Ending the HIV Epidemic in DC
2018 Progress Report

Tracking the Goals and Impact of the 90/90/90/50 Plan
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On December 1, 2016, the 90/90/90/50 Plan was released through a public-private partnership between the Washington AIDS Partnership; DC Appleseed Center for Law and Justice; The Honorable Muriel Bowser, Mayor of the District of Columbia; Dr. LaQuandra Nesbitt, Director of the DC Department of Health (now DC Health); Dr. Nesbitt’s staff in the HIV/AIDS, Hepatitis, STD and TB Administration (HAHSTA) led by Senior Deputy Director Michael Kharfen; and Dr. Leah Varga, HIV Services Planner. DC Appleseed appreciates the work it takes to implement the Plan and thanks our partners for their continuous collaboration.

The work of the 90/90/90/50 Plan is generously supported by the Washington AIDS Partnership under the direction of Channing Wickham. They have been a steadfast partner for over a decade, and we are deeply grateful for their insight and guidance each year.

Foundational to the HIV project at DC Appleseed is the work of pro bono partners at Hogan Lovells US LLP and Paul, Weiss, Rifkind, Wharton & Garrison LLP. We sincerely thank them for their continuous commitments of energy and expertise towards this important work as well as that of their associates Pauline Abijaoude, Patrick Campbell, Delia Deschaine, Carlo Felizardo, H. Bola George, Sally Gu, Jessica Robinson Hanna, E. Elizabeth Halpern, SheeShee Jin, Laurie Lai, Ali Lakhani, Maria Malas, Meredith Manning, Breanne Palmer, and Akila Sarathy.

In the process of compiling this progress report, DC Appleseed worked alongside HAHSTA staff who were instrumental in explaining the Administration’s work over the past year. We also consulted with experts at the Office of the State Superintendent for Education (OSSE), DC Public Schools (DCPS), the DC Public Charter School Board (DCPCSB), the Office of the Deputy Mayor for Health and Human Services, the Office of the Deputy Mayor for Education, and staff of the Council of the District of Columbia. We interviewed many healthcare providers and representatives of community-based organizations who shared their experiences with us. We appreciate each of these groups and individuals for sharing their perspectives and insights.

Last, but not least, we thank the valiant DC Appleseed staff, Board of Directors, and alumna and consultant Amber Rieke for their persistence and commitment to creating a healthier District of Columbia.
About the 90/90/90/50 Plan

The District of Columbia’s strategic plan for “ending the epidemic,” was released on World AIDS Day, December 1, 2016, through a public-private partnership between Mayor Muriel Bowser, Dr. LaQuandra Nesbitt of the DC Department of Health (DC Health), and staff within the HIV/AIDS, Hepatitis, STD and TB Administration (HAHSTA), the Washington AIDS Partnership, and DC Appleseed Center for Law & Justice. The “90/90/90/50 Plan” (Plan) was named for its four overarching goals: by 2020, 90% of all District residents with HIV will know their HIV status, 90% of District residents living with HIV will be in sustained treatment, 90% of those in treatment will reach viral suppression, and, ultimately, DC will achieve a 50% reduction of new HIV infections by 2020.

In creating these goals for 2020, our partners studied data on HIV in DC and consulted community stakeholders, and our academic partners created detailed models outlining what could be achieved if certain efforts were scaled up. Those efforts are included among the 42 tasks in the 90/90/90/50 Plan as the groundwork necessary to achieve our goals. Most of the tasks (activities and interventions) are designed to link HIV-positive individuals to and maintain or sustain them in care, as well as define effective approaches to maintain individuals’ HIV-negative status. The Plan heavily relies on two important clinical advances to catalyze further progress: “treatment as prevention” and “Pre-exposure Prophylaxis” (PrEP). Research has demonstrated that sustained anti-retroviral treatment (ART) not only improves the health of persons living with HIV, but can prevent
those who have HIV from passing it on to others. PrEP, which is a modified regimen of ART, can prevent infection for those who are HIV-negative but at a higher risk of contracting the virus, such as people in sexual relationships with HIV-positive partners. As recently reported, an influential panel of medical experts recommends that physicians offer PrEP to all persons at high risk of acquiring HIV.

In order to end the epidemic, we must also tackle a range of social, educational, and health factors, many of which fall outside the traditional purview of the DC Health. This includes addressing healthcare outside of traditional settings, like providing sexual health resources to the Public Charter Schools (DCPCS), District of Columbia Public Schools (DCPS), and the Office of State Superintendent for Education (OSSE). It also includes mental health, substance use treatment, housing stability, economic opportunity, educational attainment, and stigma prevention. Furthermore, groups that have been historically underserved or alienated from the healthcare system such as Black women, Latinx people, Black men who have sex with men (MSM), and the Lesbian, Gay, Bisexual, and Transgender (LGBT) community need to be engaged in care in culturally competent settings. The 42 tasks in the Plan are designed in part to address these issues.

Data on the HIV epidemic in DC offer critical insight into where efforts should be focused to implement the 90/90/90/50 Plan; however, consistent communication with community partners and organizations that are connected to people who are potentially at risk of infection or at risk of not remaining in care is also critical. The 2018 Annual Epidemiology & Surveillance Report (the Epi Report) shows us where the focus of all these efforts is needed. Significantly, the Epi Report shows an increase in new infections for youth, with the largest share of new cases among 13-29 year-olds, from 134 in 2016 to 150 in 2017. These alarming data bring into question whether the Plan has effectively incorporated the Healthy Schools Act, whether the District is effectively educating our youth about sexual health, and whether at-risk youth have adequate access to preventative health services like PrEP and condoms.

Conclusions and Recommendations of this Report

In the joint Plan released on World AIDS Day 2016, DC Appleseed committed to issue a Report and update on each successive World AIDS Day concerning progress being made under the Plan and to offer recommendations concerning further steps needed to ensure successful implementation of the Plan.

Progress in implementing the Plan, at this point is mixed. The primary goal of the Plan and its 42 tasks is to reduce the number of new HIV infections by 50% by the end of 2020. Unfortunately, now that the District is almost two years into the four-year duration of the Plan (2017-2020), it is clear that the city is not on track to meet the projected 50% reduction of new infections by the end of 2020.

Even though the District had significant and steady declines in the number of new infections during the years prior to the Plan, that has not been the case since the Plan’s adoption. In 2015, the year before the Plan’s adoption, the number of new infections was 401; to reduce that number by 50% means the number of new infections in 2020 should be approximately 200.

The District is not reducing infections at a pace to reach that goal: new infections in 2016 were 369; in 2017 they were 368; and preliminary numbers for the first six months of 2018 indicate 176 new infections, which suggests an annualized rate of 352 new infections for the year. Roughly speaking, this means that halfway through the Plan, new infections have been reduced by only 12% -- a long way from the 50% goal.

Why is this happening? There appear to be several reasons. First, the phenomenon of hitting a “plateau” in reducing new infections seems to be occurring in other jurisdictions throughout the country we have surveyed. It occurs in part because earlier progress represents efforts aimed at the “low-hanging fruit.” Further progress becomes harder because those vulnerable to infection can be very difficult to reach. Second, some of the tasks in the Plan that are critical

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2 Larry Bernstein, Everyone at High Risk of HIV should be offered preventive medication panel says, November 20, 2018, Washington Post.
to reaching persons most vulnerable to infection are some of the hardest tasks to implement. This must be addressed since the key to reaching the Plan’s goals is implementing the Plan’s tasks. And third—and most troubling—the most recent data concerning new infections in the District show an alarming increase among young people; in fact, new infections among District residents 13-29 years old not only rose between 2016 and 2017 but constituted 41% of all new infections. This rate is approximately double the national average (21%) for new infections among that age group.

In light of these data points, “We still have more work to do, because the message isn’t getting through enough,” Mr. Michael Kharfen, director of HAHSTA, said in a 2018 program by WAMU 88.5, “particularly with these young people.”

What should be the focus going forward to ensure successful implementation of the Plan? First, there needs to be a significant increase in efforts focusing on young people. This includes, as explained in this Report, the adoption of regulations ensuring comprehensive HIV education in all DC Public Schools—something that is not occurring, even though it is required by the Health Schools Act. Second, there needs to be greatly increased efforts to make PrEP available in the District, particularly considering the recent report from the U.S. Preventive Services Task Force which recommends that the drug be available to all persons at high risk of acquiring HIV. The District should not have 350 new infections per year when PrEP is available to prevent most, if not all, of them.

Third, a detailed analysis of progress on the 42 tasks in the Plan is needed, and specific steps must be taken to fully implement the tasks which will have the highest impact on preventing new infections. DC Appleseed intends to undertake that analysis over the next several months, in consultation with HAHSTA, the Washington AIDS Partnership, and other partners to issue a supplemental report on the issue in 2019. We will also include at that time an update to the Plan from HAHSTA incorporating new tasks and removing or replacing tasks that are considered not relevant or achievable.

We believe the goals of the Plan can be met; but redoubled efforts will be required to do so.

Organization of the Report

Following this Executive Summary, we first present an introduction to the 90/90/90/50 Plan. This describes the content of the Plan, including the four overarching goals, the 42 tasks, and the role of this Report. We then summarize the most recent data on the state of the epidemic, taken from the 2018 Annual Epidemiology & Surveillance Report, and then summarize the national trend currently experienced in other jurisdictions across the country. Next, we address the issue of rising infections among youth in the District and the impact the Healthy Schools Act can have to help reduce new infections among students. Thereafter we discuss the importance of creating greater accessibility to PrEP in the District for all residents to help prevent new infections. Finally, we provide an update on several key tasks of the 90/90/90/50 Plan that are imperative to reaching the Plan’s goal of 50% reduction in new HIV infections by 2020. We look forward to working with all stakeholders on the Plan and on the development of our supplemental report for 2019.

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“This disease is not likely to be eradicated, but with the commitment and public support of District leaders, we can reduce its terrible toll.”

This was DC Appleseed’s assessment of the HIV epidemic in 2005, in our report *HIV/AIDS in the Nation’s Capital*. At that time, there were approximately 11,517 people living with HIV in the District—nearly 3% of the combined adult and adolescent population—with 929 District residents newly diagnosed in that year alone. An infection rate any level above 1% is considered an epidemic, and the HIV epidemic in the District was the worst in the country. DC Appleseed’s report detailed the District’s lack of effective leadership, poor coordination of services, ineffective funding, inadequate data collection and analysis, and inability to meet the needs of special populations. We called for action in a time of great need. Every year afterward, we issued report cards to chart the District’s progress on tackling the epidemic.

By 2015, the District had seen a 72% decrease in new infections from that 2005 baseline. This was greatly encouraging but, because of significant efforts in data surveillance, we knew we still had a problem. Of concern were the disparities by age, race, sex, and gender that were obscured by an overall average decrease in new cases.

During the 2015 ten-year milestone, we stood alongside the Mayor; Dr. LaQuandra Nesbitt, Director of DC Health; Dr. Nesbitt’s staff in the HAHSTA led by Senior Deputy Director Michael Kharfen; Leah Varga, HIV Services Planner and the Washington AIDS Partnership to celebrate the progress and announce the District’s commitment to finally end the HIV epidemic in DC. The 90/90/90/50 Plan, the District’s new strategic plan for “ending the epidemic,” was released on World AIDS Day, December 1, 2016. It is named for its main goals: 1) 90% of all District residents living with HIV will know their HIV status, 2) 90% of District

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residents living with HIV will be in sustained treatment and 3) 90% of those in treatment will reach viral suppression. Ultimately, these and other efforts should lead to the fourth goal, a 50% reduction of new HIV cases. The Plan aimed to achieve all four by 2020. The work outlined in the 42 tasks in the 90/90/90/50 Plan is underway. These tasks provide the groundwork necessary to achieve the measurable outcomes of 90/90/90/50.

This Report will evaluate the current status of the Plan at its halfway point and assess the District’s current trajectory to reach its goal by 2020. This Report will also evaluate the District’s response to the Epi Report which provides a snapshot of the District’s HIV, Sexually Transmitted Diseases, Hepatitis, and TB complex epidemics. The data produced in the Epi Report provide insight into how DC Health, in partnership with the community and other government agencies, can continue to make progress for the health of District residents. This year, the number of new HIV diagnoses remained level while there was an increase in the number of youths who were diagnosed with HIV or STDs.

Below, an overview of how the Plan was developed, the rationale for and roadmap of the four overarching goals and the 42 tasks, and the vision for ongoing reporting and monitoring, is provided to add additional context.

The Plan: A Partnership and an Ambitious Idea

The 90/90/90/50 Plan was the product of a public-private partnership which coalesced around an ambitious idea. HAHSTA within the DC Department of Health (DC Health), the Office of the Mayor, DC Appleseed and the Washington AIDS Partnership combined forces to explore the possibility of ending the HIV epidemic in the city. A larger national trend of plans to “end AIDS” or “get to zero” was beginning, from the Obama Administration’s Office of National AIDS Policy to public health agencies in jurisdictions across the country such as San Francisco and New York State.

The District had the capacity and resources for such an initiative, as well as two important clinical advances to catalyze further progress. First, researchers had proved that rapidly initiated and sustained anti-retroviral treatment (ART) can prevent those who have HIV from infecting others. This is known as “treatment as prevention.” At the same time, a new, modified regimen of ART for persons at risk for contracting HIV but who do not have the virus was proven to prevent transmission at very high rates when taken consistently and under proper supervision. This new tool is called Pre-exposure Prophylaxis, or PrEP.

However, we knew that ending the epidemic would require more than clinical advances; it would also require tackling a range of social and health factors, many of which fall outside the traditional purview of DC Health, such as behavioral health (including issues related to mental health and substance use), housing stability, economic opportunity, and stigma. We also knew success would depend on engagement of the entire community.

In researching and writing the Plan, the project team from HAHSTA, led by Senior Deputy Director Michael Kharfen, and DC Appleseed relied on several key academic partners for support, including experts at The George Washington University, Howard University, and Johns Hopkins University. DC Health also drew on its involvement in DC Partnership for HIV Progress (DC PFAP) with the National Institutes of Health; the DC Center for AIDS Research (DC CFAR), a unique collaboration among multiple academic and medical institutions in the District; and the DC Cohort, which is the largest single-jurisdiction research study of people living with HIV conducted by National Institutes of Health (NIH) in a study that tracks health outcomes over a period of many years.

Studying the data and detailed modeling conducted by academic partners, the project team set ambitious but achievable goals from baseline parameters informed by DC’s HIV surveillance and grant-making activities, as well as information on the subset of the

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HIV-positive population receiving services through the federal Ryan White Program. Additionally, information from peer-reviewed research on patterns in HIV transmission and the efficacy of HIV prevention strategies was used to assess the impact of scaling up HIV care and prevention activities.

Community engagement and input was a key component of the development process. Qualitative and quantitative data were collected via questionnaires, town halls, and focus groups, and integrated into the Plan. We also had in-depth conversations with government officials in New York State, San Francisco, and Washington State who had developed similar plans to learn from their experience. DC Appleseed also conducted key interviews with community stakeholders and subject matter experts.

Our Goals: How We Will Measure an End to the Epidemic

The Plan is framed around the HIV Care Continuum, or treatment cascade, which is widely used by public health agencies and experts. The traditional continuum outlines the stages from testing to achieving viral suppression for individuals living with HIV, recognizing that all steps along the way are fluid and interlinked. The District also uses a Prevention Continuum to describe the steps of decreasing HIV acquisition and transmission. Together, these illustrate the stages of HIV prevention and care along a continuum that includes screening for the virus, linking patients to care, retaining and engaging patients in treatment, and drug therapy. Most of the activities and interventions designed to link and maintain HIV-positive individuals to care are also effective approaches to help keep individual HIV-negative.

Most metrics in the Plan relate directly or indirectly to one important baseline measure: the number of diagnosed infections in DC. The baseline year for measurement is 2015, the year for which the most recent data were available when the Plan was published at the end of 2016. When the Plan was being developed in 2015 and when the Plan was announced in 2016, an earlier year was being used as the baseline—2013. However, since then HAHSTA has determined to use 2015 as the base year, since data were available for that year when the Plan was adopted at the end of 2016.

In 2015, 401 new infections were reported. Thus, to meet the requirements of the Plan’s goal to reduce new infections by 50%, the number of new infections should be no more than 200 by the end of 2020.

Goal 1: 90% of HIV-Positive District Residents Know Their Status

The first step of successful HIV treatment is timely diagnosis. To meet the goal of 90% of HIV-positive District residents knowing their status, the Plan called for increases in targeted HIV testing in addition to the successful routine testing program already in place, as well as more active engagement among residents and all healthcare providers. In 2015, DC

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<tbody>
<tr>
<td>Goal #1: 90% of HIV-positive District residents know their status</td>
<td>86%</td>
<td>86%</td>
<td>87%</td>
<td>Pending</td>
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<tr>
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<td>76%</td>
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<td>Pending</td>
<td>90%</td>
</tr>
<tr>
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<td>82%</td>
<td>84%</td>
<td>Pending</td>
<td>90%</td>
</tr>
<tr>
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<td>401</td>
<td>369</td>
<td>368</td>
<td>176*</td>
<td>196</td>
</tr>
</tbody>
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*Preliminary data from first six months of 2018. If annualized, this figure would be 352.
Health estimated that 86% of HIV-positive individuals were aware of their HIV status.

The number or proportion of people who have HIV but are not yet diagnosed cannot be precisely counted because they are, by definition, not identified. However, there are several statistical methods to estimate the percentage of the HIV-positive population unaware of their status. DC Health's chosen model was developed by researchers at the University of Washington and the firm Fellows Statistics for use by health departments. The model uses the date of an individual's positive test and the date of that individual's last negative test to define the window of time during which the individual could have become infected (when a negative test is not recorded, a conservative estimate of the earliest possible time that the individual could have been infected is used). The probabilities from these time windows for all individuals are averaged to derive an estimate of the "distribution of time from infection to diagnosis" for the population, and, further, an estimated number of people who have HIV but remain undiagnosed right now. The number of estimated undiagnosed cases divided by the total number of persons living with HIV in the jurisdiction provides the estimated "undiagnosed percentage."

When employed by DC Health, the described model produced estimates that 9% to 14% of actual HIV cases were undiagnosed within the District in 2015. DC Health used the more conservative (upper bound) estimate (14%) for its reported estimates of total HIV infection. Application of the estimate that 14% of individuals with HIV are undiagnosed to the 13,391 people diagnosed with HIV and currently living in the District according to surveillance data translates into an estimated 15,571 individuals living with HIV (i.e., diagnosed and undiagnosed cases) in 2015. Therefore, as stated above, DC Health estimates that 86% of HIV-positive individuals are aware of their HIV status.

Until there is a cure for HIV, people must maintain medical treatment and anti-retroviral therapy to stay healthy. Further, doing so helps keep their partners healthy. When HIV-positive individuals adhere to a prescribed treatment regimen and maintain viral suppression—that is, the number of copies of the virus in the blood stays below 200 per microliter—it is highly unlikely that they will pass on the virus. To meet the goal of 90% of HIV-positive District residents being in treatment, the Plan examines how to improve linkage and adherence to treatment, as well as ways to expand and protect access to care, while ensuring the care provided is grounded in evidence-based and culturally appropriate practices. The Plan also envisions new policies to improve data sharing, and to help providers connect with patients who have fallen out of care. DC Health’s best estimate is that 66% of DC residents diagnosed with HIV were on ART in 2015. This is the baseline used in the Plan.

The estimated percentage of people living with HIV in treatment is based on incomplete data, because it does not currently track whether everyone diagnosed is actively taking ART. Not all persons living with HIV in care have been prescribed—or are actively taking—ART. And, DC Health does not have data on ART prescriptions among all those diagnosed with HIV. But DC Health does have complete data for ART uptake among those who access Ryan White-funded providers; in that group, 90% of clients with at least one documented medical visit in 2015 were prescribed ART. Applying a similar uptake rate among the 73% of the total population diagnosed with HIV who are retained in care, DC Health estimates that 66% are in treatment. In order to more precisely count this metric in the future, the Plan outlines policies that would give DC Health more exact data on ART uptake among all persons diagnosed with HIV.

Goal 2: 90% of District Residents Diagnosed with HIV are in Treatment

Goal 3: 90% of DC Residents Living with HIV Who Are in Treatment Reach Viral Load Suppression

Achieving viral suppression or an “undetectable” viral load through drug therapy improves both health

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8 Ian E. Fellows et al., A New Method for Estimating the Number of Undiagnosed HIV Infected Based on HIV Testing History, with an Application to Men Who Have Sex with Men in Seattle/King County, WA. (2015), http://journals.plos.org/plosone/article/asset?id=10.1371/journal.pone.0129551.PDF.
outcomes for PLWH and reduces the risk of transmitting the infection. To meet the goal of 90% of District residents in treatment reaching viral suppression, the Plan includes strategies to enhance support for people to maintain their treatment, addresses socioeconomic conditions that may cause lapses in treatment, and examines how federal funding provided through the Ryan White Act can be used more effectively. DC Health estimates that 78% of those in treatment were maintaining viral suppression in 2015, which is the baseline used for the Plan.

Currently, DC Health receives all lab results showing viral suppression rates for HIV-positive District residents. However, it is impossible to determine the exact percentage of those in treatment who have reached viral suppression because of the difficulty of precisely counting the number of HIV-positive District residents who are on ART as described above regarding Goal 2. Therefore, the model for the Plan used the rate of viral suppression among those who accessed care in any way—not just those actively taking ART—as indicated by a lab test. That figure is 78%, which is consistent with other reports which found that 80% of individuals on ART achieve viral suppression. However, assuming that all HIV-positive residents who received a lab test are actively taking ART probably results in an overrepresentation.

**Goal 4: 50% Reduction in New HIV Infections Overall**

The goals of this Plan follow the cascading effect of the HIV Continuum: as more District residents know their HIV status, the more likely they are to be engaged in care if they are HIV-positive. As more are in care, more are likely to reach viral load suppression. When more reach viral load suppression, not only will their own health be improved, but fewer will transmit the virus to others and there will be decreases in the number of new infections over time. As a result of that cascading effect, the District aims to achieve a 50% reduction in new HIV cases by 2020. To help reach that reduction, the Plan details policies that will, among other things, increase access to PrEP and post-exposure prophylaxis (PEP), especially for the groups at the highest risk of infection, in addition to improvements in youth education and expanded funding for successful syringe access programs.

As noted, when the 90/90/90/50 Plan was announced by Mayor Bowser at the end of 2016, the most recent surveillance data estimates available were from 2015. In that year, 401 newly diagnosed HIV cases were documented. Cutting that number in half means we will have only 200 new infections in 2020. This will require that the District (1) continues the effective policies that have been implemented over the last 10 years, (2) meets the 90/90/90 goals described above, and (3) increases the number of District residents taking advantage of preventive interventions—especially PrEP.

Pre-Exposure Prophylaxis (PrEP) has been shown to be up to more than 90% effective in preventing transmission of HIV when used consistently and correctly. Some studies reported zero new infections among HIV-negative individuals on PrEP. The efficacy of the regimen depends on individual adherence. The modeling that guided the Plan assumed an 86% efficacy rate for PrEP in preventing HIV transmission in DC. By incorporating efforts to increase the utilization of PrEP among focus populations, such as men who have sex with men and high-risk heterosexual women (Black women), DC Health anticipates that the number of newly diagnosed HIV cases in 2020 can be reduced by up to approximately 56%. The model developed for DC Health by The George Washington University assumes that approximately 8,000 District residents will be on PrEP consistently, while the best estimate currently is that only about 2,000 residents have ever been prescribed PrEP. Therefore, in order to meet the 50% reduction target, in addition to having more people who are HIV-positive virally suppressed, the District must also increase the number of PrEP prescriptions by 6,000 at-risk individuals.

As with the number of prescriptions of PrEP, several supporting targets must be met or exceeded in order to achieve the overarching goals described above. These metrics assume consistent or expanded activities and proliferation of materials in the community by 2020.

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9 Report at 6.
The Tasks: The Work Necessary to Achieve Our Goals

Within the Plan, the project team outlined 42 detailed and specific tasks that will need to be accomplished in order to realize our ambitious goals. The rationale and particulars of these tasks made up the bulk of the 90/90/90/50 Plan. Also included were six proposed demonstration projects and four public calls to action.

Most of the work was planned by and delegated to HAHSTA. For example, the Plan emphasizes the importance of community health workers and peer navigators who can help residents access services and effectively engage those who have fallen out of care. Therefore, several tasks relate to DC Health supporting these models of care through their own work and through their grants to community-based organizations.

However, due to the broad and holistic nature of the Plan, several tasks fall within the purview of other entities and agencies. For example, the Plan calls for an examination of the DC Healthcare Alliance’s requirement that participants recertify their insurance every six months because providers noted it caused patients to lose insurance and fall out of care. Similarly, the Plan recommends increased access to stable housing for people living with HIV, as this is one of the most critical factors in an individual’s life to ensuring the stability, safety, and capacity to manage other aspects of their lives such as medication adherence. When a task falls outside of the purview of the Department of Health, DC Appleseed takes primary responsibility for the research, advocacy, and follow-up to achieve that task. There are also several tasks that DC Appleseed and DC Health staff have been undertaking in cooperation.

The staff at HAHSTA organized working groups for the implementation of the tasks, beginning with an assessment of the various activities underway. The groups were planned through the spring and summer of 2017 and convened for the first time in September 2017. The groups focus on each of the four goals and are organized so that at least one representative from all divisions within HAHSTA are included in each of the four groups. Volunteers within the groups serve as facilitators, coordinators, and documenters for group activities. DC Appleseed staff participated in many of these activities. The HAHSTA staff was instrumental in consulting colleagues and documenting progress on the various tasks, and their work is included in this Report.

While the 90/90/90/50 Plan’s four goals will remain fixed, it is possible that the tasks within each goal may change, evolve, or be revised within the four years of implementation of the Plan. In that way, the Plan is a living document. By design, the Plan did not include exhaustive details about measures and timelines. These details were to be determined by the appropriate parties.

Data will be vital to planning, implementing, and tracking initiatives related to the Plan. In fact, several of the tasks relate to enhancing and expanding the systems by which the District collects and utilizes data on the major indicators associated with the Plan, including testing, treatment, STD infections, PrEP, needle sharing, and other factors. While some of this information is currently available for subsets of the HIV-positive population, it is not available for all DC residents living with HIV.

For example, providers who treat clients through the federally-funded Ryan White Program are required to provide DC Health with detailed information about clients’ treatment, because the treatment is primarily funded through federal grants distributed by DC Health. Gathering similar information on the broader high-risk negative and HIV-positive populations would improve the ability to target intervention efforts and monitor progress in meeting targets. It would also facilitate the tracking of services at an individual level in order to more effectively identify those in need of targeted case follow-up; this would, in turn, help to increase the number of HIV-positive District residents who are in effective and consistent treatment. In recent years, DC Health has established data-sharing agreements with the DC Department of Health Care Finance and DC Department of Behavioral Health to support routine data exchange. DC Health recently partnered with health insurance plans in the District to discuss sharing data on healthcare measures to support the goals of the Plan while respecting patient privacy. DC Health will also, with new U.S. Centers for Disease Control and Prevention (CDC) funding, purchase pharmacy data to better understand District-level uptake both of ART for persons with HIV and of PrEP.

The development of the 90/90/90/50 Plan happened to coincide with federal planning requirements for DC Health. In 2015, the Centers for Disease Control
and Prevention (CDC) and the Health Resources and Services Administration (HRSA) issued a joint requirement for jurisdictions to prepare a coordinated Plan (merging separate requirements under the HIV Prevention Cooperative Agreement for a Jurisdictional HIV Prevention Plan and the Ryan White CARE Program for a Comprehensive Care Plan). Therefore, the Ryan White Planning Council and the HIV Prevention Planning Group formed a joint working group to prepare the 2017-2021 District of Columbia Eligible Metropolitan Area Integrated HIV/AIDS Prevention and Care Plan.

This Integrated Plan covers activities related to federal funding throughout the entire Eligible Metropolitan Area (EMA) as defined by HRSA, inclusive of the District of Columbia, five counties in suburban Maryland, 11 counties and six independent cities in Northern Virginia, and two counties in West Virginia. The 90/90/90/50 Plan informed the Integrated Plan’s development, and the 90/90/90/50 goals are echoed in the Integrated Plan. However, there is not complete overlap between the 90/90/90/50 Plan and the Integrated Plan’s goals and tasks due to the requirements, scope, and demographic reach of the Integrated Plan. Each plan follows a four-year timeframe, though the 90/90/90/50 Plan’s work began in 2016, one year before the Integrated Plan. The 90/90/90/50 Plan’s working groups within HAHSTA have prepared crosswalks, identifying activities that satisfy both Plans and those activities that are unique to each document. Cross-referencing the goals and tasks will be an ongoing exercise for HAHSTA.

This Progress Report: Current Status of Work

The Plan for reaching the 90/90/90/50 goals anticipated not only the steps needed to reach them, but also the method for a transparent, cooperative, and ongoing implementation and monitoring process.

Every year on World AIDS Day, DC Appleseed will publish a Report on the activities undertaken in the previous year to achieve the goals of the 90/90/90/50 Plan. This marks a new chapter in our effort to tackle the HIV/AIDS epidemic in DC, which had begun in 2005 with a call for a serious overhaul of nearly every aspect of the District government’s response to the HIV crisis. DC Appleseed spent the nine years after 2005 issuing periodic report cards that monitored the success of the steps taken by the District government and other stakeholders. By the time we issued our final report card in December 2014, many local policymakers and advocates anticipated our report findings and grades. In fact, many District officials contacted DC Appleseed throughout the course of the year to find out how they could obtain a higher grade. While our role has shifted in the process of writing and becoming a partner in the 90/90/90/50 Plan, we have continued our tradition of monitoring and engaging in inclusive community conversation.

This Report is the second of four annual publications in which we will reflect on the latest HIV statistics, check in on the District’s work towards meeting the goals of the 90/90/90/50 Plan, and assess the increase in new HIV infections. The goal of the Report is to continue to foster the transparency and accountability that have been essential elements of our progress to date. It is also an opportunity to help residents and advocates understand the bird’s eye view of the District-wide, cross-sector endeavors underway.

Because this year’s data show a plateau in progress toward reducing infections by 50% and an increase in infections among District youth, DC Appleseed will issue a supplemental report in 2019 which further assesses the District’s progress, implementation, and development of the Plan with a deeper investigation into the 42 Plan tasks. This will allow us and the public to gain a further understanding of where the District stands as it relates to the execution of the Plan.

As we approach 2020, and considering the recent data from HAHSTA, more now than ever it is time for strong action to ensure that the District continues to reduce infection rates in communities that are experiencing the epidemic at the greatest proportions. Through continued leadership, ambitious thinking, and implementation of the tools and steps that underpin the 90/90/90/50 goals, the District can bring about ever-larger decreases in new HIV infections and, eventually, end the epidemic in DC.
In July of 2018, HAHSTA published its 2018 Annual Epidemiology Report. The Epi Report details citywide historical trends as well as current statistics for new HIV, STDs, Hepatitis, and Tuberculosis infections, diagnoses, treatments, and fatalities. Fortunately, tremendous progress has been made over the last several years: the number of newly diagnosed HIV cases in the District has declined 31% since 2013 and 73% since 2007. There were no babies born with HIV in 2017, and HIV infections from drug use have decreased by 95% from 2007. Thousands of DC residents are healthier today thanks to the efforts of the District to respond to HIV, in areas that overlap with progress towards meeting the goals outlined in the 90/90/90/50 Plan. More residents who are living with HIV are in treatment and more of those in treatment are reaching viral suppression than in 2016.

Despite this good news, it is important to highlight a factor in the new Epi Report that causes us great concern, and no doubt causes the District government concern as well—new HIV diagnoses among our youth.

The current statistics for young people are grim: as the Epidemiology Report mentions, “There were increases in new HIV diagnoses among young people ages 13-29 from 134 in 2016 to 150 in 2017,” and “[y]outh now represent 41% of new HIV diagnoses, higher than any proportion in the past 10 years.” The Epi Report accordingly calls for “working with school-based health centers and community-based partners to make sexual health services more easily available; and enhancing the DC Health youth focused Sex is... campaign” sexual health social marketing campaign.

The fact that the infection rate points downward for DC’s overall population while heading upwards for our youth requires redoubled efforts to address youth infections. We hope to work with all stakeholders in the coming months to make recommendations through the Healthy Schools Act and the increased usage of PrEP to reduce the rate of new infections among youth.

We would like to highlight these overall key elements from the Epidemiology Report:
• There were 17,217 documented HIV cases in DC in 2017.12

• 2,368 individuals initially diagnosed with HIV outside of DC but moved into DC.13

• An estimated net of 13,003 individuals (1.9% of the population) diagnosed with HIV were presumed to be living in DC at the end of 2017.14

• The number of newly diagnosed HIV cases in the District remained statistically level at 368 cases, a decline of 31% from 535 cases in 2013 and 73% from 1,362 cases in 2007.15

• The District corrected the number of new infections in 2016 from 347 to 369.16

• There were increases in new HIV diagnoses among:17
  • young people ages 13-29 years old from 134 in 2016 to 150 in 2017
  • men who have sex with men from 159 in 2016 to 177 in 2017
  • Latinos from 41 in 2016 to 43 in 2017

• There was a decrease in new HIV diagnoses among heterosexual men from 44 in 2016 to 34 in 2017.18

• Black men through sex with men and black women through heterosexual contact have the highest proportion of newly diagnosed HIV.19

• There were record numbers and increases among reported STDs with 10,157 cases of chlamydia, a 35% increase from 2013 to 2017; 5,070 cases of gonorrhea, a 56% increase from 2013 to 2017; and 318 cases of primary and secondary syphilis, a 13% increase from 2013 to 2017.20

• There were 1,268 persons newly diagnosed and reported with hepatitis C in 2017.21

• After nine years of continued decreases, the District experienced a pause in reducing new HIV diagnoses. While this is a one-year period, it spotlights areas where the District needs heightened attention.22

More Focused Attention on Young People:

“Youth now represent 41% of new HIV diagnoses, higher than any proportion in the past 10 years. The number of cases of chlamydia increased by 19% and gonorrhea by 36% for young people ages 15-19 years old from 2016 to 2017. DC Health will be moving forward with four efforts in 2018: providing easy access to expedited partner treatment of STDs at the DC Health and Wellness Center; promoting and making PrEP available for adolescents (FDA recently approved the medication for people younger than 18 years old), including financial assistance to young people to get PrEP through the PrEP Drug Assistance Program (DAP); working with school-based health centers and community-based partners to make sexual health services more easily available; and enhancing the DC Health Sex is... campaign.”23

More Focused Attention on Gay/Bisexual/Same Gender Loving Men:

The Report recognizes that there was an “11% increase in new HIV diagnoses among gay/bisexual/same gender loving men or men who have sex with men. Two-thirds of new HIV diagnoses among men are gay/bisexual. Through its IMPACT DMV demonstration project, DC Health is collaborating

13 Id.
14 Report at 6.
15 Id.
16 Id. at 11.
17 Id. at 3-4.
18 Id. at 4.
19 Id. at 4.
20 Id.
21 Id.
22 Id. at 5.
23 Id. at 5.
with community partners to ensure more culturally affirming services across the metropolitan area.”

Ensuring Health Equity in the District:

Recognizing that “social factors impact a person’s health and inequities exist that present barriers to persons achieving healthy outcomes,” the District is planning on launching an initiative “to provide temporary rental assistance for persons with HIV who need some extra support to live stably. DC Health is also offering a new housing and employment program for persons with HIV that provides workforce development along with rental assistance. DC Health also has incorporated workforce development in its IMPACT DMV project for gay/bisexual/same gender loving men of color and transgender women of color.”

Information on the Means of Infection:

Once again, sexual contact was the leading mode of transmission among newly diagnosed HIV cases at 75.5%, a slight increase from 73.4% in 2016. Men who have sex with men (MSM) is the leading transmission mode reported among newly diagnosed (61.9%) and identified (60.4%) HIV cases. Among females, heterosexual contact constituted the largest category mode of transmission of newly diagnosed HIV cases at 66.3%.

Demographic Breakdown:

The following information was provided on the transmission and treatment of HIV from reported cases:

Gender:

Although the number of newly diagnosed cases has declined from 2013 to 2017, the proportion of cases by gender identity has remained constant. Men in the District continue to be disproportionately affected by HIV. While men represent only 47% of the District’s population, they accounted for over 70% of new HIV diagnoses.

- For newly diagnosed HIV cases in the District among women in 2017, 9 in 10 were Black and 1 in 4 were aged 30-39.

Race:

- For newly diagnosed HIV cases in the District between 2013 and 2017, 1 in 3 were men who have sex with other men of color and 1 in 5 were Black women.
- Within the category of adults aged 55 and older, 8 in 10 of those newly diagnosed with HIV in the District from 2013-2017 were Black and 2 in 3 were men.
- 1% of Latinos living in DC are known to be living with HIV.
- Blacks still constitute a significant majority of newly diagnosed HIV infections at 70.9%. That figure has not changed much from the 72.3% in 2013.
- The Epi Report includes data on the proportion of residents living with HIV by race/ethnicity and gender. Within this category, 4.4% of Black men in the District are living with HIV, more than twice the percentage in the second largest group, 2.1% of Latino men.
Age:

- Of those newly diagnosed with HIV cases in the District between 2013 and 2017, 1 in 3 were aged 20-29.  
- Among individuals within the 50-59 age group, 5% were living with HIV at the end of 2017.  
- The Epi Report indicates that 1 in 2 residents aged 20-24 and living with HIV were virally suppressed in 2017, whereas 7 in 10 residents 60 years or older were virally suppressed.  
- Persons living with HIV aged 0-19 were least likely to ever be virally suppressed and least likely to be virally suppressed in 2017, followed by persons aged 20-24 for both groups. However, persons in those age groups who were involved in the Ryan Care Program showed higher viral suppression rates.

Sexual Orientation:

- Of the newly diagnosed cases in 2017 within the population of men who have sex with other men, 6 in 10 were Black, 1 in 5 were White, and 3 in 10 were aged 30-39.  
- Also included is information on the retention in HIV Care among residents with HIV by gender identity: 80% of transgender individuals, 82.4% of cisgender females, and 77.2% of cisgender males were in HIV Care retention.  
- For newly diagnosed cases from 2013-2017 within the transgender community, 31% were individuals aged 25-29.

People Who Inject Drugs:

- There has been a steady decline in newly diagnosed HIV cases among people who inject drugs, from 19 in 2013 to 7 in 2017.  
- Among new cases from 2012-2016, persons who use injection drugs were the least likely (out of the reported groups) to attain viral suppression within six months, with only 29% doing so. By contrast, 48% of individuals who obtained the virus through sexual contact attained viral suppression within six months.
Table 1: Comparison of Reported Data for 2016 and 2017 Reports on Newly Diagnosed HIV Cases by Diagnosis, Gender Identity, Race/Ethnicity, Mode of Transmission, and Age at Diagnosis

<table>
<thead>
<tr>
<th></th>
<th>2016</th>
<th>Percentage (%)</th>
<th>2017</th>
<th>Percentage (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Gender Identity</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>267</td>
<td>75.3</td>
<td>268</td>
<td>72.8</td>
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<tr>
<td>Female</td>
<td>91</td>
<td>22.9</td>
<td>89</td>
<td>24.2</td>
</tr>
<tr>
<td>Transgender</td>
<td>11</td>
<td>1.7</td>
<td>11</td>
<td>3.0</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>369</td>
<td>100</td>
<td>368</td>
<td>100</td>
</tr>
<tr>
<td><strong>Race/Ethnicity</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>White</td>
<td>53</td>
<td>14.4</td>
<td>43</td>
<td>11.7</td>
</tr>
<tr>
<td>Black</td>
<td>264</td>
<td>71.5</td>
<td>261</td>
<td>0.9</td>
</tr>
<tr>
<td>Latino</td>
<td>41</td>
<td>11.1</td>
<td>43</td>
<td>11.7</td>
</tr>
<tr>
<td>Other*</td>
<td>11</td>
<td>3.0</td>
<td>21</td>
<td>5.7</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>369</td>
<td>100</td>
<td>368</td>
<td>100</td>
</tr>
<tr>
<td><strong>Mode of Transmission</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sexual Contact</td>
<td>271</td>
<td>73.4</td>
<td>278</td>
<td>75.5</td>
</tr>
<tr>
<td>IDU</td>
<td>8</td>
<td>2.2</td>
<td>7</td>
<td>1.9</td>
</tr>
<tr>
<td>Sexual contact/IDU</td>
<td>2</td>
<td>0.5</td>
<td>4</td>
<td>1.1</td>
</tr>
<tr>
<td>Risk not identified</td>
<td>87</td>
<td>23.6</td>
<td>77</td>
<td>20.9</td>
</tr>
<tr>
<td>Other**</td>
<td>1</td>
<td>0.3</td>
<td>2</td>
<td>0.5</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>369</td>
<td>100</td>
<td>368</td>
<td>100</td>
</tr>
<tr>
<td><strong>Age of Diagnosis</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>&lt;13</td>
<td>1</td>
<td>0.3</td>
<td>2</td>
<td>0.5</td>
</tr>
<tr>
<td>13-19</td>
<td>10</td>
<td>2.7</td>
<td>15</td>
<td>4.1</td>
</tr>
<tr>
<td>20-24</td>
<td>55</td>
<td>14.9</td>
<td>58</td>
<td>15.8</td>
</tr>
<tr>
<td>25-29</td>
<td>69</td>
<td>18.7</td>
<td>77</td>
<td>20.9</td>
</tr>
<tr>
<td>30-39</td>
<td>101</td>
<td>27.4</td>
<td>105</td>
<td>28.5</td>
</tr>
<tr>
<td>40-49</td>
<td>57</td>
<td>15.4</td>
<td>53</td>
<td>14.4</td>
</tr>
<tr>
<td>50-59</td>
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<td>14.1</td>
<td>34</td>
<td>9.2</td>
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<tr>
<td>≥60</td>
<td>24</td>
<td>6.5</td>
<td>24</td>
<td>6.5</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>369</td>
<td>100</td>
<td>368</td>
<td>100</td>
</tr>
</tbody>
</table>
Other cities across the United States are experiencing similar patterns in new HIV diagnoses as the District. That is, while there is still a downward trend in new HIV diagnoses, that trend has slowed into a “plateau” in other jurisdictions too.

It is important to note the difficulty in drawing useful comparisons between cities, given the vast differences in demographics, funding, and geography. In the United States, HIV diagnoses are not evenly distributed across states and regions. While southern states accounted for more than 50% of new HIV diagnoses in 2016, they make up only 38% of the national population. In addition, most people in the United States who receive an HIV diagnosis live in urban areas. However, in the South, 23% of new diagnoses are in suburban and rural areas, and in the Midwest, 21% are suburban or rural. The South’s larger and more geographically dispersed population of people living with HIV creates unique challenges for prevention and treatment.

Even with these differences, it appears that most jurisdictions with comprehensive plans to manage HIV transmission and treatments have experienced a similar “plateau” effect in the past year. We reviewed the data presented in annual epidemiological reports released by jurisdictions with comprehensive plans to eliminate HIV, excluding cities that began implementing Plans in 2017 or later, as there is likely not enough data to be able to tell if those plans have had any effect yet. We primarily focused on cities with plans similar or equivalent to DC’s 90/90/90/50 Plan, who implemented their plans around the same time as DC, including San Francisco, CA; San Diego, CA; Sacramento, CA; Houston, TX; Hennepin County, MN;
Pittsburgh, PA; and New York, NY. Although some of these cities did not have epidemiological data since implementation of the Plan, the cities that did have data (e.g., San Francisco and New York) showed a plateau in the number of new HIV diagnoses.

In sum, DC is not alone in experiencing a plateau in the decrease in new HIV diagnoses since implementation of a comprehensive, city-wide plan to control and/or eliminate HIV. As many stakeholders have noted, it may take some time to notice the positive effects of the 90/90/90/50 Plan on the community, in part because it takes time to implement the many tasks in the Plan, and in part because there is a lag in data collection. It also appears that other jurisdictions face similar issues in collecting data and evaluating the effects of their plans. Nevertheless, it is important that we encourage HAHSTA to continue to push forward and acknowledge that given the recent data it may take some doubling down on efforts to achieve the goals of the Plan.

Source: CDC Diagnoses of HIV infection in the United States and dependent areas, 2016
We earlier noted the significant increase in youth infections in 2017 and the need to address it. This section of the Report will first provide background from last year’s Report, which noted the need to increase efforts targeting the District’s youth, and then note again the increase in youth infections from this year’s Epi report. We then address the need for the adoption of regulations ensuring comprehensive HIV education in all DC Public Schools54—something that has not occurred, even though it is required by the Healthy Schools Act. Thereafter, we will address the need to make PrEP more widely available in the District, particularly in light of the recent report from the U.S. Preventive Services Task Force recommending that the drug be available to all persons at high risk of acquiring HIV. This applies not only to youth in the District, but to others as well. The District should not have 350 new infections per year when PrEP is available to help prevent most of them from happening.

Background on HIV and STDs Among Youth

DC Appleseed’s 2017 Report noted the rate of DC youth with new HIV and STD infections began to increase and urged healthcare providers, educators, and others in the community to retool how they interact with them to impact their sexual education. We brought attention to the fact that the provision of sexual health education in public and public charter schools is critical in the effort to reduce HIV infections, especially as 20-29-year-olds lead all age groups in new diagnoses and expressed our concerns that sexual health education is not uniformly implemented across all public schools, including independent charter schools. Additionally, we urged the DC Council to consider providing additional oversight of the Healthy Schools Act’s implementation.

Since that Report, as earlier noted, the 2018 Annual Epidemiology & Surveillance Report stated that young people represent an increasing number of HIV and STD diagnoses in DC. In 2017, the District saw

54 The term “DC schools,” as used in this report, refers to both DC Public Schools and DC Public Charter Schools.
young people ages 13-29 diagnosed at an alarming rate with 150 new HIV diagnoses, an increase of 16 from 2016.65 HAHSTA reported that young people now represent 41% of new HIV diagnoses, higher than any proportion in the past 10 years.66 Additionally, from 2016 to 2017, the number of cases of chlamydia and gonorrhea increased by 19% and 36%, respectively, for young people ages 15-19.67

The Healthy Schools Act

In May 2010, the DC Council passed the Healthy Schools Act (HSA), a landmark law designed to improve the health and wellness of students attending all DC schools.58 The law created standards and oversight in a number of areas, including school nutrition, local food sourcing, and physical education, health and wellness and health education.59 A strong impetus for the passage of the HSA was the HIV/AIDS epidemic in Washington, DC. In 2009, DC had the highest HIV/AIDS rate in the United States—at 3%, an infection rate even higher than West Africa’s at the time.60 Over the years, the number of newly diagnosed DC residents has decreased as has the overall infection rate—in 2017, the infection rate of individuals living with HIV in the District was 1.9%.61

The HSA was enacted with the understanding that it would help ensure better HIV/AIDS education for DC schoolchildren.62 To accomplish its goal of better health education, the HSA requires minimum weekly time (“at least 75 minutes of health education per week for students in grades K-8”) spent on effective health education for grades K-8.63 The HSA also specifies, only for grades K-8, that the health education requirements of Public and Public Charter Schools “shall meet the curricular standards adopted by the State Board of Education.”64 The Office of the State Superintendent of Education (“OSSE”), the office charged with setting curricular standards for DC schools, has since clarified that the curricular standards referenced in the HSA are the Health Education Standards, which were first adopted in 2007 and subsequently approved by the DC Board of Education.65 According to OSSE, which updated the Standards in 2016, the Standards measure “the knowledge and skills that students need to maintain and improve their health and well-being, prevent disease, and reduce health-jeopardizing behavior.”66

The HSA grants OSSE “the authority to verify compliance” with the HSA, and mandates that OSSE measure students’ knowledge as it relates to its education Standards, including those on health and sexual health education. OSSE works in concert.

56 Id. at 5.
57 Id.
58 See DC Code § 38-821.01 (taking effect in August 2010).
59 Id.
62 See Comm. on Gov’t Operations and the Environment, Report on Bill B18-564, Healthy Schools Act of 2010, Attachment B at 14 (“Health education teaches students about important topics such as HIV/AIDS prevention, another epidemic plaguing the District’s population. . . The Healthy Schools Act would phase-in health education requirements over a five year period in order to increase the amount of health education in schools”); See also Joint Public Hearing on B18-564, Healthy Schools Act of 2010, Before the Comm. of the Whole and the Comm. on Gov’t Operations and the Environment (“As this Council knows well, HIV/AIDS is 100 percent preventable.”) (testimony of Adam Tenner, Executive Director of MetroTeenAIDS).
63 DC Code § 38-821.01. The HSA time requirements do not apply to DC Public and Public Charter high school education. DC MUN. REGS. tit. 5-A § 2299.1 (Apr. 8, 2016). Beyond the eighth grade, DC Public and Public Charter high school time requirements are set by the DC municipal regulations, which are official regulations that underwent notice and comment. Id. In order to graduate, high school students must earn 1.5 Carnegie units in Health and Physical Education. DC MUN. REGS. tit. 5-A § 2203.3(b) (Apr. 8, 2016). These regulations were promulgated by OSSE, and are enforceable by the same. Id.
64 DC Code § 38-824.02. OSSE also states that DC high schools shall include courses integrating both basic and advanced levels of the Health Education Standards. OSSE, 2016 Health Education Standards at 5. The standards for high school education, however, do not specify grade-by-grade curricular guides, but instead are divided into topic areas called ‘strands.’ Regarding HIV/AIDS education, the standards specify that graduating high school students should know and be able to:
with local education agencies to comply with the Healthy Schools Act by evaluating health education, as described in task 4.14.

Based on research by DC Appleseed and Paul, Weiss, Rifkind, Wharton & Garrison LLP, not all DC schools appear to be meeting their obligations under the Act. Remediating low participation and enthusiasm for health education across all schools is vital to arm students with evidence-based facts and skills that can lead to a reduction in new HIV infections. Although some charter school teachers report using standards-aligned health education curricula, including those obtained through OSSE’s curriculum training or curricula library, without dedicated attention or enforcement from the Public Charter School Board or individual schools’ independent boards of trustees, the actual implementation and oversight of sexual education in charter schools present a challenge. Although there are some regulations governing health education in DC schools,67 the official rulemaking contemplated by the HSA has never been completed for DC schools. Accordingly, in order to ensure uniform and effective enforcement of the statute, DC Appleseed recommends that the Mayor take action through her rulemaking authority to create an enforceable HSA that will fully aid students in learning about sexual health, and potentially decrease new youth infection rates for HIV and STDs.

The HSA and its Applicability to All DC Public Schools, Including DC Public Charter Schools

By its terms, the HSA requires health education in all DC Public Schools. Over the course of DC Appleseed’s annual production of the District’s report card, questions were raised about the applicability of the HSA to charter schools and the effectiveness of their education of their students related to HIV. We therefore have addressed with the assistance of our partners at Paul, Weiss the validity of the HSA generally and its applicability to DC Public Charter Schools specifically.

As we discovered in our research, the authority to enact educational statutes such as the HSA clearly falls within the DC Council’s police powers.68 The Office of the General Counsel of the DC Council also independently concluded that “[t]he Council has the authority to impose nutritional and physical education standards for students in Public Charter Schools by amending the School Reform Act, to make the HSA applicable to Public Charter Schools, or through an exercise of its police power to legislate to promote the public health.”69 Thus, the HSA was a valid exercise of the DC Council’s legislative authority.

Based on the statute’s language, the HSA applies to DC Public Charter Schools, as well as DC Public Schools. The HSA explicitly refers to DC Public Charter Schools in almost every section of the Act.70 The legislative history supports the interpretation that HSA applies to DC Public Charter Schools. Councilmember Mary M. Cheh, who introduced the HSA, specified that the HSA will substantially improve the health of the “public and Public Charter Schools.”71 Public hearings on the topic echoed this understanding, noting that the HSA should be passed because all students, “whether they attend traditional public schools or charter schools – have a right to the information that can save their lives.”72 Secondary evidence also shows that the HSA was established

67 See DC MUN. REGS. tit. 5-A § 2203.3(i) (Apr. 8, 2016) governing DC Public and Public Charter high school education. See also DC MUN. REGS. tit. 5-E § 2304.3(a) (Dec. 30, 1994).
68 See, e.g., Jackson v. DC Bd. of Elections and Ethics, 999 A.2d 89, 124 (DC 2010) (noting that DC has the authority to enact educational policies).
69 Memorandum from Brian K. Flowers to Hon. Mary Cheh, Feb. 26, 2010 at 1 (citations omitted). See also id. at 8 (“The Council has the authority to make the requirements of the HSA applicable to public charter schools in accordance with the School Reform Act itself or pursuant to its police power.”).
70 See, e.g., § 38-821.02(c)(1) on Healthy Schools Fund (“[OSSE] shall reimburse public schools and public charter schools”); § 38-822.01(a) on HSA goals (“public charter schools . . . shall serve”); § 38-822.02(a) on nutritional standards (“All . . . meals served to students in public schools, public charter schools”); § 38-822.03(a)(1) on additional food requirements (“public charter schools . . . shall offer free breakfast”); § 38-826.02(c) on public disclosure (“public charter schools shall post the information”); § 38-823.01 on local food sourcing (“public charter schools shall serve”); § 38-824.02(b) on physical education (“public charter schools shall promote this goal”); § 38-824.05 on mandatory reporting (“[OSSE] shall report to . . . annually regarding compliance of public schools and public charter schools with the physical and health education requirements in this subchapter”).
72 See Joint Public Hearing on B18-564, Healthy Schools Act of 2010, Before the Comm. of the Whole and the Comm. on Government Operations and the Environment (testimony of Adam Tenner, Executive Director of Metro TeenAIDS).
for all DC schools, including DC Public Charter Schools. For instance, OSSE clearly states that the HSA “is a comprehensive piece of legislation that ensures District of Columbia Public Schools, Public Charter Schools, and participating private schools are a healthy place for all students.” Additionally, the Board of Education announced the Health Education Standards as the first learning standards outlining what “all DC Public and Public Charter School students are expected to know” in areas of health and sexual education.

OSSE’s Role Under the HSA

Under the HSA, OSSE is charged with setting the curricular standards for DC schools and has clarified that the curricular standards referred to in the HSA are the Health Education Standards, last revised in 2016. These revised Health Education Standards include core concepts in the prevention of HIV and other sexually transmitted infections across multiple grade bands. In addition to developing the Health Education Standards, OSSE is required to report annually to the Mayor, the DC Council, and the Healthy Youth and Schools Commission (“HYSC”) regarding the compliance of DC Public Schools and Public Charter Schools with the physical and health education requirements under the HSA, and student achievement with respect to the Health Education Standards. Additionally, all DC Public Schools and Public Charter Schools must submit annual information related to compliance with the Health Education Standards (as well as the physical education requirements) and other aspects of the HSA to OSSE in the form of the School Health Profiles. OSSE is required to post the School Health Profiles on its website within 30 days of receipt of the information.

OSSE measures student knowledge of the Health Education Standards through the Health and Physical Education Assessment (“HPEA”), administered annually to fifth grade, eighth grade, and high school students in the year they complete a health course. This assessment includes questions on sexual health concepts.

Additionally, every two years, to understand the prevalence of certain health behaviors, OSSE administers the Youth Risk Behavior Survey (YRBS) to DC Public and Public Charter middle and high school students. Students complete the assessment by providing self-identified responses to questions regarding health behaviors, covering topics such as violence and safety, and disease prevention/sexual health. Notably, in the 2017 YRBS Report, OSSE found that among both DC middle and high school students, condom use during their most recent incident of sexual intercourse decreased as compared to previous years.

On November 13, 2018, OSSE released the 2018 Healthy Schools Act Report, in compliance with its obligations under the HSA. According to OSSE, 94% of applicable schools—DC Public and Public Charter Schools—completed the mandatory School Health Profile in 2018. In total, 210 schools that completed Profiles were included in the data analysis, and 14 schools that failed to complete Profiles were not included. As for the HPEA, 172 schools participated in the assessment, with 10,149 students completing the HPEA, representing a 70.4% student-level completion rate. OSSE lists schools that failed to complete...

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76 The HYSC is a commission established by the HSA to advise the Mayor and Council on health, wellness, and nutritional issues concerning youth and schools in the District.
77 DC Code § 38-824.05.
78 DC Code § 38-824.02.
79 DC Code § 38-826.02(d).
82 DC Code § 38-824.05.
84 Id.
85 Id.
Profiles and schools with HPEA completion rates of less than 10% in its attachments to the Report.86

The School Health Profiles include questions regarding the average number of minutes per week students receive health education instruction, as compared to the required 75 minutes per week of health education for grades K-5 and grades 6-8 under the HSA. In the 2017–2018 school year, OSSE found the average health education minutes per week for grades K-5 was 52 minutes.87 For grades 6–8, OSSE found the average health education minutes per week for grades 6-8 was 81 minutes, exceeding the required amount under the HSA for the first time since OSSE began tracking compliance in 2010.88 OSSE states that this indicates that “a majority of schools are meeting the health education requirements for grades six through eight.”89 OSSE notes, in a graphic, that the average minutes per week for grades K-5 and grades 6-8 have generally increased annually since the 2011-2012 school year.90 OSSE states that it will “continue to work with all schools to reach the average of 75 minutes of health education per week.”91

DC Schools are Currently Not Subject to Effective HSA Enforcement

As noted, DC Public and Public Charter Schools are bound by the HSA’s explicit requirements to provide “an average of at least 75 minutes per week” of health education for students in grades K-8.92 Additionally, for grades K-8 only, the HSA specifies that “[t]he physical education and health education required by this section shall meet the curricular standards adopted by the State Board of Education.”93 OSSE has clarified that these curricular standards refer to the Health Education Standards originally adopted in 2007 and last updated in 2016.94

Under the HSA, every DC school must also complete and submit to OSSE an annual School Health Profile, which is a basic survey of the school’s health education program.95 OSSE also conducts its own independent evaluation of school compliance and reports annually to the Mayor, Council, and the HYSC regarding the performance of DC Public Schools and DC Public Charter Schools with respect to the HSA’s physical and health education requirements and standards.96

In addition, the HYSC must produce and submit an annual comprehensive report to the Mayor and Council including an assessment of District efforts to improve health, wellness, and nutrition of youth in schools, along with recommendations for further improvement.97 In theory, the DC Public Charter School Board, in conjunction with schools’ individual boards of trustees, could also monitor DC Public Charter Schools’ compliance with the HSA by requesting on an annual basis sufficient documentation demonstrating compliance with the statute.98

Importantly, none of this oversight amounts to the systematic enforcement we believe is required. In fact, the current oversight is insufficient precisely because no enforcement mechanisms are in place for non-complying DC schools. This deficiency in enforcement, however, does not rest with OSSE alone. OSSE’s Health Education Standards, last updated in 2016, are not official regulations that went through the notice-and-comment process required for rules to have legally binding effect. For procedures to attain the force of law, the DC Administrative Procedure Act dictates that notice of proposed rulemaking must be published in the DC Register and “any interested

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86 Id. at Attachments 11, 12. Notably, seven schools (a mix of DC Public and Public Charter Schools) had a HPEA completion rate of 0.00 percent in 2018.
87 Id. at 32 (Figure I).
88 Id.
89 Id. at 33.
90 Id. at 33 (Figure J).
91 Id.
92 DC Code § 38-824.02(b).
93 See DC Code § 38-824.02 (d) (emphasis added).
95 See DC Code § 38-826.02.
96 See DC Code § 38-824.05.
97 DC Code § 38-82701(c).
Thus, OSSE is not empowered to enforce the Health Education Standards upon non-complying DC schools as legally binding requirements.

Although official HSA rulemaking has not been promulgated, OSSE has led multi-pronged efforts to support alignment of instruction in District schools with the Health Education Standards. According to OSSE, these activities have included:

- Assessments of student knowledge of the Health Education Standards (Health and Physical Education Assessment) and behavior (Youth Risk Behavior Survey), including timely and actionable reports and resources shared with schools, partners (including sister agencies and clinicians), and policymakers;
- Capture and analysis of information around health curricula used and services offered by schools through School Health Profiles;
- Grant opportunities and extensive technical assistance, trainings, and resources, including health education curriculum guidance and crosswalks, to help schools and educators understand the HSA and implement its provisions; and
- Transparency to the public and policymakers by publishing reports, data, and resources online.

This approach has been informed by the fact that, soon after the HSA’s passage in 2010, limited local resources and a lack of understanding of comprehensive health education were identified as major barriers for schools implementing Health Education Standards and meeting weekly health education minutes. Accordingly, OSSE has leveraged the School Health Profiles, the Health and Physical Education Assessment, and the Youth Risk Behavior Survey to identify schools in need of assistance. Local education agencies and individual schools also regularly contact OSSE for direct technical assistance on health education. Many schools, especially newly established charter schools, continue to acknowledge a lack of local resources as a barrier to meeting the required minutes of health education, so OSSE has chosen to continue to provide resources and technical assistance rather than enforce penalties for non-compliance.

OSSE has also invested significant attention to the timely and actionable collection, analysis, and reporting of relevant knowledge and behavior data for a diverse range of stakeholders, including greater transparency for the public. These data continue to demonstrate that there is work to be done collectively to support universal access to high-quality health education and compliance with the Healthy Schools Act, even though there are bright spots to be celebrated. OSSE has identified a steady increase in the amount of time devoted to health education in schools for grades K-8, demonstrating continued progress for District schools in meeting requirements of the HSA. Schools have demonstrated improvements in student knowledge within the HPEA: from school year 2015–16 to 2017–18 on the Health and PE Assessment, District high school students demonstrated a 9% increase in Human Body and Personal Health and a 13% increase in Safety Skills comprehension. In school year 2017–18 School Health Profiles, 97% of District high schools and 63% of District middle schools reported providing prevention materials on HIV and sexually transmitted diseases.

The Mayor is Urged to Promulgate Official Rules to Adequately Enforce the HSA

Although there are some regulations governing health education in DC schools, the official rulemaking required by the HSA has never been formally completed for DC schools. Given the new infection numbers affecting young people in the District—and in order to ensure uniform and effective enforcement of the statute—the Mayor can and should invoke her rulemaking authority under the HSA.

Prior existing regulations charge OSSE with ensuring that health instruction include at least eleven content areas, two of which are “HIV/AIDS and...
other sexually transmitted diseases” and “prevention and control of disease.” Notably, these regulations were promulgated prior to the creation of the DC Public Charter School system in 1995, and prior to the enactment of the HSA in 2010. Nonetheless, more can be done to ensure full and effective enforcement of the HSA in all DC Public Schools.

Pursuant to Section 38-828.01 of the HSA, “[t]he Mayor . . . shall issue rules to implement the provisions of this act.” Such enforcement power is based on the Mayor’s authority under Section 2-503 of the DC Code, which provides that the Mayor shall establish, or require subordinate agencies to establish, procedures for code enforcement. Although the HSA was enacted in 2010, the Mayor has not yet taken action to enforce its provisions through rulemaking. Again, we believe the new infection numbers among the District’s youth should persuade the Mayor that now is the time to move forward with the rulemaking contemplated by the HSA.

Until the Mayor promulgates notice-and-comment rules regarding the Health Education Standards, likely through OSSE, it will remain ambiguous as to whether—and how—these standards should be enforced as to noncomplying DC Public and Public Charter Schools under the HSA. The regulations should further clarify whether private persons (e.g., students, parents, teachers, and community members) have a right of action or whether OSSE has sole authority to bring legal actions against schools based on violations of the HSA. Once regulations regarding the Health Education Standards have passed through the notice-and-comment process and are published in the DC Register, the application of the Standards to any DC school may be resolved by an administrative hearing before the Mayor or before the applicable agency, or by a declaratory order issued by the Mayor.

Recent Legislative Developments Directly Affecting OSSE’s Role

On June 6, 2017, DC Councilmembers Mary Cheh (who introduced the HSA in 2010) and Charles Allen introduced the Healthy Students Amendment Act of 2017 (“HSAA”), which proposes to amend the HSA in multiple ways regarding the nutrition and wellness requirements of the HSA, with a special focus on school meals and physical education. This proposed bill refers explicitly to DC Public and Public Charter Schools, in the same manner as the HSA. The bill, which remains under Council review as of the time of this writing, would require OSSE to submit annual reports to the Mayor, the DC Council, and the HYSC regarding compliance with the HSAA. The proposed bill grants OSSE expanded enforcement power under the HSA. In particular, it requires schools providing less than 100 hours of physical education for more than one week during the school year at the elementary level and less than 150 minutes for more than one week at the middle school level to submit an action Plan to OSSE detailing efforts to increase physical education, and work with OSSE to increase physical education minutes. Although the proposed bill does not require schools failing to meet the health education time requirements of the HSA to submit action plans to OSSE and collaborate to encourage compliance, such a requirement may help foster more meaningful accountability and information-sharing for DC schools not in compliance with the HSA.

Additionally, Councilmember Mary Cheh introduced the DC Education Research Advisory Board and Collaborative Establishment Amendment Act of 2018 on April 10, 2018. This bill, currently under Council review, would establish a DC Education Research Collaborative under the office of the DC Auditor, which would be tasked with managing data collection from schools and reporting to the Mayor, the Auditor, the DC Council, the State Board of Educa-

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102 Id. at §2304.3(a).
103 Again, the DC Public and Public Charter high school graduation requirements regarding health education and the comprehensive health education requirements applicable to DC Public Schools have undergone the notice-and-comment process and are enforceable as legally binding. See DC MUN. REGS. tit. 5-A § 2203.3(g) (Apr. 8, 2016); DC MUN. REGS. tit. 5-E § 2304.3(a) (Dec. 30, 1994).
104 See DC Code §§ 2-508-509.
106 Id.
107 Id.
Notably, the Collaborative would conduct an audit of DC Public Schools, the DC Public Charter School Board, OSSE, and the Office of the Deputy Mayor for Education, and local education agencies—including collecting data regarding course offerings, curriculum standards, policies, and manuals on instructional requirements.\textsuperscript{109}

Finally, on September 18, 2018, Councilmember David Grosso (Chairperson of the Committee on Education) introduced the State Education Agency Independence Act of 2018, which would remove OSSE from the Office of the Mayor, establish OSSE as an independent agency with hiring power over all staff, remove the Mayor’s discretion to remove the Superintendent at will, and increase the Superintendent’s term from 4 years to 6 years.\textsuperscript{111} These three proposed bills, if passed, will have a significant impact on not only OSSE’s function in general, but its practical role in enforcing the requirements of the HSA and supporting schools in doing the same. Even should these bills pass and become part of the DC Code, the Mayor (or OSSE, if established as an independent agency) should promulgate regulations to determine exactly how the new requirements and powers are to be utilized to ensure that DC schools and students are receiving high-quality health education. If the Mayor or an executive agency does not promulgate such regulations to make HSA enforcement a reality, the DC Council should give serious consideration to amending and strengthening the HSA’s health education requirements, as it proposes doing so with the 2017 HSAA’s physical education and nutrition amendments to the HSA.

\textsuperscript{109} Id.

\textsuperscript{110} Id.

The Critical Importance of PrEP

Over the past year, we have seen remarkable growth in the usage of PrEP throughout the country, including the District; however, access to PrEP is not as readily available and in use the District as the Plan contemplated it would be in order to meet the 50% reduction of new infections by 2020. Moreover, in the wake of the noted recent announcement from the scientific panel, PrEP should be available to all people who are considered high risk of HIV infection, and in light of the effectiveness of PrEP in preventing infection, increasing access to PrEP should now be a high priority under the Plan.

For example, because of the increase in youth infections, it is important to note that DC public health law enables minors (persons less than 18 years old) to access sexual health services without parental or guardian notification or approval. The services include testing and treatment in public high schools and in community settings throughout the District. The current rates of new infections and the behaviors documented in behavior the Youth Risk Behavior Survey indicate the significant need for making sure PrEP is accessible to District youth.

Moreover, as earlier mentioned, while PrEP is obviously a tool that can appropriately be used to address the increased infections among youth, it is also one that can and should be used for other demographic groups as well. DC Health estimates currently that less than 10% of the persons who could benefit from PrEP are using it and recognizes that more people should have access. One strategy the District has to increase access to PrEP is to encourage more clinicians to make PrEP available and support patients who ask for PrEP. This approach is supported by the CDC as an essential strategy to reduce HIV infection.

While the essential component of PrEP is the prescription for the medication, patients may need extra support to keep taking the medication and education on sexual health. DC Health is funding community-based organizations to provide that ongoing support similar to other preventive health

approaches, i.e. reducing obesity or smoking cessation, medical providers can connect patients to these organizations for sexual health support. Additionally, DC Health has a team that assists medical providers one-on-one in starting to provide PrEP in their offices. DC Health also offers a Continuing Medical Education (CME) credit for clinicians.

It is critical that these and other measures to increase accessibility to PrEP be employed. PrEP has been shown to be up to 90% effective in preventing transmission of HIV when used consistently and correctly. Some studies reported zero new infections among HIV-negative individuals on PrEP. The efficacy of the regimen depends on individual adherence. The original modeling guiding the Plan assumed an 86% efficacy rate for PrEP in preventing HIV transmission in DC. By incorporating efforts to increase the utilization of PrEP among focus populations, such as men who have sex with men and high-risk heterosexual women, DC Health anticipated that the number of newly diagnosed HIV cases in 2020 can be reduced by up to approximately 56% from the 520 new infections in 2013. As earlier noted, the model developed for the DC Health by The George Washington University and Howard University assumed that approximately 8,000 people at high risk for HIV infection would need to consistently use PrEP on an annual basis to reach the goal, a huge increase from the uptake at the time of about 2,000 people. Expanding the network of medical professionals prescribing PrEP in DC is critical. The DC Health planned to produce educational materials, utilize contracted clinics, work with community partners to recruit more prescribers, and advise clinicians to connect people to counseling and adherence support.

Currently, nine contracts between providers and the District include prescription of PrEP. HAHSTA reflected that while there are many provider education efforts going on, PrEP enrollment is still slow. To understand the reasons, the District has proposed future community listening sessions with Wellness Center users to understand perceptions around PrEP in the community. As of fall 2018, HAHSTA was hiring a PrEP Coordinator to assist in expansion; the scope of work will include a coordinated effort to collect, share, store, and update and disseminate information on providers who are prescribing PrEP.

Task 4.1 also includes building the capacity of providers to offer appropriate care and information for special populations in culturally affirming settings. The CDC-funded IMPACT DMV project funded 11 organizations to increase the uptake of PrEP among men who have sex with men and

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113 Id.
transgender persons of color in the DC, Northern Virginia, and Suburban Maryland area. These activities include PrEP education, referral to medical providers, on-site provision of PrEP medication, and provider capacity building. As part of the PrEP for Women initiative (described below), Children’s Research Institute was funded to map adolescent primary care providers that serve female patients who test positive for STDs and provide PrEP education to those providers.

In late 2016, the PrEP for Women initiative was launched as a public-private partnership between HAHSTA and WAP. Grants were awarded to Children’s Research Institute, Family and Medical Counseling Service, Mary’s Center, and Planned Parenthood of Metropolitan Washington to support a range of programs and services, including PrEP and sexual health education for young and adult women, provider and support staff training on PrEP (a total of 555 clinical and non-clinical staff were trained to date), and efforts to integrate PrEP into clinical and prevention services. In 2017, DC Health conducted 12 provider education sessions. This initiative is funded through 2019.

In June 2017, Alosa Health was contracted to conduct educational visits at doctor’s offices throughout DC using academic detailing to reach 500 medical providers in 2018. In July 2018 (the latest report), 29 providers (physicians, nurses, and physician assistants) were visited for medical detailing. By specialty, 17 were primary care, six were in emergency medicine, and six were in pediatric medicine. Alosa is currently preparing a detailed report for HAHSTA based on field notes, outcomes, and post-visit evaluations. Medical detailing will update existing PrEP content to include U=U messaging and to reference PrEP DAP; programming is also being revised now that PrEP is approved for use by adolescents.

In 2017, HAHSTA reported that Alosa Health would provide an online module on PrEP education that provides one continuing education credit. The status of this project is unknown.

We recommend that the District ensure provider education efforts focus on providers in areas known to have limited access to PrEP. According to one provider, PrEP access is extremely low east of the Anacostia River.

Task 4.5: Work with Medicaid, MCOs, and Private Health Plans in order to Ensure Insurance Coverage of PrEP Treatment and Related Clinically Recommended Laboratory Monitoring

2018 Status: No Progress

To implement this task, DC Health planned to work with DHCF and private insurance carriers to cover PrEP medication as well as screening, medical visits, and ongoing laboratory tests. In 2017, the MCOs participating in DC Medicaid would cover only the cost of labs, not the medication. DC Alliance clients had to use an assistance program operated by biotechnology company Gilead, due to non-coverage of ART on plans. Five private insurance companies were identified as providing full coverage of PrEP treatment and labs. In 2018, HAHSTA believed that the DC Alliance and Medicaid both covered PrEP. The to-be-hired PrEP coordinator is expected to cover this task as part of their scope of work.

We are concerned that the District has not made progress on Task 4.5 since the Plan’s implementation. The District should aggressively focus on ensuring that DC Alliance and Medicaid provide adequate coverage for PrEP to reduce barriers to care, especially given previous reports of a lack of such coverage. Given the importance of this task and the lack of progress to date, the District should consider taking actions beyond relying on the to-be-hired PrEP coordinator to manage implementation.

Task 4.9: Improve Timely Notice to DC Health of All New HIV Diagnoses

2018 Status: In Progress

We encourage the District’s efforts to increase the public’s awareness regarding PrEP and recommend that DC Health connect to Gilead Sciences, the makers of PrEP, to form an agreement that will begin to help those who are not insured or unable to afford PrEP, and increase, students access to PrEP.
For this Report, in addition to focusing on youth infections and the need for increased access to PrEP, DC Appleseed conducted a preliminary analysis of the status of the four goals of the Plan and their associated tasks. Because of the need to redouble efforts to get to the 50% reduction in new infections, and because of the critical role of the tasks in achieving that goal, in 2019 we intend to do a further review of the current state of all tasks and make recommendation where stepped up efforts are needed. For this Report, in order to be timely and constructive, we are reporting some current information available to us about certain key tasks and offering recommendations where appropriate.

**Goal 1: 90% of HIV-Positive District Residents Know Their Status**

The core from which the other goals of the 90/90/90/50 Plan can grow is diagnosis. In order for individuals to receive effective HIV treatment, they must first be aware of their HIV status, and as more DC residents know their status, it will then increase the opportunity for them to engage in care. Further, as more residents who are HIV-positive are in care, they are more likely to reach viral load suppression.

And when more individuals reach viral load suppression, not only will their own health be improved, but fewer will transmit the virus to others, and the number of new infections will decrease over time.

The baseline for the first goal is the estimate of the percentage of HIV-positive DC residents who know their status. The District aims to have 90% of HIV-positive residents know their status by 2020. In 2015, HAHSTA estimated that 86% of HIV-positive individuals were aware of their HIV status.

On November 23, 2018, HAHSTA provided DC Appleseed the estimate for 2017: 87% of HIV-positive individuals were aware of their HIV status—an increase of 1% from last year. While this is a small increase,

The number of individuals who have HIV but are not diagnosed can never be known with certainty. However, statistical methods can be used to estimate the percentage of the HIV-positive population unaware of their status. As earlier noted, in 2015, the District used a model which estimated that 9% to 14% of actual HIV cases were undiagnosed within the District. Based on the surveillance data at the time, HAHSTA estimated that 86% of HIV-positive individuals were aware of their HIV status.

On November 23, 2018, HAHSTA provided DC Appleseed the estimate for 2017: 87% of HIV-positive individuals were aware of their HIV status—an increase of 1% from last year. While this is a small increase,
it moves the District closer to the 90% goal and is a welcome development. DC Appleseed appreciates the District providing this updated data for our Report and urges HAHSTA to offer further updates on the four goals as they become available, so that residents, community partners, and stakeholders involved in the Plan can be usefully up to date and can helpfully participate in reaching the Plan’s goals.

As we move into 2019, DC Appleseed recommends that the District increase its efforts to reach the goal of 90% of HIV-positive DC residents knowing their status by 2020. Part of that can include further progress on certain key tasks.

As in our 2017 report, below we detail the District’s progress on key tasks related to this goal that we believe are most likely to have a significant impact and assign to each one of three status categories—Implemented, In Progress, or No Progress.

To the extent that activities need to be sustained until 2020 and beyond, the status of “implemented” is not a fixed end point and may be moved back to “in progress” in future years as necessary.

**Task 1.1: Use Geospatial and Demographic Data to Increase Targeted Testing, and Require Providers Receiving Testing grants to utilize Evidence-Based Programs that Target Social Networks Where New Infections are Most Likely**

**2018 Status: In Progress**

The District has made progress on this task in the past year. HAHSTA has continued to produce maps which show the geospatial mapping of HIV to identify high risk areas where new infections are more likely to take place and where focused testing efforts should be provided, and shares those maps with providers, community partners, and stakeholders. HAHSTA also has an initiative to ensure that providers are sharing information with the District. HAHSTA is requesting providers’ assistance in locating additional testing sites within their assigned census tracts and reporting metrics of testing events in those locations back to the HIV Testing Coordinator to collect additional data to feed into its targeted testing programs.

In May 2018, DC mobile HIV testing providers shared with HAHSTA lists of all their mobile testing locations, which the HAHSTA Geospatial Analyst mapped. As a result of this analysis, HAHSTA found mobile HIV test sites that were in lower risk neighborhoods. The agency then identified certain duplication of testing sites, a concentration of sites in the center of the District, and a large proportion of areas identified as elevated risk areas that were not covered by the mobile testing units. HAHSTA is assessing this data and mapping analysis to maximize resources, allow partners to focus activities on higher risk populations, and yield a higher positivity rate than routine or standard HIV testing. HAHSTA plans to also use additional demographic data with its surveillance resources to identify “hotspots” of HIV prevalence, such as income, education, and race or ethnicity.

In a current pilot program, HAHSTA is requiring mobile testing contractors receiving grants to target testing to individuals at elevated risk of infection. These rapid testing providers are expected to achieve a 1% positivity rate, to close the gap on diagnosis. Five providers were selected to participate in the pilot, and HAHSTA aims to acquire additional providers to participate in the program in the future. This pilot program could produce data key to assessing the success of the work in implementing this task.

As noted in last year’s report, HAHSTA’s latest “social network screening” (SNS) program was discontinued in August 2017. HAHSTA had previously proposed requiring providers to target high-risk social networks as a condition of grants. HAHSTA cited poor performance and low adherence to the model as reasons for rolling back the program and proposed making necessary changes to the monitoring and evaluation procedures, and providing
additional appropriate support, in order to revise the program. Currently, the District has not set an implementation date for any future iteration of the program, and no current SNS initiatives are being funded by the Department.

HAHSTA has made strides in working toward implementation of this task. The additional data collection and analysis activities have provided useful information to identify targeted testing sites. Increasing testing in these optimal testing locations will also be helpful in prevention and care resource allocation mapping. Establishing a renewed model for HAHSTA targeted testing grants, such as thoroughly reviewing the successes of the pilot program, should be part of these activities to increase such testing.

Upon implementation of this task, the District should work to assess positivity rates across target sites, areas, and populations in order to evaluate whether the strategies were effective in increasing efficiency of testing programs.

**Task 1.2: Continue Media Campaigns and Medical Provider Education to Ensure New and Ongoing HIV Testing Approaches**

**2018 Status: Implemented**

HAHSTA has continued to develop and maintain successful media and medical provider education campaigns. This task has been implemented for 2018 and should continue going forward.

This year, HAHSTA launched its new Sexual+Being campaign, a public health effort to promote sexual health and wellness and to address stigma through a “sex positive approach.” HAHSTA has stated that Sexual + Being is a key strategy for meeting the District’s goals to reduce HIV, STD and Hepatitis rates in the city. To help achieve these goals, Sexual + Being promotes HIV, hepatitis, and STD screening; PrEP; use of male and female condoms; and safe, effective treatment for persons living with HIV. HAHSTA has also stated that the Sexual + Being campaign will amplify the message of Undetectable equals Untransmittable (U=U), a global effort to promote information on the fact that people with HIV who take daily medication and achieve viral load suppression (Undetectable) do not sexually transmit the virus to others (Untransmittable). HAHSTA endorsed this global campaign in 2017 and will further integrate it into its outreach and education in the coming year.

Last year, HAHSTA identified a need to monitor and evaluate the reach and efficacy of educational campaigns, including: gathering feedback from providers and community members, identifying measurable outcomes from the dissemination of educational information, and examining the impact of these efforts. This year, HAHSTA began a process to evaluate its media campaigns. HAHSTA plans to continue these evaluation activities in the coming year.

Although this task is considered implemented, the District should sustain effective campaigns over the course of the next two years to maintain this status. Implementing any outcomes from the evaluation of the active campaigns can assist in increasing effectiveness and efficiency. The current campaigns of focus for the Department are PrEP for Her, Sex is..., and Sexual + Being. HAHSTA also identified opportunities to review and update certain educational campaigns to ensure information remains current (e.g., PrEP, men who have sex with men of color). The District should ensure that these media campaigns include up-to-date approaches, especially regarding HIV testing.

Maintaining and enhancing provider education is especially critical to increasing testing. HAHSTA maintains materials geared toward making information available to providers, but states that there are no active testing media campaigns. Instead, HAHSTA maintains a focus on collaboration with and education of providers or including information on testing in education about treatment or prevention (e.g., PrEP). Options for increasing opportunities for effective provider education may be webinars for providers—a peer-to-peer model for physicians working in the space is an approach for HAHSTA to consider.

Some stakeholders in the community have commented that HAHSTA has not been as effective in its outreach efforts to communities in Wards 7 and 8 as elsewhere. We encourage HAHSTA to consider partnering with organizations that already maintain a footprint in those communities that may have a general shared interest in community health but have not been previously involved in specific HIV efforts.

In marking this task as “Implemented,” we recognize DC Health’s successful campaigns here, but we
also encourage the Department to continue to assess and take advantage of opportunities to specifically increase awareness of and provide education about testing to maintain this status in future years.

**Task 1.3: Identify Those Who Test Negative but are at Elevated Risk and Engage Counseling for Prevention Strategies—including Counseling for Pre-Exposure Prophylaxis (PrEP)**

**2018 Status: In Progress**

Targeted prevention strategies have continued at certain sites within the District, but broader requirements are not yet in effect and there may be missed opportunities to engage individuals at elevated risk in prevention strategies.

HAHSTA asks participating testing sites to interview patients regarding their sexual histories to identify high-risk individuals, and report actions such as treatment of STDs and whether a provider offered PrEP and Expedited Partner Therapy (EPT). Locations such as the DC Health and Wellness Center (DCHWC) and Whitman-Walker Health identify candidates for prevention interventions, including PrEP, through a screening and counseling process. In addition, at DCHWC, patients who test positive for any STD are recommended for a three-month re-screening. HAHSTA is also currently in the initial stages of developing automatic electronic reminders for patients with certain positive STD results to return for re-infection tests. PrEP is discussed with those returning patients.

Some sites within the District have successful models to further engage patients following a negative HIV test, but others do not. As in last year’s Report, we recommend that compliance or effectiveness indicators, or more stringent grant requirements, may be needed to more broadly impact providers’ practices. This task is currently noted as “In Progress,” and HAHSTA should assess how to broadly apply and enforce requirements across all testing grantees to reach implementation.

**Goal 2: 90% of District Residents Diagnosed with HIV are in Treatment**

Upon diagnosis, it is critical for patients to be linked with medical treatment and anti-retroviral therapy for them to stay healthy. In addition, when individuals adhere to treatment and maintain viral suppression, there is effectively zero risk that they will pass on the virus. In the 90/90/90/50 Plan, the District focused on consistent ART use as the best way to both improve health outcomes for those living with HIV and to reduce new infections in DC. Because ART prescription information for all HIV diagnoses is not collected by the Department of Health, progress towards this goal of consistent ART use is evaluated by using completed laboratory testing as a proxy for engagement in care.

The 2018 Epi Report, reflecting data through December 2017, estimated that 77% of residents living with HIV were actively engaged in treatment with one or more medical visits, a 1% increase from the previous report’s estimate. However, because not all patients who attend appointments or complete laboratory tests necessarily adhere to daily ART regimens, the number of individuals adhering to a treatment regimen is likely to be lower. Without a more exacting definition of “in treatment,” the District’s progress towards this goal remains unclear. HAHSTA should consider defining the measure related to this goal to align with its stance that treatment goes beyond connection to a provider.

As mentioned in Goal 2, above, we detail the District’s progress on key tasks related to this goal that we believe are most likely to have a significant impact and assign each one of three status categories—Implemented, In Progress, or No Progress.

To the extent that activities need to be sustained until 2020 and beyond, the status of “implemented” is not a fixed end point and may be moved back to “in progress” in future years as necessary.

**Task 2.1. Reduce the Time From Initial Diagnosis to Initiation of ART Through a Relaunch of the Red-Carpet Entry Program**

**2018 Status: Implemented**
The Plan’s proposal to revamp and expand the Red-Carpet Entry Program, which was developed to ensure that all persons newly diagnosed with HIV are linked with an HIV provider right away, depended on grant funding that HAHSTA applied for but ultimately did not receive. As such, the program was not relaunched. HAHSTA reports the task as complete because providers are still implementing the model.

Many providers that we spoke with confirmed that they implement some version of the Red-Carpet program. Although definitions of the program varied, broadly speaking, providers were referring to a program intended to reduce as many barriers as possible from diagnosis to treatment. Some noted difficulties arising from the fee-for-service funding model. For instance, one provider noted that the fee-for-service model creates disincentives for navigating a client through HIV treatment in a timely manner. The provider also mentioned that because there is not a high volume of demand for the service, the cost associated with the program has become an obstacle to maintaining it.

Although the Red-Carpet Entry program was not relaunched, HAHSTA expressed in last year’s progress report that it would “review how a connection to an HIV specialist and the rapid initiation of ART can be improved outside of the original Plan.” To this end, HAHSTA has taken several steps:

- **New HIV Care Review Panel.** A cross-divisional internal workgroup has been formed that will explore how to measure linkage to HIV care for newly diagnosed individuals.

- **Information gathering.** Input across HAHSTA programs that are involved in supporting fast-track services is being gathered to determine how an alternative goal may be rewritten. Below are a few items that are being discussed:
  - Clarification of Red-Carpet Entry Program goals, objectives, and elements of the program, perceived versus actual
  - Stakeholder understanding and buy-in
  - List of verified providers and up-to-date contact information currently available at https://dchealth.dc.gov/service/red-carpet-entry-program

- HAHSTA-funded linkage activities

- Performance measures and/or client-level data tracking, for both current and needed

HAHSTA should ensure that the program’s goals and elements are completed in a timely manner. Further, the review of the program should result in action steps that are subsequently implemented.

### TASK 2.3. Expand Access to Treatment and Related Services, Targeting Demographics and Geographic Areas Where Populations are at Higher Risk

#### 2018 Status: Completed

HAHSTA provided maps that demonstrate the expanded distribution of Ryan White providers between 2016 and 2018. HAHSTA reports that, currently, there are providers that can support the needs of each service category in each jurisdiction in the eligible metropolitan area (Suburban Maryland, Northern Virginia, two West Virginia counties, and the District), accommodating patient mobility and increasing options for consumers throughout the region.

Although this task has been marked completed by HAHSTA, ensuring continued access to treatment and services requires ongoing monitoring. As Goal 2 has not yet been achieved, it is necessary to continue efforts in this area.

HAHSTA has reported that it is currently in the planning phase for Molecular Surveillance activities that can help monitor population-level drug resistance and identify HIV transmission networks for targeted partner services and targeted re-engagement in care. Molecular Surveillance is the collection, reporting, and analysis of HIV genetic sequences generated through HIV-drug resistance testing. HAHSTA’s plans for Molecular Surveillance community outreach are intended to be used to re-engage people living with HIV who have been out of care for seven months or more and those who are not virally suppressed.

In the upcoming year, planned activities include:

- Expanding community and provider engagement
• Developing community and provider educational materials for molecular networks

• Expanding protocol to include outbreak detection and response

• Exploring expanding legal protections for the subpoena of surveillance data

Goal 3: 90% of District Residents Diagnosed with HIV Who are in Treatment Reach Viral Load Suppression

The District aims by 2020 to reach viral load suppression for 90% of DC residents living with HIV who are in treatment. In 2015, HAHSTA estimated that 78% of DC residents living with HIV who were in treatment were maintaining viral load suppression, and this figure became the baseline for the Plan. The 2018 Annual Epidemiology & Surveillance Report states that the 84% of DC residents who were living with HIV and in treatment in 2017 maintained viral load suppression. This 2018 Epi Report also measures the number of DC residents living with HIV—not just those who are in treatment. It indicated that in 2016, only 63% had reached viral load suppression. The most recent data available from HAHSTA indicates that in 2017, 65% of DC residents with HIV had reached viral load suppression. The Epi Report also notes that White and Latino residents had the highest rates of viral suppression in 2017 (each around 67%) which is consistent with the 2017 Epidemiology & Surveillance Report, representing a 1% increase for both groups from 66% in 2016. Black residents had slightly lower viral suppression rates (63.8%). This represents a 1.8% increase from 62% in 2016. The 2016 data identified no notable differences by gender identity, but in 2017 residents identifying as male or female had a higher viral suppression rate (64.5% for males and 65.2% for females) than transgender residents (60%).

Another consistency the District saw among the 2016 data and 2017 data was that DC residents aged 50-59 had the highest rate of viral suppression (69.8%). This represents a 0.8% increase since 2016. While in 2016, the age group least likely to be virally suppressed was 20-24-year olds, in 2017, this figure shifted—instead, youth aged 0-19 were least likely to be virally suppressed (46.3%) compared to other age groups. The 20-24 year-old age group, which had a 47.7% viral suppression rate in 2016, increased to 50.4% in 2017.

To meet the goal of 90% of District residents in treatment reaching viral suppression, the Plan includes strategies to enhance support for patients in maintaining their treatment, to address socioeconomic conditions that may contribute to lapses in treatment, and to examine how federal funding provided through the Ryan White Act can be used more effectively. The 2% increase in DC residents in treatment who have reached viral load suppression (as shown in the 2018 Epidemiological Report) is encouraging but DC Health should renew its focus on pursuing these strategies in order to make significantly more progress towards reaching the 90% goal. There would need to be at least a 6% increase in the next two years to achieve the 90% goal.

As mentioned in Goal 2, below we detail the District’s progress on key tasks related to this Goal 3 that we believe are most likely to have a significant impact and assign each one of three status categories—Implemented, In Progress, or No Progress.

As before, to the extent that activities need to be sustained until 2020 and beyond, the status of “implemented” is not a fixed end point and may be moved back to “in progress” in future years as necessary.

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**Goal 3.1: Work to Make Health Care Services More Accessible by Hours, Location, and Providers.**

**2018 Status: In Progress**

As noted in the Plan, most residents living with HIV in the District maintain routine visits with medical providers. In 2015, 73% of DC residents with HIV had one or more medical visits during the year. In 2017, this figure increased to 77%. But some of these residents face barriers to accessing care, such as lack of transportation, forgetting appointments, and competing priorities.\(^{117}\) As part of the Plan, the District committed to work with community-based organizations (CBOs) to develop strategies to address these barriers and to facilitate access to health care services, including by: (i) shifting available times for appointments to evenings and weekends; (ii) co-locating providers at CBOs; (iii) working with providers to create opportunities for lab testing at more convenient times outside of a medical visit; and (iv) considering using Directly Observed Therapy (DOT) for initial HIV treatment. In our supplemental report we hope to work with HAHSTA concerning the implementation of these initiatives.

In 2017 we reported that staff at HAHSTA was drafting a directory to equip Ryan White providers and clients with a one-stop source of information on service locations, hours, and provider details. The target completion date provided in the 2017 report was March 2018. HAHSTA has since indicated that it completed a statement of work for this directory in June 2018 and that the statement of work has been undergoing review and approval processes. HAHSTA expects to have a contractor on board in November 2018, and the website built for the directory in December 2018 with a launch and trainings for staff and CBO providers on how best to utilize the resource in January 2019.

HAHSTA is also piloting a ride sharing program to help residents with HIV who lack access to transportation access care. The program will use Uber Health or Lyft Health to transport residents to and from HIV-related service appointments. HAHSTA has indicated that it will make $11,000 available to six providers participating in the ride sharing program: La Clinica Del Pueblo, Family and Medical Counseling Service, Inc., Women’s Collective, AIDS Healthcare Foundation, Howard University, and Whitman-Walker Health. $10,000 of the award amount is for direct service, and $1,000 may be allocated to administrative costs. HAHSTA and the participating providers are collecting data regarding how many residents are using the ride sharing service, and the number of residents who are lost to care due to lack of transportation, in order to gauge the efficacy of the pilot program. The pilot will run for seven months, from August 2018 through February 2019. HAHSTA has not indicated whether it intends to extend the pilot beyond February 2019 or if it intends to consider adopting the program permanently if the pilot program is successful.

This task is in progress. While the development of the directory and the ride sharing pilot program are important steps, additional progress on this task will need to include further development of other planned concrete strategies to extend and/or redesign services for the task to be considered implemented.

**Goal 4: 50% Reduction of New HIV Cases**

The District aims to achieve a 50% reduction in new HIV cases by 2020. The 90/90/90/50 Plan details policies that will enhance prevention efforts through increased access to PrEP and post-exposure prophylaxis (PEP), especially for the groups at the highest risk of infection, improve youth education, and expand funding for successful syringe access programs. The Plan follows the cascade of the HIV Continuum; as more District residents know they have HIV, more are likely to be engaged in care. As more are in care, more are likely to reach viral load suppression. When more reach viral load suppression, not only will their own health be improved, but fewer will transmit the virus to others, leading to a decrease in the number of new infections over time.

As earlier noted, when Mayor Bowser announced the 90/90/90/50 Plan at the end of 2016, the most recent estimated infection data were from 2015. During that

year, HAHSTA reported, 401 HIV cases were newly diagnosed. Cutting that number in half means we aim to see only 200 new infections by the end of 2020. The 2018 Epi Report identified 368 new infections in 2017 and revised the 2016 data to report 369 new infections that year. Interim data for 2018 indicate that there have been 176 new cases in the first half of this year, only a slight change (352 infections at an annualized rate) from 2017. These recent data represent only a 12% reduction from the number of new infections in the base year 2015. This means, as said before, that the District is not currently on track to get to a 50% reduction of new infections by the end of 2020. But also, as said before, with redoubled efforts on the various tasks—and particularly regarding young people and PrEP—the 50% reduction is achievable.

Other than the Goal 4 tasks relating to PrEP (discussed above), one task related to PrEP that is also more broadly related to the 50% reduction goal is worth mentioning again here -- Task 4.9

**Task 4.9: Improve Timely Notice to DC Health of All New HIV Diagnoses**

**2018 Status: In Progress**

Healthcare providers are required to report a positive HIV diagnosis to DC Health within 48 hours, which allows HAHSTA to notify potentially exposed individuals through its Partner Services team. To improve timely—even earlier—case reporting, DC Health previously planned to consult with and educate practitioners about reporting.

In 2017, HAHSTA staff made site visits to six clinics to discuss the importance of reporting within 48 hours. HAHSTA held three drop-in sessions for clinicians on the required forms and reporting deadlines. Also, in 2017, HAHSTA created a one-page, electronic form for easier completion by clinics which is now available on the DC Health website, though broader provider education is necessary. Staff planned to raise awareness in the year ahead as well. Some analysis is being done related to uptake. The Strategic Information Division implemented a Quality Improvement team this past year to focus on issues around provider reporting.

The providers we interviewed said the electronic form is easy to use. However, one provider said that the District could improve reporting by ensuring adequate funding to support the administrative burden that accompanies reporting. One provider also recommended that the District take initiative to enable reporting to other jurisdictions, especially Maryland and Virginia.

The 90/90/90/50 Plan proposed a Rapid HIV Surveillance and PEP-Plan B demonstration project through which the Department of Health would assess the effectiveness of a timelier deployment of Partner Services, including possible on-call distribution of PEP. Preliminary parameters would include, *inter alia*, immediate notification to the Department of Health 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. The Plan proposed this demonstration project would begin in 2016, however, it is unclear whether it has ever been active.

### HIV Wellness and Prevention Measures

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*Data from first six months of 2018*
DC Appleseed understands that the plateau in reducing new HIV infections that the District is experiencing is occurring in other jurisdictions as well. This plateau calls for a redoubling of efforts in the city. DC Appleseed believes that two areas in particular merit increased focus: implementing the Healthy Schools Act uniformly and comprehensively in all DC Public Schools; and stepping up efforts to make PrEP available to all District residents at high risk of HIV infection.

Additionally, as part of the redoubled efforts, we urge HAHSTA and other stakeholders to work with DC Appleseed to do a close analysis of all the tasks in the Plan, with a view toward determining which are key to achieving the Plan’s goals, and which further efforts are needed to meet those goals by the end of 2020. Finally, we urge HAHSTA to consider the other specific recommendations made in this Report concerning the tasks as to which we have provided updated information.
We are at a critical moment in implementing the Plan to ultimately end HIV/AIDS in the District of Columbia. The District is currently not on track to meet the Plan’s goals by the end of 2020. DC Appleseed believes that there is a strong need for continued evaluation of each of the Plan’s 42 tasks over the course of the next several months and will prepare a second report in 2019 with a deeper dive into all the tasks with the expectation that there may need to be adjustments in the Plan to put the District back on track.

Meanwhile, we think immediate attention needs to be paid to protecting the city’s youth from HIV infection and that this protection should include rigorous implementation of the Healthy Schools Act. We also think that stepped-up efforts to make PrEP more widely available is critical to implementing the Plan and eventually ending the epidemic.

Rates of HIV infection have decreased significantly in the District over the last decade, but those who remain vulnerable are often those who have historically been shut out or underserved by healthcare and political institutions, especially black residents, transgender people, and young people. Trust-building, education, and engagement—especially through community-based programs—are vital for a person-centered response to the epidemic and are critical to meeting the 90/90/90/50 goals.

This work will require an unprecedented effort at cross-sector work and cross-agency collaboration to address issues like housing, education, and insurance coverage. The more progress we make, the harder won future progress will be—there is no more low-hanging fruit. With the same ambition, dedication, and partnerships that enabled our progress in the fight against HIV over the last decade, we can achieve our goals to finally end the epidemic in DC. DC Appleseed looks forward to working with all stakeholders to make that happen.