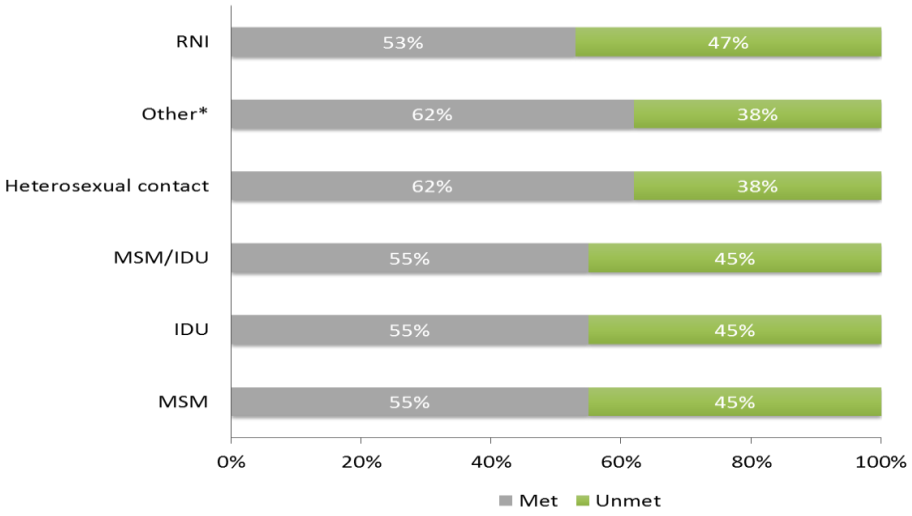
* Not all jurisdictions collect data for transgender individuals

Estimated Unmet Need in the DC EMA by Race/Ethnicity, 2014, N=36,369



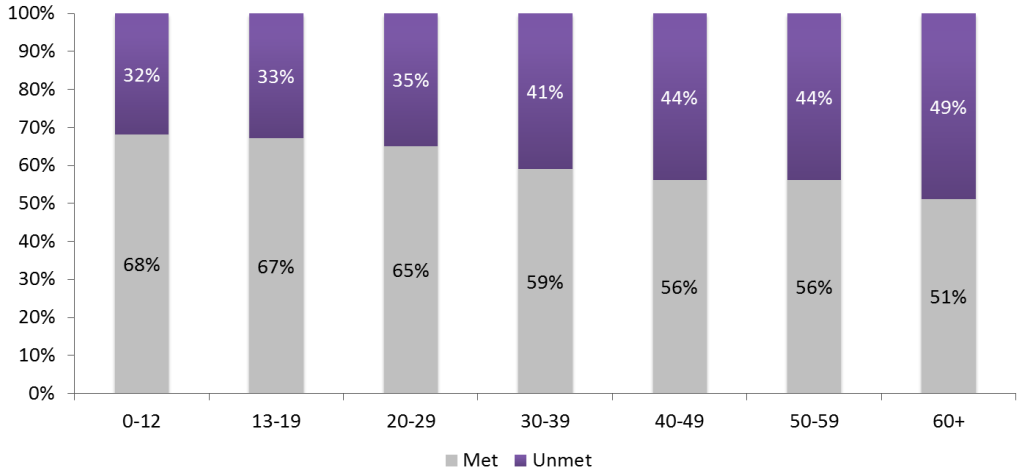
People living with HIV of all races and ethnicities are experiencing high levels of unmet need ranging between 41-53%. However, for some of these groups with high unmet need, overall number of people living with HIV is relatively low. For instance, American Indian/Alaska Natives have a high amount of unmet needs (53%) but represent a low number of PLWH in the EMA (20). Whereas, 41% of Black non-Hispanics report unmet needs, the number of Black non-Hispanics living with HIV is 10,159. There are 3,637 White non-Hispanics living with HIV in the DC EMA, and 52% have unmet needs. Hispanics account for 1,412 of the people in the DC EMA living with HIV and 45% have unmet need. Asian/Hawaiian/Pacific Islanders account for 205 of the people in the DC EMA living with HIV and 48% have unmet needs.

Estimated Unmet Need in the DC EMA by Mode of Transmission, 2014, N=36,369



Estimated unmet need varied by mode of transmission, from 38% for those whose mode of transmission was heterosexual sex to 47% among those with an unidentified mode of transmission.

Estimated Unmet Need in the DC EMA by Current Age, 2014, N=36,369



Estimated unmet need varied by age at the end of 2014, from 32% among people up to 12 years of age to 49% among those 60 year of age and older.

Methodology for Estimate of Met and Unmet Need. In the traditional calculation of unmet need, DC estimated met need primarily through linking Medicaid, Laboratory report data, ADAP data, RW HIV/AIDS Program Services Reports (RSR), surveillance data from the enhanced HIV/AIDS Reporting System (eHARS), and CAREWare in 2014. Potential limitations of this unmet need calculation may result from the incomplete laboratory data reporting, clients moving out of jurisdiction, and unknown deceased cases. The Virginia jurisdiction assessed unmet need by determining the proportion of persons "in care," or those with either a viral load or CD4 test, evidence of antiretroviral therapy, or a HIV-related health care visit at any time during the 12-month period in 2013. Virginia also linked data from multiple sources including eHARS, the Virginia Client Reporting System (RW Part B database), the Medical Monitoring Project, electronic lab reports, ADAP, CAREWare, and Medicaid. In West Virginia, unmet need was estimated from a linked provider service database, Medicaid, and eHARS. No new sources of data for estimation were used for the calculation. In the Maryland jurisdiction, the Department of Health and Mental Hygiene utilized data from the Medical Monitoring Project where patient level antiretroviral prescription was extracted from the national IMS Health LRx Database. eHARS was used to quantify the total HIV cases in suburban Maryland.

In the non-traditional calculation of the estimated unmet need, each jurisdiction used eHARS data to create the HIV Care Continuum Framework. On the HIV Care Continuum, people who are HIV positive and know their status are referred to as *Diagnosed*, the known/reported cases of HIV infection, regardless of stage 3 HIV (AIDS) status. The number of people who are "in care" aligns with the third stage of the HIV Care Continuum, *Retained in Care*. Retained in

Care is the number of diagnosed individuals who had two or more documented medical visits, viral load or CD4 tests performed at least three months apart in the 2013 calendar year. The Unmet Need estimate was then calculated by subtracting the number of *Retained in Care* from the number of *Diagnosed*.

The wide array of data sets used in these calculations has increased the chances that those in care are appropriately counted. Likewise, the datasets may potentially increase the chance of multiple inclusions within a jurisdiction, albeit insignificantly because the data sources are so disparate and varied. All surveillance datasets, which are captured through eHARS, are comprehensive. In each DC EMA jurisdiction, CD4 and viral load tests are incorporated in the reporting system through electronic lab reporting. These jurisdictions utilize mature name-based reporting for HIV.

Using the traditional method of calculating unmet need, by the end of 2014, the total estimated number of cases with an unmet need for primary medical care is 15,794 or 43.4 percent of diagnosed cases. The table below profiles the distribution of cases of unmet need by jurisdiction within the EMA, and notes the proportion of total cases for which each group accounts. These data indicate that WV has the highest proportion of unmet need for primary medical care, followed by Northern Virginia. The following tables illustrate met and unmet need by AIDS and HIV cases.

Current Methodology: Estimated Unmet Need among HIV and AIDS Cases By Jurisdiction, DC EMA, 2014

							TOTAL		TOTAL
	HIV only			AIDS					
	Unmet need		TOTAL	Unmet need		TOTAL	Unmet need		
	N	Percent	N	N	Percent	N	N	Percent	N
DC	2,985	40.2	7,426	3,766	39.6	9,512	6,751	39.9	16,938
Maryland	2,354	43.6	5,395	2,218	37.3	5,949	4,575	40.3	11,344
Virginia	2,273	59.8	3,801	2,055	50.5	4,072	4,328	55.0	7,873
W. Virginia	66	73.3	90	77	62.1	124	143	66.8	214
Total	7,678	45.9	16,712	8,116	41.3	19,657	15,794	43.4%	36,369

Using the nontraditional method of calculating unmet need, of the 36,369 diagnosed HIV cases in the DC EMA, only 15,137 were considered retained in HIV care, with a total of 21,232 not considered in care in 2014 (58.4%). The table below profiles the distribution of cases of unmet need by jurisdiction within the EMA, and notes the proportion of total cases for which each group accounts. By subpopulation, the use of the continuum sustained considerable amounts of unmet need. Among men who have sex with men unmet need was calculated at 62.4%, injecting drug users at 61.1%, cases who acquired HIV through heterosexual contact at 52%, and youth (ages 13–24) at 55.3%.

New Methodology: Estimated Unmet Need among HIV Cases by Retention in Care and Jurisdiction, DC EMA, 2014

Jurisdiction	Cases Diagnosed	Retained in Care	Unmet need	
	N	N	N	%
DC	16,938	6,007	10,931	64.5
Maryland	11,344	6,772	4,572	40.3
Virginia	7,873	2,265	5,608	71.2
West Virginia	214	93	121	56.5
Total	36,369	15,137	21,232	58.4

There is a substantial difference between the two calculations of unmet need, which is assessed at 15%. Although the use of calculating unmet need through the use of the HIV continuum of care is useful and gives a different perspective of care services used in the EMA, it is very limited, both by definition and resources.

Service Gaps and Barriers[9]

Identified service gaps within the jurisdiction. Service gaps refer to all service needs not currently being met for all PLWH, except for the need for primary medical care. These were identified based on a needs assessment survey the DC EMA PC conducted in 2014. Although limited to 608 respondents, the results provide insight into service gaps and needs among the target populations in the EMA.

Across the DC EMA, the most needed core services that are not currently being met are HIV medical care, HIV medications, primary medical care, dental care, medical case management, and non-HIV medications. Of these service gaps, dental care is the service that is most needed and not received (18.4%). For the remaining highest priority core services gaps, more than 10% of participants reported needing and not receiving these services:

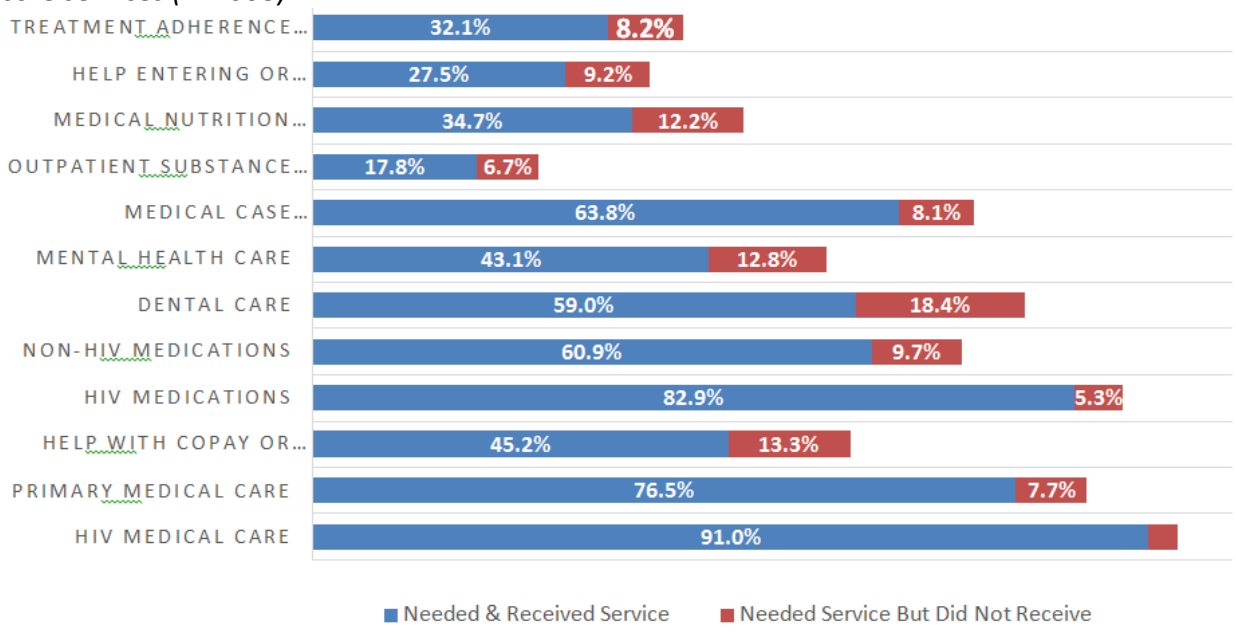
- Dental care (18.4%)
- Help with copay or medical premium (13.3%)
- Mental health care (12.8%)
- Medical nutrition therapy (12.2%)

The table below depicts the DC EMA core services gaps as a percentage of survey respondents who needed and received or did not receive the services.

[9] These data were collected and prepared by Emily Gantz McKay and Hila Berl at EGM Consulting, LLC for the Metropolitan Washington Regional Ryan White Planning Council, August 2015.

Service Gaps in Core Services

Percentage of respondents reported needed and received or needed and did not receive core services (n = 608)



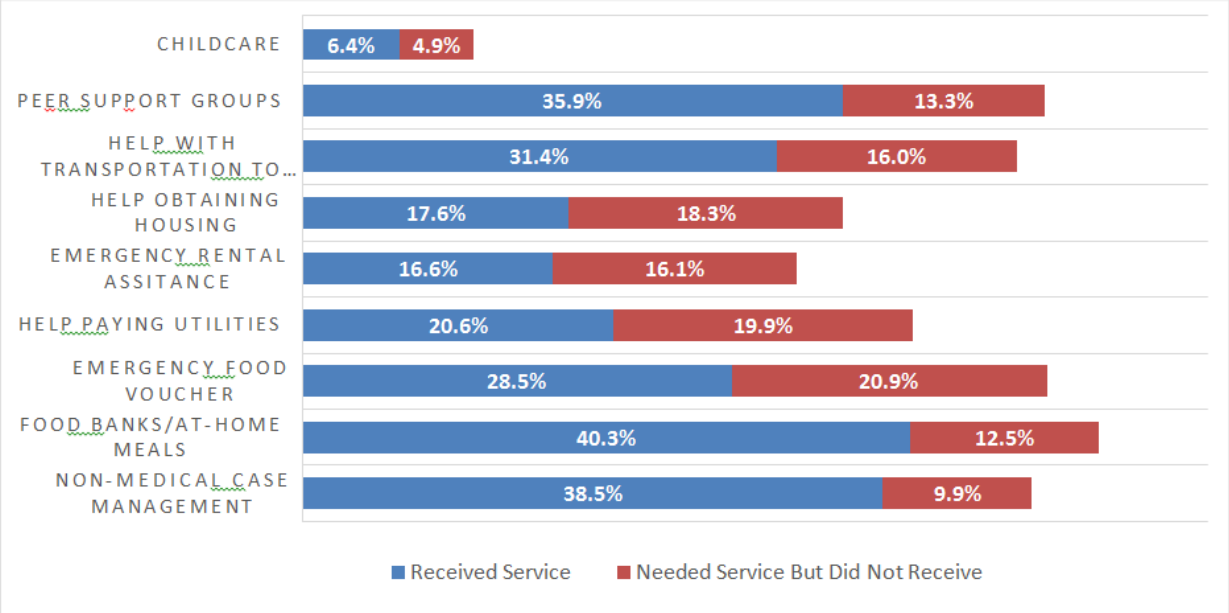
Support services are essential to HIV treatment and care. Overall the most needed support services are food banks or at-home meals, peer support groups, emergency food vouchers, help with transportation to appointments, and the following non-medical case management services:

- Emergency food voucher (20.9%)
- Help paying utilities (19.9%)
- Help obtaining housing (18.3%)
- Emergency rental assistance (16.1%)
- Transportation to appointments (16%)

The table below shows the support services gaps and their priority order based on survey respondents' reported needs and the highest priorities by state.

Service Gaps in Support Services

Percentage of respondents reported needed and received or needed and did not receive support services (n = 608)

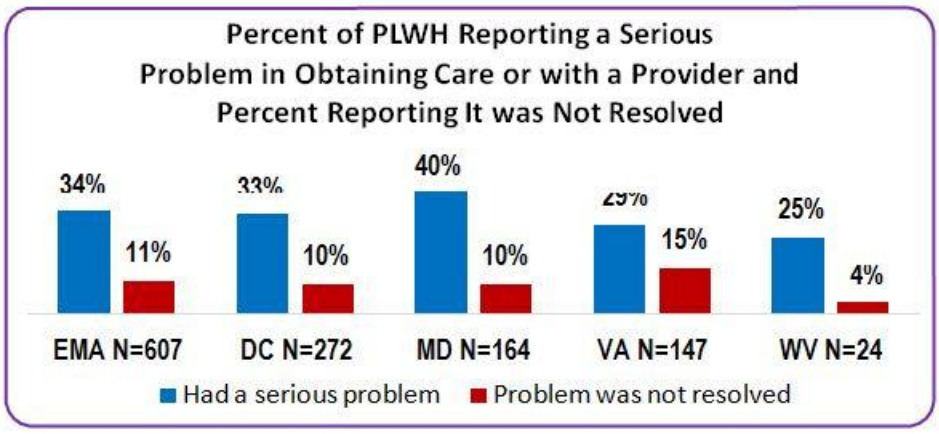


The survey found that key target populations with the most demonstrated needs are people who are homeless, transgender, previously Incarcerated, and substance users. Most people living with HIV in the survey self-report prompt linkage to care and high rates of viral suppression. Survey results show there is a need to improve connection to care for specific groups by addressing population-specific service problems, concerns, and barriers. Among populations needing attention were those with co-occurring conditions—homelessness, mental health issues, substance abuse—as well as formerly incarcerated, transgender people living with HIV, and young people living with HIV including young men who have sex with men of color. In addition, a subset of recently diagnosed may need special attention to ensure close linkage to care.

All PLWH who responded to the survey were asked to identify problems or concerns they had with their HIV services during the previous 12 months, barriers to care they encountered, and whether they had a serious problem with obtaining care or with a provider, and if so, whether it was resolved. They were also asked to identify what they would change if they could change just a few things about HIV services in the EMA.

When asked whether they had a serious problem with obtaining care or with a provider, 34% of respondents said yes, and of those 11% said the problem was not resolved. As the chart shows, serious problems were most often reported by people living with HIV in Maryland (40%), and most likely to remain unresolved in Virginia (15%). When asked more generally whether they had a problem or concern with their HIV services, a large majority of respondents (72%) reported no problems. Among all respondents, only two problems were identified by as many as 10% of people living with HIV: transportation problems (11%), including availability, access, or cost, and the long waiting time after they arrived for an appointment. Some target

populations were less likely to report no problems, especially formerly out of care people living with HIV (60%) and substance users (60%), while young people living with HIV transitioning to adult care were most likely to report no problems or concerns (87%).



Respondents identified their most important barriers to care and indicated how often they were encountered. The chart shows the barriers PLWH most often reported encountering “always” or “often”, by jurisdiction. The two barriers reported by the highest percent of respondents were not wanted people to know they were HIV positive and lack of transportation. There were some important differences by jurisdiction. As the chart indicates, DC respondents identified most of the nine barriers more frequently than resident of other jurisdictions, while WV residents identified barriers least frequently. MD residents were more likely than residents of other jurisdictions to report that they couldn’t afford services or co-pays. DC residents were most likely to mention lack of transportation even though it is the most urban jurisdiction. They also most often

Identified Barriers to Care by Jurisdiction

Barriers Encountered "Always" or "Often" in Past Year	All N=607	DC N=272	MD N=164	VA N=147	WV N=24
1. Didn't want people to know I am HIV+	20%	21%	23%	19%	8%
2. Lack of transportation	18%	23%	17%	12%	4%
3. Couldn't afford service or co-pays	13%	13%	16%	12%	8%
4. Care not available evenings and weekends	11%	12%	12%	10%	8%
5. Difficulty in getting an appointment	11%	14%	12%	8%	4%
6. Needed service was not available	9%	11%	8%	10%	4%
7. Wasn't comfortable with the service provider	9%	12%	8%	7%	0%
8. Appointment was canceled because my transportation was late	8%	10%	7%	3%	4%
9. Needed an interpreter	7%	8%	4%	9%	0%

reported having their appointments canceled because their transportation was late – this may refer to Metro Access issues. Virginia residents were the most likely to identify needing an interpreter as an important barrier. VA has the largest Hispanic/Latino population, and many of those in the survey self-identified as immigrants.

When asked about the changes they would most like to see in the region's system of HIV care, the most frequent recommendations were one-stop shops and more access to services evening and weekends, followed by more choices in providers, better coordination of care, and case managers with more knowledge of available services. There is a statistically significant relationship between being in the labor force (employed or looking for work) and identifying more access to services on evenings and weekends as one of the most needed changes in the system of care. Nearly two-thirds of PLWH in the labor force recommended this change, while three-fourths of PLWH not in the labor force did not. Having case managers with more knowledge of available services could help address one particular emerging need: referrals to help PLWH obtain job training and placement or other employment assistance, since 19% of PLWH said they were unemployed and looking for work and another 16% were working part-time; under non-medical case management, RW can pay for the navigation to employment services.

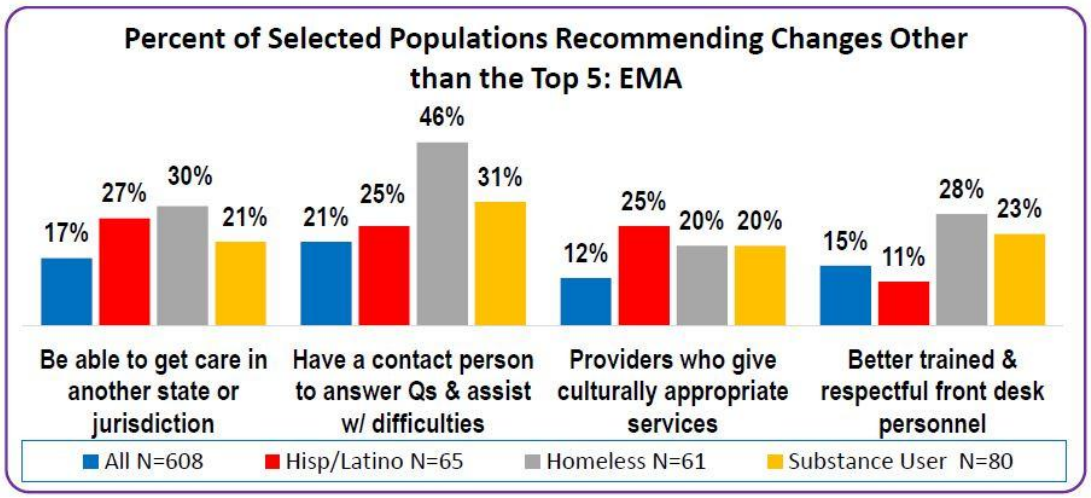
Most Often Recommended Changes in the System of Care

Top 7 Recommended Changes in HIV Services in the Metro Area	All N=607	DC N=272	MD N=164	VA N=147	WV N=24
1. One-stop shop (multiple services in one location)	42%	37%	39%	54%	54%
2. More access to services on evenings & weekends	34%	33%	40%	29%	38%
3. More choice in providers	29%	29%	30%	27%	25%
4. Better coordination of care	28%	35%	26%	20%	17%
5. Case managers w/ more knowledge of available services	28%	34%	29%	14%	29%
6. Have a contact person who can answer Qs & assist with difficulties in getting care	21%	23%	21%	18%	17%
7. Be able to get care in another state or jurisdiction (near where I live now)	17%	16%	21%	14%	17%

All of the top five recommended changes could result in better access to needed RW and non-RW services and culturally competent care for diverse target populations. Additional analysis indicates that consumers were most likely to recommend the seventh priority change, being able to get care in another jurisdiction, when they had encountered both limited provider choice and transportation problems.

Some target populations placed greater emphasis on particular recommendations for change, sometimes not in the top five, as the chart below shows. Almost half (46%) of PLWH dealing with homelessness recommended having a contact person to answer questions and assist with difficulties in getting care, as did almost one-third (31%) of substance users; this relationship is statistically significant. More than one-quarter (28%) of PLWH dealing with homelessness recommended better trained and respectful front

desk personnel. One-fourth of Hispanics/Latinos recommended more providers who deliver culturally competent services. Transgender PLWH agreed with the high priority changes recommended by all respondents, but a higher percent urged such changes, and transgender consumers were considerably more likely to indicate a need for better trained and respectful front desk personnel, and for a contact person to answer questions and help with difficulties in getting care (as is often done through EIS).



Implications

When considering the data reviewed here as a whole, there are several important themes to note.

- **Use of the 2014 Consumer Survey data and 2016 Town Halls:** The total respondent group appears representative of RW consumers in the Washington, DC EMA. Jurisdictional groups are smaller and not necessarily representative, but are deliberatively diverse and provide a wealth of information due to the scope and depth of the topics addressed. There are always limitations to self-reported data. The method of survey administration (including involvement of community members, most of them PLWH, as survey administrators, and a high level of cooperation from providers) was an effort to increase the comfort level and honesty of respondents. The town halls were held at known provider locations in the jurisdictions, but the hours may have not been convenient for everyone in the community. However, there was diverse community representation, and many of the themes that emerged and are presented here were repeated across jurisdictions. It is always the goal to have more participation from those who would not regularly attend a town hall. In the upcoming 2017 Comprehensive Needs Assessment, specific efforts will be made to hold town halls at different hours and locations, as well as extend the level of outreach to access people living with HIV who have not attended previous town halls.
- **Need for population-specific planning and services:** The 2014 Consumer Survey results show that great differences exist among subpopulations of PLWH, particularly among PLWH from the various focus populations but also by jurisdiction, race/ethnicity, and other characteristics. In diagnosis, linkage to care, and treatment,

one size clearly does not fit all. The need to focus on strategies for reaching and serving specific populations, especially those facing the greatest challenges, is an important finding from the survey.

- **Changes in PLWH life situations:** The greatest demographic difference between respondents to the Planning Council's 2009 survey and the 2014 survey appears to be the greatly increased proportion of PLWH who are in the labor force – employed full- or part-time, working informally, or looking for work – and the decreasing proportion of PLWH who are disabled and receiving disability benefits. As previously noted, the recommendation for more access to services on evenings and weekends comes largely from PLWH in the labor force. This trend is likely to continue, and it has many implications for the system of care. The high proportion of PLWH who are unemployed and looking for work also creates a need for help in accessing employment training and placement opportunities. They are not paid for by RW funds, but RW case managers need to be familiar with available services and able to provide knowledgeable advice and referrals.
- **Improving the system of care:** Most respondents agreed on a set of high-priority needed changes in the system of care – changes that would facilitate population relevant services and reflect changes occurring in the external environment and in the life situations of people living with HIV. For example, the need for one-stop shops providing multiple services at a single location and for access to care evenings and weekends reflect the growing proportion of people living with HIV who are in the labor force and find it very difficult to leave work to obtain multiple services, each on a different day. Transportation challenges contribute to the preference for one-stop shops. There is also broad interest in better coordination of care and more choice in providers, specialists, as well as case managers with more knowledge of available services and community health workers who are familiar with the unique circumstances of the communities. In addition, with the continued lack of sufficient mental health services, support groups become even more vital for people living with HIV, not only individual level but also for partners and family members. These changes would facilitate population-specific case management and referrals.

I-E: Data Access, Sources, and Systems

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

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

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

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

The District of Columbia Public Health Information System **(DC PHIS)** was designed to be a comprehensive and integrated monitoring and evaluation tool that combines program and surveillance data at the client-level for the diseases that DC DOH has responsibility for providing public health services and activities. It was intended to enhance the ties between resources and performance, enabling a user to monitor and evaluate the quality of programs and services. DC PHIS is supported by the Maven Suite, a user configurable case management, workflow and rules assessment system. Maven is a modifiable-off-the-shelf (MOTS) web-based solution,

which enables interactive, automated information gathering and decision support processes while complying with state and national IT standards such as the CDC Public Health Information Network (PHIN) published standards. The DC PHIS system continues to evolve through ongoing improvements, development, and implementation of specific programs and activities within the information system. Currently, DC DOH is focusing on developing the surveillance aspects before incorporating the data from RW and HIV prevention programs.

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

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

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

In addition, through facilitation by the DC Department of Insurance, Securities and Banking, DC DOH has recently partnered with the health insurance carriers in the District. Though in the early stages of understanding data system parameters, opportunities for collaboration are

being actively explored with Aetna, CareFirst BlueCross BlueShield, Kaiser Permanente, and United Healthcare. These partnerships are essential to success by filling in missing components of the continuum. The key data points include overall annual testing rates by District residents, PrEP uptake and utilization, initiation of ART and medication adherence through prescription utilization data. These elements represent accountability and accomplishment of the plan's strategies.

The PC will conduct a comprehensive needs assessment in 2017. In 2017, data will be collected using consumer surveys, provider surveys, key informant interviews, and focus groups with special populations. The Needs Assessment portion of this Integrated Plan will be updated with the new data at the completion of this comprehensive assessment. Currently, Medicare data and data from private insurers are lacking and would be a useful part of capturing an epidemiologic profile and assessment of need in the EMA. The data sharing agreement DC DOH now has with Medicaid has been essential towards efforts to more accurately represent resources and needs for people living with HIV.

Moving forward, DC DOH is working to move testing data collection through DCPHIS in order to better be able to track positive testing events and provide more comprehensive information for their testing behaviors, previous HIV test histories, and linkage to care information. A data sharing agreement between jurisdictions for testing data would give DC DOH a better understanding on who is truly a new positive as opposed to just a new positive in DC.

SECTION II- The Integrated HIV Prevention and Care Plan

II-A. Integrated HIV Prevention and Care Plan

The DC EMA is committed to collaboration, efficiency, and innovation to achieve a more coordinated response in addressing HIV. The five year plan will include the implementation of DC DOH's 90/90/90/50 goals aligning with the National HIV/AIDS Strategy goals and a redesign of the Ryan White funding structure in response to changes in service needs. The following National HIV/AIDS Strategy goals provide the organizing framework for DC DOH's five year Integrated Plan: 1. Reducing New HIV Infections; 2. Increasing access to care and improving health outcomes for people living with HIV; 3. Reducing HIV-Related health disparities; and 4. achieve a more coordinated national response to the HIV epidemic. DC DOH has aligned the 90/90/90/50 goals within NHAS goals 1 and 2. Given the demographics of the DC EMA, DC DOH has integrated NHAS goal 3 throughout the other goals. For NHAS goal 4, although not a requirement of the Integrated Plan guidelines, DC DOH is in the midst of redesigning and restructuring the coordination of care for the region. These will all be described in more detail below.

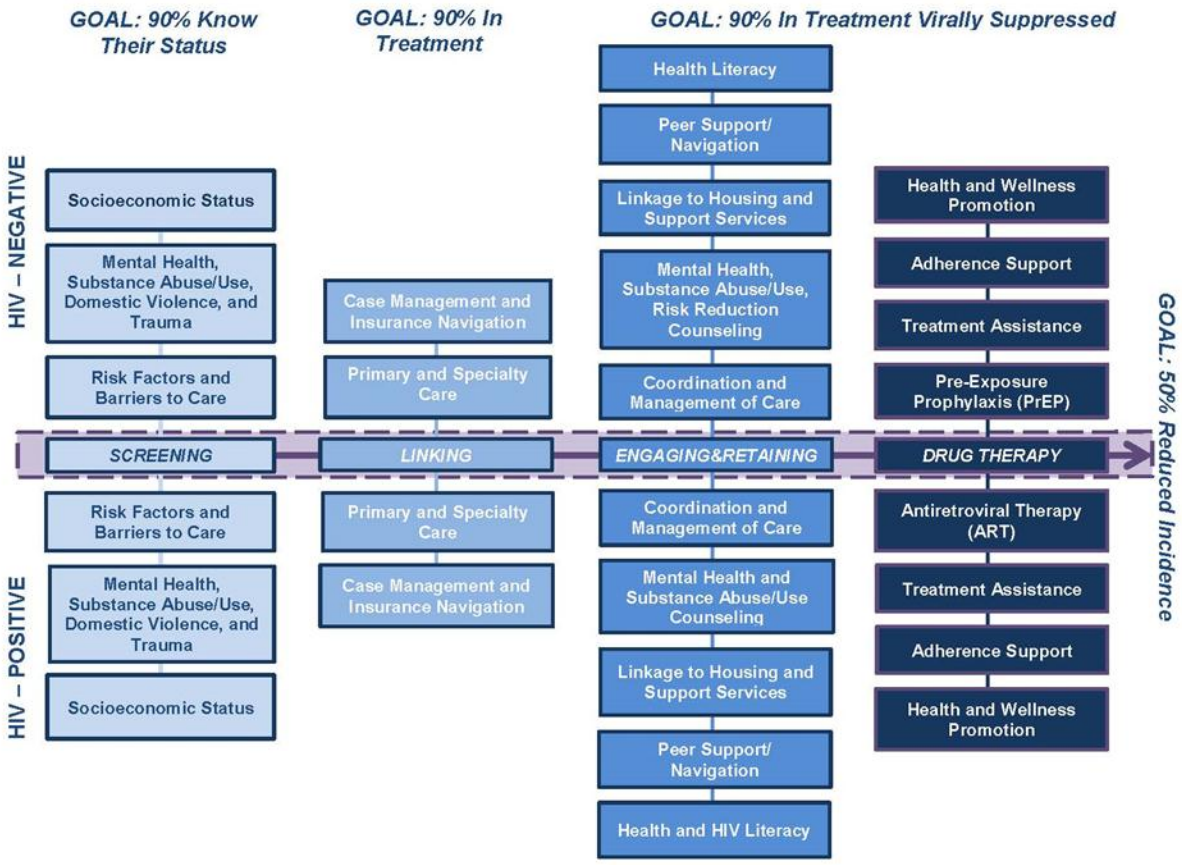
While the District government has the biggest role to play in implementing this plan, there are opportunities for all sectors of the regional community to contribute to preventing the transmission of HIV and supporting persons with HIV to be successful in treatment. The Integrated Plan, and the 90/90/90/50 framework includes strategies generated from evidence-based and evidence-informed practice sourced from the HIV field and community. It also contains demonstration projects based on promising practice that implemented and evaluated within a short period of time could then be scaled up to accelerate the plan goals.

DC DOH 2017-2021 Goals for the DC EMA

The Integrated Plan aligns with the goals of the National HIV/AIDS Strategy (NHAS). The NHAS has encouraged jurisdictions to adopt the care continuum as a way to understand the steps in HIV care from testing through treatment sustainability, as well as the level of current success in utilizing these services and achieving the goals outlined under the NHAS strategy. As reflected in this plan, DC DOH is moving in that direction with a regional plan to improve capacity and achieve a number of goals focused on prevention/diagnosis, linkage, retention, and viral suppression.

The traditional continuum outlines the stages involved in achieving viral suppression—testing and diagnosing, linking to care, retaining in care, initiating and sustaining use of antiretroviral therapy—for individuals living with HIV. Though the continuum is typically viewed as an "engagement in care" model, DC DOH also uses a prevention continuum to describe the steps involved with decreasing HIV acquisition and transmission. Together, the Prevention and Care Continuum framework illustrates the stages of HIV prevention and care along a continuum that includes screening, linking, retaining and engaging, and drug therapy, as well as the overarching goal of each strategy. Most of the activities and interventions designed to link and maintain HIV-positive individuals in care are also effective approaches to keep individuals HIV-negative.

The plan for reaching each of the 90/90/90/50 goals includes not only the steps needed to reach the goals, but also methods for monitoring progress.



District of Columbia HIV Prevention and Care Continuum – May 2016

The Integrated Plan process provides the perfect platform to continue applying this combined continuum regionally across the DC EMA. While the NHAS goals guided the structure and approach to planning, DC DOH's 90/90/90/50 goals provided the practical means to guide efforts and strategies regionally. A detailed outline of the corresponding objectives, strategies, and activities can be found in the tabled portion of the Integrated Plan in this section. Some of the primary elements of the plan and information describing the demonstration projects are presented below.

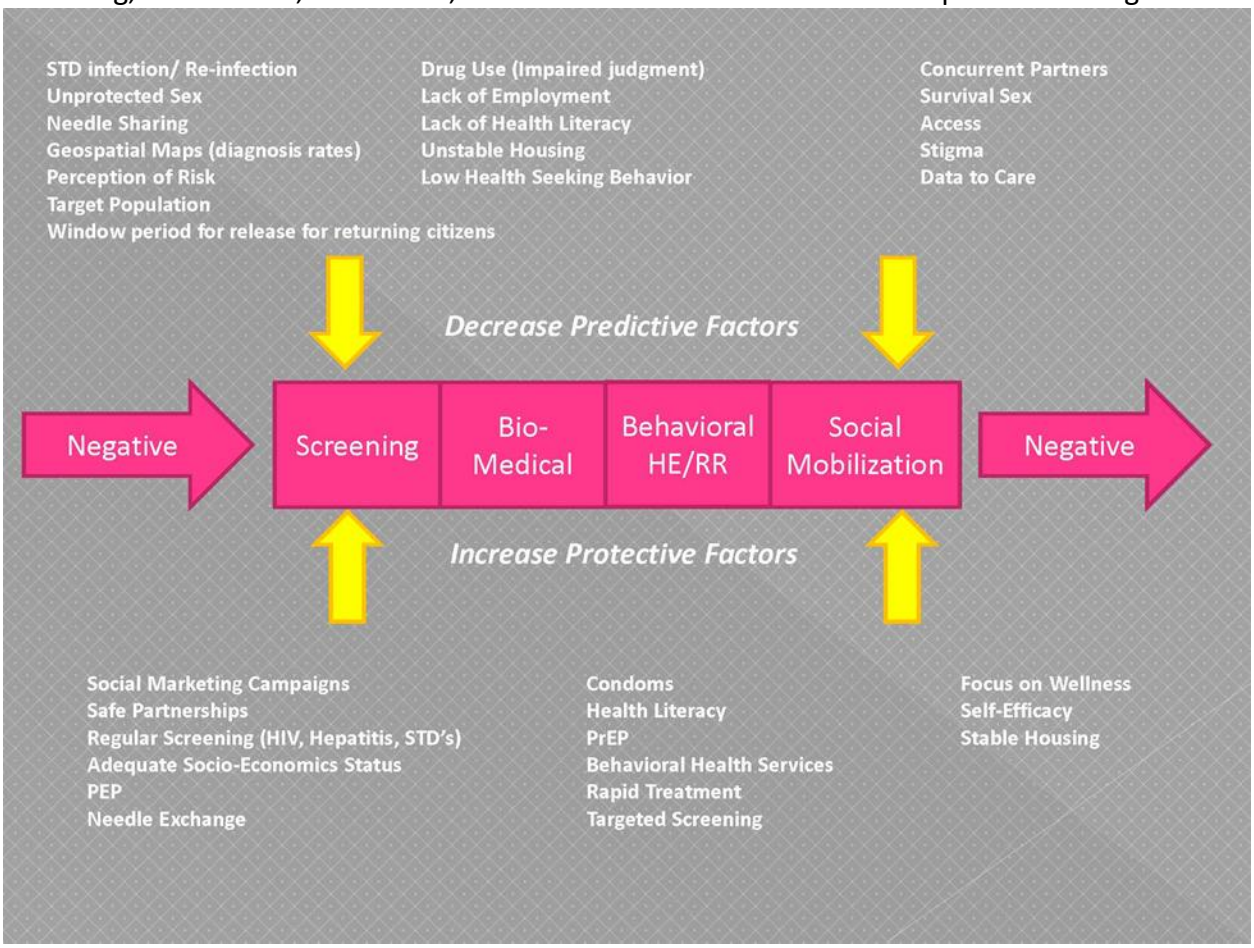
DC DOH GOAL 1: PREVENTION

(NHAS GOALS: Reduce New Infections; Reduce HIV-related health disparities and inequities)

Objective 1: PREVENTION

By 2021, the DC EMA will reduce the new HIV infection rate by 50%

Those who are HIV-negative must have access to information, interventions and supports that will help them to stay negative. This section of the plan outlines strategies to expand biomedical and SDH (social determinants of health) prevention interventions. To develop this plan section, the discussion among DC DOH, HIV practitioners, community members, academics and stakeholders was that multiple factors contribute pressures for HIV negative persons to remain HIV negative. These factors are grouped by predictive factors that increase the risk of HIV infection and protective factors that avert HIV transmission. This bi-directional construct can be depicted as a caliper, also known as a device used to measure the distance between two opposite sides of an object. In this case, it is an approach to decrease the predictive factors and increase the protective factors along a continuum of evidence-informed approaches – screening, bio-medical, behavioral, social mobilization – that maintain a person HIV negative.



DC EMA Prevention Continuum 2016

The traditional HIV Care Continuum, formerly known as the treatment cascade, has a sequential and consequential construct of diagnosis, linkage/retention in care and treatment and viral load suppression. The HIV Prevention Continuum does not have that easily transferable logic and dynamic. There are some factors as noted in the prevention caliper above that do not have distinct or reportable measures. However, there are some directly associated measures that could comprise a prevention continuum. For example, based on an analysis of STD diagnoses and HIV diagnoses by DC DOH of surveillance data, there were findings that prior repeat STD infection increased by two times the risk of HIV infection (it is already documented that active, undiagnosed STD infection increases opportune HIV infection by about five times). Also, there was a median period of 4-6 years between STD diagnosis and HIV diagnosis. There are also measurements that can be tracked to interrupt HIV transmission, such as STD treatment, PrEP and PEP utilization and proportion of persons sharing needles and participating in needle exchange.

The strategies and activities around the first DC DOH goal of reducing infections by 50% are focused on sustaining regional models of biomedical interventions and social determinants of health approaches. The biomedical interventions are driven towards the expansion of PrEP in new settings, expansion of network of providers of PrEP, enhanced coverage for PrEP treatments, identification of best practices for regional PrEP expansion, and improved health literacy on PrEP. Another important element in the biomedical approach is focused on enhanced STD screening, verification of STD treatment, and improvement in partner services.

DEMONSTRATION PROJECT: PrEP for Women

African-American women have the second highest rate of HIV infection in DC and. PrEP could be an effective prevention tool for many women of color. DC Appleseed interviewed providers and advocates in DC and found that the groups at highest risk for HIV infection often are the least likely to know about PrEP or to ask their provider for more information. Recent focus groups of African-American women conducted by DOH found that nearly all the participants were unaware of PrEP. Many were angry to learn that information about PrEP had not been more widely distributed.

DOH and the Washington AIDS Partnership (WAP) will employ $1 million in funding from the MAC AIDS Fund over the next two years to develop a “DC PrEP for Women” initiative. The Initiative will have several aims: (1) to leverage HIV and women’s health providers to adopt and offer PrEP as an effective strategy to reduce HIV infection; (2) to educate high-risk women to increase interest in PrEP; (3) to change and expand the conversation about PrEP with women from “protecting her from him” to “taking care of yourself;” and (4) to increase the number of medical providers prescribing PrEP for women. The initiative’s dual focus – women and providers – is designed to increase requests for PrEP from women and increase the number of providers offering and prescribing it.

Sustainable models using socio-environmental/ behavioral approaches will have broad as well as more focused strategies. Broadly, there will be efforts by the DC DOH prevention team and its community partners to improve the current portfolio of behavioral models and interventions that support healthy decision making, self-efficacy, and increase availability of sexual health information for the identified target populations. Geospatial analysis will be used to identify areas with high rates of new infections for targeted testing and intervention programs. Some of the focused elements will specifically target people who inject drugs and youth as DC DOH assesses an expansion of syringe availability and exchange program and launches a Youth Sexual Health Plan.

In 2005, the District was still barred by Congress from spending any funds on syringe exchange services (SES). As a consequence, the spread of HIV among people who inject drugs and shared needles was substantial. In 2005, 163 new cases of HIV were attributable to people who inject drugs. Today that number has decreased to eight, thanks to the lifting of the congressional ban in 2008 and the work of local organizations like HIPS and Family and Medical Counseling Services. These organizations are funded by the District government and provide clean needles and other services for people who inject drugs in DC. A study by researchers at GWU has estimated that the SES policy change averted 120 new infections in the first two years after the congressional ban was lifted. Part of the prevention goals in this Integrated Plan is to assess the challenges of a regional needle exchange program. This would involve working with jurisdictional agents in Virginia, Maryland, and West Virginia in order to eventually, expand the program across the DC EMA.

Youth Sexual Health Plan

While the number of new infections among young people (i.e., aged 13-24) in D.C. has fallen from 107 in 2005 to 69 in 2015, D.C. youth still disproportionately engage in sexual behaviors that accelerate risk for sexually transmitted infections (STIs), including HIV as compared to youth nationally. Across DC, in 2012, 16% of male students and 3% of female students reported initiation of sexual intercourse by age 11, while 25% of male students and 6% of female students reported initiation by age 13.[10] Additionally, 19% of high-school students had a recent sexual partner that was three or more years older. [11] In particular, young men who have sex with men and transgender youth are showing significant increases in HIV infection.[12]

The DC DOH formed a collaboration across health care providers, researchers, District government agencies, community organizations and young people to develop the 2016-2020 Youth Sexual Health Plan. The Plan offers a multi-level approach to focus on all areas that shape young people's sexual and reproductive health. While HIV and sexually transmitted infection prevention remains a key objective, the plan combines health equity and youth development

[10] Ost, Julie C. & Maurizi, Laura K. (2013). *2012 District of Columbia Youth Risk Behavior Survey Surveillance Report*. Office of the State Superintendent of Education: Washington, DC, p.23

[11] Ost, Julie C. & Maurizi, Laura K. (2013). 2012 *District of Columbia Youth Risk Behavior Survey Surveillance Report*. Office of the State Superintendent of Education: Washington, DC, p.23.

[12] *HIV among Transgender Persons in the District of Columbia HIV/AIDS, Hepatitis, STD, and TB Data through 2014*, Government of the District of Columbia Department of Health, p.36.

approaches while looking at the social determinants of youth sexual and reproductive health. It also includes the prevention of unplanned pregnancies, the support for contraceptive choice, the promotion of health literacy and the integration of health in all relevant policies.

The plan sets three primary ambitious and achievable goals:

1. Provide accessible resources and pathways that support all District youth to make healthy decisions around relationships and sexual health.
2. Reduce unintended outcomes of unprotected sex (STI/HIV infections and unintended pregnancies).
3. Enhance District coordination and collaboration to provide an equitable service continuum.

While the recommendations that follow provide some elements of the approach for young people, the Youth Sexual Health Plan contains detailed recommendations and action steps that will create positive resources and pathways that support all DC Youth to make healthy decisions around relationships and sexual health.

In the era of PrEP and PEP, treatment as prevention has become a standard model of prevention, creating the natural integration of prevention and care efforts and programs. DC DOH Goal 1 includes strategies and activities targeting those who are HIV positive in order to increase the rate of viral suppression among people living with HIV in the DC EMA, ultimately decreasing new HIV infections. As noted previously, 83.6% of DC EMA residents living with HIV had laboratory tests during 2014. Of those persons, 58% of RW clients were virally suppressed and 41.9% were virally suppressed according to surveillance data. In 2015, viral suppression among RW consumers improved to 77% for the EMA. While this number is encouraging, it indicates two issues that must be addressed to meet the goal: First, a significant proportion of persons in HIV medical care are not achieving optimal health outcomes, viral load suppression. The strategies in this plan aim to address this gap. Second, there are still a large number of persons known to be living in the DC EMA with HIV who have not had laboratory tests. Engaging and re-engaging persons in care as described in DC DOH Goal 2 is essential to improve both individual health and community health. These efforts include targeted treatment adherence support, whole person health approaches, housing capacity building, and Data-to-Care. These will be described in more detail in the following sections.

Objective 2: DIAGNOSIS

By 2021, increase the number of people living with HIV who know their status in the DC EMA from 88% to 90%

Since 2006, DC DOH has promoted routine, opt-out testing when residents visit their medical providers to increase the number of tests administered. In an effort to reach more people with testing, it has used innovative initiatives, such as testing in hospital emergency rooms and at the Department of Motor Vehicles offices. While the general testing approach has been successful, the number of persons diagnosed in many of these settings has decreased. For example, in 2015, while more than 3,000 people were tested at the motor vehicles office, there was not one person diagnosed as HIV positive. A recent study from researchers at GWU has

shown that testing directed to populations at higher risk of HIV infection is much more likely to identify new cases of HIV. Accordingly, GWU researchers recommended that DC DOH implement a "combined testing strategy among community-based organizations."[13] To ensure that testing connects the largest possible number of HIV-positive District residents to care, DOH will encourage a mix of testing strategies: the most successful current testing programs—those with positivity rates of 1% or more, such as testing in hospital emergency departments—will continue, while some funding will be redirected to new more targeted testing programs.

This recommendation will build on DC DOH's traditional practice of using geospatial data to examine where HIV infections are occurring and to document the geographic distribution of newly diagnosed cases of HIV. DC DOH will identify "hot spots" to focus care and prevention efforts, including expanded testing. Further, some new testing grantees will be required to show that their methodology for determining how to target testing will focus efforts on social networks at the highest risk. Studies show that, for example, among African-American MSM, HIV vulnerability "increases when an individual enters a high-risk sexual network."[14] While routine, opt-out testing is necessary to truly reach 90% of all residents, DC DOH and the EMA will direct its limited resources toward networks at the highest risk.

The other piece to this strategy involves establishing a regional epidemiologic data sharing system in order to enhance understanding around trends in testing and new infections. While a positive test requires engagement with treatment, a negative test often does not lead to any particular action. This can be a missed opportunity to identify individuals at risk for HIV infection and to avert future infections. Elevated risk factors can include past positive sexually transmitted infection (STI) tests, STI non-genital diagnosis (particularly anal gonorrhea infection), frequent testing, self-reported unprotected sex, or a relationship with an HIV-positive partner. For providers using an electronic medical record, prompts could identify individuals at risk and suggest possible prevention counseling. DC DOH is creating a workgroup with regional surveillance experts to determine data to be shared as well as the details and nature of the data exchange. Only aggregate data on negative tests will be exchanged or collected, not the individualized data that grantees will use for follow-up. However, having data on the number of residents who test negative will provide a better picture of the epidemic in the EMA and inform strategy going forward.

[13] CITE GW study on targeted testing

[14] Yuri A. Amirkhanian, *Social Networks, Sexual Networks and HIV Risk in Men Who Have Sex with Men*, 11 CURRENT HIV/AIDS REP. 81, 81 (2014), *available at* CITE http://www.ncbi.nlm.nih.gov/pubmed/24384832

DEMONSTRATION PROJECT: Rapid HIV Surveillance and PEP-Plan B

DC DOH will develop a demonstration project of a rapid HIV surveillance protocol. The project will assess the effectiveness of a more timely deployment of partner services to new HIV diagnoses as a means to interrupt HIV transmissions. Preliminary parameters would include:

- Immediate notification to DC DOH by providers of a new HIV diagnosis, such as at the time of scheduling the appointment with the patient to inform him or her of the test result.
- Rapid deployment of DC DOH Disease Intervention Specialist (DIS) who will arrive at the provider location to be available to the newly diagnosed patient to discuss potential partners.
- DIS will proceed with immediate contact with potentially exposed partners. The DIS would attempt a prompt face to face meeting with the partner(s) to administer either a rapid HIV test or draw blood for a laboratory test.
- DIS will also carry PEP starter packs, such as 7-day regimen, to provide to the partner immediately or transport the individual to the DC DOH Health and Wellness Center. Prescription or dispensing or referral to the Center are also options.
- To understand phylogenetic aspects of transmission, a more detailed conversation with the newly diagnosed person would be required, either at the time of diagnosis or subsequently. This could lead to a genotype analysis (a process that examines the DNA sequence of the genes in HIV) to trace the transmission network, which would be facilitated by a blood sample for separate laboratory processing. The results could be used to engage or re-engage the individual who transmitted the virus.

DC DOH has research partners with the DC Cohort Study and NIH on a potential collaboration that would support this rapid surveillance deployment, including a robust evaluation. DC DOH is aiming to implement the collaboration in late 2016.

DC DOH GOAL 2: ENGAGEMENT

Increase and sustain care engagement among people living with HIV in the DC EMA

(NHAS GOALS: Increase access to care and improve health outcomes for people living with HIV; Reduce HIV-related health disparities and inequities)

Objective 1: LINKAGE

Improve systems at regional levels to sustain the DC EMA of 83.6% linked to care within 30 days of diagnosis

While DC DOH does not currently collect treatment information for all individuals diagnosed with HIV, laboratory information reported to DOH as part of routine HIV surveillance activities is used as a proxy to assess HIV care engagement. Among all HIV cases diagnosed through 2014 currently living in the EMA, 83.6% have evidence of receiving care services in 2015, as indicated by having received one or more CD4 and/or viral load laboratory tests during the year. Among RW clients in the EMA with one or more medical visits during 2015, 89% were prescribed

antiretroviral (ARV) medication. As part of future Data-to-Care efforts to routinely monitor individual care and treatment status, DC DOH will more actively monitor HIV care and treatment adherence through active surveillance activities and the integration of insurance claims data. This will provide a more accurate gauge of the number of patients in sustained treatment.

DEMONSTRATION PROJECT: Data-to-Care

DC DOH proposes to implement a data-to-care strategy incorporating both provider and health department case outreach and follow-up efforts informed by active data integration and monitoring activities. At the foundation of the proposed data-to-care strategy is the effective integration and utilization of the various surveillance, monitoring and evaluation, and administrative data systems maintained by the DC DOH and other governmental agencies which collect information concerning population health and care and treatment utilization. The linkage of case information across multiple data sources will facilitate an individual level assessment of care utilization, treatment provision, and health outcomes among those living with HIV, aiding in the identification and prioritization of those targeted for care re-engagement efforts. In addition to housing the District's eHARS, ADAP, and CAREWare database; DC DOH currently has a data use and security agreement with the District Department of Health Care Finance which administers the Medicaid program. Under the current proposal, DC DOH plans to expand beyond the current reliance on HIV laboratory data retained in eHARS to define individual care status by incorporating service utilization and prescription information collected through these ancillary data systems.

A major factor in getting more DC residents into sustained care over the past six years can be attributed to DC's Red Carpet Entry Program. Through the Red Carpet program, a "concierge" at a DC DOH-funded clinic will ensure that clients are seen quickly by providers who can get them on to anti-retroviral treatment (ART). The Red Carpet program in DC should be revamped to expand on previous success by implementing intensive linkage and navigation efforts to "anchor" the patient into care with a medical home. A medical home or patient-centered medical home is a redesign of primary health care where persons receive comprehensive and continuous medical care with the goal of obtaining maximized health outcomes. A project manager will provide oversight for case managers or other peer navigators who can help establish and maintain linkage with care.

DEMONSTRATION PROJECT: Rapid ART

San Francisco General Hospital initiated a pilot project to start newly diagnosed individuals on ART at/or about the time the person was informed of the HIV test result. This start of ART within 24 hours sought to determine whether viral load suppression could be achieved faster and whether it would enhance initiation and adherence to treatment. The early results have been very promising, especially with viral load suppression. The time to suppression was

reduced in half from 56 days compared with 119 days for those in a universal ART standard-of-care group and 283 days in people starting ART based on CD4 count."[15]

DC DOH will develop a similar demonstration project on Rapid ART at its new Health and Wellness Center (formerly known as STD and TB clinics). It will also engage one or two clinical partners to ensure a diverse population cohort and range of settings (e.g. primary care and hospital) to gauge effectiveness. The DC DOH Health and Wellness Center is in the process of acquiring new stat laboratory capacity to run routine select tests before administering a HIV medication regimen. DC DOH will provide initial 30-day starter packs of a frontline ART regimen. The demonstration will measure effectiveness of uptake, adherence, time to viral load suppression, need to change regimen based on genotype testing results and patient self-efficacy. This demonstration will be informed, as mentioned earlier, by the resistance profile found in the DC Cohort.

Although most RW program clients accessed medical providers, for many people living with HIV, there are barriers to accessing in care. According to a study conducted by GWU, as well as the Consumer Needs Survey and town hall results reviewed earlier, individuals cited multiple barriers: transportation, forgetting appointments, and competing priorities.[i] Those who participated in these studies and discussions shared common approaches that would improve their access: flexible appointments, appointment reminders, providers co-located in sites and transportation assistance.

DC DOH will work with medical providers and CBOs on strategies to address barriers and facilitate access to healthcare services. One critical area would be shifting available times for appointments, particularly in non-core business hours as in evenings and weekends. While flexible hours may present challenges for some providers, another approach is co-locating providers in community-based organizations. HIPS, a CBO serving diverse populations such as transgender people, injection drug users and commercial sex workers, has initiated a partnership with medical providers and made private, confidential space available for limited medical visits. This model could be expanded to other populations, settings and hours.

Ideally, laboratory testing, is a part of every medical visit. Missing the opportunity to track viral load and CD4 status could have significant health consequences for a person with a compromised immune system. DC DOH will work with medical providers on practices that might create opportunities for lab testing to be done outside of a medical visit through engagement with community partners.

[15] http://betablog.org/rapid-program-leads-to-faster-hiv-suppression/

DEMONSTRATION PROJECT: Retention in HIV Care and Treatment

In 2015, the Washington AIDS Partnership and DC DOH launched a new public-private partnership aimed at reaching DC residents living with HIV who struggle with engagement in HIV care though the traditional provision of medical services. The Mobile Outreach Retention and Engagement (MORE) initiative will pilot a new mobile medical team approach in Washington, DC, with medical and supportive services provided in the home and at pop-up community clinics. It will address common and persistent barriers associated with engagement in HIV care including transportation challenges, inability to attend daytime medical appointments, and past bad experiences with the medical system.

As part of the MORE initiative, the Washington AIDS Partnership awarded a grant to Whitman-Walker Health to implement this new mobile approach.[16] The MORE team is deployed in the community, to find out-of-care individuals and provide medical evaluations, blood draws for lab tests, and counseling either in the home or at pop-up community clinics, with the ultimate goal of supporting effective engagement in care.

Getting people into treatment right away helps get them to viral suppression sooner. This achieves two important ends: First, it improves the quality of life for people with HIV. As a result of advances in treatment, individuals diagnosed with HIV are living longer and healthier lives. Second, those who are at viral suppression do not transmit the virus on to others. Making sure people are in treatment will help to end the epidemic. Data programs have been developed and tested to assist outreach efforts in finding people living with HIV who have no record of a visit with a provider, or according to out dated lab reports, may have fallen out of HIV care.

DEMONSTRATION PROJECT: Black Box Program

In 2012, Georgetown University invited the DC, Maryland and Virginia health departments to discuss the barriers and challenges to data sharing across the three jurisdictions. This initial conversation led to Georgetown developing a prototype technological solution that would provide more efficient and timely matching of data among the three HIV data sources. Georgetown pioneered the creation and application of a novel computerized algorithm and privacy device that would receive data from the Enhanced HIV/AIDS Reporting System (eHARS) data base and detect matches of identifiable information. The device would report back the matches to the jurisdiction and then destroy the data within the device to ensure security and confidentiality. The device is a computer unit that would be housed in a secure environment without any human contact. With the health departments, Georgetown tested a proof of concept and prototype device. The test was successful. This initial phase demonstrated that the technology could quickly and routinely identify persons who were diagnosed in another jurisdiction and had subsequently moved to DC, Maryland or Virginia. Further, it could identify persons who appeared to drop out of HIV medical care in one of the three jurisdictions by

[16] This initiative was made possible with generous support from the Bristol-Myers Squibb Foundation and the MAC AIDS Fund. HAHSTA is supporting the initiative's evaluation efforts.

moving to another one. The opportunity would be to more accurately measure the HIV care continuum in a region and address gaps in care and treatment.

The technology offers tremendous potential. The demonstration project will now seek to test two expansion opportunities: (1) inclusion of more jurisdictions, particularly as residential patterns fluctuate considerably; and (2) inclusion of more data related to the health of individuals living with HIV, such as laboratory test results currently reported to health departments, and potentially by accessing "big data" elements, such as prescription benefit management data on prescription dispensing. Georgetown will create a multi-organizational governance process for systematically identifying, evaluating, and responding to questions that emerge about the ethics and practice of protecting data security and individual privacy in large data consortia across jurisdictional lines. This phase of the project will be housed at the Oak Ridge National Laboratories, to increase security and computing power.

DC DOH has committed an initial funding in 2016 for the demonstration that will be matched by Maryland, Virginia, New York and one or more jurisdictions. The demonstration will test whether this technology can improve the timeliness, accuracy, and completeness of HIV care continuum data and improve the health of persons living with HIV in the region.

Objective 2: RETENTION

By 2021, increase the proportion of Ryan White clients who are retained in care from 87% to 90%

However, sustaining treatment is more than just taking medications. For many patients, making appointments, taking medication, and remaining engaged in care is made more difficult by life circumstances like unstable housing, transportation, employment, and insurance coverage. This is especially true for those not currently experiencing health issues; managing any chronic illness often takes a back seat to more immediate, everyday problems when there aren't urgent health concerns to address. When those patients drop out of care, providers have noted that the best way to reengage is through peer counseling, including community health workers who they trust and who best understand their circumstances and barriers.

Social factors can be instrumental in ensuring a patient stays in care and reaches viral suppression—in particular, access to stable housing is frequently cited by stakeholders. In its 2012-2014 Comprehensive HIV Care Plan, the PC noted that the most frequently cited need in the DC metro area among people living with HIV is housing. During the 2016 RW consumer town halls, housing was mentioned as a need across jurisdictions, but particularly in DC. DC DOH collects data on RW clients related to their housing stability. In 2015, 11% of DC RW clients reported their housing status as unstable. The report also emphasized the importance of constant access to supportive services.[17]

[17] Metropolitan Washington Regional Ryan White Planning Council, "2012-2014 Comprehensive HIV Care Plan," 28 March 2014 <http://doh.dc.gov/sites/default/files/dc/sites/doh/publication/attachments/Comprehensive%20HIV%20Care%20Plan%202012-2014%20%282%29_0.pdf>.

DEMONSTRATION PROJECT: Joseph's House- Maycroft Program (JHMP)
Through funding Joseph's House – Maycroft Program (JHMP), DOH is implementing an enhanced supportive housing demonstration project with basic and enhanced, intensive care and support services to persons living with HIV who have low-incomes. JHMP will provide support services in order to increase rates of engagement in care and to foster suppressed viral load. Joseph's House shall provide basic non-medical case management/community support. The approach will include trauma-informed and Assertive Community Treatment (ACT) best-practices. In this collaboration with Jubilee Housing, the JHMP will address immediate barriers to accessing housing and challenges to fulfilling housing plans. Through its partnership, Joseph's House and Jubilee Housing will provide transitional housing and support services.

The HOPWA program is the primary federal program by which affordable housing is offered specifically to people living with HIV in the District and metropolitan area. The Department of Housing and Urban Development (HUD) distributes funds via a grant formula. DOH uses HOPWA to support the following services in the District: Tenant-Based Rental Assistance (TBRA); facility-based housing (supportive housing); Short-Term Rent, Mortgage, and Utilities (STRMU) services; housing information and referral services; and supportive services. Supportive services in the District include case management, substance use services, and meals or nutritional services.[18] Of the 479 new individuals placed in housing in 2014, 54 were homeless individuals newly placed in housing. Of those newly housed individuals, 33% were chronically homeless and 2% were veterans. HUD reduced DC's HOPWA funding almost $2 million between 2014 and 2015 when a bonus supplement for areas with high rates of HIV expired. Since then, HUD funding has remained nearly level with only slight adjustments.[19]

Those who are able to take advantage of programs like HOPWA have improved health outcomes. Among HOPWA clients, 93% were retained in care in 2014, while 73% of all DC residents living with HIV were engaged in care.[20] This mirrors results around the country and recent studies have shown stable housing improves the quality of life for those with chronic illnesses. For example, a May 2016 report from the Center on Budget and Policy Priorities (CBPP) found that homeless people with chronic illnesses who are offered supportive housing "spent 23% fewer days in hospitals, had 33% fewer emergency room visits, and spend 42% fewer days in nursing homes, per year during the study period." And for those living with HIV, the CBPP study found that those in supportive housing "were 63% more likely to be alive and have an intact immune system," which aligns with the data on HOPWA clients in DC.[21]

[18] 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%20FY11-15%20Con%20Plan.pdf.
[19] 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_GranteeForm_00_WASH-DC_DC_2013.pdf.

[21] Ehren Dohler et al., *Supportive Housing Helps Vulnerable People Live and Thrive in the Community*, CTR. ON BUDGET & POLICY PRIORITIES (May 31, 2016), http://www.cbpp.org/sites/default/files/atoms/files/5-31-16hous.pdf

DEMONSTRATION PROJECT: Housing for Victims of Violence living with HIV
The District is also committed to providing the most effective and compassionate services possible to people living with HIV who are also victims of sexual assault, domestic violence, dating violence, and stalking. DC DOH will partner with the DC Office of Victims Services and Justice Grants and community partners to learn about the obstacles and promising projects for system alignment, service coordination, and intervention design for low-income people living with HIV who are homeless as a result of sexual assault, domestic violence, dating violence or stalking. Activities to increase housing stability and improve engagement along the HIV care continuum, notably treatment adherence, for this project are scheduled to run from October 2016 through September 2018.

DC DOH GOAL 3: VIRAL SUPPRESSION

(NHAS GOALS: Reduce New Infections; Increase access to care and improve health outcomes for people living with HIV; Reduce HIV-related health disparities and inequities)

Objective 1: VIRAL SUPPRESSION

By 2021, increase the percentage of Ryan White program clients who are virally suppressed from 58% to 90%

Based on CAREWare data for 2014, 58% of those in Ryan White care are virally suppressed. In 2015, because of improvements in care, as well as data reporting and sharing, that number improved to 77%. ART adherence is arguably the most effective intervention improving health outcomes of persons living with HIV and for reducing the transmission of HIV. There are many reasons why a person may not consistently adhere to medication. Understanding the barriers and facilitators of medication adherence in the HIV population and establishing a mechanism to effectively measure medication adherence will help to develop a cadre of effective and evidence-based interventions to improve treatment adherence. As part of enhanced surveillance activities, DC DOH will begin to actively solicit information from providers concerning the provision of HIV treatment for all newly diagnosed cases, as well as actively monitor the viral load status of all individuals diagnosed with HIV in order to identify those that should be targeted for treatment engagement or treatment adherence support services. Many of the activities listed under Goal 2, to engage and retain individuals in treatment, will ultimately help to achieve Goal 3. If a patient is actively on ART and regularly sees a healthcare provider, it is quite likely that the patient will reach viral load suppression.

Relationships with medical providers, regular health visits and laboratory testing are all essential components of a care and treatment plan for a person living with HIV. However, getting and taking medication is the key to ensuring that a person succeeds in achieving viral load suppression and maintaining a healthy immune system. There is currently no established process by which to report and track the initiations of ART. Similarly, there is no current data collection on medication utilization. The proxy for measuring medication adherence is the dispensing and refilling of medication. In the healthcare system, a Pharmacy Benefit Management system (PBM) is a third-party administrator of prescription drug programs, primarily responsible for processing and paying prescription drug claims. Every health insurance plan contracts with a PBM for its medication benefits, including Medicaid and ADAP. DC DOH

manages ADAP and its PBM provides regular reporting on prescription dispensing and refills. Through a data-sharing agreement with the DC Medicaid program, DC DOH can obtain equivalent Medicaid PBM reports. These two sources account for approximately half of all persons living with HIV in the DC EMA. The other half are under private health insurance plans. DC DOH has initiated a collaboration with the major health insurance plans in the DC EMA to obtain aggregate data on medication adherence. These sources combined with reporting on ART initiation will provide a critical marker on the progress to achieve Goals 2 and 3.

Objective 2: Transform Ryan White HIV support services to improve viral load suppression rates throughout the EMA

Poor access to supportive services like substance use or mental health treatment, housing stability, transportation, employment, among others are barriers to remaining in care and ART adherence, both of which are necessary to reach viral suppression. DC DOH will continue to strengthen coordination with substance use and mental health systems to mitigate the extent to which these co-morbidities impact a person's ability to adhere to HIV treatment.

Under the ACA, states are allowed to design "health homes" for care coordination and chronic disease management for certain populations with multiple conditions, such as mental health and HIV. Effective January 2016, the Department of Health Care Finance (DHCF) launched a Medicaid Health Home for people with serious mental illness. DHCF is working on a second Health Home (HH2) initiative for individuals with chronic conditions (including HIV, diabetes, and chronic homelessness) will be implemented by Medicaid in January 2017. The model aims to improve health outcomes through individual-level coordination, for example, managing adherence to medications, intervention when persons drop out of care, addressing other medical needs that could impact HIV treatment, and overall supports promoting care for the whole person. This approach helps ensure that all of a client's needs are met, without having to search separately for services.

DOH will collaborate with DHCF on the design of the chronic condition health home that would enhance health outcomes for persons living with HIV. HH2 complements traditional healthcare services, addressing gaps in the system that typically raise barriers for individuals with chronic conditions, particularly for individuals experiencing health disparities in District Wards 5, 7, and 8. For the purpose of HH2, chronic homelessness will be considered a risk factor for developing a chronic condition. This population is of focus due to its higher rates of chronic physical and behavioral health conditions, health disparities, and health spending, as compared to the general population. These individuals are frequent users of hospital services, especially emergency room services. This population is comprised largely of racial and ethnic minorities residing in lower socio-economic areas of the city (Wards 5, 7, and 8) where concentration of providers is low, and rates of chronic conditions and homelessness, health disparities, and Medicaid spending are high.

DC DOH also plans to redesign the HOPWA program to move clients towards self-sufficiency and consequentially, providing access to other people living with HIV currently locked out of the HOPWA program. DC DOH will work with the District government and other stakeholders to

redesign housing program in the DC EMA to better align with other housing programs, depending where each person is along the housing continuum: emergency shelter for the homeless, supportive housing for people with special needs, rental housing with or without assistance, homeownership, and senior housing. As people with HIV live longer, healthier lives, they will need access to all of these types of housing.

Going forward, the HOPWA program will be a goal-oriented program, including helping District residents living with HIV achieve independence from ongoing HOPWA support when possible. This can include helping individuals find and maintain employment that will allow them to generate income; it might also include a housing setting that has more supports, for example senior housing for people living with HIV who are older than 55. Future recipients of HOPWA funding will develop goals and a plan to achieve that goal; HOPWA voucher agreements will provide supportive services related to the client's goal, including peer supports when necessary, and specify time limits when the agreement will be reviewed. DOH will assess the potential for expansion of this model with HOPWA and RW funds.

DEMONSTRATION PROJECT: Housing and Employment

In several parts of the country, jurisdictions have started testing new approaches to support housing success, particularly among the population of persons living with HIV that need temporary assistance to get them to self-sufficiency. This is the framework for the housing and employment demonstration project to assist program participants in achieving economic and housing stability.

There is evidence that housing stability improves HIV health outcomes. There are also studies that show employment benefits HIV health outcomes. Employed persons were 39% more likely to have achieved optimal adherence to antiretroviral meds (>95% adherence). Employed individuals ranged from 13% to 71% greater likelihood of achieving optimal adherence rates. Employment increased self-care (49%), CD4 count (37%), and medication adherence (21%). The focus population will be unaccompanied adults, age 18 years or older, with low incomes, who are homeless or at risk of homelessness, and who are living with HIV/ AIDS. Support services will include services coordination (case management), housing search assistance, and employment assistance; financial services will include security deposits, utilities assistance, and ongoing rental assistance for a period not to exceed 24 months.

REDUCE HIV RELATED DISPARITIES AND INEQUITIES

The DC EMA contends with significant health disparities as a result of race, gender identity/expression, and sexual orientation and social determinants of health such as poverty, lack of employment opportunities, housing instability, behavioral health conditions, and transportation access, among others. These difficulties are largely driven by unique service delivery gaps, including cultural, language, and stigmas that hinder access to primary medical care. Because such a large proportion of the people living with HIV in the DC EMA represent a group experiencing health disparities, the plan aims to approach all of the goals, objectives

and strategies within a whole person framework that recognizes and responds to the multiple levels of inequities and disparities encountered by most people living with HIV in the DC EMA.

Approaching disparities in this way acknowledges all the intersecting identities that impact not only a person's health, but also their experience of health, ultimately effecting successful retention and viral suppression. To speak of inequities and disparities is to properly acknowledge not just one area of an individual's experience (for example, being a person who injects drugs), but the multiple layers in a person's everyday experiences that contribute to overall inequities (being a black transgender woman who is homeless and injects drugs). In addition, experiences associated with the intersection of micro-level social identities exist in the context of macro-level systems of oppression and marginalization maintaining and reinforcing health disparities. Attempting to account for these multiple layers of intersections considers a more complete framework when trying to understand and meet service needs of people living with HIV in the DC EMA.

As HIV Prevention, Care, and Treatment efforts are integrated structurally through federal agencies, health departments, planning bodies, and providers, it is also an appropriate time to achieve an integrated physical, mental, social, and environmental approach to health. When considering HIV and health in this way, it is also critical to understand the way people living with HIV experience health, medical services, and support services, and how these experience may relate to linkage, retention, and viral suppression. Although approaching health in this way is a significant undertaking, some of the ongoing and recent efforts are represented in various demonstration projects that have been highlighted in this section of the plan.

DEMONSTRATION PROJECT: 1509/IMPACT DMV

The purpose of this demonstration project is to develop, through a regional public, private, and health department collaborative, a whole-person health and wellness system model that addresses both the health and wellness needs of the individual in a comprehensive and culturally appropriate manner. This model will strengthen and support MSM and transgender individuals of color in healthy decision making and ensures equitable access to screening, care and treatment, behavioral health, economic opportunity, peer supports, and other supportive services.

The DC DOH, along with Maryland and Virginia Departments of Health established the Regional IMPACT DMV Coalition. DC DOH is leading this collaborative, multidisciplinary, multijurisdictional coalition providing comprehensive care for MSM and transgender individuals of color at substantial risk for and living with HIV, particularly those who need to be engaged in care and treatment. The IMPACT DMV Coalition includes health care providers (e.g., FQHCs, FQHC look-alikes, other clinics, or health care providers); HIV care providers (e.g., clinics funded through the RW program, other HIV care clinics, or HIV care providers); behavioral health and social services providers (i.e., mental health and substance abuse services, housing programs, and job training or employment services); and community-based organizations (CBOs). The result will be a comprehensive regional health system model that will: increase the uptake of

PrEP; support individuals with access to develop economically; increase access to substances abuse and mental health services; increase the number of PLWH that are in care; support sustainable housing; increase the number of PLWH who are virally suppressed; and any other psychosocial needs that may arise for an individual of this targeted population. Ultimately, the model will create an environment that foster greater health and wellness outcomes and support a quality sustainable livelihood for those that access the model. Additionally, this model can serve as a demonstrated mechanism for other jurisdictions that seek to have similar outcomes for this target group within their locale. Regional collaboration reduces barriers to accessing services (eligibility), ensures individuals are not lost to care and reduces fragmented service delivery.

ACHIEVE A MORE COORDINATED RESPONSE TO THE HIV EPIDEMIC

Although not a requirement of the Integrated Plan Guidelines, DC DOH does have significant five year planning objectives that respond to this NHAS goal. For DC DOH, this structural level goal will would set the proper framework to most effectively respond to and carry out the identified need, as well as, objectives, strategies, and activities of the other NHAS goals.

The first objective is to fully integrate the HIV Prevention and Planning Group and the Ryan White Planning Council into one regional planning body by 2018. To accomplish this, DC DOH will: 1. develop a workgroup combining the planning bodies to begin discussions on integration and the processes for the structure and role of a new fully integrated planning body; 2. study other jurisdictions who have already achieved full integration, obtaining logistical and technical support for a unified transition; and 3. coordinate with state entities on prevention resources and how those would be allocated regionally. The analysis of other integrated jurisdictions has already begun and is being led by DC DOH's partner at GWU.

In line with the jurisdiction's commitment to collaboration, efficiency, and innovation to achieve a more coordinated response to addressing HIV, for the second objective, DC DOH envisions a regional HIV health system in the EMA that is patient-centered and integrates the prevention to care continuum. DC DOH has been working with the health departments in Maryland and Virginia on system changes, such as business processes that are more patient-centered and unit cost–based, which will contribute to a regional health system as a feature of the integrated plan. To accomplish this objective, the three health departments have launched a quarterly series of meetings to discuss and structure regional initiatives.

The departments have formed work groups on surveillance, Care Continuum, and HIV prevention. The intention is to develop a seamless regional health system to provide overall access for consumers, as well as better coordination of resource allocation to address gaps more effectively, avoid duplication, and prioritize towards service needs. The Surveillance Workgroup is comprised of the surveillance units at the DC DOH, Virginia Department of Health and the Maryland Department of Health and Mental Hygiene. This group will hold monthly conference calls and will be responsible for: routine inter-jurisdictional meetings and calls to discuss issues related to data exchange protocols, processes, and infrastructure as well as issues concerning data utilization, interpretation, and dissemination. The Care Continuum work group

is developing a protocol for identifying clients out-of-care or not achieving optimal health outcomes and establishing a mechanism to prioritize clients for re-engagement in treatment. The Prevention Workgroup will review and assess all regional HIV partner services protocols to develop a protocol for use in the DC EMA.

DC DOH has also established a collaborative effort with the Baltimore City Health Department and the Philadelphia Health Department. The health departments are implementing the CDC-supported 1509 demonstration projects. The collaborative process reflects the recognition that persons at risk of and living with HIV have social networks that align with the geography of the three cities, which the departments have named the "I-95 Corrdior". The three departments have also plans to engage with the New York City health department as the corridor extends to that metropolitan area.

In order to achieve DC DOH's vision of operating as a regional health system, DC DOH has redesigned the way Ryan White funding will be structured for the DC EMA. For over 25 years, the RW program has supported a system of clinical care, medication access and support services for persons living with HIV. The program design has promoted a dynamic full range of care and support, which has consistently demonstrated effectiveness in high rates of service utilization, care retention and viral load suppression.

Funding is allocated by formula of persons living with HIV in each jurisdiction. In turn, each jurisdiction develops its own area and funding priorities. While this system has ensured a safety net for persons living with HIV, it has promoted a fragmented system of care in the region. With the adoption of the Patient Protection and Affordable Care Act (ACA), the landscape of health insurance coverage changed extensively. As the RW program has a statutory provision to be a payer of last resort, this change has a direct consequence and opportunity on the allocation of RW funds.

DC DOH will redesign the Ryan White CARE Program as implemented in the metropolitan area as follows:

- **Funding mechanism** — DC DOH will change the funding mechanism of community providers from the current capacity-based approach to a unit cost-based approach. The unit cost approach will retain many of the programmatic advantages of RW, including bundled services, to ensure health outcomes. It will also ensure that for those persons with insurance, the services provided will be attributed to the appropriate funding source. This accountability system will ensure that funds previously supporting insurance-covered costs can be reallocated for non-insurance covered services. It will also enable a patient-driven approach to services as funding will follow persons.
- **Regional health care system** — DC DOH will implement a regional health system with portability for RW eligible persons across the metropolitan area. This will be facilitated by a change in funding mechanism, streamlining how funds are delivered to providers. This regional system will support persons selecting service providers that meet their

needs, regardless of location or residence. In the current system, persons can only get care in the jurisdiction of their residence.

- **Performance-based approach** — With the previous changes, DC DOH can then implement a performance-based approach that offers financial incentives to providers to increase and enhance health outcomes. This will complement the goals of routine medical visits and treatment adherence resulting in viral load suppression.
- **Redirect funds to non-clinical services** — The Ryan White CARE Act has a statutory provision that a minimum of 75% of funds are allocated among core medical services and no more than 25% among non-clinical services. The program does include a waiver provision to that fund distribution. DC DOH will apply for a waiver of the 75/25 rule. With most medical services covered by health insurance, funds could be redistributed to services regularly identified as crucial for persons with HIV, such as housing, transportation, child care, nutrition support, emergency financial assistance and assistance with insurance, benefits, and other health and non-health related needs.

2017-2021 District of Columbia Eligible Metropolitan Area Integrated HIV/AIDS Prevention and Care Plan
Provided by the DC Department of Health
HIV/AIDS, Hepatitis, STD, and TB Administration (HAHSTA)

NHAS 2020 GOAL: REDUCE NEW HIV INFECTIONS					
DC EMA Goal 1: PREVENTION					
Objectives	**Strategies**	**Activities / Measurements**	**Responsible Entities**	**Metrics**	**Timeframe**
O1.1. By 2021, the DC EMA will reduce new HIV infection by 50%	**Focus Populations: Men who have sex with men and transgender of color; African immigrants; Youth/young adults 13-29; African American heterosexual cisgender men; African American cisgender women**				
	S1.1 Create a sustainable regional model of biomedical interventions	Promote the adoption of PrEP and nPEP in communities, clinics, schools, and healthcare settings; working with community partners, create and disseminate PrEP guide for users/providers	Department of Health (DOH)-HAHSTA	75% increase in # of network providers that are culturally competent prescribers of PrEP and nPEP; # of PrEP participants	September 2021
		Expand the network of prescribers of PrEP by increasing knowledge and capacity of private medical providers at a regional level (Demonstration Project: PrEP for Women)	DOH-HAHSTA	50% increase in capacity of network providers to understand the effective use of PrEP and nPEP	January 2018
		Provide academic detailing to medical providers/prescribing professionals on PrEP dispensing	DOH-HAHSTA	# of trainings held; # of providers who participate in trainings	Fall 2017
		Work with Medicaid, MCOs and private medical plans to enhance coverage for PrEP treatment, as well as related clinically recommended laboratory monitoring	DOH-HAHSTA	# of full PrEP coverage plans	2018

NHAS 2020 GOAL: REDUCE NEW HIV INFECTIONS					
DC EMA Goal 1: PREVENTION					
Objectives	**Strategies**	**Activities / Measurements**	**Responsible Entities**	**Metrics**	**Timeframe**
		Increase collaboration with jurisdictionally based health departments and planning bodies to investigate and identify best practices for regional PrEP expansion including a "no wrong door" model addressing regional barriers to PrEP access	DOH-HAHSTA	Increase in the number of collaborative partners by 50%	September 2021
				Compilation of best practices to be disseminated across the jurisdiction	September 2019
		Increase community awareness and education on PrEP by developing a regional social marketing/media campaign	DOH-HAHSTA	# of hits on site; # of persons educated	2018
		Promote the expansion of STD screenings and treatment services in CBOs, STD Clinics, and other settings	DOH-HAHSTA and community partners	Increase # of STI screenings conducted by CBOs to the target populations by 50% from 1,000 to 2,000 STI screenings	By 2019
		Implementation of self-screening as an enhanced component for STD screening in clinics and regional providers	DOH-HAHSTA	# of sites; # of persons self-screening	September 2017
		Continue exploring and staying informed on new and upcoming and/or additional biomedical interventions	DOH-HAHSTA	# of roundtable sessions	On-going

NHAS 2020 GOAL: REDUCE NEW HIV INFECTIONS					
DC EMA Goal 1: PREVENTION					
Objectives	**Strategies**	**Activities / Measurements**	**Responsible Entities**	**Metrics**	**Timeframe**
		Support research partners who are conducting research on new biomedical interventions as part of the Center for AIDS Research collaboration (George Washington University) Currently: long acting injectables for PrEP	DOH-HAHSTA/ Surveillance	# of: new studies, participants in studies, new researchers	2018 clinical trial completion
		Disease Intervention Specialists to verify STD treatment (especially for Gonorrhea)	DOH-HAHSTA	% of positive cases with treatment verification	On-going
		Increase capacity of health care providers to offer Expedited Partner Therapy for patients who test positive for Chlamydia.	DOH-HAHSTA	# of providers offering EPT	December 2017
	Focus Populations: Men who have sex with men and transgender of color; African immigrants; Youth/young adults 13-29; African American heterosexual cisgender men; African American cisgender women; people who inject drugs				
	S1.2 Develop a sustainable regional model of socio-environmental/ behavioral prevention approaches	Assess challenges and increase accessibility and availability of needle exchange programs (and syringes) across DC EMA	DOH-HAHSTA and community partners	Increase # of syringes collected from street by 60,000/year for a total of 900,000 syringes	By 2021

NHAS 2020 GOAL: REDUCE NEW HIV INFECTIONS					
DC EMA Goal 1: PREVENTION					
Objectives	**Strategies**	**Activities / Measurements**	**Responsible Entities**	**Metrics**	**Timeframe**
		Improve current portfolio and promote behavioral models and interventions that support healthy decision making and increase availability of sexual health information	DOH-HAHSTA and community partners	# of interventions implemented; # of persons served	By 2020
		Pilot interventions to address youth in school based screening programs and youth STD screening programs with repeat STD infections to decrease days from diagnosis to treatment, increase partner treatment and refer for PrEP when appropriate (Youth Sexual Health Plan)	DOH-HAHSTA	# of days between diagnosis and treatment; # of tests conducted for rescreening purposes; # of partners being treated	October 2017

NHAS 2020 GOAL: REDUCE NEW HIV INFECTIONS					
DC EMA Goal 1: PREVENTION					
Objectives	**Strategies**	**Activities / Measurements**	**Responsible Entities**	**Metrics**	**Timeframe**
		Develop and implement a trusted adult model to support healthy decision making among youth (Youth Sexual Health Plan)	DOH-HAHSTA	At least 3 CBOs funded to implement evidence informed program	October 2107
		Increase the visibility and availability of developmentally appropriate sexual health information for youth through social media, peer education , health education outlets and trusted adult model (Youth Sexual Health Plan)	DOH-HAHSTA	# of social media engagement; 250 trained peer educators	1. January 2017 2. October 2016-June 2017 3. December 2017
		Condom Distribution Program providing free condoms and lubricant to DC residents, businesses, and organizations (Rubber Revolution campaign)	DOH-HAHSTA	# of condoms distributed, increased # of locations offering condoms	2019
	S1.3 Assess structural and social barriers to HIV prevention approaches and implement findings	Use geo-spatial data and mapping to understand socio-environmental issues that may be a barrier or asset to HIV prevention efforts per regional jurisdictions	DOH-HAHSTA/ Surveillance	# of neighborhoods identified as focus area	June 2016
		Conduct an environmental scan of what services people already have and the social support systems that are available	DOH-HAHSTA	Completed Environmental Scan	By 2018
		Conduct an insurance scan to ascertain what is covered, who is covered, and what they have access to	DOH-HAHSTA	Completed Insurance Scan	By 2018

NHAS 2020 GOAL: REDUCE NEW HIV INFECTIONS					
DC EMA Goal 1: PREVENTION					
Objectives	**Strategies**	**Activities / Measurements**	**Responsible Entities**	**Metrics**	**Timeframe**
		Create a standardized measure for monitoring social support needs	DOH-HAHSTA	Dissemination of measure	Ongoing through 2017
		Use what is learned from assessment to discern and disseminate funding opportunities that are available for CBOs to provide preventive and social support services	DOH-HAHSTA	# of FOA made available	Ongoing
		Develop a resource guide of best practices that addresses stigma, self-efficacy, STD and HIV education, and adult/youth prevention	DOH-HAHSTA	Completed Resource Guide	By 2018
	Focus Populations: all persons living with HIV				
	S1.4 Increase rate of viral suppression among people living with HIV in the DC EMA: Treatment as prevention (please also see Goal 3)	Provide targeted treatment adherence support to key populations	DOH-HAHSTA	1. # of persons served; 2.Increase # of/expansion of treatment adherence programs; 3. Annual data report on key populations	By 2018, then annual data report
		Create directory of providers who offer High-impact prevention (HIP) behavioral interventions to use for referring people living with HIV involved in high risk behaviors	DOH-HAHSTA	Directory of providers	By 2018

NHAS 2020 GOAL: REDUCE NEW HIV INFECTIONS					
DC EMA Goal 1: PREVENTION					
Objectives	**Strategies**	**Activities / Measurements**	**Responsible Entities**	**Metrics**	**Timeframe**
		Data-to-Care 1. Routine surveillance and administrative data integration and review to identity and monitor HIV positive individuals that are not engaged in care and/or not virally suppressed; 2. Routine dissemination of customized out-of-care lists to participating provider and community partners to inform targeted case follow up efforts; 3. Implementation of protocol for health department led outreach activities targeting hard to reach cases	DOH-HAHSTA, Provider facilities, Disease Intervention Specialists	# identified for Targeted Outreach Activities; # of Target Cases contacted; % re-engaged in care	December 2016
		Community Outreach programs- Establish a network of providers under a fee for services model to address needs of target populations	DOH-HAHSTA and community partners	# of providers; # people served	2017
		Help address economic barriers that affect treatment and adherence (Whole person approach)	DOH-HAHSTA	# of jobs	By 2018
		Engage developers and design housing financing proposals leveraging HOPWA funds to increase the stock of affordable housing for persons with HIV.	DOH-HAHSTA	Approximately 35 units will be added to the affordable housing stock	By 2021
		Add units to the affordable housing stock for households and families that include persons living with HIV/AIDS			

NHAS 2020 GOAL: REDUCE NEW HIV INFECTIONS					
DC EMA Goal 1: PREVENTION					
Objectives	**Strategies**	**Activities / Measurements**	**Responsible Entities**	**Metrics**	**Timeframe**
		Tenant Based Rent Assistance Program rental subsidies: includes supportive services and housing case management to increase positive health outcomes, self-sufficiency, and to transition into permanent or best housing situation based on need	DOH-HAHSTA	Assist an estimated 3000 households	By 2021

NHAS 2020 GOAL: REDUCE NEW HIV INFECTIONS					
DC EMA Goal 1: DIAGNOSIS					
Objectives	**Strategies**	**Activities / Measurements**	**Responsible Entities**	**Metrics**	**Timeframe**
O1.2 By 2021, Increase the number of people living with HIV who know their status in the DC EMA from 88% to 90% ***based on 2014 data, in each of the jurisdictions, about 88% (total number of reported and diagnosed HIV, including AIDS) of cases are reported and diagnosed with HIV	**Focus Populations: Men who have sex with men and transgender of color; African immigrants; Youth/young adults 13-29; African American heterosexual cisgender men; African American cisgender women; people who inject drugs**				
	S1.1 Increase effectiveness of focused testing by the use of geospatial and demographic data	Generate geospatial maps and data to document the geographic distribution of newly diagnosed cases to identify areas for targeted testing efforts for identified focus populations	DOH-HAHSTA	Dissemination of Targeted Report	Annually
		Develop and implement technical assistance for testing providers to improve and strengthen social network models and testing among youth/young adults using network mapping and geospatial analysis	DOH-HAHSTA	Guide to Social Networks Training for Providers	By 2018
		Require new testing grantees to utilize evidence-based programs that target social networks where new infections are most likely	DOH-HAHSTA and community partners	A network of at least 4 community partners applying SNS model	By 2017

NHAS 2020 GOAL: REDUCE NEW HIV INFECTIONS					
DC EMA Goal 1: DIAGNOSIS					
Objectives	**Strategies**	**Activities / Measurements**	**Responsible Entities**	**Metrics**	**Timeframe**
		Develop marking/social media campaigns designed specifically for populations in identified areas to reduce HIV test related stigma and educate on differences between testing modalities • Youth- include STI screening in any youth focused HIV screening program activity	DOH-HAHSTA	Increase # of campaigns; # of impressions	Ongoing
	S1.2 Establish a regional epidemiologic data sharing system to enhance understanding around trends in testing and new infections	Create a workgroup of surveillance experts from each jurisdiction to determine the data to be shared, details and nature of the information exchange	DOH-HAHSTA, VDH; MD DHMH; WV DHHR	Monthly Conference Calls	October 2016
		Continue data sharing agreement between all jurisdictions of the DC EMA	DOH-HAHSTA;VDH; MD DHMH; WV DHHR	Monthly Data Exchanges	December 2016
		Enhance and modify DC PHIS HIV testing module	DOH-HAHSTA	Finalized HIV Testing Question Package	December 2016

NHAS 2020 GOAL: REDUCE NEW HIV INFECTIONS					
DC EMA Goal 1: DIAGNOSIS					
Objectives	**Strategies**	**Activities / Measurements**	**Responsible Entities**	**Metrics**	**Timeframe**
		Establish an indicator for a provision beyond routine testing for those presenting with repeat STD infections (Data to Care)	DOH-HAHSTA/ Surveillance	Reduce # of repeat infections; Algorithm for identifying individuals with elevated risk of HIV infection based on routine STD surveillance; implementation of strategies to monitor PrEP utilization among individuals identified as having elevated risk of HIV infection	December 2016
		Establish an indicator for a provision to identify those who test negative but are at elevated risk (Data to Care)	DOH-HAHSTA/ Surveillance	Proportion of annual testing; proportion tested > than once annually	December 2016
		Establish a functional health information/data exchange agreement with all major private insurance companies in order to obtain data on HIV testing provisions	DOH-HAHSTA	% persons in insurance plans annual screening	December 2016

NHAS 2020 GOAL: REDUCE NEW HIV INFECTIONS					
DC EMA Goal 1: DIAGNOSIS					
Objectives	**Strategies**	**Activities / Measurements**	**Responsible Entities**	**Metrics**	**Timeframe**
		Develop a sustainable regional model partnering with other health agencies, such as behavioral health, to include co-occurring conditions to attain a comprehensive reporting structure that will respond to needs more effectively and holistically	DOH-HAHSTA; VDH; MD DHMH	# of new partnerships	By 2019
	S1.3 Assess and improve HIV testing capacity and performance	Assess regional provider capacity to ensure 4th generation testing is being provided and identify any challenges	DOH-HAHSTA	Proportion of providers using 4th generation testing	2017
		Develop HIV testing performance measures and thresholds for use by Managed Care Organizations	DOH-HAHSTA	% MCO beneficiaries annual testing	2019

NHAS 2020 GOAL: INCREASE ACCESS TO CARE AND IMPROVE HEALTH OUTCOMES FOR PEOPLE LIVING WITH HIV OR AIDS					
DC EMA Goal 2: ENGAGEMENT- Increase and sustain care engagement among people living with HIV in the DC EMA					
Objectives	**Strategies**	**Activities/Measurements**	**Responsible Entities**	**Metrics**	**Timeframe**
O2.1 Improve systems at regional levels to sustain the DC EMA of 83.6% linked to care within 30 days of diagnosis* *based on 2014 Surveillance data, Linked to HIV Care within 3 months of diagnosis is 83.6%	**Focus Populations: Men who have sex with men and transgender of color; African immigrants; Youth/young adults 13-29; African American heterosexual cisgender men; African American cisgender women; Youth transitioning out of pediatric care; Adults 50+; people who inject drugs**				
	S1.1 Analyze the state of linkage performance and establish best practices standards	Surveillance workgroup formation	Regional workgroups with health dept. representa-tion of all jurisdictions	Workgroup	2016
		Require each jurisdiction to create flow chart of the linkage process to identify potential barriers or challenges and ways to eliminate these		Flowchart of each jurisdiction	2018
		Identify opportunities to improve process in each region to reach targeted linkage time frame		Monitor linkage time between diagnosis and linkage	2018
		Create a regional standardized definition of linkage to care		Standard regional definition of linkage	2018
		Assess and improve linkage to care data indicator to be more timely, accurate, and comprehensive across jurisdictions		Result of assessment: Linkage to care data indicator and/or reporting TA for providers	
	S1.2 Implement a comprehensive linkage service system that connect individuals to prevention, care, treatment, and	Use regional epidemiological data to establish linkage performance at regional level	DOH-HAHSTA; VDH; MD DHMH; WV DHHR	Quarterly Data Report	March 2016
		Monitor and evaluate linkage process improvements	DOH-HAHSTA	% newly diagnosed HIV cases linked to care within 3 months by testing facility	June 2016

NHAS 2020 GOAL: INCREASE ACCESS TO CARE AND IMPROVE HEALTH OUTCOMES FOR PEOPLE LIVING WITH HIV OR AIDS					
DC EMA Goal 2: ENGAGEMENT- Increase and sustain care engagement among people living with HIV in the DC EMA					
Objectives	**Strategies**	**Activities/Measurements**	**Responsible Entities**	**Metrics**	**Timeframe**
	support services (Demonstration Project: Data to Care)	Ensure synchronization of data collection variables across regions	DOH-HAHSTA; VDH; MD DHMH; WV DHHR	Finalized Variable List	December 2016
		Identify and recapture people living with HIV who have been out of care for six or more months	DOH-HAHSTA	# re-engaged in care	December 2016
	S1.3 Reduce the time from initial diagnosis to linkage from 90 days to 30 days	Re-launch of the Red Carpet Entry Program	DOH-HAHSTA	#of days from diagnosis to linkage	2018
		Develop and Implement Demonstration Project: Rapid ART	DOH-HAHSTA	% of uptake, adherence and time to viral load suppression	2018
		Maintain and expand Community Health Worker model	DOH-HAHSTA	Increased # of sites using CHWs; # of CHWs	Maintain 2017, Expand 2018
		Utilize peer navigators to engage with key target populations	DOH-HAHSTA	Increased # of sites using PN/IMPACT Specialist; # of peers	2020
		Ensure the provision of more accessible services (Demonstration project: Retention in HIV Care and Treatment)	DOH-HAHSTA	# of new service sites providing client access; # of retained in care	2017-2018

NHAS 2020 GOAL: INCREASE ACCESS TO CARE AND IMPROVE HEALTH OUTCOMES FOR PEOPLE LIVING WITH HIV OR AIDS					
DC EMA Goal 2: ENGAGEMENT- Increase and sustain care engagement among people living with HIV in the DC EMA					
Objectives	**Strategies**	**Activities/Measurements**	**Responsible Entities**	**Metrics**	**Timeframe**
	S1.4 Identify opportunities to expand knowledge of culturally aware and flexible HIV/AIDS services	Community engagement/outreach to collect feedback on satisfaction with services being received and determine needs	DOH-HAHSTA	# of surveys and focus groups completed	2019
		Develop a provider toolkit from consumer feedback to be used across the region	DOH-HAHSTA	Toolkit created and the # distributed	2020
		Develop technical assistance and trainings for providers to remain culturally informed	DOH-HAHSTA	# of trainings and technical assistance materials created	2019
		Implement a dissemination plan between HAHSTA, regional health departments, regional providers	DOH-HAHSTA	# of plans distributed	2018

NHAS 2020 GOAL: INCREASE ACCESS TO CARE AND IMPROVE HEALTH OUTCOMES FOR PEOPLE LIVING WITH HIV OR AIDS					
DC EMA Goal 2: ENGAGEMENT- Increase and sustain care engagement among people living with HIV in the DC EMA					
Objectives	**Strategies**	**Activities/Measurements**	**Responsible Entities**	**Metrics**	**Timeframe**
O2.2 By 2021, Increase the proportion of Ryan White consumers who are retained in care from 87% to 90% * *based on 2014 Retention in Care for Ryan White Consumers	**Focus Populations: Men who have sex with men and transgender of color; African immigrants; Youth/young adults 13-29; African American heterosexual cisgender men; African American cisgender women; Youth transitioning out of pediatric care; Adults 50+; people who inject drugs; homeless or at risk of homelessness**				
	S1.1 Work with other agencies to address social determinants of health, including health behaviors, clinical care, social and economic factors and physical environment, particularly in target populations	Develop technical assistance program for cross provider partnerships to address the whole person and their needs living with HIV	DOH-HAHSTA	# of training and TA courses, webinars, and materials that address whole person health and living with HIV; # of providers that engage through the program in partnerships across various specialty, primary, and ancillary services	2018
		Develop, test, and implement a standardized screening for mental health and substance use issues	DOH-HAHSTA	Creation, roll out of standardized screening modality	2018
		Develop a web-based resource warehouse where tools, policies, resources are available	DOH-HAHSTA	Creation of the web-based site	2019

NHAS 2020 GOAL: INCREASE ACCESS TO CARE AND IMPROVE HEALTH OUTCOMES FOR PEOPLE LIVING WITH HIV OR AIDS					
DC EMA Goal 2: ENGAGEMENT- Increase and sustain care engagement among people living with HIV in the DC EMA					
Objectives	**Strategies**	**Activities/Measurements**	**Responsible Entities**	**Metrics**	**Timeframe**
		Work with regional employment readiness experts and housing service providers to complete a demonstration project for unaccompanied adults, age 18 years or older, with low incomes, who are homeless or at risk of homelessness, and who are living with HIV/ AIDS. Support services will include services coordination (case management), housing search assistance, and employment assistance; financial services will include security deposits, utilities assistance, and ongoing rental assistance for a period not to exceed 24 months.	DOH-HAHSTA	Assist an estimated 50 households	Two years, by 2018
	S1.2 Redefine the concept of retention to correspond to the current state of HIV Care and Treatment in the region	Creating a regional standardized working definition of retention in care	Regional health dept. workgroup	Standardized regional definition of retention	2018
		Wrap around services for people living with HIV to increase adherence (Anchoring-to-care program: anchoring patients to treatment and services by utilizing care management/navigators to provide traditional linkage complemented by health care providers)	DOH-HAHSTA	% persons linked and retained in care	November 2017
	S1.3 Re-direct resources so strategies can be optimized in developing approaches to expand	Develop/improve telemedicine programs	DOH-HAHSTA	# of patients enrolled in a telemedicine adherence support program	Ongoing through 2021

NHAS 2020 GOAL: INCREASE ACCESS TO CARE AND IMPROVE HEALTH OUTCOMES FOR PEOPLE LIVING WITH HIV OR AIDS					
DC EMA Goal 2: ENGAGEMENT- Increase and sustain care engagement among people living with HIV in the DC EMA					
Objectives	**Strategies**	**Activities/Measurements**	**Responsible Entities**	**Metrics**	**Timeframe**
	access to treatment and related services, targeting populations and geographic areas where communities are at higher risk	Increase transportation supports	DOH-HAHSTA	# of persons served	2017
		Expand housing assistance and wrap-around services through a demonstration project for victims of domestic violence, dating violence, sexual assault, or stalking to maintaining healthy relationships, stable housing and overall wellbeing. (VAWA Housing)	DOH-HAHSTA	Assist an estimated 27 households	3 year period, by 2019
		Develop community partnerships to address whole person well-being: fitness and recreation	DOH-HAHSTA	# of re-engaged and new community partnerships; # of persons participating	2020
		Maintain and expand community health worker model	DOH-HAHSTA	Increased # of sites using CHWs	Maintain 2017, Expand 2018
	S1.4 Implement a comprehensive model of care addressing retention/ reengagement of established HIV consumers , targeting populations and geographic areas where communities are at higher risk	Decrease the number of persons living with HIV that have service needs through addressing the whole person and the social determinants of health	DOH-HAHSTA	Unmet Need Calculations; Trend decrease over 5 years from waiver	Ongoing through 2021
		Increase the use of data (geospatial, surveys, ethnographic) to identify and address stigma around HIV care and treatment	DOH-HAHSTA	Mapping hotspots/ pockets of unmet need	By 2018

NHAS 2020 GOAL: INCREASE ACCESS TO CARE AND IMPROVE HEALTH OUTCOMES FOR PEOPLE LIVING WITH HIV OR AIDS					
DC EMA Goal 2: ENGAGEMENT- Increase and sustain care engagement among people living with HIV in the DC EMA					
Objectives	**Strategies**	**Activities/Measurements**	**Responsible Entities**	**Metrics**	**Timeframe**
		Support Demonstration Project: Retention in HIV Care and Treatment/ The Mobile Outreach Retention and Engagement (MORE) initiative	DOH-HAHSTA	# of persons served; # of persons in care; # virally suppressed	By 2018
		Implement an enhanced supportive housing demonstration project with basic and enhanced, intensive care and support services to low-income persons living with HIV through the Joseph's Housing – Maycroft Program (JHMP) Demonstration Project	DOH-HAHSTA	Assistance for households residing in 8 subsidized units	2 year period, by 2018

NHAS 2020 GOAL: REDUCING NEW HIV INFECTIONS, INCREASE ACCESS TO CARE AND IMPROVE HEALTH OUTCOMES FOR PEOPLE LIVING WITH HIV OR AIDS and REDUCING HIV-RELATED HEALTH DISPARITIES AND INEQUITIES					
DC EMA Goal 3: VIRAL SUPPRESSION- Continue to support capacity of care engagement for people living with HIV					
Objectives	**Strategies**	**Activities/Measurements**	**Responsible Entities**	**Metrics**	**Timeframe**
O3.1 By 2021, increase the percentage of Ryan White program consumers who are virally suppressed from 58% to at least 90% * (In accordance with Treatment as Prevention Strategy) *based on 2014 Viral Suppression among Ryan White Consumers	**Focus Populations: Youth/young adults 13-34; Men who have sex with men and transgender of color; African immigrants; African American heterosexual cisgender men; African American cisgender women; people who inject drugs**				
	S1.1 Build relationships and work with pharmacies and Pharmacy Benefits Managers around treatment adherence	Implement pharmacies, providers, and treatment adherence programs	DOH-HAHSTA/ ADAP	# of pharmacies (MOU/MOA)	By 2019
		Work with pharmacies to refer patients who do not pickup medications regularly to treatment adherence programs	DOH-HAHSTA/ ADAP	# of prescriptions dispensed; # of patients referred	By 2019
	S1.2 Build relationships with HIV care providers to improve treatment adherence and health outcomes for people living with HIV	Build connections to recruit and include new HIV providers to join the Ryan White network in services where there are gaps in providers	DOH-HAHSTA	# of new providers	By 2018
		Connect non-Ryan White providers to the Ryan White community to build referral networks		Resource List	By 2018
		Create opportunities for Ryan White, non-Ryan White and prevention providers to network		Biannual meetings	By 2018

NHAS 2020 GOAL: REDUCING NEW HIV INFECTIONS, INCREASE ACCESS TO CARE AND IMPROVE HEALTH OUTCOMES FOR PEOPLE LIVING WITH HIV OR AIDS and REDUCING HIV-RELATED HEALTH DISPARITIES AND INEQUITIES					
DC EMA Goal 3: VIRAL SUPPRESSION- Continue to support capacity of care engagement for people living with HIV					
Objectives	**Strategies**	**Activities/Measurements**	**Responsible Entities**	**Metrics**	**Timeframe**
		Add performance measures to future contracts with Medicaid, Managed Care Organizations, and private third party payers to encourage treatment adherence, viral load suppression, and funding for support services	DOH-HAHSTA	# of MCO beneficiaries virally suppressed	By 2019
	S1.3 Provide targeted treatment adherence support to key populations	Use Ryan White dollars to support new and expanded treatment adherence support programs: direct observed therapy for initial HIV treatment and Technology based interventions	DOH-HAHSTA	# of persons served; % virally suppressed	By 2018
		Re-assess and identify key populations in need of treatment adherence support on an annual basis		Annual data report on key populations	Annually
	S1.4 Enhance mechanisms to collect and analyze data of treatment status and medical providers' treatment outcomes	Identify other data sources to help determine whether an individual is virally suppressed	DOH-HAHSTA	# of persons identified through sources	2020

NHAS 2020 GOAL: REDUCING NEW HIV INFECTIONS, INCREASE ACCESS TO CARE AND IMPROVE HEALTH OUTCOMES FOR PEOPLE LIVING WITH HIV OR AIDS and REDUCING HIV-RELATED HEALTH DISPARITIES AND INEQUITIES					
DC EMA Goal 3: VIRAL SUPPRESSION- Continue to support capacity of care engagement for people living with HIV					
Objectives	**Strategies**	**Activities/Measurements**	**Responsible Entities**	**Metrics**	**Timeframe**
		Expand surveillance data point to identify other information that should be collected to truly understand viral suppression- collect this from providers to help us understand viral suppression	DOH-HAHSTA	Expanded data points collected in surveillance	2020
O3.2 Transform Ryan White HIV support services to improve viral load suppression rates throughout the EMA (In accordance with Treatment as Prevention strategy)	S1.1 Increase access to HIV support services, including mental health services, substance use services, housing services, and enhanced economic opportunities throughout the EMA	Create an EMA wide fee for service payment model to increase access to services	DOH-HAHSTA	Payment Model Complete	2017-2020
		Expand provider network to create new access points	DOH-HAHSTA	# of new access points	Begin 2017
		Collaboration with Medicaid on the Health Homes 2 initiative through services and supports promoting care for the whole-person	DOH-HAHSTA	# of persons served by health homes	Implementation January 2017
		DC EMA HOPWA program redesign, to provide comprehensive services and resources to a larger and increasing group of participants (Demonstration Project: Housing and Employment)	DOH-HAHSTA	# of persons achieving housing self-sufficiency; # of persons transitioned to other supported housing settings; # of persons served with housing assistance	By 2021

NHAS 2020 GOAL: REDUCING NEW HIV INFECTIONS, INCREASE ACCESS TO CARE AND IMPROVE HEALTH OUTCOMES FOR PEOPLE LIVING WITH HIV OR AIDS and REDUCING HIV-RELATED HEALTH DISPARITIES AND INEQUITIES					
DC EMA Goal 3: VIRAL SUPPRESSION- Continue to support capacity of care engagement for people living with HIV					
Objectives	**Strategies**	**Activities/Measurements**	**Responsible Entities**	**Metrics**	**Timeframe**
		Empower people living with HIV to access economic opportunities, increase self-sufficiency and improved health outcomes through an employment and housing demonstration project	DOH-HAHSTA	Assist in an estimated 50 households	2 year period, by 2018

NHAS 2020 GOAL: Achieve a More Coordinated National Response to the HIV Epidemic				
DC EMA Goal 4: INTEGRATION				
4.1 By 2018, HAHSTA will fully integrate the HIV Prevention and Planning Group and the Ryan White Planning Council into one regional planning body				
4.2 By 2021, the DC EMA continue structural coordinated efforts to operate as a regional health system with complete integration of all jurisdictions				
Surveillance Workgroup	Routine inter-jurisdictional meetings/calls to discuss issues related to routine data exchange protocols, processes, and infrastructure; and issues concerning data utilization, interpretation, and dissemination; Compile and discuss best practices and opportunities for data systems integration and improvements; Compile, share and discuss the opportunities to standardize data collection forms and platforms; Establish protocol for routine data sharing and real-time access to data for client monitoring	Strategic Information Division	Monthly Conference Calls	October 2016
Care and Continuum Workgroup	Develop protocol for identifying consumers for follow-up; Establish mechanism to prioritize consumers for follow-up	Care Division		
Field Services	Review and assess all regional HIV partner services protocol to develop a regional model for use in the Washington EMA.			

II-B: Collaborations, Partnerships, and Stakeholder Involvement

District Mayor Muriel Bowser announced a public–private collaboration to develop a plan to "end" the epidemic. The District established the goals of 90/90/90/50 by the year 2020 aiming to achieve 90 percent of persons with HIV to know their status, 90 percent engaged in HIV care and treatment, 90 percent of persons with viral load suppression, and a 50 percent decrease in new diagnoses of HIV. The 90/90/90/50 goals guided the development of the Integrated Plan and provided the framework for the DC EMA's objectives responding to the NHAS goals. As health departments throughout the DC EMA create goals and plans to end the epidemic, the current HIV Prevention Planning Group and Ryan White Planning Council and subsequent integrated HIV planning council, and DC DOH will work collaboratively to incorporate strategies and ensure a regional approach.

DC DOH is working to create a coordinated and concentrated effort to prevent HIV and ensure care is provided to people living with HIV. These partnerships cross program and community sector, including but not limited to District government agencies for housing (Department of Housing and Community Development), health insurance (Department of Health Care Finance/Medicaid and Department of Insurance, Security and Banking), mental health and substance use (Department of Behavioral Health), workforce development (Department of Employment Services, Office of Disability Services), regional prevention services and planning groups, RW Parts B and C, HOPWA programs, local community-based organizations, and GWU.

DC DOH maintains an institutional collaboration with the GWU Department of Health Policy and Management. GWU has conducted research and analysis on a wide range of policy topics for DC DOH since 2012. In the past year, key components of this work have included ongoing research support for DC DOH's payment reform plans; analysis of a set of issues related to the District's HIV reporting requirements; an assessment of coverage of HIV and hepatitis C drugs in plans sold in the DC Health Insurance Marketplace (DC Health Link); and a synthesis and summary of the current body of evidence on the effectiveness of linkage to care activities. For this Integrated Plan, GWU was instrumental in coordinating and preparing the development of the extensive, DC EMA wide Financial and Human Resources Inventory.

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

II-C: People living with HIV and Community Engagement

In order to form the Integrated Plan workgroup, members from the HIV Prevention Planning group (HPPG) and the Ryan White Planning Council (RWPC) were invited to participate in the integrated HPPG/RWPC workgroup (Integrated Plan Workgroup) and planning process, including persons living with HIV, key stakeholders in prevention, care and related services, and representatives of organizations that can inform and support development and implementation. The group included prevention, care, mental health and substance abuse providers, including prevention providers for MSM, heterosexuals, IDUs, sex workers, transgender women and youth; Black, Latino and white MSM; Black Heterosexual men and women; Black transgender women; and youth. Members from the HIV Prevention Planning group that consistently attended and contributed to workgroup meetings represented:

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

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

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

This represents 31% of the 13 categories that HRSA requires for the Ryan White Planning Council. The HPPG/RWPC workgroup obtained the commitment and support from all members to contribute to the development of Integrated Plan goals, objectives, strategies, and activities. The planning body chairs, coordinators, and participants convened meetings of the HPPG/RWPC workgroup on a monthly basis through the year to coordinate work plans, set time lines, identify goals, develop strategies, list activities, and edit drafts for the workgroup to make changes and improvements that ultimately led to a robust and comprehensive integrated five-

year plan for the DC EMA.

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

SECTION III: Monitoring and Improvement

Monitoring and improvement will involve frequent evaluation of plan activities to ensure implementation of objectives, strategies, and activities is being performed as stated and are effective in responding to the needs of the DC EMA. In order to monitor plan activities, recognize progress, and identify needed improvements, the HPPG/RWPC work group that was established to develop this Integrated Plan will evolve into a standing body Integrated Plan (IP) Committee. The Integrated Plan is a living document that will adjust as activities get underway. The Integrated Plan committee would be charged to oversee all communication with the planning bodies and elicit information and updates from relevant DC DOH staff. Once initial monitoring and evaluation strategies are refined, the IP Committee would meet up to four times a year, or as needed, for general monitoring. This committee will eventually be part of the newly integrated regional planning body when the HPPG and RWPC are merged by 2018.

The IP Committee will initially meet monthly to:

- Outline strategies and expectations towards developing a focused monitoring and evaluation plan
- Review goals, strategies, and activities on routine basis to ensure continual assessment of plan activities and progress
- Examine the appropriateness, effectiveness, and efficiency of the activities designed to accomplish the Integrated Plan's objectives and strategies
- Ensure planning bodies are kept informed on plan progress
- Ensure planning bodies are provided opportunities to discuss perspectives or concerns about plan progress
- Examine and incorporate planning bodies' suggestions into realistic process activities for use in achieving Integrated Plan goals
- Organize efforts to amend or update the plan when needed

Through the development of this Integrated Plan, DC DOH also formed collaborations with planners at the other regional state health departments. Through those partnerships, as well as through the administrative agents representing each state, DC DOH will maintain open dialogue regarding the progress of each state plan and how effectively efforts relate, overlap, and respond to the shared regions. DC DOH representatives will initiate and lead communications between the EMA and the state health department representatives in Virginia, Maryland, and West Virginia. As plans are implemented regionally and challenges arise, these partnerships can provide a support system for trouble shooting and resolving complex, systemic challenges. The health department collaboration will also assist on brainstorming quality improvement approaches as well as what modifications and updates to the planning process are required for a more coordinated and realistic regional response.

Finally, relevant DC DOH prevention, care and treatment health department personnel will meet every other month to review timelines, status on the activities and strategies in the plan, internal modifications that need to be made, and challenges or barriers to desired outcomes.

Communication channels will also be unrestricted between IP committees, planning bodies, and health department personnel with the planner acting as a liaison between all groups.

Data Monitoring. Building on previous efforts, the current data to care strategy utilizes expanded surveillance and data monitoring activities to better target outreach efforts directed toward ensuring that HIV positive individuals are engaged in appropriate care and treatment services.

At the foundation of proposed data to care efforts within the District is the effective integration and utilization of the various surveillance, monitoring and evaluation, and administrative data systems maintained by the DC DOH and other governmental agencies which collect information concerning population health and care and treatment utilization. The linkage of case information across multiple data sources will facilitate an individual level assessment of care utilization, treatment provision, and health outcomes among those living with HIV, aiding in the identification and prioritization of those targeted for care re-engagement efforts. In addition to housing the District's Enhanced HIV/AIDS Reporting System (eHARS), AIDS Drug Assistance Program (ADAP), and Ryan White CAREWare database; DC DOH currently has data use and security agreements with the District Department of Health Care Finance (DHCF) which administers the Medicaid program. Under the current proposal, DC DOH plans to expand beyond the current reliance on HIV laboratory data retained in eHARS to define individual care status by incorporating service utilization and prescription information collected through these ancillary data systems. Given the variation in provider practices and client needs, the utilization of expanded metrics for assessing care engagement is integral to the accurate identification of HIV positive individuals that could potentially benefit from targeted outreach efforts.

Given the multiple Maryland and Virginia counties bordering the District of Columbia that are included as part of the greater metropolitan area, another essential component of outlined data integration processes is the routine matching of case information across jurisdictions. Recently established data sharing agreements between the District of Columbia, Maryland, and Virginia health departments will facilitate the assessment of HIV case migration between jurisdictions. Under the established inter-jurisdictional data sharing agreements, the Maryland and Virginia health departments will forward HIV testing and laboratory reports they receive to DC DOH if the information included in the report is indicative of a current residential address within the District and/or the receipt of care and treatment services by a provider facility located in the District. In collaboration with Georgetown University, each jurisdiction is also currently participating in the development of an automated data matching and exchange system for routinely identifying HIV positive individuals within the metropolitan area that have testing and/or laboratory reports across multiple jurisdictional eHARS databases. These efforts are essential for accurately identifying HIV cases diagnosed in the District that have relocated to surrounding jurisdictions, as well as HIV positive individuals living in the District that are receiving care and treatment services outside of the jurisdiction. The identification of HIV cases diagnosed in the District that have relocated to jurisdictions other than Maryland and Virginia will be dependent on CDC supported routine interstate duplicate review processes.

Based on quarterly assessments of matched case information from multiple data systems, provider and DC DOH led outreach efforts will be directed toward HIV positive individuals without evidence of recent care and/or treatment utilization for a nine month period, as well as individuals in care that have marginal clinical laboratory results potentially indicative of barriers to treatment compliance. The effectiveness of data to care efforts will be based on the routine assessment of the percentage of targeted individuals re-engaged with care services.

In addition the outlined data to care activities, DC DOH will also implement efforts directed toward increased provider feedback concerning client outcomes, as well as the expanded analysis of demographic and spatial patterns in outcomes along the HIV care continuum. As part of expanded monitoring activities, DC DOH is in the process of developing a template for care facility report cards documenting site-specific patient population HIV care utilization and health outcome characteristics relative to the overall jurisdiction. Once finalized, the routine dissemination of individual care facility report cards will provide a means for providers to assess their performance relative to other facilities in the jurisdiction, as well as facilitate dialogue between DC DOH and providers concerning the challenges encountered in serving target populations and the identification of ways in which DC DOH can better support their efforts.

As a means of better understanding the social, economic, and structural factors impacting care utilization and outcomes among those living with HIV in the region, DC DOH is in the process of analyzing geographic patterns in HIV care linkage and retention and viral suppression. Information concerning spatial patterns in outcomes along the HIV care continuum will be utilized by DC DOH to better target resources in communities exhibiting suboptimal outcomes. Additionally, this information will be utilized to inform the further development of partnerships and programs to address macro level health determinants.

Amanda D. Castel, 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

Appendix

Expanded Financial Inventory

Name: Financial Inventory

Description: This table is an HIV resource inventory which includes (1)(a) public and private funding sources for HIV prevention, care, and treatment services in the DC EMA; the dollar ($) amount of available funds from that source in fiscal year (FY) 2016; the services those funds deliver; (d) the agencies that deliver those services, and (e) the HIV Care Continuum Step(s) that are impacted.

Where FY16 data are not available but the funding source is known or presumed to still be in place, earlier data are provided, as indicated. See notes column for further details on each section.

Funding sources listed in the CDC/HRSA guidance that are excluded from this chart because no amounts are currently awarded for HIV/AIDS purposes in the EMA are: AETCs, Federal Office of Rural Health Policy, Indian Health Service, and the Office of Women's Health.

Link to Guidance: Guidance on Integrated Plan

(1)(a) Funding Source	(1)(b) Funding Amount ($) from (1)(a) [FY16 unless otherwise indicated]	(1)(c)Services Delivered Using (1)(b)	(1)(d) Agencies Providing (1)(c)	(1)(e) HIV Care Continuum Step(s) Impacted	Data Source(s)	Notes
Grant Funding						
Ryan White Part A						
DC	$10,833,050	Outpatient Ambulatory Medical Care, Medical Case Management, Mental Health Services, Medical Nutrition Therapy, Early Intervention Services, Home & Community-Based Health Svcs*, Substance Abuse Services - Outpatient, Medical Transportation Services*, Treatment Adherence Counseling*, Outreach Services*, Psychosocial Support Services*, Emergency Financial Assistance, Food Bank/Home-Delivered Meals*, Oral Health Services, Early Intervention Services (EMA), Linguistics Services*, Legal Services*	AIDS Healthcare Foundation, Andromeda Transcultural Health, Casa Ruby, Children's National Medical Center, DC Care Consortium, Family & Medical Counseling Services, Helping Individuals Prostitutes Survive (HIPS), Howard University (CIDMAR), Institute for Public Health Innovation, La Clinica del Pueblo, Metro Health, United Medical Center, Unity Health Care, Whitman-Walker Health	Diagnosis, Linkage to Care, Retention in Care, Antiretroviral Use, Viral Load Suppression	Financial and Human Resources Inventory for RW 07-29-16.csv	Award includes $1,246,920 MAI
MD	$7,302,788	Outpatient Ambulatory Medical Care, Medical Case Management, Non-Medical Case Management, AIDS Pharmaceutical Assistance (local), Early Intervention Services, Health Insurance Premium & Cost Sharing, Medical Transportation Services*, Medical Nutrition Therapy, Mental Health Services, Substance Abuse Services - Outpatient, Emergency Financial Assistance*, Food Bank/Home-Delivered Meals*, Oral Health Services, Child Care Services, Linguistics Services*, Outreach Services	AIDS Healthcare Foundation, Charles County Department of Health, Children's National Medical Center, Frederick County Health Department, Greater Baden Medical Services, Heart to Hand, Montgomery County DHHS, Prince George's County FHS	Diagnosis, Linkage to Care, Retention in Care, Antiretroviral Use, Viral Load Suppression	Financial and Human Resources Inventory for RW 07-29-16.csv	Includes $504,864 MAI
VA	$5,173,847	Outpatient Ambulatory Medical Care, Medical Case Management, Non-Medical Case Management, Outreach Services, Housing Services, Emergency Financial Assistance, Child Care Services, Oral Health Services, Mental Health Services, Health Insurance Premium & Cost Sharing, Substance Abuse Services - outpatient, Linguistics Services*, Medical Transportation Services*, Early Intervention Services, Food Bank/Home-Delivered Meals*, Medical Nutrition Therapy, Services*, Legal Services*, AIDS Pharmaceutical Assistance (local)	AIDS Response Effort, Neighborhood Health, Institute for Pulic Health Innovation, Food and Friends, Fredericksburg Area HIV/AIDS Support Services, INOVA Juniper Program, Legal Services of Northern Virginia, Mary Washington Healthcare, NovaSalud, Virginia Health Options	Diagnosis, Linkage to Care, Retention in Care, Antiretroviral Use, Viral Load Suppression	Financial and Human Resources Inventory for RW 07-29-16.csv	Includes $338,175 MAI
WV	$397,273	AIDS Pharmaceutical Assistance (local), Emergency Financial Assistance, Health Insurance Premium & Cost Sharing, Mental Health Services, Medical Nutrition Therapy, Medical Case Management, Medical Transportation Services*, Outpatient Ambulatory Medical Care, Food Bank/Home-Delivered Meals*, Outreach Services*	Shenandoah Valley Medical System	Diagnosis, Linkage to Care, Retention in Care, Antiretroviral Use, Viral Load Suppression	Financial and Human Resources Inventory for RW 07-29-16.csv	Includes $25,433 MAI
EMA Total	$23,706,958					
Ryan White Part B						
DC	$3,793,698	Medical Case Management, Medical Nutrition Therapy, Food Bank/Home-Delivered Meals*, Health Insurance Premium & Cost Sharing, Early Intervention Services, Medical Transportation Services*, Outreach Services*, Mental Health Services, Psychosocial Support Services*, Treatment Adherence Counseling*	Community Family Life Services, Damien Ministries, DC Care Consortium, Food and Friends, Homes for Hope, Howard University Hospital (HUHCARES), La Clinica del Pueblo, Terrific, Inc., The Women's Collective, Us Helping Us	Diagnosis, Linkage to Care, Retention in Care, Antiretroviral Use, Viral Load Suppression	Financial and Human Resources Inventory for RW 07-29-16.csv	Includes $157,925 MAI
MD	$18,958,343				Peter Demartino, peter.demartino@maryland.gov, 8/16/16	Multiply total federal Part B plus rebate spending ($50,555,582 for Ryan White grant year 2016) times proportion PLW diagnosed HIV in EMA (37.5% - see Prevalence Calculations worksheet for more info)
VA	$1,544,673	OAMC(Specialty), Oral Health, Mental health, Non-Medical Case Management, Medical Transportation and EFA Food. The total award also includes NVRC Admin Dollars.	Northern Virginia Regional Commission	Diagnosis, Linkage to Care, Retention in Care, Antiretroviral Use, Viral Load Suppression	Draft Financial Inventory from VA, sent by Bruce Taylor, 8/12/16, Bruce.Taylor@vdh.virginia.gov	
WV	$666,450	ADAP, Medical Case Management, Oral Health, Co-insurance and ADAP insurance premiums, medical transportation and nutrition food vouchers	WV ADAP, AIDS Task Force	Diagnosis, Linkage to Care, Retention in Care, Antiretroviral Use, Viral Load Suppression	Jay Adams, HIV Care Coordinator WV Ryan White Part B Program, jayadams3@sbcglobal.net, 8/16/16	
EMA Total	$24,963,164					
Ryan White Part C						**See Part C Funding Worksheet for details**

DC	$1,980,115		Unity Health Care, Whitman-Walker Clinic Inc, Family and Medical Counseling Service, Howard University, Inc, Providence Health Foundation, Inc		HRSA Data Warehouse, http://datawarehouse.hrsa.gov/Tools/DataPortalResults.aspx?paramGrantId=active&paramTyp=State&paramCd=11&paramFilterId=HAB	
MD	$302,052		Greater Baden Medical Service Inc, Medstar Health Research Institute		HRSA Data Warehouse, http://datawarehouse.hrsa.gov/Tools/DataPortalResults.aspx?paramGrantId=active&paramTyp=State&paramCd=11&paramFilterId=HAB	
VA	$376,442	Primary Medical Care, Medical Case Management, Oral Health, Mental Health, Substance Abuse [Inova]; Primary Medical Care [MWH]	Inova Healthcare Services, Mary Washington Healthcare	Diagnosis, Linkage to Care, Retention in Care, Antiretroviral Use, Viral Load Suppression	HRSA Data Warehouse, http://datawarehouse.hrsa.gov/Tools/DataPortalResults.aspx?paramGrantId=Active&paramTyp=State&paramCd=51 Barb Lawrence, Senior Manager, Inova Health Systems barbara.lawrence@inova.org http://www.novaregion.org/index.aspx?nid=872	
WV	$2,500	Primary Medical Care	Shenandoah Valley Medical System	Diagnosis, Linkage to Care, Retention in Care, Antiretroviral Use, Viral Load Suppression	Stacey McIe, West Virginia University (prime recipient for Part C funding) smcie@hsc.wvu.edu	$2500 of WVU Part C goes to Shenandoah Valley Medical System
EMA Total	$2,661,109					
Ryan White Part D						
DC	$0					
MD	$0					Medstar had Part D - reached out to check status
VA	$542,049	Primary Medical Care, Medical Case Management, Oral Health, Mental Health, Substance Abuse, and Transportation	Juniper Program, Inova Health System		Barb Lawrence, Senior Manager, Inova Health Systems barbara.lawrence@inova.org	
WV	$0				Stacey McIe, West Virginia University (prime recipient for Part C funding) smcie@hsc.wvu.edu	Stacey McIe, WVU, confirmed zero goes to Martinsburg site or any other part of EMA.
EMA Total	$542,049					
Ryan White Part F - Dental						
DC	$0		Howard University and Washington Hospital Center Department of Oral & Maxillofacial Surgery (need to get activities, amounts)		https://careacttarget.org/grants/593; data from HRSA data warehouse, last revised 10/1/15	
MD	$0				Confirmed with Peter DeMartino, peter.demartino@maryland.gov, 8/16/16	
VA	$0				Confirmed with Claire Husted	
WV	$0					
EMA Total	$0					
CDC HIV Prevention						
DC	$4,443,361	Condom distribution, HIV prevention for high-risk negatives, Full-Range clinical support for positives (treatment adherence, HIV screening, and linkages to care), HIV screening and linkages to care.	Family and Medical Counseling Service, Whiteman Walker Health, Community Education Group, Medstar Washington Hospital Center, La Clinica del Pueblo	Prevention, Diagnosis, Linkage to Care		FY16 from HAHSTA
MD	$2,681,956			Prevention	Peter Demartino, peter.demartino@maryland.gov, 8/16/16	Note: this reflects total CDC prevention, testing, linkage to care and partner services funding allocated to the MD counties in the EMA. Therefore additional funding levels are not reflected under Testing.
VA	$1,024,166	Prevention	Alexandria Health Department, Fredericksburg Area HIV/AIDS Support Services, Inova Health Systems, Institute for Public Health Innovation, NovaSalud	Prevention	Bruce Taylor - bruce.taylor@vdh.virginia.gov Elain Martin - elaine.Martin@vdh.virginia.gov	Bruce Taylor email on 08/25/16
WV	$71,625	HIV Testing, Outreach testing, CTR/recertification, educational presentation, partner services, Condom Distribution.		Prevention	Jay Adams, HIV Care Coordinator WV Ryan White Part B Program, jayadams3@sbcglobal.net , 8/16/16, inl info from Susan Hall, state	Note: this reflects total CDC prevention and testing funding for WV allocated to the counties in the EMA.
EMA Total	$8,221,108					
CDC HIV Testing						
DC	$1,200,000	Routine HIV Screening is conducted in clinical settings in addition to linking HIV positive infividuals into care.	Howard University, Georgetown MedStar Washington Hospital, Children's National Medical Center, United Medical Center, Providence Hospital	Diagnosis, Linkage to Care		FY16 from HAHSTA
MD	$0					Note: CDC testing funds is included under CDC prevention for MD
VA	$368,000	Testing	Fredericksburg Area HIV/AIDS Support Services, NovaSalud	Diagnosis	Bruce Taylor - bruce.taylor@vdh.virginia.gov Elain Martin - elaine.Martin@vdh.virginia.gov	Taylor email 8/25/16

WV	$0				Jay Adams, HIV Care Coordinator WV Ryan White Part B Program, jayadams3@sbcglobal.net , 8/16/16, inl info from Susan Hall, state	Note: CDC testing funds is included under CDC prevention for WV
EMA Total	$1,568,000					
CDC HIV Surveillance						
DC	$1,396,836					FY16 from HAHSTA
MD	$492,410				hhs taggs search	$1,313,093 * .375 See surveillance worksheet and prevalence worksheet
VA	$516,170				hhs taggs search	$1,720,566 * .30 See surveillance worksheet and prevalence worksheet
WV	$25,696				hhs taggs search	$197659 * .13 See surveillance worksheet and prevalence worksheet
EMA total	$2,431,112					For MD, VA, WV: Multiplied statewide award times proportion of PLWH in the EMA
CDC HIV CBOs						
DC	$1,750,000	PS15-1502: Comprehensive High-Impact HIV Prevention Projects for Community-Based Organizations	Family and Medical Counseling Service, Inc. Washington $350,000.00 La Clinica del Pueblo, Inc. Washington $350,000.00 Sasha Bruce Youthwork, Inc. Washington $350,000.00 Us Helping Us, People Into Living, Inc. Washington $350,000.00 Women's Collective Washington $350,000.00(http://www.cdc.gov/hiv/pdf/funding/announcements/ps15-1502/cdc-hiv-ps15-1502-funding--by-state-and-grantee.pdf)	Prevention	http://kff.org/hivaids/state-indicator/cdc-funding-hivaids/ for total	FY15
MD	$0				http://kff.org/hivaids/state-indicator/cdc-funding-hivaids/ confirmed Peter Demartino, peter.demartino@maryland.gov, 8/16/16	
VA	$0				http://kff.org/hivaids/state-indicator/cdc-funding-hivaids/	None in EMA
WV	$0	0	0		http://kff.org/hivaids/state-indicator/cdc-funding-hivaids/	
EMA Total	$1,750,000					
CDC HIV School Health						
DC	$698,683	Collect and report Youth Risk Behavior Survey (YRBS) and School Health Profiles data. Deliver exemplary sexual health education emphasizing HIV and other STD prevention (ESHE); increase adolescent access to key sexual health services (SHS); and establish safe and supportive environments for students and staff (SSE).	DC Board of Education Office of the State Superintendent	Prevention, Diagnosis, Linkage to Care	https://taggs.hhs.gov/SearchAdv/AdvSearchResults; http://www.cdc.gov/healthyyouth/partners/funded_states.htm; http://www.cdc.gov/healthyyouth/partners/funded_locals.htm	Two awards, one to BoE and one to OSSE
MD	$29,843	Cooperative Agreements to Promote Adolescent Health through School-Based HIV/STD Prevention and School-Based Surveillance		Prevention	http://kff.org/hivaids/state-indicator/cdc-funding-hivaids/ http://www.cdc.gov/healthyyouth/partners/funded_states.htm confirmed Peter Demartino, peter.demartino@maryland.gov, 8/16/16	$79,581 * .375 See surveillance worksheet and prevalence worksheet
VA	$20,723	Cooperative Agreements to Promote Adolescent Health through School-Based HIV/STD Prevention and School-Based Surveillance		Prevention	hhs taggs search; http://www.cdc.gov/healthyyouth/partners/funded_states.htm	$69,078 * .30 See surveillance worksheet and prevalence worksheet
WV	$8,450	Collect and report Youth Risk Behavior Survey (YRBS) and School Health Profiles data			hhs taggs search; http://www.cdc.gov/healthyyouth/partners/funded_states.htm	$65,000 * .13 See surveillance worksheet and prevalence worksheet
EMA Total	$757,699					For MD, VA, WV: Multiplied statewide award times proportion of PLWH in the EMA
SAMHSA HIV AIDS Grants						
DC	$1,383,448	Student peer educator (SPE) model designed to raise awareness and educate about the risk and protective factors associated with HIV/AIDS, Substance Abuse (SA), and HCV Peer educator program to implement a multifaceted HIV/AIDS and substance abuse prevention Substance abuse, HIV and viral hepatitis prevention services for high-risk and HIV positive immigrant Latino young adults. Residential substance abuse treatment; HIV/AIDS care; emergency and transitional housing; nutritional counseling; and out-patient primary medical care.	UDC ($299,637) Howard University ($299,936) La Clinica del Pueblo ($283,875) Regional Addiction Prevention ($500,000)	Prevention, Diagnosis, Linkage to Care, Retention in Care, Antiretroviral Use, Viral Load Suppression	http://www.samhsa.gov/grants-awards-by-state/details/District%20of%20Columbia 2016 levels confirmed at https://taggs.hhs.gov/SearchAdv/AdvSearchResults	

MD	$300,000	Substance use, HIV, and HVC prevention education and services will be provided to minority college students at BSU youth, ages 18-24, in communities neighboring the campus disproportionately affected by HIV	Bowie State University ($300,000)	Prevention, Diagnosis, Linkage to Care, Retention in Care, Antiretroviral Use, Viral Load Suppression	http://www.samhsa.gov/grants-awards-by-state/details/maryland 2016 levels confirmed at https://taggs.hhs.gov/SearchAdv/AdvSearchResults	
VA	$0				http://www.samhsa.gov/grants-awards-by-state/details/virginia	
WV	$0					
EMA Total	$1,683,448					
SAMHSA SUBSTANCE ABUSE PREVENTION AND TREATMENT Block Grant						
DC	$348,390	HIV Early Intervention services		Prevention, Diagnosis	Tanya A Royster, Director, DC Department of Behavioral Health tanya.royster@dc.gov	This is from the SABG Planning Tables. Table 2, with planning period start date 07/01/2015 and end date 06/30/2017 Amount for FY2016, confirmed by Anthony, Administrative Service Manager
MD	$428,775	Sexual Health in Recovery; plus Testing.		Prevention, Diagnosis	Peter Demartino, peter.demartino@maryland.gov, 8/16/16	Block grant set-aside for Charles, Frederick, Montgomery and Prince George's Counties
VA	$0					Federal funds for this program ended in 2008. Post-2008, state funds fund program and are reflected in Virginia State Funds
WV	$0					
EMA Total	$777,165				http://www.samhsa.gov/grants-awards-by-state	Note: for states with prevalence over a certain threshold, there is a set-aside for HIV EIS in the substance abuse block grant
HOPWA Formula						
DC	$6,187,765	Permanent housing in facilities, permanent housing placement, short term or transitional housing facilities, Short Term Rent Mortgage and Utility Assistance (STRMU), Supportive Services, Tenant Based Rental Assistance, Housing Information and Referral Services, Capital Investment	Community Family Life Services, Homes for Hope, Greater Washington Urban League, Housing Counseling Services, Gaudenzia, Inc.	Retention in Care, Viral Load Suppression	https://www.hudexchange.info/grantees/cpd-allocations-awards/?filter_year=2016&filter_program=8&filter_state=DC&filter_coc=	Calculation using total HOPWA EMA figure from HAHSTA: $11,107,054 (total) - $2,101,848 (charles and PGC) - $190,000 (Calvert) - $2,547,943 (nova) - $79,498 (WV)
MD	$3,606,529	Tenant-based rental asst. , Short-term rent, mortgage and utilities	The Housing Authority for the City of Frederick serves Frederick County. Montgomery County Department of Health and Social Services serves Montgomery County. The Prince George County Department of Housing and Community Development serves Prince George's County, Calvert County and Charles County Greater Washington Urban League MD, Southern Maryland Tri-county Community Action Committee	Retention in Care, Viral Load Suppression	https://www.hudexchange.info/grantees/cpd-allocations-awards/?filter_year=2016&filter_program=8&filter_state=MD&filter_coc= file:///I:/DC%20Project%202012/Integrated%20Plan%202016/Data%20sources/HOPWA/hopwa%20MD%20info.html Confirmed Peter Demartino, peter.demartino@maryland.gov, 8/16/16	HUD lists $1,314,681 awarded to Frederick, Maryland and Montgomery. Email from Leah and Andre Tayborn says that Charles and PGC receives $2,101,848 and Calvert receives $190,000 - did not include the frederick and montgomery amount. Includes 7% Administrative Costs
VA	$2,547,943	Tenant-based rental asst. , Short-term rent, mortgage and utilities, first month's rent/security deposit, Housing Info, Housing Case-Management, Job Training and Transportation. The Total award also includes NVRC Admin Dollars	Northern Virginia Regional Commission, Arlington County Department of Human Services, Fredericksburg Area HIV/AIDS Support Service, Homestretch, Inc., HIV Resources Project/HOPWA Regional Waiting List, Northern Virginia Family Service, Prince William Office of Housing & Community Development, Wesley Housing Development Corp. (Agape House)	Retention in Care, Viral Load Suppression	https://www.hudexchange.info/grantees/cpd-allocations-awards/?filter_year=2016&filter_program=8&filter_state=VA&filter_coc= http://www.novaregion.org/index.aspx?NID=696 http://www.novaregion.org/index.aspx?NID=697	HAHSTA figure
WV	$79,498		Community Networks Incorporated		https://www.hudexchange.info/grantees/cpd-allocations-awards/?filter_year=2016&filter_program=8&filter_state=WV&filter_coc= file:///I:/DC%20Project%202012/Integrated%20Plan%202016/Data%20sources/HOPWA/WV%20Housing%20Opportunities%20for%20People%20with%20AIDS%20(HOPWA).html	
EMA Total	$12,421,735					
HOPWA/VAWA						
DC	$1,297,520	Housing Assistance (Permanent Housing Placement Assitance, Housing Information Services, Other HUD-Approved Activities), Resource Identification.	District Alliance for Safe Housing, Greater Washington Urban League	Retention in Care, Viral Load Suppression	http://portal.hud.gov/hudportal/HUD?src=/press/press_releases_media_advisories/2016/HUDNo_16-088	HAHSTA: "Money for VAWA has not been received, currently only an 'intent to fund.'"
MD	$0					Peter Demartino, peter.demartino@maryland.gov confirmed 8/16/16
VA	$0					Claire Husted confirmed for VA
WV	$0					
EMA Total	$1,297,520					
HRSA Bureau of Primary Health Care						
DC	$ 1,056,387.14		Community of Hope; Family and Medical Counseling Services; La Clinica del Pueblo; Mary's Center for Maternal and Child Care; Unity Health Care; Whitman-Walker	Prevention, Diagnosis, Linkage to Care, Retention in Care, Antiretroviral Use, Viral Load Suppression		

MD	$ 577,934.00		Community Clinic, Inc; Elaine Ellis Center of Health; Greater Baden Medical Service, Inc.	Prevention, Diagnosis, Linkage to Care, Retention in Care, Antiretroviral Use, Viral Load Suppression	http://www.hrsa.gov/about/news/pressreleases/140918healthcentershiv.html	Includes $500k grant to Community Clinic, Inc for HIV integration.
VA	$ 39,673.65					See BPHC calculations for methodology. [Claire agrees with methodology - check awards for oral health care too]
WV	$ 18,411.77					
EMA Total	$ 1,692,406.55					Based on FY14 data for total BPHC grant award expenditures times reported percentage of clientele living with HIV.See BPHC worksheet for details on calculations
HHS Office of Minority Health						
DC	$374,993	Employs evidence-based disease management and preventive health program and supportive services to: Reduce the transmission of HIV; Address gaps and fragmentation of HIV/AIDS treatment; Reduce HIV/AIDS stigma and barriers to culturally and linguistically appropriate care; Address social determinants of health that impede treatment adherence; Prevent opportunistic infections; and Improve clinical outcomes of MSM and young minority males living with HIV or at high risk for HIV infections.	Us Helping Us/People Into Living, Inc. (need to check if annual or three-year total)	Prevention, Diagnosis, Linkage to Care, Retention in Care, Antiretroviral Use, Viral Load Suppression	http://minorityhealth.hhs.gov/omh/browse.aspx?lvl=2&lvlid=66	HIV/AIDS Initiative for Minority Men (AIMM), Grant period 2014-2017
MD	$0				Peter Demartino, peter.demartino@maryland.gov confirmed 8/16/16	
VA	$0					Claire Husted confirmed for VA
WV	$0					
EMA Total	$374,993					
HHS Office of Population Affairs						
DC	$473,000	High-impact HIV prevention services integrated with Title X Family Planning Services	Unity Health Care serves as overall Title X grantee (contact Unity for more info on subs, funding level?)	Prevention	http://www.hhs.gov/opa/news/archive-news/ http://www.unityhealthcare.org/HealthX.html	FY15 award activated 7/15/15. Unity was one of 18 nationwide recipients of Integrating Routine HIV Testing and Linkage to HIV Care and Treatment in Family Planning Services grants.
MD	$0				Peter Demartino, peter.demartino@maryland.gov confirmed 8/16/16	
VA	$0					Claire Husted confirmed for VA
WV	$0					
EMA Total	$473,000					
Administration for Children and Families						
DC	$899,322		Whitman-Walker Clinic, Inc.		https://taggs.hhs.gov/Detail/AwardDetail?arg_AwardNum=90CB0201&arg_ProgOfficeCode=187	Comprehensive Support Services for Families Affected by Substance Abuse and/or HIV/AIDS
MD	$0				Peter Demartino, peter.demartino@maryland.gov confirmed 8/16/16	
VA	$0					
WV	$0					
EMA Total	$899,322					
Washington AIDS Partnership						
DC	$1,809,218	Broad range; see link in data sources column for further details	Medical Morale: Georgetown University, Joseph's House Access to Care/Positive Pathways: Institute for Public Health Innovation, Family and Medical Counseling Service, HIPS (Helping Individual Prostitutes Survive), Unity Health Care, Whitman-Walker Health, Women's Collective HIV Prevention: AIDS United, Family and Medical Counseling Service LGBTQ Health and Wellness: Children's National Health System, Whitman-Walker Health Mobile Access: Whitman-Walker Health Public Policy: DC Appleseed Center Sector Evolution: HIPS, La Clinica del Pueblo, Us Helping Us	Prevention, Diagnosis, Linkage to Care, Retention in Care, Antiretroviral Use, Viral Load Suppression	http://www.washingtonaidspartnership.org/grantmaking/recent-grants/	2015 awards. Washington AIDS Partnership conducts coordinated foundation grantmaking across the DC metropolitan area.
MD	$125,000	Retention in care	Retention in Care: Total Health Partners, Prince George's County	Retention in Care	http://www.washingtonaidspartnership.org/grantmaking/recent-grants/	
VA	$0					
WV	$0					
EMA Total	$1,934,218					
Private Virginia Funds						
VA	$189,830	Home & Comm Based Support, OAHS, Drug Assistance, Interpreter, Food Bank, Admin/Other	Institute for Public Health Innovation, Inova Juniper, Mary Washington Healthcare	Retention in Care, Antiretroviral Use, Viral Load Suppression	Self reported by service providers to NVRC	Attachment K - Other Public Funding Summary GY 26 (16-17) Projected Funds
EMA Total	$189,830					
Total Grant Funding	$88,344,836.61					
State Funding						
Local DC Funds						
Support HAHSTA	$500,000	Integrated Housing, nursing, and support services for homeless people with late-stage AIDS or terminal cancer	Joseph's house	Retention in Care, Viral Load Suppression	http://cfo.dc.gov/sites/default/files/dc/sites/ocfo/publication/attachments/DCOCFO_FY17_Budget_vol_4.pdf	Budget fy2017
Total local DC funds	$500,000					

Maryland State Funds						
State Department of Human Resources	$840,625	Meal delivery for counties in EMA	Food and Friends	Retention in Care, Viral Load Suppression		FY15
Total MD state funds	$840,625					
Virginia State Funds						
Item 292 - HIV/AIDS Prevention and Treatment Services	$6,503,327	State Pharmaceutical Assistance Program (SPAP) for insurance premium payments, coinsurance payments, and other out-of-pocket costs for individuals participating in the Virginia AIDS Drug Assistance Program (ADAP) with incomes between 135 percent and 300 percent of the federal poverty income guidelines and who are Medicare Part D beneficiaries. The State Health Commissioner shall monitor patients who have been removed or diverted from the Virginia AIDS Drug Assistance Program due to budget considerations. At a minimum the Commissioner shall monitor patients to determine if they have been successfully enrolled in a private Pharmacy Assistance Program or other program to receive appropriate anti-retroviral medications. The commissioner shall also monitor the program to assess whether a waiting list has developed for services provided through the ADAP program.		Prevention, Diagnosis, Linkage to Care, Retention in Care, Antiretroviral Use, Viral Load Suppression	http://dpb.virginia.gov/budget/buddoc16/pdf/parte/2016-18_Introduced_BudgetsByServiceArea.pdf	Base Budget from FY2016, Chapter 665, 2015 Acts of Assembly Statewide Awaiting info from Diane Jordan and colleagues
Item 307 - Medical Assistance Services (Non-Medicaid), Insurance Premium Payments for HIV-Positive Individuals	$556,702	Out of this appropriation, $556,702 the first year and $556,702 the second year from the general fund shall be provided for insurance payment assistance to HIV-infected persons in accordance with § 32.1-330.1, Code of Virginia, except that the eligibility threshold for assistance shall allow a maximum income of no more than 250 percent of the federal poverty threshold.		Prevention, Diagnosis, Linkage to Care, Retention in Care, Antiretroviral Use, Viral Load Suppression	http://dpb.virginia.gov/budget/buddoc16/pdf/parte/2016-18_Introduced_BudgetsByServiceArea.pdf	Base Budget from FY2016, Chapter 665, 2015 Acts of Assembly Statewide Also have access to 2015 expenditures Awaiting information from Diane Jordan and colleagues
Community Service Boards funding	$172,710	HIV Early Intervention services		Prevention, Diagnosis	Sterling Deal, Manager of Evaluation and Data Support, Office of Behavioral Health Services (VA) sterling.deal@dbhds.virginia.gov	These funds are allocated to community service boards in Arlington, Alexandra, and Fairfax In 2008, VA dipped below threshold for grant, so now allocations come from general state funds
ADAP 340b Drug Rebates	$9,022,763			Antiretroviral Use, Viral Load Suppression	http://datapoint.apa.virginia.gov/rev/rev_agy_srccls_src.cfm?AGY=115&SRCCLS=Other%20Revenue	For 2015 Statewide: Claire: Yes, include rebate funding. VA using some for PrEP.
Other Public Funding	$155,000	OAHS, Food Bank, Transportation	FAHASS, Inova Juniper, NovaSalud	Retention in Care, Antiretroviral Use, Viral Load Suppression	Self reported by service providers to NVRC	Attachment K - Other Public Funding Summary GY 26 (16-17) Projected Funds
Total VA state funds	$16,410,502					
West Virginia State Funds						
Fund 5186 - HIV Testing Fund	$14,200			Diagnosis	http://www.budget.wv.gov/executivebudget/Documents/AD2017.pdf	FY 2016 budget
Total WV State Funds	$14,200					
TOTAL STATE FUNDING	$17,765,327					
Insurance and VHA Expenditures						
Medicaid						
DC	$249,557,353			Prevention, Diagnosis, Linkage to Care, Retention in Care, Antiretroviral Use, Viral Load Suppression	John Wedeles, John.Wedeles2@dc.gov Email to colleague Julia Hidalgo, julia.hodalgo@positiveoutcomes.net on 08/23/16	FY15, Only includes FFS and Medicaid managed care expenditures paid via FFS.
MD	$57,314,786			Prevention, Diagnosis, Linkage to Care, Retention in Care, Antiretroviral Use, Viral Load Suppression		See Medicaid Worksheet for calculations. Includes $17.315 medical plus $40 million medications Pam from planning council seeking further info from Alyssa Brown they're in process of developing data sharing, and also participating in NASTAD
VA	$16,213,380			Prevention, Diagnosis, Linkage to Care, Retention in Care, Antiretroviral Use, Viral Load Suppression	http://kff.org/hivaids/state-indicator/enrollment-spending-on-hiv/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D	Used FY2011 KFF state estimate multiplied by the proportion of HIV prevalence within the EMA As discussed further in subsection (d) below, these estimates are rough. Therefore, they are no counted toward the "Total Funding" in this chart.
WV	$1,387,719			Prevention, Diagnosis, Linkage to Care, Retention in Care, Antiretroviral Use, Viral Load Suppression	http://kff.org/hivaids/state-indicator/enrollment-spending-on-hiv/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D	Used FY2011 KFF state estimate multiplied by the proportion of HIV prevalence within the EMA As discussed further in subsection (d) below, these estimates are rough. Therefore, they are no counted toward the "Total Funding" in this chart.
EMA Total	$306,872,139					
Medicare						
EMA Total	$295,175,042			Prevention, Diagnosis, Linkage to Care, Retention in Care, Antiretroviral Use, Viral Load Suppression	http://doh.dc.gov/sites/default/files/dc/sites/doh/publication/attachments/HAHSTA-PreliminaryHIV-Data-Report.pdf	1.2 million PLWHA in US. 35,599 in DC EMA $9,950,000,000 Medicare Spending for HIV/AIDS in US in FY2016 As discussed further in subsection (d) below, these estimates are rough. Therefore, they are no counted toward the "Total Funding" in this chart.
DC Alliance						

EMA Total	$7,076,419			Prevention, Diagnosis, Linkage to Care, Retention in Care, Antiretroviral Use, Viral Load Suppression	John Wedeles, John.Wedeles2@dc.gov Email to colleague Julia Hidalgo, julia.hodalgo@positiveoutcomes.net on 08/23/16	
Veterans Health Administration						
EMA Total	$40,645,945.34			Prevention, Diagnosis, Linkage to Care, Retention in Care, Antiretroviral Use, Viral Load Suppression	Based on 2013 enrollment and expenditure data.	See VHA worksheet for details on calculations
Private Insurance						
DC	$0					
MD	$0					
VA	$0					
WV	$0					
EMA Total	$0					
TOTAL INSURANCE FUNDING	$354,594,503.79					
TOTAL FUNDING	**$460,704,667.40**					