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Integrated HIV Prevention and Care Plan

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

REGION	South
PLAN TYPE	Integrated state/city/county prevention and care plan
JURISDICTIONS	District of Columbia (includes Washington, D.C. and counties in Virginia, Maryland, and West Virginia)
HIV PREVALENCE	High

The District of Columbia's Integrated HIV Prevention and Care Plan includes a thorough description of how the Integrated Plan objectives were developed, and how they align with NHAS and HIV Care Continuum goals in DC. The jurisdiction provides detailed narrative descriptions of the Integrated Plan, as well as a chart with the required components (objectives, strategies, focus populations, activities, metrics, timeframe, and responsible parties).

SELECTION CRITERIA: INTEGRATED HIV PREVENTION AND CARE PLAN

Exemplary Integrated HIV Prevention and Care Plan sections met the following criteria (based on the Integrated HIV Prevention and Care Plan Guidance):

- ☑ Comprised of SMART objectives, strategies to correspond to each objective, activities, targeted population, timeframe, resources needed, who is responsible for each task, covers time period 2017-2021
- ☑ Specific metrics to monitor activities
- ☑ Objectives and activities aimed at addressing gaps along the HIV Care Continuum.
- ☑ Objectives that align with the National HIV/AIDS Strategy (NHAS)
- ☑ Description of how the Integrated Plan was developed

Additional exemplary plan sections are available online:
www.targetHIV.org/exemplary-integrated-plans

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.

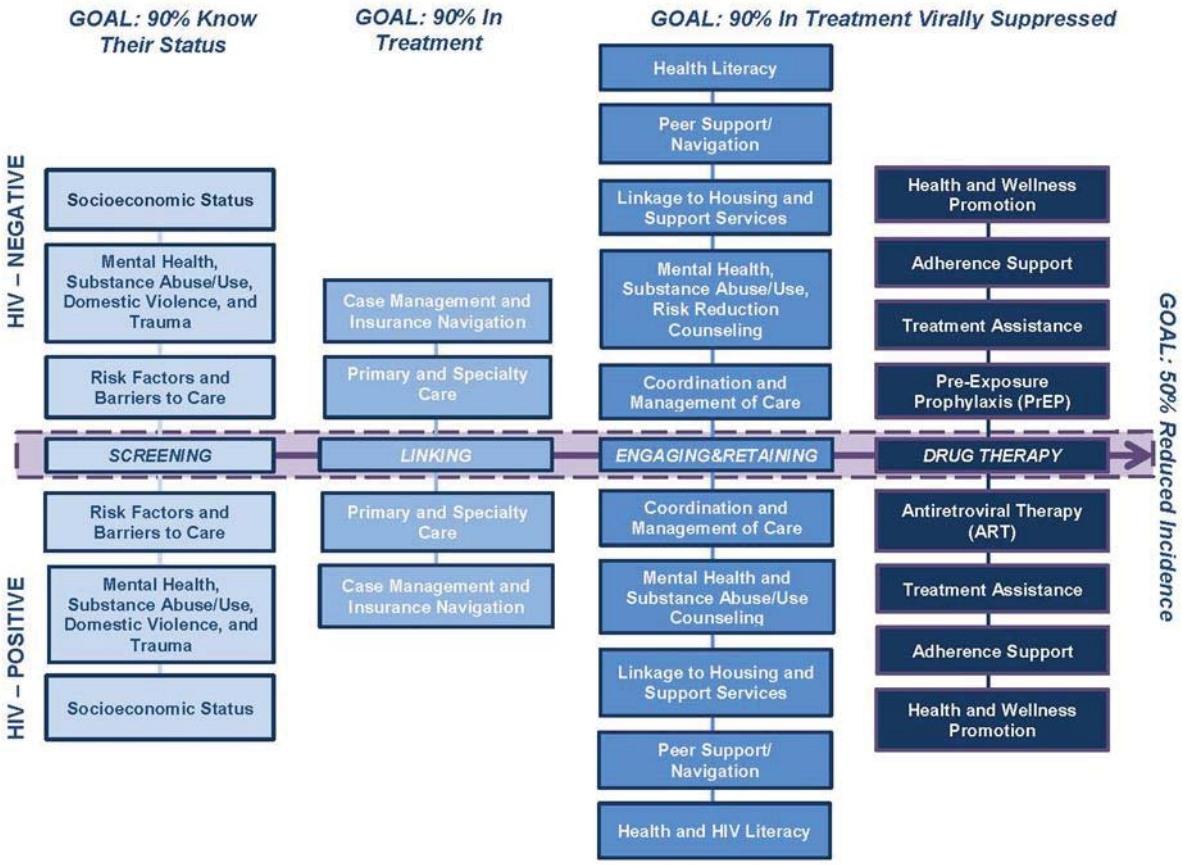
While the District government has the biggest role to play in implementing this plan, there are opportunities for all sectors of the regional community to contribute to preventing the transmission of HIV and supporting persons with HIV to be successful in treatment. The Integrated Plan, and the 90/90/90/50 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.

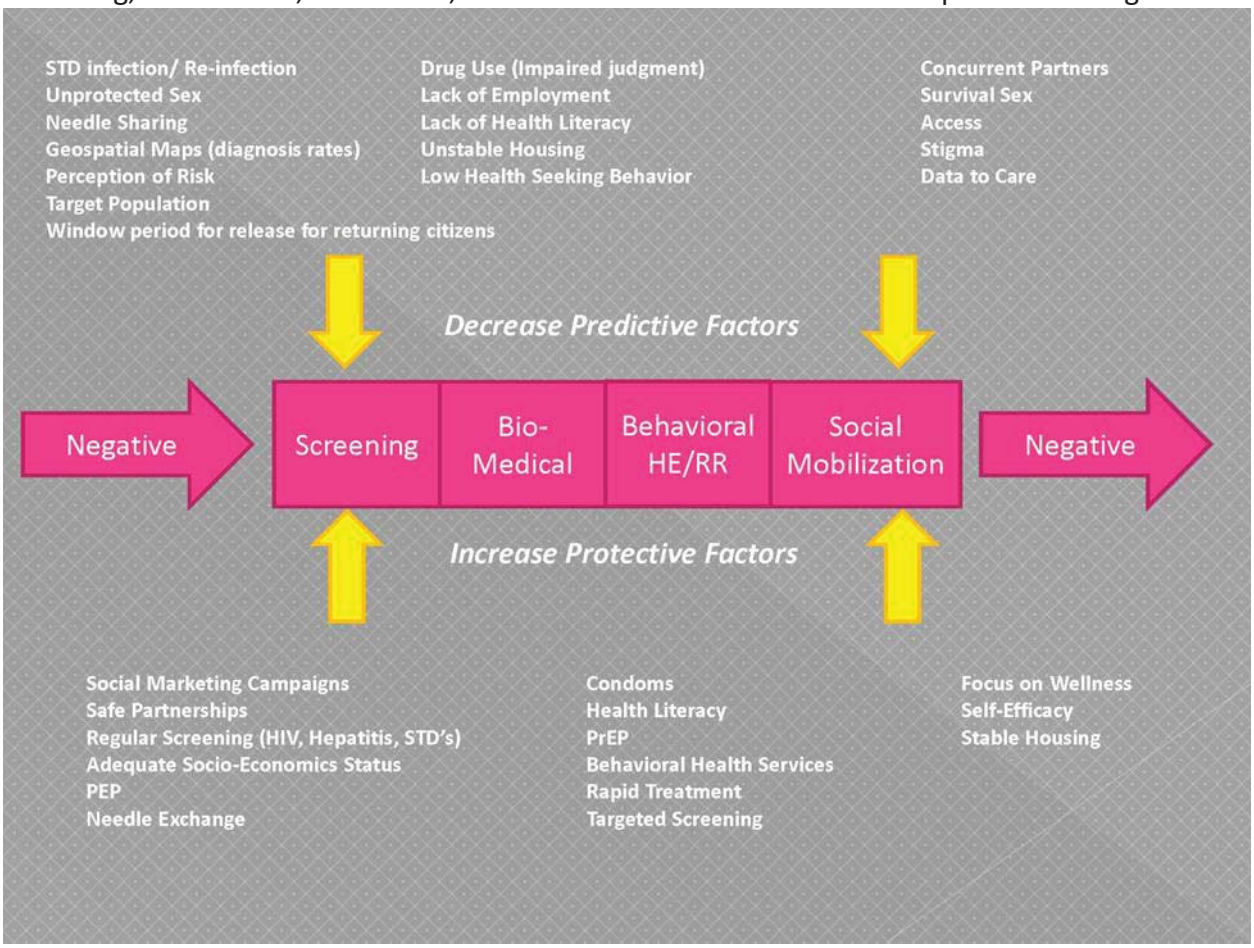
DC DOH GOAL 1: PREVENTION

(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.			