

District of Columbia Enhanced Comprehensive HIV Prevention Plan Executive Summary

The District of Columbia welcomed the release of the National HIV/AIDS Strategy (NHAS) and is grateful to be part of the 12 jurisdictions receiving support from the Centers for Disease Control and Prevention (CDC) to develop the Enhanced Comprehensive HIV Prevention Plan (ECHPP). Both presented the opportunity for the DC Department of Health HIV/AIDS, Hepatitis, STD and TB Administration (HAHSTA) – developing and administering ECHPP – to strategically re-examine its current efforts and build upon several elements that have been essential in the mounting of an effective response: a) data driven programming, b) strengthened public and private partnerships, c) monitoring and evaluation with a focus on outcomes, and d) community mobilization. The District continues to address a severe and generalized epidemic with rates higher than 1% among all population groups (race/ethnicity, gender), all three modes of transmission and seven out of the city's eight wards. To achieve greater results in its epidemic, the DC ECHPP aims to leverage the strong foundation the District has already built with new strategies and programmatic directions – based on current data – to reduce new infections. The DC ECHPP contains the two components of (1) a situational analysis on the epidemic and related comorbidities with the District's current response and (2) specific goals, strategies and objectives for all the required interventions and selected recommended interventions to optimize prevention, care and treatment and community engagement.

The Washington, DC Metropolitan Statistical Area consists of the District of Columbia, a high density, urban environment of eight political sub-divisions, multiple local government agencies and an extensive network of community providers and partners. In the development of the DC ECHPP, HAHSTA formed a core internal team to develop the plan comprised of staff from the Prevention and Intervention, Strategic Information and Capacity Building bureaus. The team also engaged staff from the Care, Housing and Support Services and STD Control bureaus. The HAHSTA team also conferred with colleague DC agencies on addiction services, mental health and health care financing. HAHSTA convened a working group of community stakeholders, which included formal planning bodies (Ryan White Planning Council, HIV Prevention Community Planning Group), HIV service providers, persons living with HIV/AIDS, academic institutions, researchers and other experts. HAHSTA provided drafts of the two workbooks to the stakeholders. In two meetings and through electronic comments, HAHSTA collaborated with stakeholders on all aspects of the DC ECHPP and in particular on the specific goals, strategies and objectives in Workbook Two. HAHSTA reviewed and factored the cost effective data provided by CDC in its deliberations. HAHSTA also benefited from CDC staff comments in revising and finalizing its ECHPP.

Starting in 2006 and building since, the District has scaled up its response to the epidemic by focusing in three core areas: routine HIV testing for early diagnosis, linkage to and retention in care and treatment to improve health outcomes and reduce new transmissions, and large and structural interventions to prevent new transmissions. For instance, DC was the first jurisdiction to adopt the CDC recommendations on routine testing in clinical settings and has been effective in implementing the approach in its hospital emergency departments and major primary care providers. DC changed its policy to require preliminary testing results to be followed directly by linkage to care and treatment and implemented rapid access to HIV medical providers within 48 hours of diagnosis. DC was one of two jurisdictions to implement Health Care Reform early expanding the opportunity for persons living with HIV to obtain more comprehensive medical insurance coverage. DC was the first of two cities to implement a public sector condom distribution program, enhanced and diversified its harm reduction/needle exchange programs and shifted from individual and group prevention interventions to community level interventions. This is the context in which DC developed its ECHPP and how it prioritized enhancing its response to the epidemic. DC was judicious in generally leveraging existing resources to increase the current platform of

interventions while maximizing new resources on selected gaps and innovative strategies. DC will continue to shift its core prevention funding from limited impact behavioral interventions to larger scale approaches and targeted population activities.

In the identification of new positives, the DC ECHPP will continue to increase its testing in clinical settings by utilizing existing resources. DC will work with its community providers to optimize third party reimbursement for testing and will be incorporating incentives to providers on other than HAHSTA funding for testing. Based on epidemiological data and behavioral studies, HAHSTA will focus its new testing strategies on social networks of targeted populations of high prevalence and highest risk, including gay/bisexual men, African-American heterosexuals, Latino MSM and heterosexuals and older adults. HAHSTA will continue to invest in its adolescent STD and HIV screening in school-based and expansion in more community-based settings. A new feature is reminder text messages on testing and partner notification. Partner services already conducted in DC has demonstrated significant results in positivity rates. HAHSTA will increase its collaboration with community partners and implement new strategies, such as use of the surveillance system and Internet-based and text messaging notifications. DC epidemiological data shows co-morbidities with STDs and hepatitis among target populations. HAHSTA will direct efforts to build capacity among HIV service providers on ensuring that relevant STD and hepatitis screening are implemented among positive persons, gay/bisexual men, injection drug users and adolescents.

DC has valued the opportunity in ECHPP to build on its care and treatment strategies by enhancing the nexus between treatment and prevention among HIV positive persons. With the new findings on the prevention benefits of treatment, HAHSTA will be focusing its efforts on capacity building among HIV medical providers to ensure on retention (and recapture) in care and treatment and the implementation of ART guidelines. HAHSTA will be using data collection tools to monitor and evaluate provider performance on key indicators, such as viral load suppression. HAHSTA will also increase competency among service providers for risk screening and prevention with positives, including the development of a new tool kit for providers and consumers, and education and promotion of condom use.

DC will be developing strategies, plans and implementation of new approaches, including post-exposure prophylaxis, HIV testing in non-traditional sites (such as pharmacies, income maintenance centers and schools), and syringe-exchange for new and higher functioning injection drug users. DC has agreed to be a demonstration site for pre-exposure prophylaxis. DC will invest in expanding its social marketing and community mobilization programs to reach general and targeted populations including new media outlets and capacity building.

Through ECHPP, DC will continue to leverage and maximize resources across federal, local and private funding streams, with closer collaboration at the DC government (such as addiction services, mental health, housing and human services) and community level and with federal partners HRSA and SAMHSA. DC intends to take full advantage of the opportunity presented by ECHPP and NHAS to build on its screening, treatment and prevention model; redirect its investments into higher impact approaches; and strengthen partnerships and the integration of services.