Welcome and Setting the Stage

Dashiell Sears
Regional Director, North America
Fast-Track Cities Institute

Washington, DC
April 30, 2024
Setting the Stage

Washington, DC, joined Fast-Track Cities December 1, 2015, and was identified as an Ending the HIV Epidemic (EHE) priority jurisdiction in 2019.

<table>
<thead>
<tr>
<th>Fast-Track Cities</th>
<th>Ending the HIV Epidemic</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Global initiative, local implementation</td>
<td>• Federal initiative, local implementation</td>
</tr>
<tr>
<td>• A technical and political initiative inclusive of</td>
<td>• HHS inter-agency leadership engaging</td>
</tr>
<tr>
<td>engagement from Mayor offices, health departments,</td>
<td>community and local stakeholders</td>
</tr>
<tr>
<td>and affected communities</td>
<td>• National targets, local action for impact:</td>
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<tr>
<td>• Global targets, local action for impact:</td>
<td>• Reduce # new HIV infections in the United States by</td>
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<tr>
<td>• 95-95-95-95 treatment/prevention targets</td>
<td>75% by 2025</td>
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<tr>
<td>• 30-80-60 community targets</td>
<td>• Reduce # new HIV infections in the United States by at</td>
</tr>
<tr>
<td>• Ending AIDS as public health threat by 2030</td>
<td>least 90% by 2030</td>
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</table>
Setting the Stage...

The purpose of this workshop is to:

• Leverage synergistic efforts of EHE and FTC initiatives

• Discuss gaps in and opportunities to achieve common goals:
  o Prevention and treatment policy implementation
  o Community access to HIV services
  o Criminalization as a barrier to ending HIV
  o Equitable scale up of PrEP
  o Implementation of status neutrality

• Define short- and long-term next steps for closing EHE and FTC gaps
Welcome Remarks

Dr. José M. Zuniga
President/CEO, IAPAC and FTCI
Chair, UNAIDS Task Force on Urban Health

Washington, DC
April 30, 2024
• Significant **PROGRESS HAS BEEN MADE** in Washington, DC

• Yet, much work remains to ensure **EQUITABLE ACCESS** to:
  - HIV prevention/treatment, **PERSON-CENTERED CARE**, social support
    - Within context of environment enabled to respect every person’s **DIGNITY**

• Multistakeholder **HIV COMMITMENT, LEADERSHIP** is critical
  - Including in relation to **POLITICAL DETERMINANTS OF HEALTH**
    - But also **COMMUNITY ENGAGEMENT** that places people at center of HIV response

• EHE and FTC are well **ALIGNED AND SYNERGISTIC**
  - Notably as we strive to attain EHE and FTC (and **NHAS**) objectives
    - On trajectory towards **ENDING AIDS AS A PUBLIC HEALTH THREAT** by 2030

• 1 year from deadline of **REDUCING NEW HIV INFECTIONS BY 75%**
Welcome on Behalf of DC Health

Dr. Ayanna Bennett
Director
DC Health
Welcome on Behalf of UNAIDS

Vinay Saldanha
Director of the U.S. Liaison Office
United Nations Joint Programme on HIV/AIDS

Washington, DC
April 30, 2024
Welcome from HHS

Dr. Marissa Robinson
Health Equity Specialist Lead
Office of Infectious Disease and
HIV/AIDS Policy
Office of Assistant Secretary of Health

Washington, DC
April 30, 2024
Welcome on Behalf of Washington D.C. EHE

Clover Barnes
Senior Deputy Director
HIV/AIDS, Hepatitis, STD and TB Administration (HAHSTA)
DC Health
Welcome on Behalf of Community

George S. Kerr, III
Community Coordinator, DC CFAR
Chair, National CFAR CAB Coalition
Welcome on Behalf of ViiV Healthcare

J. Maurice McCants-Pearsall
Director, Government Relations
ViiV Healthcare US

Washington, DC
April 30, 2024
Increasing Access to Treatment and Rapid START

Jason Beverley, MS, RN, FNP-BC
STD & TB Control Division Chief
DC Health HIV, AIDS, Hepatitis, STD, & TB Administration (HAHSTA)

INTRA-JURISDICTIONAL
EHE ➔ FTC ALIGNMENT
2023/2024 WORKSHOPS

Washington, DC
April 30, 2024
• >6000 encounters for ~3000 patients
• 500-600 PrEP patients
• 12% of GC cases in DC, 7% of CT cases
• Approximately 100 ART patients
• 75-80% patients are from highest HIV incidence wards
Rapid ART at DC Health and Wellness Center

• Rapid ART for all new HIV infections diagnosed at DCHWC
  • 11 new HIV infections at DCHWC last year
  • 100% were started on ART within 7 days (most same-day)

• Referral site for local community organizations who perform HIV testing but don’t offer treatment.

• Rapid ART restart for patients who are reengaging in care
Rapid ART Process at DCHWC

• Same-day medication start and bridge supply
• Close follow-up
• Counseling/Case Management (ADAP enrollment, etc)
• Referral to community provider as appropriate
Local trends in Rapid ART

• Expanded awareness of clinical benefits of Rapid ART
  • Rapid ART Clinician Workgroup (currently inactive with plans to restart)

• Rapid ADAP enrollment

• ART covered fully by DC Medicaid programs
Increasing Access to Biomedical Prevention

Rachel Harold, MD
Supervisory Medical Officer
DC Health, HIV/AIDS, Hepatitis, STD and TB Administration (HAHSTA)
PrEP Services at DCHWC

• Universal screening
• Referral site
• Same-day starter pack
• PrEP navigation
• TelePrEP
• Lab tests and appointments at low to no cost
• Long Active Injectable PrEP (LAIP)

“Are you aware of PrEP?”

Get PrEP in the comfort of your home and protect yourself from HIV today!
Call (202) 741-7692
PEP to PrEP

Getting nPEP to the people who need it, when they need it

In first 18 months of the program: **407 nPEP initiations**

40% who started nPEP transitioned to PrEP after 28 days (163/407)
LAIP Program, May 2023-April 2024

71 patients initiated the process for LAIP

- 49 (69%) were approved by insurance or patient assistance program
- 37 (75.5%) received first injection
- 33 (89.2%) still actively enrolled in LAIP

Successes
- Wide interest
- Indicated for all genders
- Overall safe and low side effect profile

Challenges
- Logistical complexities
- Insurance coverage and prior authorizations
- Discontinuation due to side effects
# DC HIV Behavioral Surveillance Study, 2017-2022

<table>
<thead>
<tr>
<th>Cycle (sample population)</th>
<th>2017</th>
<th>2018</th>
<th>2019</th>
<th>2020</th>
<th>2022**</th>
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</thead>
<tbody>
<tr>
<td>Men who have sex with men</td>
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<tr>
<td>People who inject drugs</td>
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<tr>
<td>High-risk Heterosexuals</td>
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<td>Transgender women</td>
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<tr>
<td>People who inject drugs</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>% of HIV+ tests were new infections</td>
<td>20%</td>
<td>12.5%</td>
<td>33%</td>
<td>4%</td>
<td>6%</td>
</tr>
<tr>
<td>Know their HIV status*</td>
<td>62%</td>
<td>65%</td>
<td>61%</td>
<td>52%</td>
<td>87%</td>
</tr>
<tr>
<td>Condom use at last encounter</td>
<td>30%</td>
<td>25%</td>
<td>20%</td>
<td>41%</td>
<td>33%</td>
</tr>
<tr>
<td>Knowledge of PrEP</td>
<td>94%</td>
<td>25%</td>
<td>49%</td>
<td>87%</td>
<td>30%</td>
</tr>
<tr>
<td>Use of PrEP</td>
<td>38%</td>
<td>0.9%</td>
<td>0.8%</td>
<td>8.5%</td>
<td>0.5%</td>
</tr>
</tbody>
</table>

*Self-reported HIV test in past 12 months  
**No data collection occurred in 2021 due to the COVID-19 pandemic
Patient characteristics of PrEP users in DC, 2015-2020

Next Steps:
• Broader PrEP promotion
• Increased outreach to priority populations
• Increased collaboration with community partners
• Easier access to PrEP medication and expansion of injectable PrEP

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<td>2015</td>
<td>2,524</td>
<td></td>
<td></td>
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<tr>
<td>2016</td>
<td>4,135</td>
<td></td>
<td></td>
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<tr>
<td>2017</td>
<td>5,131</td>
<td></td>
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<tr>
<td>2018</td>
<td>6,694</td>
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<tr>
<td>2019</td>
<td>7,542</td>
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<td></td>
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<tr>
<td>2020</td>
<td>7,406</td>
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Eliminating Disparities in HIV Health Outcomes

Dr. Ashley Elliott
Clinical Psychologist and Consultant
Vivid Wellness Collective
Current Disparities in HIV Infections

Statistics on HIV prevalence in Washington DC
17,975*/11,904** (71% of Residents were Black)

Demographic disparities in new HIV infections
230 New Cases  Male (73.9%)  Female (22.6%)  Trans (3.5%)
Women(n=52) 8 out of 10 Black Women  Trans(n=37) Older Adults (n=34) Youth (n=22)

Black Men, Latinx Men, & Black Women represent the highest proportion of residents living with HIV

Key socioeconomic factors contributing to disparities
Low/No-Income, Race/Ethnicity, Gender*, Ward Residence
Trends in Disparities

Wards 5, 6, 7 & 8 represent the highest rates of diagnosis

Black residents have the highest rates of newly reported cases since Covid-19 Pandemic

Resources removed from neighborhoods due to ward boundaries being shifted

Unhoused and immigrant/refugee population underreported
Factors Contributing to Disparities

**Structural Barriers**
- Access to Healthcare
- Housing
- Employment

**Socioeconomic Factors**
- Poverty
- Education
- Health Literacy

**Impact of Stigma and Discrimination on Testing, Treatment, and Care**
Strategies for Eliminating Disparities

- Strengthening access to testing and prevention services
- Improving access to treatment and care
- Addressing structural and socioeconomic determinants
- Combating stigma and promoting cultural competency
- Improving assessment and intake systems
Have you ever considered…

what HIV & COVID have in common?
- Racial, ethnic, sexual, and gender minoritized patients are disproportionately affected by HIV and COVID
- They are constantly burdened with discrimination, stigma, and prejudice
- The enduring impact of racism, heterosexism and gender oppression affect healthcare access and health outcomes

PCPs should be trained to be more culturally responsive when caring for racial, ethnic, sexual, and gender minoritized patients
Over the past four years, much attention, research, and resources have been paid to COVID (and rightly so), but unfortunately this has happened at the expense of HIV.

• Since 2006, the CDC has recommended opt-out HIV testing for anyone between the ages of 13 and 64 at least once as part of their routine healthcare (CDC, 2019).

• This recommendation was at the center of the 2019 launch of the U.S. Department of Health and Human Services Ending the HIV Epidemic: A Plan for America initiative to end the HIV epidemic by 2030 (CDC, 2021).
In response to this discrepancy, our Two in One Model aims to routinize COVID vaccine screening and HIV/PrEP screening for all patients in the primary care visit.

We also provide capacity building support for PCPs to engage in culturally responsive communication about HIV and COVID with their racial, ethnic, sexual and gender minoritized patients.
<table>
<thead>
<tr>
<th>Terms</th>
<th>Definitions</th>
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<tbody>
<tr>
<td>Cultural “Competence”</td>
<td>• The ability to acknowledge and incorporate- at all levels- the importance of culture, the assessment of cross-cultural relations, vigilance towards the dynamics that result from cultural differences, the expansion of cultural knowledge, and the adaptation of services to meet culturally unique needs (Cross, Bazron, and Isaccs, 1989)</td>
</tr>
<tr>
<td>Cultural Humility</td>
<td>• Having an interpersonal stance that is other-oriented rather than self-focused, characterized by respect and lack of superiority toward an individual’s cultural background and experience (Hook, et. al., 2013)</td>
</tr>
<tr>
<td>Cultural Safety</td>
<td>• An examination by healthcare professionals of themselves and the potential impact of their own culture on clinical interactions and healthcare service delivery. This requires a critical consciousness where healthcare professionals and organizations engage in ongoing self reflection and hold themselves accountable for providing culturally safe care, as defined by the patient and their communities, and as measured through progress towards achieving health equity (Maier-Lorentz, 2008)</td>
</tr>
</tbody>
</table>

*There are many other terms: Cultural Awareness, Cultural Sensitivity, Cultural Respect, Cultural Mindfulness, Cultural Adaptation*
Culturally Responsive Communication (CRC)

- The ability to translate diversity, equity, inclusion, and justice (DEIJ)-based values within patient interactions that stem from reflexivity and shared power of the health professional alongside the culture of racism.

- CRC is an extension of DEIJ-based policies, systems, and protocols that allow for effective cross-cultural safety and respect, as well as compassionate, nonjudgmental and antiracist care.

(Curtis, 2019; Metzl & Hansen, 2014; Ring, et. al., 2009)
Project Overview

Program Components & Logic Model
Overview

Problem & Approach

Problem: Racial, ethnic, sexual, and gender minoritized patients are disproportionately affected by HIV and COVID and are constantly burdened with discrimination, stigma, and prejudice. The enduring impact of racism, heterosexism, and gender oppression affect healthcare access and health outcomes.

Approach: Our Two in One Model aims to routinize COVID vaccine screening and HIV/PrEP/PEP screening for all patients in the primary care visit and to build capacity for PCPs to engage in culturally responsive communication (CRC) about HIV and COVID with their racial, ethnic, sexual and gender minoritized patients.

Theories of Change

Dimensionality and R4P Health Equity Framework (Hogan et. al., 2018)
Indicates equity-based actions to address harms and historical conditions perpetuating disparate HIV and COVID outcomes among minoritized populations.

Social Ecological Model (McLeroy et al., 1988)
Organizes what the literature describes as facilitators and barriers to care.

Queer Theory and CRT (Alexander, 2017; Bell, 1995)
Centers perspectives of patients in our social marketing messages, toolkit, and asynchronous training course to reflect decolonizing critique and analysis.

Design-Based Research Approach
(Barab & Squire 2004)
Guides iterative refinement of these activities over time.

National Program

Research
• Interviews with racial, ethnic, sexual, and gender minoritized patients
• Literature review on COVID and CRC

Training
• 9 live CME-bearing webinars recorded for integration into online modules
• 9 online CME-bearing training modules
• Healthcare team toolkit (embedded in online training)

Policy/Advocacy
• 3 white papers outlining policy recommendations (on website and embedded in online training)
• Clinician vignettes (support policy change)
notes that HIV testing should be an element of all prenatal testing and occur during the third-trimester of pregnancy in regions with high HIV transmission rates, unless they opt-out of testing. The guidance further notes that clinicians do not need to request separate written consent from patients to provide this screening.¹

A stakeholder group including Primary Care Practitioners (PCPs), policy experts, public health practitioners, and academics vetted the following policy recommendations which address existing problems with the CDC’s HIV Screening Guidelines.

**Gap 1: HIV Screening Omits Discussion**
HIV screening is narrowly defined as diagnostic testing, which does not include the vital priming conversations and counseling that should preface and follow all clinical testing. This is especially salient since the HIV screening guidelines rely on more than one HIV testing approach. The conversations that occur in a clinical setting between patient and practitioner are a critical part of screening and are not clearly addressed in any of the guidance documents released by the CDC.

**Gap 2: Testing Is Discretionary**
HIV testing approaches are not implemented in a standardized and comprehensive way. CDC HIV screening guidance calls for a minimum of risk-based HIV testing. With this approach, clinicians use risk-based screening to determine which of their patients are suited for testing. The problem with this approach is that when HIV testing is left to the discretion of clinicians, patients are inherently profiled for their perceived risks. As implemented, risk-based screening increases the stigma associated with having HIV and getting tested.

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**Policy Recommendations**
- Include Discussion
- Reduce Bias
- Increase Testing
- Support Practitioners
- Focus on Patients

patients. The Give-Offer-Ask-Listen-Suggest (GOALS) framework² recommends that clinicians introduce sexual history taking as part of primary care that is not focused on risks but on health. In this way, patients may feel more comfortable talking about sex as a natural part of their lives and healthcare. Clinicians can use the sex and STI counseling ICD-10 code (Z70) to bill for time spent posing and fielding questions during limited clinical time. Policy makers can also investigate creating a CPT code and other billing codes for HIV screening discussions.
Screening for Preexposure Prophylaxis (PrEP) and Post-exposure Prophylaxis (PEP) for the Prevention of HIV Transmission in the United States, 2021 Guidelines: Policy Background and Recommendations

Abigail Konopasky, Maranda C. Ward, Leah Hoey, Patrick G. Corr

**Background**

*Pre-exposure Prophylaxis (PrEP)*

The Centers for Disease Control and Prevention’s (CDC) 2021 guide recommends routinely taking a sexual history and informing all adolescents and adults who are sexually active or use intravenous drugs about daily use of PrEP and recommending it to those with substantial risk to help prevent HIV infection. Screening can occur virtually (e.g., phone- or web-based consultations with clinicians).

*Post-exposure Prophylaxis (PEP)*

The CDC’s 2016 guide recommends use of PEP within 72 hours for anyone who has been exposed to HIV to help prevent HIV transmission.

This policy brief reviews current definitions of PrEP and PEP screening, outlines the problems with current practice around PrEP and PEP screening, and offers specific policy recommendations for addressing these problems.

**Policy Recommendations**

- Licensing bodies should require clinician training
- Insurance companies should create new billing codes
- Clarify and expand the definition of screening
- Require more frequent discussions with patients
- Include resources for clinicians on not stigmatizing patients

**PrEP and PEP Screening, Defined**

For PrEP, HHS and the CDC recommend clinicians initiate a conversation around HIV transmission in order to determine whether patients have “substantial risk”: a sexual partner who is HIV positive, a recent sexually transmitted infection, history of inconsistent condom use, or
Scoping Review
What is a scoping review?

“Scoping reviews serve to *synthesize evidence* and assess the *scope of literature* on a topic.”

Do

- Follow a systematized process

Do Not

- Evaluate levels of evidence/quality of evidence

PRISMA, 2018
Primary research question: “What factors influence culturally responsive HIV and PrEP screening for historically marginalized populations?”

Subquestion: “What themes and gaps exist in the literature regarding culturally responsive HIV and PrEP screening for historically marginalized populations?”
Qualitative Research
Design, Analysis, & Next Steps
Qualitative Study Design

• **Research Question:** Which factors (multi-level) do patients and PCPs identify as important for receiving quality HIV and COVID prevention and/or care?

• **Method:** Semi-structured focus group and individual interviews (n=9)

• **Analysis:** Facilitators and barriers to culturally responsive communication at five levels:
  - Public Policy
  - Community
  - Institutional
  - Interpersonal
  - Individual
Socio-Ecological Model - Facilitators

Patient

- Patient public health attitude
- Mandate

- Patient network and education
  - PCP race
  - Working for their community
  - Access to community health workers

- Environmental factors
  - Policies/approaches
  - PCP availability

- PCP behavior
  - PCP race
  - Patient networks
  - Work for their community

- Exhibit agency
  - Initiate discussion
  - Knowledge
  - Attitude

Public Policy

- PCP Education
- Policies

Community

- Outreach
- PCP Patient Education

Institutional

- Policies/approaches
- PCP behavior

Interpersonal

- PCP behavior
- History and screening

Individual

- Initiating discussions
- Education and awareness
- PCP behavior

Socio-Ecological Model - Barriers

**Patient**
- Patient public health attitude
- Patient network
- Patient education
- Environmental factors
  - Policies/approaches
  - PCP availability
  - Patient’s work
- PCP behavior
  - Racism
  - Patient networks
- Patient agency
  - Attitude
  - Racism/racial profiling.
  - Allergies to meds

**Public Policy**
- Policies/approaches
- PCP behavior

**Community**
- PCP behavior
- Racism
- Patient networks

**Institutional**
- PCP availability
- Patient’s work
- Policies/approaches
- PCP behavior

**Interpersonal**
- PCP behavior
- Burnout

Key Research Takeaways

• PCPs are largely unaware and/or unfamiliar with patient experiences and perceptions of care

• PCPs attend to individual-based, institutional-based, and policy-based facilitators to care (i.e. overlooking interpersonal-based and community-based facilitators)

• Patients and PCPs align on the community-based barriers to care
Online CME-bearing Course is Live!

<table>
<thead>
<tr>
<th>Module #</th>
<th>Module Title</th>
<th>Speakers other than Maranda Ward, EdD</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Confronting U.S. History: We must End Racism to End Disparities</td>
<td>Nikole Hannah-Jones</td>
</tr>
<tr>
<td>2</td>
<td>Culturally Responsive Communication in Clinical Care</td>
<td>Susan LeLacheur, DrPH Lalit Narayan, MD</td>
</tr>
<tr>
<td>3</td>
<td>How Clinicians Shape Community Narratives on HIV and COVID</td>
<td>Oni Blackstock, MD</td>
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<td>4</td>
<td>Restoring Patient Trust Through a Health Justice Approach</td>
<td>Clover Barnes, RN, MSN</td>
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<tr>
<td>5</td>
<td>We Test Everyone, Unless You Say No: State Level HIV Opt Out Testing and Screening Guidelines</td>
<td>Philip Alberti, PhD</td>
</tr>
<tr>
<td>6</td>
<td>Primary Care IS Prevention: Why PrEP and PEP Belong in the Primary Care Setting</td>
<td>Adedotun Ogunbajo, PhD</td>
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<tr>
<td>7</td>
<td>Culturally Responsive Communication, Part II: Sharing Power with Patients</td>
<td>Stephen Lee MD, MA Edwin Corbin-Gutierrez, MA</td>
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<tr>
<td>8</td>
<td>Combating PCP Burnout with Emergent Infections</td>
<td>Leon McCrea II, MD, MPH</td>
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<td>9</td>
<td>Culturally Responsive Communication, Part III: Language and Literacy Access</td>
<td>Joaquin Carcño</td>
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## Anticipated Outcomes

<table>
<thead>
<tr>
<th>Short-term</th>
<th>Medium-term</th>
<th>Long-term</th>
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| - Increased knowledge of population preferences  
- Increased awareness of barriers and facilitators to culturally responsive communication | - Increased perceived capacity to act  
- Improved self-efficacy to address barriers  
- Increased culturally responsive communication on HIV, PrEP/PEP and COVID vaccines with racial, ethnic, sexual and gender minoritized patients | - Changed narrative of patient populations  
- Changed practice guidelines  
- Changed clinical operations  
- Routinized HIV, PrEP/PEP and COVID vaccine screenings for all patients |
Key Activities

- Developed a communications plan outlining tactics and strategies for promotion of the program.
- Researched and engaged with stakeholders to secure speaking opportunities, newsletter placements, social media posts, and podcast appearances.
- Conducted earned media outreach to clinician and consumer outlets and coordinated interview requests.
- Developed and distributed eleven press releases about the program on PR Newswire.
- Drafted and placed seven commentary articles in clinician and consumer-based outlets.

Reach and Impact

- **2.93 Billion** Total Impressions*
- **37** Stories Secured
- **7** Commentary Articles Placed

*Impressions represent combined unique monthly visitors from stories and press releases placed.

Secured and Upcoming Opportunities

<table>
<thead>
<tr>
<th>Stakeholders</th>
<th>Stories and Commentary Articles</th>
<th>Press Releases</th>
<th>Upcoming Opportunities</th>
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<tr>
<td>50 +</td>
<td>5</td>
<td>4K</td>
<td><strong>The Moth</strong></td>
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<td>5</td>
<td>5</td>
<td>2.1B</td>
<td>Strategic Partnership with Blue Cross Blue Shield</td>
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 достигнутые и приближающиеся возможности

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<tr>
<th>Участники</th>
<th>Статьи и комментарии</th>
<th>Пресс-релизы</th>
<th>Приближающиеся возможности</th>
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остигнутые и приближающиеся возможности

<table>
<thead>
<tr>
<th>Участники</th>
<th>Статьи и комментарии</th>
<th>Пресс-релизы</th>
<th>Приближающиеся возможности</th>
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<tbody>
<tr>
<td>50 +</td>
<td>5</td>
<td>4K</td>
<td><strong>The Moth</strong></td>
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<tr>
<td>5</td>
<td>5</td>
<td>2.1B</td>
<td>Strategic Partnership with Blue Cross Blue Shield</td>
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<td>Prioritizing Equity Episode with The AMA</td>
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### Two in One Training Series Impact

<table>
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<tr>
<th>Metric</th>
<th>Number</th>
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<tbody>
<tr>
<td>Number of Speakers</td>
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</tr>
<tr>
<td>Number of Learners</td>
<td>3K</td>
</tr>
<tr>
<td>Viewing Parties</td>
<td>2</td>
</tr>
</tbody>
</table>

### Collaborators

**Co-Sponsoring Organizations:**
- Latino Commission on AIDS
- National Alliance of State and Territorial AIDS Directors
- Drexel University
- GW SMHS Antiracism Coalition
- AAMC
- GW SMHS Office of Diversity
- D.C. Center for AIDS Research

**Promoting Organizations:**
- Social Mission Alliance
- GW SMHS Office of Diversity
- Physician Assistant Education Association
- D.C. Center for AIDS Research

---

### Two in One Black Women Thought Leaders as Webinar Speakers

- **Nikole Hannah-Jones**
  - Pulitzer-prize-winning author and racial scholar
- **Oni Blackstock, MD**
  - HIV physician, researcher, and founder of Health Justice
- **Clover Barnes, RN, BSN, MBA**
  - Bureau Chief, DC Health HIV, AIDS, Hepatitis, TB Administration
- **Annette Gadegbeku, MD**
  - Associate Professor of Community Health, Drexel School of Medicine, Faculty Director, Healing Hurt People
Two in One Policy Vignettes

Vignette #1:
Why Routinize HIV and Vaccine Screening in the Primary Care Setting.

Vignette #2:
Why Routinize HIV, PrEP/PEP and COVID Vaccine Screenings?

Vignette #3:
What is Culturally Responsive Communication?

Vignette #4:
How Clinicians Can Reshape Community Narratives to Address HIV + COVID Stigma.

Two in One Policy Recommendations

- 3 Policy White Papers
- 30 Organizations Identified for Endorsement of National Policy Strategy
- 10 Advisory Board Members Who Voted White Papers
- 3 Policy Stakeholder Videos (Advocacy, Education and Medical)

Two in One Policy Vignettes Impact

- 75k Clinicians Reached with Vignettes
- 4 Vignettes Promoting Value for Standard of Care Practice Changes

Two in One Policy Vignettes

3
Organizations Identified for Endorsement of National Policy Strategy
Advisory Board Members Who Voted White Papers
Policy Stakeholder Videos (Advocacy, Education and Medical)
Clinicians Reached with Vignettes
Vignettes Promoting Value for Standard of Care Practice Changes

Policy White Papers
Organizations Identified for Endorsement of National Policy Strategy
Advisory Board Members Who Voted White Papers
Policy Stakeholder Videos (Advocacy, Education and Medical)
Clinicians Reached with Vignettes
Vignettes Promoting Value for Standard of Care Practice Changes

2023/2024 INTRA-JURISDICTIONAL EHE → FTC ALIGNMENT
For more information

You can direct all questions to the study PI:

Maranda C. Ward, EdD, MPH
Assistant Professor & Director of Equity
Department of Clinical Research and Leadership
GW School of Medicine and Health Sciences
maranda@gwu.edu | (202) 994-0202
Break until 11:15am
Enhancing HIV Prevention in Washington DC: Challenges, Opportunities, and Strategies

Kenya Hutton
Deputy Director
Center for Black Equity

Washington, DC
April 30, 2024
Introduction

• Rates of HIV - By end of 2021: confirmed cases were 17,975

• Understanding risks = Better protection strategies

• Rates higher among:
  - Gay (MSM)
  - Those who use drugs
  - Occupational exposure

Source: (DC Health, 2022)
Challenges to Implementing Prevention Policies

• Complex policy implementation processes
  ❖ Sensitive target population
  ❖ Risk of stigma and discrimination

• Lack of resources/ need to renegotiate resource allocation
• Need for compromises that may complicate policy implementation

☐ Conflicting interests among policy makers and healthcare leaders

• Unexpected policy outcomes during pilot implementation
Cont.

- Unexpected policy implementation requirements
  - Additional documentation burden
  - Integration with existing electronic health system
  - Quality assurance monitoring
• Challenges in addressing existing complications

- e.g. transmitted drug resistance

<table>
<thead>
<tr>
<th>Antiretroviral Drug Classification</th>
<th>Antiretroviral Drug (ARV)</th>
<th>High-Level Resistance %</th>
<th>Intermediate Resistance %</th>
<th>Low-Level Resistance %</th>
<th>Susceptible %</th>
<th>N</th>
</tr>
</thead>
<tbody>
<tr>
<td>Integrase Strand Transfer Inhibitors</td>
<td>Dolutegravir</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
<td>100.0</td>
<td>147</td>
</tr>
<tr>
<td></td>
<td>Elvitegravir</td>
<td>0.0</td>
<td>0.0</td>
<td>0.7</td>
<td>99.0</td>
<td>147</td>
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<tr>
<td></td>
<td>Raltegravir</td>
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<td>0.0</td>
<td>0.7</td>
<td>99.0</td>
<td>147</td>
</tr>
<tr>
<td>Non-Nucleotide Reverse Transcriptase Inhibitors</td>
<td>Doravirine</td>
<td>0.8</td>
<td>1.3</td>
<td>3.4</td>
<td>95.0</td>
<td>613</td>
</tr>
<tr>
<td></td>
<td>Efavirenz</td>
<td>10.3</td>
<td>1.8</td>
<td>1.1</td>
<td>86.6</td>
<td>613</td>
</tr>
<tr>
<td></td>
<td>Etravirine</td>
<td>1.0</td>
<td>1.5</td>
<td>1.6</td>
<td>93.9</td>
<td>613</td>
</tr>
<tr>
<td></td>
<td>Nevirapine</td>
<td>11.3</td>
<td>1.8</td>
<td>0.8</td>
<td>86.1</td>
<td>613</td>
</tr>
<tr>
<td></td>
<td>Rilpivirine</td>
<td>2.8</td>
<td>0.8</td>
<td>5.7</td>
<td>90.7</td>
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<tr>
<td>Nucleotide Reverse Transcriptase Inhibitors</td>
<td>Abacavir</td>
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<td>0.5</td>
<td>2.4</td>
<td>96.6</td>
<td>613</td>
</tr>
<tr>
<td></td>
<td>Didanosine</td>
<td>0.3</td>
<td>0.5</td>
<td>1.0</td>
<td>98.2</td>
<td>613</td>
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<tr>
<td></td>
<td>Emtricitabine</td>
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<td>0.0</td>
<td>0.0</td>
<td>97.2</td>
<td>613</td>
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<tr>
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<tr>
<td></td>
<td>Tenofovir</td>
<td>0.2</td>
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<td>613</td>
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<tr>
<td></td>
<td>Zidovudine</td>
<td>0.5</td>
<td>0.5</td>
<td>1.3</td>
<td>97.7</td>
<td>613</td>
</tr>
</tbody>
</table>

Source: (DC Health, 2022)
Opportunities for Improvement

For policy makers and healthcare providers

• Education and training to address:
  - Limited knowledge on priority group for PrEP
  - Limited knowledge of eligibility for PrE

• Advocacy for policy cycle flow improvement

Source: (Agovi et al., 2020)
Cont.

• For leaders in the healthcare industry

• Steps:
  ❖ Collaboration with policy makers developing HIV prevention policies
  ❖ Pushing for funding for PrEP kits
  ❖ Creating awareness about existing PrEP program
  ❖ Improved access to PrEP in communities
Cont.

• For Patients, family members, and caregivers
  ❖ Community outreach and engagement on HIV prevention
  ❖ Proper PrEP use education

Source: (Brito et al., 2021)
Gaps in Integrating Co-infections and Opportunistic/Emerging Conditions into HIV Prevention

• Lack of awareness

• Vaccine recommendations for HIV patients e.g. Mpox, Hepatitis, and flu vaccine

• Fragmented healthcare systems

• Limited resources
Cont.: Challenges

• Stigma and discrimination

• Complex treatment regimen

• Risks of drug resistance

• Healthcare service access barriers
Cont.: Opportunities

• Comprehensive care models
  - Promoting vaccinations for opportunistic infections (e.g. Mpox and Hepatitis)
  - Vaccination notification reminders for patients

• Community education programs on HIV opportunistic infections and co-infections
  - Education on STI pathophysiology and complications
  - Innovative education approaches like monthly movie screening at drive-in theaters

• Advocacy and policy change
  - Evidence-based approaches for policy promotion
References


References


• CDC. (2024, April 22). Mpox and HIV. *Centers for Disease Control and Prevention*. https://www.cdc.gov/poxvirus/mpox/prevention/hiv.html
References


References


References

Treatment Policy and Implementation

Dr. Susan Shepard
Executive Director
TERRIFIC, Inc.

Washington, DC
April 30, 2024
Susan Shepard, DHA, MURP
Executive Director
TERRIFIC, Inc.
DC Health HAHSTA
TERRIFIC, Inc., an acronym for the Temporary Emergency Residential Resource Institute for Families In Crisis, Inc., founded in 1975 by The Reverend Debbie Tate and volunteers, is an internationally recognized, nonprofit housing and human service organization. Its mission is to meet the bio-psychosocial needs of “Families in Crisis” (people who share similar challenges that impede their access to care, resources and quality life). TERRIFIC, Inc. believes that all people should have access to affordable housing and quality support services. TERRIFIC, Inc. has received national/international recognition and media coverage for its quality services and program prototypes. Its programs have been visited and supported by dignitaries including the Late Princess Diana, First Lady Barbara Bush, First Lady Madam Museveni of Uganda, First Lady of France Madam Cherac; Countess Albina du Boisvouray; celebrities Patty LaBelle, Sugar Ray Leonard, Vivica Fox, Daryl Green and many others.
Ending the HIV Epidemic in the United States (EHE) Initiative
Treatment and Policy

- Optimizing social determinants of health to achieve U=U,
- Aligning county and state HIV policies and health financing,
- Addressing barriers to optimizing HIV prevention and treatment, and
- Implementing HIV status neutrality frameworks in various settings
**Goal:**

HHS will work with each community to establish local teams on the ground to tailor and implement strategies to:

- **Diagnose** all people with HIV as early as possible.
- **Treat** people with HIV rapidly and effectively to reach sustained viral suppression.
- **Prevent** new HIV transmissions by using proven interventions, including pre-exposure prophylaxis (PrEP) and syringe services programs (SSPs).
- **Respond** quickly to potential HIV outbreaks to get needed prevention and treatment services to people who need them.

- **75%** reduction in new HIV infections in 5 years and at least **90%** reduction in 10 years.
HIV Cases Living in DC

• Estimation of the Number of People Living in DC Of the 17,781 individuals diagnosed with HIV while a District resident, approximately 42% (n=7,520) were presumed to have moved outside of the jurisdiction (out-migration) prior to the end of 2019, as evidenced by a non-District residential address on their last reported laboratory report or the lack of any reported laboratory information for more than 5 years.

Annual Epidemiology & Surveillance Report Data Through December 2019 District of Columbia Department of Health HIV/AIDS, Hepatitis, STD, and TB Administration (HAHSTA)
The information refers to individuals ages 13 and older unless otherwise noted.

Approximately 1.2 million people in the U.S. have HIV. About 13 percent of them don’t know it and need testing.

HIV continues to have a disproportionate impact on certain populations, particularly racial and ethnic minorities and gay, bisexual, and other men who have sex with men (MSM).

In 2021, an estimated 32,100 new HIV infections occurred in the U.S.*

Estimated new HIV infections declined 12% from 36,500 in 2017 to 32,100 in 2021.

In 2021, 36,136 individuals received an HIV diagnosis in the U.S. and 6 dependent areas.

HIV diagnoses are not evenly distributed across states and regions. The highest rates of new diagnoses continue to occur in the South.
According to the latest estimates from the Centers for Disease Control and Prevention (CDC), approximately 32,100 new HIV infections occurred in the United States in 2021. Annual infections in the U.S. have been reduced by more than two-thirds since the height of the epidemic in the mid-1980s. Further, CDC estimates of annual HIV infections in the United States show hopeful signs of progress in recent years.
**Table 1. Cumulative Number of People Diagnosed and Living with HIV by Jurisdiction, DC EMA, 2018-2022**

<table>
<thead>
<tr>
<th>Jurisdiction</th>
<th>Number of People Living with HIV 2018</th>
<th>Number of People Living with HIV 2019</th>
<th>Number of People Living with HIV 2020</th>
<th>Number of People Living with HIV 2021</th>
<th>Number of People Living with HIV 2022</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N</td>
<td>%</td>
<td>N</td>
<td>%</td>
<td>N</td>
</tr>
<tr>
<td>Washington, DC</td>
<td>17,830</td>
<td>46.4</td>
<td>17,781</td>
<td>45.6</td>
<td>18,087</td>
</tr>
<tr>
<td>Maryland</td>
<td>12,558</td>
<td>32.7</td>
<td>12,859</td>
<td>33.0</td>
<td>13,095</td>
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<td>Virginia</td>
<td>7,761</td>
<td>20.2</td>
<td>8,100</td>
<td>20.8</td>
<td>8,301</td>
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<tr>
<td>West Virginia</td>
<td>265</td>
<td>0.7</td>
<td>247</td>
<td>0.6</td>
<td>NA</td>
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<tr>
<td>Total</td>
<td>38,414</td>
<td>100.0</td>
<td>38,987</td>
<td>100.0</td>
<td>39,483</td>
</tr>
</tbody>
</table>

*The number of individuals diagnosed with HIV residing in WV is only available through 2019*

All data in the following section are jurisdictional health department data submitted to the DC Health’s Surveillance, and Investigation Division. Data for 2020-2022 from the DC EMA Counties in West Virginia were not available at the time of the report due to limited staffing availability for required data cleaning and analysis.
Four Pillars of *Ending the HIV Epidemic in the U.S.*

- Diagnose all people with HIV as early as possible
- Treat people with HIV rapidly and effectively
- Prevent new HIV transmissions by using proven interventions, including pre-exposure prophylaxis (PrEP)
- Respond quickly to potential HIV outbreaks to get vital prevention and treatment services to people who need them
SOCIAL DETERMINANTS OF HEALTH

What Are Social Determinants of Health?

According to the CDC, SDHs are:
"the conditions where people live, learn, work, and play that affect a wide range of health and quality of life risks and outcomes."

They are the non-medical factors that influence our health outcomes.

There are 5 key areas of SDHs:

1. Healthcare Access and Quality
   - How easy is it for someone to access healthcare?
   - What financial barriers may stand in the way?
   - Determinants in this category include: healthcare, primary care, insurance coverage, and health literacy.

2. Education Access and Quality
   - Education is one of the strongest predictors of individual and community health.
   - Determinants in this category include: high school graduation, higher education, language and literacy, and childhood development.

3. Social and Community Context
   - Not all communities have a sense of togetherness.
   - Community cohesion can play a big part in health.
   - Determinants in this category include: civic participation, discrimination, workplace conditions, and incarceration.

4. Economic Stability
   - Individuals who are economically insecure may have added difficulty in addressing their health needs.
   - Determinants in this category include: income, living cost, poverty, housing, socioeconomic status, and food security.

5. Built Environment
   - Neighborhoods play a big part in assessing health.
   - Where someone lives can make a big difference.
   - Determinants in this category include: access to transportation, healthy foods, air and water quality, and local crime and violence.
Susan Shepard, DHA, MURP
Executive Director
TERRIFIC, Inc.
1222 T Street, NW Washington, D.C. 20009
202.882.1160
sshepard@terrificinc.org
Federal, State and City Health Policy Alignment

Greg Millett
amfAR
4/30/24
Health policies that may affect HIV epidemics:

- Harm reduction
- Sexual health
- Gender affirming care
- Reproductive Health services
- Support for unhoused
- HIV criminalization
- Medicaid expansion
- PrEP DAP
- Reinforcing efforts to address overlapping epidemics
Seattle, Washington

Rate of people living with HIV per 100,000 population, by Geography, 2021

Rate of people newly diagnosed with HIV per 100,000 population, by Geography, 2021

Percent of Population with a High School Education, 2021

Median Household Income, 2021

Percent of Population Living in Poverty, 2021

Percent of Population Unemployed, 2021

(AIDSVu.org)
How a nonprofit dramatically lowered HIV rates among Boston's homeless population

170 HIV cases in 2022 reduced to 5 in 2023.

Figure 3.4 Trends in median time from HIV diagnosis to viral suppression by race/ethnicity, transmission category, and housing status, 2017-2021, San Francisco

1. Includes people whose addresses at diagnosis were unknown.
Iowa leads U.S. in HIV suppression

<table>
<thead>
<tr>
<th>Quintile of PrEP Coverage</th>
<th>Lowest (1st)</th>
<th>2nd</th>
<th>3rd</th>
<th>4th</th>
<th>Highest (5th)</th>
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</thead>
<tbody>
<tr>
<td>EAPC in HIV Diagnosis Rate (%)</td>
<td>81.7</td>
<td>80.8</td>
<td>79.7</td>
<td>79.2</td>
<td>78.6</td>
</tr>
</tbody>
</table>

Data: CDC; Chart: Axios Visuals

Trend p-value = 0.0077
The Right Policies Successes Can Reduce New Diagnoses, Washington, DC

Figure 2. Newly Diagnosed HIV Cases, Deaths, and Living HIV Cases, by Year, District of Columbia, 1983-2022

- Living HIV cases who were DC residents at diagnosis
- 2022 deaths not available at time of publication
Orlando Sentinel

Orlando HIV rates continue to outpace national average

New analysis also raises concerns about whether those who need treatment are getting it.
Nashville, Tennessee

Rate of people living with HIV per 100,000 population, by Geography, 2021

- City: 773
- State: 318
- Region: 461
- United States: 384

Percent of Population Unemployed, 2021
- City: 3.8%
- State: 4.5%
- Region: 4.8%
- United States: 5.3%

Percent of Population Living in Unstable Housing, 2021
- City: 12.0%
- State: 11.9%
- Region: 13.6%
- United States: 14.3%

At most, narrowly focusing HIV prevention efforts on the priority populations identified by state officials could prevent an estimated 9 HIV cases per year:

- Cases among first responders: 0
- Cases among victims of human trafficking: 1
- Cases from perinatal transmission: 1
- Cases among pregnant women: 7

In contrast, preventing new HIV cases among those populations most at risk in Tennessee could prevent an estimated 509 cases of HIV per year:

- Cases among transgender people: 20
- Cases among people who inject drugs: 43
- Cases among cisgender women: 86
- Cases among men who have sex with men (MSM): 360

By limiting HIV prevention activities to only 2% of those “at risk,” the missed prevention opportunities in the Tennessee state officials’ plan could end up adding $255 million in HIV treatment costs per year for the state.*
How populations shifted in those 48 D.C. census tracts

How populations shifted in those 35 New Orleans census tracts

How populations shifted in those 32 Denver census tracts

<table>
<thead>
<tr>
<th>CITY (COUNTRY)</th>
<th>WHITE</th>
<th>NON-WHITE</th>
<th>TRACTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Brooklyn (Kings)</td>
<td>54,026</td>
<td>-18,784</td>
<td>75</td>
</tr>
<tr>
<td>Washington (District of Columbia)</td>
<td>37,473</td>
<td>-2,076</td>
<td>48</td>
</tr>
<tr>
<td>Denver (Denver)</td>
<td>25,429</td>
<td>-10,154</td>
<td>32</td>
</tr>
<tr>
<td>Philadelphia (Philadelphia)</td>
<td>21,735</td>
<td>-6,604</td>
<td>28</td>
</tr>
<tr>
<td>Austin (Travis)</td>
<td>21,116</td>
<td>-4,912</td>
<td>27</td>
</tr>
</tbody>
</table>

For tracts where White population share increased by more than 9 percentage points over the decade.

Source: Census 2010, 2020

Source: U.S. Census Bureau
Summary

• County and state policies affect HIV trajectories
• Successes in addressing HIV in urban and rural areas
  • Some populations still left behind
• Successes are not linear—sometimes there are steps back
• Policies that address overlapping epidemics (opioids, homelessness) are key
• Urban renewals and gentrification may displace HIV epidemics
Community Access to HIV Services

Dr. DeMarc Hickson
Executive Director
Us Helping Us, People Into Living, Inc.
If You Build It, Will They Come?

Are we truly increasing access?

April 30, 2024

DEMARC A. HICKSON, PHD
EXECUTIVE DIRECTOR

Self-help support group; followed principles of mind, body and spirit.

Today, the oldest and one of the largest Black gay-founded/led, Black serving, HIV services organizations in the nation.

**Mission:** To improve the health and well-being of Black gay men* & to reduce the impact of HIV/AIDS in the entire Black community.
A Historical Perspective: The Coming of a National Community-Based Leader

1985-1988
Us Helping Us
Founded & Incorporated

1st AIDS Case
1982

AZT
1996

ART
1993

First CDC Grants & HIV Testing grant
1999 2000

Us Helping Us: The L Street Corridor, including: T.H.E.
2004

Black Gay Chat
2006

SMS
2002

PrEP
2012

Grindr
2015-17

Dr. Hickson becomes ED
2020

COVID-19

Us Helping Us Purchases 3636 Georgia Avenue

Continued Direct Funding from CDC: >$7M
PS09-094
PS11-1113 (DENIM)
PS10-1003
PS15-1502

PS17-1704
PS10-1003
PS15-1502

1985-1988
Us Helping Us
Founded & Incorporated

12-Week Curriculum
1985-1988

AZT
1996

ART
1993

First ever grant: Washington AIDS Partnership

Began distributing condoms
HIV among BSMM

Oral swabs for HIV testing

Dr. Simmons: First ED; Org.
Budget: $8,000

ClubHouse Closed

1st AIDS Case
1982

ClubHouse Closed

Began distributing condoms

HIV among BSMM

Oral swabs for HIV testing

Dr. Simmons: First ED; Org.
Budget: $8,000

ClubHouse Closed

Began distributing condoms

HIV among BSMM

Oral swabs for HIV testing

Dr. Simmons: First ED; Org.
Budget: $8,000

ClubHouse Closed

Began distributing condoms

HIV among BSMM

Oral swabs for HIV testing

Dr. Simmons: First ED; Org.
Budget: $8,000
Us Helping Us: Who Are We Now?

### Current Programs, Services and Activities

<table>
<thead>
<tr>
<th>Service</th>
</tr>
</thead>
<tbody>
<tr>
<td>PrEP &amp; PEP services, including education and navigation services</td>
</tr>
<tr>
<td>HIV treatment (Ryan White: Outpatient Ambulatory Medical Services)</td>
</tr>
<tr>
<td>Integrated HIV/STD Testing, incl. Syphilis, gonorrhea, Chlamydia, Hepatitis C</td>
</tr>
<tr>
<td>STD Treatments &amp; Vaccinations (HPV, Hepatitis A &amp; B)</td>
</tr>
<tr>
<td>TeleHealth services, incl. TeleScreening, TeleMental Health, TeleCase Management</td>
</tr>
<tr>
<td>Psychotherapy / Counseling</td>
</tr>
<tr>
<td>Behavioral HIV Interventions (e.g., Healthy Relationships)</td>
</tr>
<tr>
<td>Case Management (Medical, non-Medical, Housing)</td>
</tr>
<tr>
<td>Psychosocial Support Groups (Various)</td>
</tr>
<tr>
<td>Community-Based Outreach &amp; Education (Mobile Health)</td>
</tr>
<tr>
<td>Syringe Services Program ( Needle Exchange)</td>
</tr>
<tr>
<td>Drop-In Center: The DENIM Collection</td>
</tr>
<tr>
<td>Workforce Development (Project GROWTH, Peer Educators)</td>
</tr>
<tr>
<td>Research: Epi of HepC; SNS and PrEP; SRD and PrEP</td>
</tr>
</tbody>
</table>

- An experienced community-based non-profit organization
- Addresses the unmet needs of underserved, marginalized, and overlooked populations
  - Racial, [sexual and gender minorities], people [living & thriving with HIV], persons with mood and substance us disorders.

Pre-exposure (PrEP) and Post (PEP) prophylaxis; prevents someone that is HIV-negative from acquiring HIV.
• Lessons from COVID.
  • Did we really listen to the lessons learned?

• Is Mobile or Portable Health a lost approach?

• What about TeleHealth?

• Partnerships still have value.
Us Helping Us: A Community-Based Leader on the Frontlines of Mpox

- **1982**: 1st AIDS Case
- **1985-1988**: Us Helping Us Founded & Incorporated
- **1993**: AZT
- **1996**: ART
- **1999-2000**: First CDC Grants & HIV Testing Grant
- **2004**: Oral swabs for HIV testing
- **2006**: SMS
- **2008-2010**: First ever grant: Washington AIDS Partnership
- **2010**: Dr. Hickson becomes ED
- **2012**: PrEP
- **2015-17**: PrEP Prescription
- **2020**: COVID-19
- **2021-2022**: HIV among BSMM
- **2021**: ClubHouse Closed
- **2022**: Dr. Simmons: First ED; Org. Budget: $8,000

**Mpox Clinic**
- **Us Helping Us**: July 14
- **Us Helping Us**: Aug. 7

**Expanded Eligibility Criteria**
- **Community Townhall**: Aug. 31

**Data Source**: DC Health (as of 9/27/2022)
Cases are included by date of symptom onset if known, or date of estimated symptom onset (6 days prior to specimen collection date)
* Infections that began during this time period may not yet be reported
Data are subject to change
Demographics and Health Beliefs of Black Gay, Bisexual, and Other Sexual Minority Men Receiving a Mpox Vaccination in the United States

Adedotun Ogunbajo · Alexa Euceda · Jamil Smith · Raven Ekundayo · Justise Wattree · Mitchell Brooks · DeMarc Hickson
• Lessons from COVID.
  • Did we really listen to the lessons learned?

• Is Mobile or Portable Health a lost approach?

• What about TeleHealth?

• Partnerships still have value.
About Us: Community-Based at its Fullest

- One Tent Health: Youth-driven, people-serving
- Us Helping Us: Black-SMM led, minority-focused, client-centered
Taking It To The Streets

• Intake and behavioral assessment, incl. PrEP awareness & knowledge

• HIV Testing & Referrals: Two non-reactive results
  – One Tent Health: INSTI. Us Helping Us: Alere Determine

• PrEP assessment: venipuncture, urine specimen

• Start-pack (e.g., 7-day supply)

• Normal physiological lab values; 30-day prescription
It's About Culturally Effective Approaches
The Blueprint to Eliminating Inequities & Ending the HIV Epidemic

- **SAMHSA:** $125,000
- **DC Health:** $187,500
- **Prince George’s:** $31,000
- **Montgomery:** $42,000
- **TOTAL:** $510,500

- **DC Health (EIS MAI):** $63,636
- **RWhite Part A*:** $122,728
- **Prince George’s: **$31,000
- **TOTAL:** $217,364

- **RWhite Part A:** $727,244
- **RWhite Part B:** $306,823
- **Prince George’s:** $81,000
- **Gilead Sciences:** $233,333
- **TOTAL:** $1,348,400

- **NIH:** $1,135,689
- **CFAR EHE Suppl:** $527,610
- **ViiV Healthcare:** $348,400
- **TOTAL:** $2,011,699

- **EFA (Broadway):** $35,000
- **ViiV Health:** $200,000
- **Gilead Sciences:** $600,000
- **GenOps**: $600,000
- **TOTAL:** $1,435,000

- **DC Dept. Bev. Hlth:** $35,000
- **Dept Hum Serv:** $300,000
- **Prince George’s:** $200,000
- **TOTAL:** $1,235,000
View our History Video: www.youtube.com/watch?v=N5PG384vEOE
Lunch – Back at 1:30pm
Addressing Criminalization as a Barrier to Ending HIV

Panelists

- **Leslie Demus** – Manager, Substance Use Disorders, Unity Healthcare and DC Jails
- **Jona Tanguay** – Medical Program Lead, Substance Use Disorders, Whitman-Walker Health
- **Dr. Monica Ruiz** – Associate Professor, Dept. of Prevention and Community Health, George Washington University

Moderator:

Dr. Kim Blankenship
Distinguished Professor, Sociology
American University
Scaling Up PrEP Access and Utilization

Panelists

- **Martha Sichone-Cameron** – Regional Coordinator, International Community of Women Living with HIV North America – Georgetown University

- **Camilla Stanley** – Investigator – DC Health, HIV/AIDS, Hepatitis, STD & TB Administration

- **Brian Hujdich** – Executive Director – HealthHIV and National Coalition for LGBT Health

Moderator:

**Dr. David Fessler**
Director of Clinical Practice
Whitman-Walker Health
Optimizing Social Determinants to Achieve U=U

Panelists
- **Anthony Fox** – Division Chief – DC Health, HIV/AIDS, Hepatitis, STD & TB Administration
- **Dr. DeMarc Hickson** – Executive Director – Us Helping Us, People Into Living, Inc.
- **Dr. Leah Varga** – Assistant Research Professor, Milton Institute of Public Health, George Washington University – Health Literacy Program Manager – DC Health Office of Health Equity

Moderator:
**George S. Kerr, III**
Community Coordinator, DC CFAR
Chair, National CFAR CAB Coalition
Implementing HIV Status Neutrality in Practice

Panelists

• Dr. Suyanna Barker – Chief of Programs and Community Services – La Clinica del Pueblo

• Michael Shankle – Chief Operating Officer – Washington Health Institute

• Clover Barnes – Senior Deputy Director – DC Health, HIV/AIDS, Hepatitis, STD & TB Administration

Moderator:

Abby Charles
Program Manager
Institute for Public Health Innovation
Identified Challenges and Opportunities to EHE in Washington D.C.

Scott Lyles
EHE and FTC Alignment Consultant
Fast-Track Cities Institute
HIV Care Continuum Optimization for EHE and FTC Goals

- Routine testing needs to be implemented in all clinical settings
- Florida Medicaid Extension/Expansion needs to occur – need political will to support it
- Too system centered, needs to be patient-centered care model - Meet people where they are at the times that work for them
- Eligibility system is broken – too burdensome on patients for documentation
- HIPAA allows for data sharing on behalf of the client, should be one Broward County eligibility system, patients shouldn’t have constant burden of proof
- Care centers should be proactive on awareness of clients’ eligibility timeframes and time for renewal
- Bringing more mobile and wider telehealth services to the community, need to go digital
- Continuous education and feedback to providers – re-educate on Rapid ART and PrEP
- Challenges with linkage to care with opt out testing at ED - sensitization on personal circumstances of people getting tested informing linkage
- Empower patients to maintain quality of healthcare, observe why people fall out of care
- Transparency between organizations and care systems
Improving Engagement

Widen the circle

• Youth
  • Find spaces outside the school to engage them
• Parents
  • Educate parents to better support their youth
• Transgender populations
• Faith-based leaders
• Black heterosexual identifying men
  • Address the stigma that is keeping them from the table – invitation not accusation
Centrality of Community

• Community needs to be at the table when developing new programs and policies – there are processes and procedures that don’t fit within the existing programs

• Community organizations need to be prioritized for funding
  • Funding is based on volume, smaller organizations may not have numbers but they have reach
  • Question the existing funding systems and how to make it more relevant to community

• How to build capacity of small community organizations to manage larger budgets?

• Engage community on HOW to spend existing funds
Policy Landscape

• Intersection of racism and HIV criminalization
• Engage other organizations that engage communities that are disproportionately hurt by HIV criminalization
  • NAACP
  • Faith community
• Assumed guilt just for living with HIV – increases stigma
• Careful with how U=U is used in criminalization so we don’t separate “good people living with HIV” and “bad people living with HIV”
• How do we mobilize to change these laws?
  • Need to educate legislators on HIV transmission – data alone is not enough
  • Community needs to be in the room in educating legislators on the impact of laws – LA Coalition on Criminalization and Health
• Once laws are changed
  • Educate law enforcement officers
  • Educate community that this is not something you can be criminalized by
  • Remove people from sex offender list
  • Prepare a body of lawyers that are equipped with the knowledge to stand by the community
Scaling up PrEP Access and Utilization

• Stigma associated with HIV makes people hesitant to hear about PrEP
• Stigma associated with PrEP makes people hesitant to consider PrEP
• Normalize PrEP as part of wholistic care
• Representation matters! – inclusion of black and Latinx women on advertisements for PrEP
• Access – need to make the processes for accessing PrEP easier
  • Need to keep up momentum so people link to PrEP
  • Same day PrEP
  • Bring PrEP directly to community events
• Engage more college/university groups on PrEP education (and advocacy) activities
  • Frats
  • Sororities
  • The Devine Nine
• De-stigmatize PrEP usage – must be seen as a tool and a big reason for advancing HIV goals
Stigma

• Stigma in healthcare settings – training as a continuous process
• Need to normalize U=U and PrEP – kitchen table conversations
• De-stigmatize black men’s assumed role in transmission
• Religion and stigma- Capacity building for faith-based leaders to support their communities.
• Language matters!
  • De-stigmatize language on sex and sexuality
Social Determinants of Health

• Federal funding cuts for affordable housing; unsustainable cost for building more affordable housing (lasagna of money) – creatively “braid” funding
  • HOPWA dollars, EHE dollars, other funding/medical dollars
  • Unique partnerships to ensure affordable housing – Gulf Coast Housing Perspective working with health insurance providers and FQHCs

• Resources that can be mobilized at local level
  • DHHS resources
  • Office of community development
  • Available lots
  • Making the budget stretch - townhomes, duplexes

• Intersecting vulnerabilities of those who are unhoused – beyond HIV. How can these intersecting vulnerabilities be addressed?

• Need to think about other social determinants of health
  • Transportation
  • Social injustices
  • Socio-economic status
HIV Status Neutral Services

• Funding – how to get funding for wrap around services to implement status neutrality

• Status neutrality is not limited to HIV – it should focus on equitable whole person quality of care and quality of life irrespective of serostatus

• Capacity building for providers on linkage to care for ALL
Actionable EHE and FTC Implementation Steps in Washington, DC

Dashiell Sears
Regional Director – North America
Fast-Track Cities Institute

Washington, DC
April 30, 2024
FTC – EHE Joint Focus

• FTC-EHE Synergies are significant
• Areas of joint focus in 2022-2025, including:
  • Technical guidance: Inter-/Intra-jurisdictional planning
  • Health inequity: Social Transformation Agenda
  • Capacity-building: LAI tx/PrEP implementation, person-centered care, cultural responsiveness
  • Best-practice sharing: Best Practice Repository
  • Assessment tools: QoC, QoL surveys
  • Public policy interventions: Housing, criminalization
  • Health workforce: Stress, burnout, well-being survey
  • Stigma elimination: #ZeroHIVStigmaDay
Leveraging FTC for EHE

EHE Goals

• Expanding Engagement Points for EHE Advocacy – Widening the Circle
• Integrating treatment and prevention strategies together to achieve status neutrality
• Local stakeholder buy-in and education [health networks/districts, clinicians, educators]
• Strengthening Health System Resilience
• Upscaling integrated care models addressing intersectional infections and conditions (MPX, hepatitis, syphilis, gonorrhea, chlamydia, under- or non-insured, unhoused, mental health, addiction
• Measuring and assessing Quality of Care and Quality of Life Metrics

FTC Advantage

• Social Transformation Agenda
  • Leveraging FTC core groups to enhance engagement with community-based stakeholders towards comprehensive planning that supports EHE and equity-based goals for social determinants
• Inter-jurisdictional holistic HIV planning,
• Best Practice documentation/validation/sharing,
• Implementation Science funded studies
• Research and guidance for universal stigma, QoC, QoL metrics
Leveraging FTC for EHE, Cont.

EHE Goals

• Policy advocacy for holistic HIV health systems
• Increase HIV awareness in non-traditional medical fields and general community
• Eliminating disparities in HIV health outcomes, rates of new infections, and PrEP uptake
• Optimizing the urban and rural HIV care continuum
• Enhancing accessibility for HIV service and clinical interfacing for key populations

FTC Advantage

• Model Policies, HIV Care Optimization Guidance, Status Neutral implementation
• Normative Implementation guidance for DoxyPep and DoxyPrEP
• Normative guidance on strengthening STI capacities for clinics and health departments
• Data and Research for policy impact
• Social Transformation Agenda, Inter-Jurisdictional Planning, QoL/QoC Assessments
• Global reach for leading edge partnership exploration
Closing Remarks

Dr. José M. Zuniga
President/CEO, IAPAC and FTCI
Chair, UNAIDS Task Force on Urban Health

Washington, DC
April 30, 2024
• **TOGETHER**, we can achieve a future in which:
  - New HIV infections are **EXCEEDINGLY RARE** and AIDS-related deaths are a thing of the past
  - People living with and affected by HIV are **VALUED** and not subjected to inequality

• Lags in our global, national, municipal HIV responses reflect underlying **SOCIAL INEQUALITIES**:
  - **GAY MEN, OTHER MSM** who are forced to live on societal margins
  - **TRANSGENDER INDIVIDUALS** whose identities are (violently) suppressed
  - **RACIAL, ETHNIC MINORITIES** who lack socioeconomic opportunity and confront racism
  - **WOMEN, GIRLS** who often lack a voice about their own bodies and healthcare decisions

• Ending AIDS as a public health threat does not just mean suppressing the virus to achieve U=U or preventing HIV acquisition, as important as these objectives are clinically and for public health
  - We must **ADDRESS MYRIAD SOCIAL INJUSTICES** that are causes and effects

• **HIV is as much about HUMAN RIGHTS AND SOCIAL JUSTICE** as it is about public health or science

• **EHE and FTC are well ALIGNED AND SYNERGISTIC** to advance a **HOLISTIC** HIV response
Closing Remarks

Dr. José M. Zuniga
President/CEO
IAPAC and Fast-Track Cities Institute

Dr. Colton Nguyen
Executive Director
360Healthx Corp.