A Report of the Conference

Held on

April 20, 2012

at

Howard University

Washington, D.C.

The views expressed in this report do not necessarily represent the view of the sponsors of this Conference or the United States government. The report is based on a recording and notes. Every effort has been made to ensure the accuracy of this report. We apologize for any inaccuracies.
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Goals of the Conference

- To identify and develop practical ways that providers can stay informed about HIV research relevant to their work;
- To identify and develop mechanisms for providers to communicate critical issues for HIV researchers to address;
- To identify and develop mechanisms to assist providers to adopt best practices associated with the implementation of HIV/AIDS prevention priorities established by the National HIV/AIDS Strategy (NHAS)\(^1\) and Centers for Disease Control and Prevention’s (CDC’s) High Impact HIV Prevention approach;\(^2\) and
- To develop a research agenda to develop evidence-based prevention programs for the emerging issues in Metropolitan Washington.\(^3\)

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\(^1\) The National HIV/AIDS Strategy is the White House’s comprehensive plan to improve the national response to HIV/AIDS. The strategy can be found at [http://www.aids.gov/federal-resources/policies/national-hiv-aids-strategy/what-is-the-nhas/](http://www.aids.gov/federal-resources/policies/national-hiv-aids-strategy/what-is-the-nhas/).

\(^2\) Information about the Centers for Disease Control and Prevention’s High-Impact HIV Prevention Approach can be found at [http://www.effectiveinterventions.org/Libraries/General_Docs/12-0209_HIP_CDCs_Approach_red_booklet.sflb.ashx](http://www.effectiveinterventions.org/Libraries/General_Docs/12-0209_HIP_CDCs_Approach_red_booklet.sflb.ashx).

\(^3\) For the purposes of this conference and report, Metropolitan Washington loosely included the District of Columbia (DC), Prince George’s and Montogomery counties in Maryland, the cities and counties of Northern Virginia that are suburbs of DC, and some jurisdictions in West Virginia included in regional HIV prevention plans.
Opening and Welcome

Anthony K. Wutoh, Ph.D.
Howard University

On behalf of Howard University (HU), Dr. Wutoh welcomed the participants and thanked the other sponsors--American Psychological Association (APA) and Office of Behavioral and Social Sciences Research (OBSSR)--and acknowledged the planning committee’s excellent effort in organizing the conference. HU is one of the six participating organizations in the DC D-CFAR which is one of the major organizations that is eager to receive the recommendations from this conference. HU programs are integrated into the DC community. Howard’s staff is providing care to persons living with AIDS and contributing to the research effort that is focused on factors that drive the epidemic and on treatment issues which are promising to reduce HIV infection.

Robert M. Kaplan, Ph.D.
National Institutes of Health

Dr. Kaplan welcomed the conferees and indicated that as a member of the Washington, DC community, NIH has spearheaded the unprecedented progress in behavioral prevention programs and drugs that both prevent its transmission and prevent the consequences of HIV infection. He presented the OBSSR cross cutting mission which is to coordinate and support social and behavioral research across the 27 Institutes and Centers of the NIH. He said OBSSR would review the recommendations from the conference deliberations and provide support for ones within the OBSSR mission. OBSSR can develop funding initiatives for research and training; set priorities for behavioral and social sciences research; provide opportunities for training and career development for behavioral and social scientists; and organize conferences, workshops, and lectures to highlight critical issues in social and behavioral science, including HIV/AIDS.

Gwendolyn P. Keita, Ph.D.
American Psychological Association

Dr. Keita presented the mission of the APA, and stated that APA has been in the vanguard for ensuring that there were sufficient funds to support HIV/AIDS research. APA’s members have been important participants in HIV prevention and treatment. She indicated that as a citizen of Washington D.C., she is devoted to the issue of HIV/AIDS in the district, especially as it relates to women. She stressed that HIV/AIDS is a multi-dimensional disease, and so all social determinants and environmental factors influencing the disease acquisition and treatment should be considered and understood to ensure effective prevention and treatment. Dr. Keita also acknowledged and applauded the efforts of the planning committee and reassured the conference participants that APA would review seriously the recommendations that would be forthcoming from the deliberations.
Dr. Valdiserri began his talk by reporting that HIV incidence is approximately 50,000 per year. There is an estimated HIV prevalence of 1.2 million persons, of whom approximately 20% were unaware of their infection, 32% were diagnosed late (had AIDS within 1 year), and about 50% were not engaged in regular HIV care. While presenting the estimates for new HIV infections (2006-2009), he highlighted that African American and Latino women were 15- and 4-times, respectively, more likely to become infected compared to Caucasian women, and that young African American men who have sex with men (MSM) were the only group with increasing HIV infection rates. Although no ethnic group was immune from HIV, the African American population exhibited the highest infection rates. The economic cost of HIV is very high, with added annual cost of care between $128 and $237 billion.

He reminded the conferees that the goals of the National HIV/AIDS Strategy (NHAS) are: (1) to reduce new HIV infections; (2) to increase access to care and improve health outcomes for people living with HIV; (3) to reduce HIV-related disparities and health inequities; and (4) to achieve a more coordinated national response to the HIV epidemic. He admonished the conferees to keep these goals in mind during their deliberations.

Dr. Valdiserri stated that a single approach cannot be used to end the epidemic, but a multi-dimensional approach bridging the biomedical and behavioral interventions is necessary. In order to reduce HIV incidence and its consequence, the social drivers of HIV risk should be identified and intervened with using combination prevention packages. He illustrated this assertion with a few examples.

A meta-analysis of over 9000 articles on HIV-positive women and trauma indicated that the prevalence of recent post-traumatic stress disorders, intimate partner violence, and lifetime sexual abuse were higher in HIV-positive women. Another study in women (biologic females and transgenders) indicated women who experienced recent trauma were more likely to have a detectable viral load on treatment. These women were more likely to report not always using condoms. A comprehensive prevention program should offer trauma recovery interventions to women with these histories.
A recent study indicated that unstable housing and homelessness increased HIV risk behavior. The odds of recent drug use, needle use, or sex exchange at baseline were 2- to 4-times higher among homeless/unstably housed individuals compared to the stably housed. At the 6- to 9-months follow-up, the risks were reduced by half among those whose housing situation improved. A study in Chicago that supported housing contributed to increased survival for HIV-positive homeless subjects.

A couple of studies highlight the need for testing uptake programs. One study involving adult MSM from a sexual networking site indicated that 9% of the study population “never” tested and among the 18-24 year old MSMs, 24% “never” tested. Among the “never” testers, 50% did not think that they were HIV positive, and about 30% were afraid of getting a HIV positive result. The study revealed that predictors of “never” testing were: (1) being a bisexual or heterosexual, (2) living outside a large metropolitan area, and (3) not having a healthcare provider. Another reason may be evident from an online survey of adult MSM that revealed that only 30% of them reported being offered an HIV test by their health care provider in the previous year, and only 44% disclosed their sexual orientation to their provider.

There are paradoxical results in a study in males diagnosed with HIV in South Carolina. African American MSM with high-care engagement had higher rates of new reportable STDs compared to Caucasians. It is not understood why HIV care engagement is less effective in preventing new STD acquisition but it warrants further study. Data from 13 states with mandatory lab reporting for adult and adolescent males with HIV indicated that only 45% were in care (2 or more tests, 3 months apart). Also, higher percentage of Caucasians were retained in ongoing care (50%) compared to African Americans (41%) and Latinos (40%).

A 2011 study demonstrated that of approximately 1.2 million HIV-infected subjects, only 300,000 had suppressed viral load, even though about a one million subjects were diagnosed with HIV positivity within a few months. These data highlight the importance of evaluating the effects of behavior on engagement and retention in treatment and adherence to the medical regimen.

Dr. Valdiserri presented a few examples where behavioral interventions resulted in better health outcomes. For example, in a study where HIV infected persons in care were randomized to one of four interventions--all interventions were associated with decreased unprotected vaginal and anal sex with HIV-negative or -unknown status partners. Participants who received interventions from medical care providers reported significant decreases at 12 months. Another study indicated that health care navigators helped patients make better use of resources, improve communication with providers, and sustain HIV care over time.

In conclusion, Dr. Valdiserri stated that there is need to identify and address the structural factors that contribute to HIV/AIDS disparities in rates of infection, diagnosis, retention in
care, and health outcomes, including mortality. He expressed the hope that the recommendations from the conference would have some suggestions on the development structural interventions as part of the research agenda.

**Convergence of the National HIV/AIDS Strategy and the Affordable Care Act and Implication for HIV Care Delivery System in Metro Washington D.C.**

**Gregory Pappas, M.D., Ph.D.**  
Senior Deputy Director, HIV/AIDS, Hepatitis, STD and TB Administration (HAHSTA)  
DC Department of Health

Dr. Pappas addressed several myths about HIV in DC. First, he wanted to provide clarification of the epidemiology in DC which is not the highest in the country. He indicated that about 50%-percent of the people who are HIV-positive in the US live in 12 cities. DC is one of those 12 cities. The district is comparable to the other cities: it is not the highest or the lowest. He conceded that DC does have a serious epidemic because two or three people become infected every day. Unprotected sex is the cause of approximately three quarters of the epidemic, with the largest share (approximately 45%) through male-to-male sex. Nearly one third is attributable to heterosexuals, with women carrying 28% of the disease burden in the nation’s capital. Second, the belief that the HIV problem in DC is increasing. Actually, there has been a steady decline in death rates, and there are indications that there is a decline in new infections among some populations. Finally, there is not adequate coverage of the medical issues of the population living in DC. D.C. has the second highest health insurance coverage in the nation after Massachusetts, with 93% of adults covered and the highest health insurance coverage for children (96%).

A major development which will provide the context in which HIV prevention and treatment programs are conducted is the convergence of HIV Care and Health Reform and NHAS. NHAS emphasizes the suppression of viral load (‘treatment is prevention’) and as a step towards this goal. Prevention and test-and-treat go together because such interventions lead to more newly diagnosed cases entering into care and treatment on time, higher CD4 counts at diagnosis, and ultimately, fewer AIDS-related deaths. Health reform is moving towards establishment of patient-centered medical homes for better care of patients. He presented an overview of patient-centered medical homes. Its history could be traced back to the Altamy Declaration, and is emerging as a key strategy in health reform to address chronic disease quality and cost of care. He said that there are four core functions of a medical home: (1) accessible, (2) comprehensive, (3) longitudinal, and (4) provide coordinated care in the context of families and community. He stated that work in the District is proceeding to better define a HIV medical home, but he recognizes that medical homes may not solve all the District’s costs for HIV care cost and quality challenges. Therefore, formation of Accountable Care Organizations and redesigning of larger units than the medical home are also being considered.

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address chronic disease quality and cost of care. He said that there are four core functions of a medical home: (1) accessible, (2) comprehensive, (3) longitudinal, and (4) provide coordinated care in the context of families and community. He stated that work in the District is proceeding to better define a HIV medical home, but he recognizes that medical homes may not solve all the District's costs for HIV care cost and quality challenges. Therefore, formation of Accountable Care Organizations and redesigning of larger units than the medical home are also being considered.

The data on the D.C. Continuum of HIV Care (2010) is disappointing. Although 4000 HIV-positive subjects (of 4879 diagnosed) were connected to care, only about a 1000 were retained in care. Young African Americans (13-24 year-olds) were less likely than older African Americans to remain in care; those diagnosed early (compared to later) and those cared in a non-hospital setting (compared to designated AIDS centers) were more likely to be lost to care. While testing and engaging in care is necessary, it is not sufficient to impact the HIV epidemic and the health of the HIV seropositive population in DC; these individuals must be retained and be adherent the care. He indicated that patients receiving additional services (e.g., mental health services, transportation, and counseling) are more likely to be in care, retained in regular care, and receive more medical services annually. As an example, he pointed to study in Africa (data from five countries) that clinical supervision of community-based programs increased adherence and viral load suppression in AIDS patients.

He talked about the need to redesign the health care delivery system, and that payment systems (incentives) alone may not be sufficient to drive redesign of the system. Investments to help clinics and community-based organizations (CBOs) collaborate to effect a change may be needed. He suggested that the local tax dollars in DC ("Effi Barry Program") could be used to encourage this redesign. Dr. Pappas urged CBOs to consider partnering with clinics (strategic alliance/mergers); develop performance measures that demonstrate contribution to care; participate in care teams; and develop contractual agreements that provide money for services rendered to the clinical centers.

In conclusion, Dr. Pappas emphasized that to reach the potential of “treatment as prevention”, the care delivery system must be improved, in coordination with community support; the medical home provides a useful model to achieve continuity and comprehensive care; and redesign of the health care delivery system should be a top priority for research in DC.
The Community Perspective

Tanya Bender Henderson, Ph.D.
Director of Faith Initiatives and Organizational Advancement
Damien Ministries

Dr. Henderson introduced herself as the Director of the Faith Initiatives and Organizational Advancement at the Damien Ministries and a participant in many other faith-based organizations. She stated that faith was important to African Americans, and so a link exists between the various faith organizations and the HIV-positive African American population. Therefore, all of the Breakout Groups should consider the role of faith in achieving the goals that they are proposing. Furthermore, faith organization and churches are also involved in the social and behavioral risk components of HIV (e.g., homelessness and abuse/violence). However, homophobia exists in the church, and therefore HIV-positive subjects and high-risk subjects are fearful of being stigmatized if they reveal their sexual orientation. Dr. Henderson also observed that congregants do not feel comfortable talking about sex and related issues with faith leaders, and that the faith organizations will have to work to show support and encourage their congregants to speak freely. There is an important role for faith organizations and the church in HIV prevention and treatment and they must be encouraged to assume more leadership.

Ken Pettigrew
MetroTeen

Mr. Pettigrew stated that he works with youth aged 13-24 years at MetroTeen. He shared the fact that data reveals that adolescence as young as 13 years of age were sexually active and in some populations; even children aged 11-12 years of age have reported being sexually active. Although 70% of the youth reported using condoms, a high incidence of sexually transmitted diseases in this population indicates that they may not be using them correctly and consistently. He observed that youth need to be educated beginning at an earlier age and adequate resources need to be allocated to achieve this goal. He called for the development of a comprehensive HIV prevention framework that can support an adequate prevention and treatment program to achieve the goal of an “HIV-free generation”.

Ron Simmons, Ph.D.
President/CEO, Us Helping Us

Dr. Simmons said he and his organization work primarily with African American homosexual men. He presented data from a 2010 District of Columbia Behavioral Surveillance Study that found 32% of African Americans MSM over the age of 30 years were HIV positive compared to 8% of Caucasians, and 12% of African Americans under the age of 30 years were HIV positive compared to 0% of Caucasians. Although the incidence of HIV is higher in African Americans, the study found that African American MSMs
reported 50% higher condom use and fewer sexual partners compared to Caucasian and Latino MSMs. He proposed that the problem in the African American community is not associated with higher risk behaviors but to the sexual ecology. Since the prevalence of HIV is higher in African Americans, even with higher condom use, the probability of becoming infected are far greater for African Americans even if they usually use condoms correctly and consistently and have fewer partners. Dr. Simmons also reported that African American heterosexual men were less likely to get tested, and therefore, could infect their female partners leading to higher prevalence of HIV in African American women (high prevalence may not necessarily be due to high-risk behavior). Dr. Simmons also highlighted the importance of the role of CBOs in HIV prevention and treatment. He emphasized that CBOs should have access to more resources, including funding, to carry out their function. Lastly, he urged all the CBOs join the DC Developmental Center for AIDS Research (DC D-CFAR) whose goal is to lead and support the scale-up of HIV/AIDS research activities in Washington D.C.
Syndemics and Dynamics

Chair: Yonette Thomas, Ph.D.
Howard University

On Syndemics and Strengths among Gay Men

David Holtgrave, Ph.D.
Chair, Department of Health, Behavior and Society
Johns Hopkins University

The Centers for Disease Control (CDC) defines syndemics as a cluster of epidemics that acts additively to predict other epidemics. (Dr. Holtgrave credited Ronald Stall, Ph.D. with providing important assistance in the preparation of this talk.) The term “syndemics” refers to the clustering of diseases in populations and the biological interaction of these diseases in individuals. It also highlights the importance of social conditions in disease concentration, interactions, and health consequences as determinants of higher prevalence of diseases in populations and sites. In syndemics, the interaction of diseases or adverse health conditions commonly arise because of poor structural social conditions (e.g., poverty, exploitation, stigmatization, oppressive social relationships) that put socially devalued groups at heightened risk. Dr. Holtgrave stated that syndemics should be considered from a life course perspective since a large literature shows that most of the syndemic phenomena are observed in very young, adolescent homosexual men and extend over a lifetime. He presented the health profile of the urban homosexual men: (1) they experience high rates of distress and depression, (2) attempted suicides, (3) childhood sexual abuse, (3) HIV infection, substance use and abuse, and (4) partner violence.

Syndemic theory yields novel hypotheses that can be tested. For example, does providing simultaneous combination interventions tailored to young MSM lower their risk behavior and HIV prevalence? Health disparities arise early in life among MSMs and violence and victimization in youth might explain some of their observed health disparities. These interventions could also enhance their resilience which is a prominent feature among MSMs. As an example, Dr. Holtgrave presented evidence that housing assistance improves health outcomes for HIV-positive subjects. Stable housing led to fewer hospitalizations, hospital days, emergency department visits, and nursing home days, in addition to saving public financial resources.

Data also indicated that development of psychosocial health problems are higher among sexual minority youth than heterosexual youth; for example, substance use, depression (suicidal ideation and depression symptoms), violence and victimization (sexual minority youth are more likely to experience sexual abuse and parental abuse, assault at school and missing school due to fear). Young men are nearly twice as like to have sex while intoxicated). All of these factors lead to increased HIV vulnerability. A Multicenter AIDS
Cohort Study (MACS) also showed higher rates of early violence/victimization among homosexual men.

Most of approaches to intervention design for homosexuals seek to identify weaknesses and address them with tailored interventions; this approach has yielded significant intervention effects with HIV risk reduction. Dr. Holtgrave proposed that an alternative strategy should be pursued by focusing interventions on resilience and strengths that could also be used to improve outcomes by impacting multiple syndemics. For example, internalized homophobia is related to multiple negative psychosocial health conditions. In the MACS, men reported far higher levels of internalized homophobia when they were coming out than during the previous year. Men in the MACS who resolved internalized homophobia were less likely to be depressed, stressed, be sexually compulsive, or be impacted by multiple syndemics.

Dr. Holtgrave admonished the conferees to identify the syndemics that are operating in Washington. He charged the Breakout Groups to develop recommendations that would ensure that combination prevention programs are developed and tested to address multiple syndemics rather than matching one intervention to a single syndemic.

**The DC Experience: Scaling up HPTN 065 – Strategies and Lessons Learned**

**Tiffany West-Ojo, M.P.H., M.S.P.H.**
Bureau Chief, Strategic Information Bureau of HIV, AIDS
DC Department of Health

The role of the public health system is not only to monitor and evaluate the epidemiology in jurisdictions, but also to facilitate disease interruption, assist in a scale up of prevention care and treatment strategies, and assess the cost and cost effectiveness of interventions. Part of the responsibility of health departments is not only to monitor the epidemic, but also use data to assess and evaluate health outcomes.

In the District of Columbia, the health care system has reported to the Health Department that 14,000 people are living with AIDS. Over the last five years, over 5,200 new HIV cases were reported in the district which is a prevalence rate of approximately 2.7 percent. More than three-quarters of the cases of HIV are among African-Americans. If you stratify by race and gender, over six percent of black males and three percent of black women are living with HIV. When you examine new diagnoses of HIV cases between 2006 and 2010, it is clear that there are shifts in trends of mode of transmission. While MSM is still the leading mode of transmission in 2010 with approximately 40 percent of cases, heterosexual sex is the next most common mode of transmission with 34 percent of new HIV diagnoses in 2010 attributed to that mode of transmission. Despite the geographic distribution, there is an issue of health disparities among the infected populations. A geospatial analysis identified that seven of eight wards in the district have a prevalence rate of over one percent which is the definition from UNAIDS of a high prevalence, severe epidemic.
The DC bureau developed a continuum within surveillance unit which examined the cases from 2005 to 2009. Of the 4,800 cases that were diagnosed in HIV, 80 percent of those cases were linked to care within three months of diagnosis. However, this analysis also revealed that either continuous care defined by two lab reports within 12 weeks or sporadic care which is one lab report in that particular time frame, there is an issue of retention in care. Only 50-percent of the diagnoses in this timeframe had ever been suppressed over the last five years.

When assessing treatment outcomes, it is important to recognize the syndemics that impact HIV. The Bureau matched HER surveillance data with the HIV surveillance data base and other disease registries. Of the 845 people who were diagnosed in 2010, almost ten percent had a diagnosis of hepatitis C, and over five percent had an STD diagnosis.

In 2010, the Office of National AIDS Policy released a national HIV/AIDS strategy. In the district, the national HIV/AIDS strategy has been used to developed metrics that help assess progress toward reaching those goals. It is important to examine this information because all these data are publicly available for all health departments within our jurisdiction. Objectives one through three of what the national HIV/AIDS strategy include metrics for reducing new HIV infections. Objective two looks at increasing access and care and improving health outcomes for people living with HIV. The final goal looks at reducing health disparities.

Because about 3.2% of the District’s population is infected with HIV/AIDS, of which one-third to a half may be unaware of their HIV status. The TLC Plus (HPTN 065) is built on the test-and-treat approach to address this problem. The program has four pillars.

**Pillar 1: All community members get tested for HIV.** She indicated that they would like to shift the burden of HIV testing cost to the healthcare system. DC has been supporting three providers to recruit individual through social networks. The goals of this strategy are to test high-risk negatives, identify and link new positives into care, and re-engage previous positives into care.

**Pillar 2: All individuals who are HIV-positive are immediately linked to medical care.** TLC Plus provides financial incentives after completion of confirmatory HIV laboratory testing, and again upon completion of a care visit that includes interaction with a healthcare provider and discussion of HIV laboratory test results (e.g., CD4 cell count and viral load measurements). The program also defines and monitors active and passive linkages to care.

**Pillar 3: HIV-positive individuals begin appropriate medications (antiretroviral therapy) and consistently take these medications (adherence) to reduce the levels of virus in their system (suppression).** The program is focused on increased retention and decreased loss to follow-up, including establishment of HIV medical homes and changes to Health Information Systems infrastructure (e.g., real time use of data) are necessary. The program is designed to re-engage people living with HIV who are 'lost to care.' Providers
are sent a list of clients who have not been seen in their clinics for more than six months. HAHSTA “matched” these lists to e-HARS, labs surveillance, and ADAP databases. Providers are provided with a form on which they can easily indicate where these individuals were found and are in care in another location. Providers are requested to prioritize those whose last activity was more than six months of viral suppression. Twenty HIV care sites will be randomized to either the financial incentive intervention or the standard of care for the achievement and maintenance of viral suppression. Financial intervention will be provided to patients who demonstrate a suppressed viral load (as defined by <400 copies/mL) at quarterly care visits.

**Pillar 4: All individuals receive appropriate supports to optimize positive health outcomes by decreasing proportion of HIV-positive individuals not in care and by decreasing impact of co-occurring diseases (sexually transmitted diseases, hepatitis, tuberculosis) and conditions (mental health, substance abuse).** Data indicates that shows that HIV-positive individuals also have co-morbid conditions like syphilis and hepatitis, and are associated with high-risk behaviors. By providing targeted services and messaging, this population’s health outcomes can be optimized (e.g., engagement with providers who serve MSMs). Clients are encouraged to seek regular routine HIV and syphilis screening and service providers are encouraged to deliver messages developed to reduce stigma; increase HIV/STD partner services).

Participating sites are DC and Bronx (intervention cities), and Houston, Chicago, Philadelphia, and Miami (control cities), and the research participants account for about 20% of HIV-positive individuals in the US. TLC Plus focuses on measuring results and health outcomes (e.g., site of diagnosis for newly identified individuals and proportion of newly identified individuals with HIV concurrently diagnosed with AIDS).

Ms. West-Ojo indicated that while the DC epidemic is serious, there is a network of public health departments, universities, community-based organizations that are collaborating to address the HIV prevention and treatment issue. She indicated that the Health Department will be reviewing the recommendations for the ones that it can address.

**The Community Perspective**

**Christine Campbell, M.S.O.D.**
Housing Works

Ms. Campbell from the Housing Works talked about the importance of providing housing resources for the HIV-positive population to prevent HIV and negative consequences for HIV. She stated that access to housing is a basic human right and she stressed that providing stable housing is sound public policy and that it is a cost effective intervention for the community. She stated that housing status has a direct impact on HIV incidence and disease progression. She stressed that it was a stronger predictor of outcome compared to several other factors, including demography. In closing, she highlighted that the homeless
are 16 times more likely to be HIV positive and need to be included any research recommendations that are proposed.

Veronica Jenkins, M.D.
Family Medical and Counseling Service

Dr. Jenkins proposed comprehensive HIV testing for all, and not just so-called high-risk population. She also stated that access to testing facilities should become easier and be available in on-stigmatizing settings. She stressed that all health care providers should be trained to test for HIV. She also advocated that the treatment of HIV-positive populations should be based on their lifestyle, preferences, and need for adherence supports. In addition to treatment, she advocated community and policy leaders work to improve employment opportunities, survival skills, and access to mental health providers for all persons who are living with HIV.

Robert M. Kaplan, Ph.D.
Office of Behavioral and Social Science Research (OBSSR), NIH

Dr. Kaplan acknowledged that the health care system has not kept up with evolving social and behavioral research in the HIV therapy area. He also recognized that the public health care system is severely underfunded. He proposed that a two percent transaction fee on all health care spending that could generate funding for programs like HIV prevention and treatment. He highlighted that the average life expectancy in the US has decreased compared to several other developed countries. Policy makers will need to aggressively consider developing programs and policy to improve the health care system in the US and reverse this disturbing trend.

Catalina Sol, M.P.H.
Chief Programs Officer
La Clinica del Pueblo

Ms. Sol reported that immigration status is a critical social determinant of HIV transmission, but is often not considered as part of delivering HIV care and treatment. She asserted that Latinos were often late testers because they were often unaware of health care opportunities in D.C. and if they knew about them, they were fearful to seek services because of their immigration status. She also highlighted that D.C. was surrounded by states that have negative policies toward immigrants that compounds the problem for the provision of prevention and treatment services by DC. She stated that even though there are several health care programs available for HIV-positive subjects, implementation of programs among special populations like immigrants can be challenging.
Breakout Group Discussions

**Breakout Group I: Balancing Behavioral Prevention and Test-and-Treat Strategies to Prevent New HIV Infections**

**Facilitators:** Goulda A. Downer, Brian Watson, Cyndee Clay

**What are the syndemics in Metropolitan Washington impacting the issues to be discussed in this Breakout Group?**
Homelessness, child abuse, violence, food insecurity, and immigration status are some of the critical factors.

**What programs and research have been useful in addressing these issues for different populations?**
- DC requires that Primary Care Physicians (PCPs) take a course on HIV to obtain and maintain their medical license.

**What are key questions that need to be addressed in future research?**
- How can PCPs be encouraged to discuss HIV with their patients, and to offer HIV testing?
- How can PCPs be encouraged to work with the prevention community?
- How can CBOs who may be complacent about working with their own ‘stable’ HIV population be encouraged to develop programs and forums to get the nonclinical and clinical community together?
- What are the community, health, and behavioral care systems necessary for a successful test-and-treat strategy (e.g., REAIM [Reach Effectiveness Adoption Implementation Maintenance Model defines the institutional characteristics that are needed; FQHC partnerships])?
- Do collaborations among CBOs, universities, hospitals, health departments, etc. contribute to better health outcomes for HIV patients?
- What are the most effective settings in which to conduct HIV testing?
- Does a site that provides multiple services (e.g., one stop shopping) have better retention rates in care?
- How can HIV services best provided (e.g., physicians working with CBOs with expertise in this area, other models?)
- What methods can be used to engage individuals in research without offering incentives?

**Are there other methods that could be used or developed?**
- Prompts or triggers to remind patients about appointments, treatments, HIV education opportunities, etc. should be designed into electronic health record system.
- Programs should be developed that foster collaboration between CBOs, prevention clinics, and educational institutions to enhance engagement and retention in care;
• Ancillary services (e.g., housing office and testing providers) should be linked to ongoing HIV care so that there are one-stop services.
• A way to integrate new science and medical advanced into the existing treatment framework, and not result in a radical shift in strategy.
• The role of peer-to-peer youth messaging and counseling should be evaluated and integrated into care.
• The factors that lead to treatment retention (e.g., focusing on a bright and better future to keeps patients motivated; develop messages empowering patients) should be identified.

What other concerns need to be addressed?
• While testing is important, repeated testing alone is not prevention. Counselors/peer-educators could examine and enforce factors that might cause an individual to modify high-risk behavior. Most prevention programs rely on the test-and-treat strategy without attempting to educate or change behavior.
• A balance between biomedical and behavioral intervention strategies need to be identified and practiced.
• Behavior is an individual decision but individual counseling post-test and treatment is not always available. Counseling during treatment should be strongly supported and prevention and risk behavior should be discussed at the individual level.
• Treatment should not focus only on medical outcome (e.g., suppressed viral loads) but should also focus on quality and social care. It is important to identify and support all the steps that lead to a suppressed viral load. A successful outcome should be defined as an individual with a long, healthy life with a good lifestyle. Educating the individuals to focus on a better future leads to better outcomes.
• It is important to adhere to issue slogans – CTR (counseling, testing, and referral) has been replaced by test-and-treat; this has led to the loss of the behavioral component (counseling).
• Cultural patterns must be closely examined as part of evaluating the patient (e.g., among certain immigrants, the women are sent to be tested, although the men may be HIV positive).

Recommendations Reported to the Panel for Breakout I (Cyndee Clay)
• No single system has the ability to address all the diverse issues that could impede the success of test-and-treat – a holistic approach is needed (e.g., provide stable housing to HIV-negative, high-risk population);
• Approaches and strategies should target at the provider level, community level, and the individual level;
• Examine models that could result in sustainable collaborations between the community and the health care systems for successful test-and-treat implementation;
• Examine and utilize lessons learned from behavioral research to advance test, intervention, and treat paradigms.
Breakout Group II: Approaches to Identifying and Testing those who are at Highest Risk who are Unaware of Their Status

Facilitators: Z. Jennifer Huang, Rodney McCoy, Terrence Young

What are the syndemics in Metropolitan Washington impacting the issues to be discussed in this Breakout Group?
Trust issues and stigma; co-morbidities; enhanced contagiousness and virulence; physical and emotional alterations; genetic mutations of the HIV virus; treatment interactions; several levels of interactions – macro (e.g., job opportunities, poverty, housing), meso (e.g., community-related: mental health), and micro (individual-related: health literacy, psychosocial issues, structural factors including distance and time); education; disclosure of sexual preference; provider competence and education; risk perception; and lack of acceptance/denial.

What programs and research has been useful in addressing these issues for different populations?
- Department of Health funding clinics and emergency rooms to increase testing;
- CBOs built capacity to boost testing;
- Youth and school-based programs;
- Availability of local epidemiology data by NIH;
- High-impact intervention by CDC (with limited funding, performed targeted testing, and used social networks to facilitate testing).

What are key questions that need to be addressed in future research?
- Describe why high-risk groups are unaware of risk and what could be done to increase this awareness (increase adolescent/young adult education; community-based prevention programs could better conceptualize risk)?
- What are the gaps in prevention and treatment services?
- What are the demographics of sexual partners of seniors?
- How can church-based education programs contribute to prevention and treatment programs?
- How can prevention programs be tailored to address stigma in order to link clients to services (MSM, older women, and adolescents)?
- What are attributes of researchers that contribute to effective transfer of programs from research to service?
- What are effective approaches to initiating evaluations and discussions of sexuality?
- What are the optimal settings and approaches for sex education (e.g., schools, churches, clinics, home)?
What methods do service providers use to keep informed about the latest research findings?
CBOs leadership training; NIH webinars; local universities involved in HIV research; town hall meetings; medical journals; social networks; word of mouth; NIAID and SAMHSA initiatives; Twitter feeds/Facebook/Google.

Are there other methods that could be used or developed?
- Expand school-based programs to reach adolescents.
- Use of technology (all platforms) to disseminate research data presented in biomedical journals (journals have limited readership).
- Adapt and modify training programs with new (data-based) research.
- Identify psychosocial and structural barriers to different audiences having access to and using the latest HIV research findings?
- What kind of mental health services are needed in HIV prevention and treatment (youth, particularly LGBT)?
- Prioritize the development of programs to meet needs of African American heterosexual men.
- Develop program that emphasis ways to stay negative.
- Integrate programs and encourage cross collaborations (supportive of medical home concepts).
- Foster collaborations between health care providers and community organizations.
- Develop programs that address cross-jurisdictional issues in HIV prevention and treatment.

What other concerns need to be addressed?
- Who is doing the research?
- How do the researchers identify with this population?
- Research needed for seasoned adults;
- Need for research on provider attitudes;
- What do research findings lead to (what are the outcomes)?
- Need for research consortia;
- Lack of funding for research facilities.

Recommendations Reported to the Panel for Breakout II (Z. Jennifer Huang)
- The barriers to the program are denial, stigma, fear of being HIV positive, isolation, and perception of risk (individuals do not want to think that they are ‘high risk’);
- Programs that benefitted the community are rapid testing, funding CBOs to increase capacity for testing, school-based testing, and collection of epidemiological data;
- Challenge/concerns: Expand outreach to non-high-risk heterossexuals and seniors; increase access to research – need for user-friendly language and translation of research findings to practice; use social media; integrate health care/community care/family care systems; and examine cultural competencies and provider-patient fit.
Breakout Group III: Approaches to Getting People who Test Positive Linked to Care and Routinely Engaged in Care

Facilitators: Abby Charles, Sarah Henn, Ernest Walker

What are the syndemics in Metropolitan Washington impacting the issues to be discussed in this Breakout Group?

Stigma (especially in youth since DC is a small community: who will find out?); late testers; denial; socio-economic issues (homeless, jobless, lack of concern, substance use); cross-jurisdictional movement; gentrification unique to DC: ‘couch-jumping’; lack of pre-test counseling; low health literacy.

What programs and research have been useful in addressing these issues for different populations?

- Housing: SMI/MH/SA programs have been successful;
- Positive pathways: Peer and trained community health workers; mentorship program for treatment adherence;
- TLC Plus (use of incentives);
- ARTAS (antiretroviral treatment adherence and support) up to 5 sessions of intervention are administered; and
- CNMC addresses many care issues.

What methods do service providers use to keep informed about the latest research findings?

CNMC; HAHSTA; email blasts (Donald.Babb@DC.gov); DC D CFAR; Trial Networks advisory board; UMDPRC; IDEHA (Infectious Disease and Environmental Health Administration) ListServ; Maple Listserv.

Are there other methods that could be used or developed?

- Approaches to address the whole individual’s needs;
- Foster collaborations between stigma-reducing programs;
- Flexible business practices and mentoring/peer support to increase subject comfort and reduce stigma;
- Needs-based assessments;
- Regular contacts using novel approaches (other than face-to-face);
- Regular discussion among providers and researchers regarding state of care; share information consistently;
- Provide care into adulthood;
- Testing and care can be provided by different organizations; need to assess provider and patient fit;
- Design approaches that recognize the uniqueness of the individual; and
- Need for coordinator or facilitator of access/use of research and information.
- Develop services to address all the steps of the cascade (how to go from dependency to self-sufficiency);
• Howard University and GMU partner in a program that offers testing in prison and treatment afterwards. *Do integrated programs work better than individual programs?*

• Create jobs that focus on the treatment process; and

• Develop red carpet programs (start care when the individual is ready, and not when it is convenient for the program/organization).

**What other concerns need to be addressed?**

• Are there special populations that need to be targeted? (e.g., youth aged 24 or older cannot remain on parents’ insurance, and hence need free/subsidized care);

• Lack of communication between care providers (e.g., SMYAL did not inform Us Helping Us that youth transitioning to them did not like the change); need a forum or space to foster communication among providers;

• The unavailability and access to HIV services available in DC to youth living in Virginia and Maryland;

• Need to share the what has been learned and what works well;

• Foster large collaborations within the industry;

• Discuss client needs and form effective linkages to appropriate service providers;

• Evaluate the funding guidelines that are often barriers to collaboration; and

• More research (longitudinal studies) is needed on the process whereby subjects link to care, why they stay in care, and how quality of care impacts that process.

**Recommendations to the Panel for Breakout III (Melissa Turner)**

• Develop a true red carpet service: Provide high level of quality care, tailor care to individual needs, and develop mentorship/peer-messaging programs. Provide comprehensive services, not just medical services;

• Address barriers to retention: Implement research-based policies/programs that were proven to be effective;

• Currently, there is no information portal for available programs/research; develop a space for information sharing (‘1-stop shop’) – this could be facilitated by a neutral body or funding agencies.
Breakout Group IV: Approaches to Getting People who Test Positive to Consistently Adhere to Their Treatment Regimens over Time and to Retain Them in Regular Care over Time

Facilitators: Justin Goforth, Rayford Kytle, Ricardo LaGrange

Foster understanding of the clinical and public health significance of antiretroviral adherence and HIV primary care retention, and the significance of adherence and retention in the context of the NHAS.

1. Maximizing treatment adherence in HIV-positive individuals results in:
   - Optimal health outcomes for the individual;
   - Significantly reduces the chance of infecting intimate partners;
   - Public health benefit of reducing community viral load, and therefore slowing down, or theoretically stopping the epidemic; and
   - Significant healthcare cost containment related to HIV disease as morbidity and mortality are reduced.

2. Maximizing treatment adherence in HIV-negative individuals (pre-exposure prophylaxis, PrEP) results in:
   - Significant reduction in new HIV infections in high-risk populations (e.g., serodiscordant couples and MSM/transgenders).

Identify barriers and facilitators to antiretroviral adherence and retention in HIV primary care.

1. Barriers to optimal adherence
   - Stigma, mental health (especially depression), substance use/abuse, poverty, access to quality health care/medications, unstable housing or homelessness, irregular access to food, poor health literacy, side effects, pill burden, disclosure issues, lack of social support, and distrust in the health care system.

2. Facilitators, health-protective behaviors, and resiliency
   - Treatment on demand: antiretrovirals, mental health, substance abuse treatment, and primary medical care;
   - Peer support: mentor models and community health workers;
   - Support groups, including family/friends/caregivers;
   - Support for those living in poverty/unstable housing/unstable food source: Access to food banks/deliveries, drop-in access for Directly Observed Therapy (DOT) or Weekly Observed Therapy (WOT; better known as pill boxes), and transportation assistance;
   - Strengths-based/self-care models;
   - Treatment readiness assessments that include lifestyle details to choose the right regimen the first time; better antiretrovirals with fewer side effects and less pill burden; and
   - Community level interventions around stigma and health literacy.
Increase awareness of community- and faith-based resources and programs designed to support antiretroviral adherence and HIV primary care retention

1. Community level awareness campaigns
   - Public school curriculum;
   - Harm reduction programs (e.g., needle exchange); and
   - Condom distribution.

2. Health provider-based campaigns – prevention/early identification
   - PCPs: Routine testing and linkage to care initiatives (<48 hours after positive result);
   - Specialty care providers: Case management and care coordination; and
   - Emergency room testing.

3. Faith-based campaigns
   - Support from clergy members; and
   - Special initiatives: Call to action - share the message with a congregation.

4. School-based and afterschool programs
   - Parent-teachers associations; and
   - Boys and Girls Club.

5. Media campaigns
   - Local (social marketing: e.g., messages on public transportation vehicles and shelters; community mobilization);
   - National.

6. Policy level programs
   - Implementing health care reform measures: Increase access to comprehensive medical insurance coverage for individuals with HIV; and
   - Linkage and coordination of care initiatives.

Be able to identify research priorities regarding antiretroviral adherence and HIV primary care retention.

1. PrEP: Implementation challenges and questions
   - Who should we target? (guidance provided by CDC)
   - How do we reach target populations?
   - What level of adherence is needed?
   - How often does the drug need to be taken? Can it be episodic?
   - What are the real life implications for risk taking behaviors?
   - When would it be recommended to discontinue PrEP?
2. Antiretroviral Adherence
   - Provider level
     - Treatment Readiness Prediction Tool;
     - Self-reported adherence assessment tool;
     - DEBI’s for treatment adherence (almost all DEBI’s to-date are prevention related);
     - Tool for first regimen choice: provider belief is that the pill burden is the number one factor in adherence; research findings show that side effects, timing, and food restrictions play important roles in adherence.
   - Community and Individual level
     - Studies of sexual networks and how they communicate;
     - Using novel media to effectively reach individuals and disseminate information (mobile devices, i.e., smart phones, texting; social media, i.e., Facebook, Twitter; internet websites)
   - Evaluation and development of tools to assist adherence
     - Pill boxes, pharmacy delivery, and refill services;
     - New technology: SMS reminders (medication and appointment) or application-based (app) smart phone programs.

**Recommendations Reported to the Panel for Breakout IV (Ellen Stover)**
- How to move health care to the community/practice – form strategic partnerships for ubiquitous health care;
- Focus on adherence to healthy lifestyle;
- Promote prevention as treatment.
Breakout Group V: Approaches to Providing Prevention Counseling/Interventions for People who are Positive and Negative

Facilitators: Meredith Gallaspy-Banas, Manya Magnus, Tori Smith

What are the syndemics in Metropolitan Washington impacting the issues to be discussed in this Breakout Group?
Violence, gangs, homelessness, and isolation—all issues lead to coerced risk behavior.

What programs and research has been useful in addressing these issues for different populations?
HAHSTA linkages

Are there other methods that could be used or developed?
- Use social and sexual networks for peer messaging (“My Space”);
- Novel message delivery – messages could be disseminated using songs, stories, movies, etc.;
- Design individualized computer-based interventions and counseling programs based on subject profiles; and
- Harness the power of media to disseminate the prevention message.

What other concerns need to be addressed?
- Populations are segregated based on risk behaviors, and are treated and counseled accordingly. However, individuals often fall into more than one risk group, and therefore providers have to devise approaches to work together to deliver optimal care;
- Need more ways to approach the youth, and emphasize that they are not victims;
- Develop partnerships that are mutually sustaining, with respect to resources;
- Providers should develop universal approaches while maintaining unique characteristics;
- Even with programs in place to address youth issues, HIV prevalence is still high among youth. Need to target youth and young adolescents, especially HIV negative youth with more effective prevention counseling programs;
- Need to develop funding strategy to encourage organizations with similar goals to work together instead of competing for diminishing funding;
- Identify issues of personal responsibility in obtaining and remaining in HIV care (e.g., LGBT youth leave care and practice high-risk behavior);
- Evaluate ‘city-wide’ allocation of support and determine if this is matched to the number of citizens who require services;
- Train more educators about HIV issues of prevention and care so that they can integrate messages into their teaching;
- Prevention messages should not be too clinical or distal; instead they should be ‘human’ (talk about love) and address emotions like desire and fear (e.g., it can be uncomfortable to use condoms or be circumcised but there are major health benefits);
• Need for more sexual abuse- and trauma-related interventions; and
• Need for PrEP interventions and messages, especially for youth.

Recommendations Reported to the Panel for Breakout V (Kate Tsubata)
• Recognize importance of universal linkages/collaborations in development and implementation of services, while continuing to focus on unique population needs;
• Working to shift cultural norms (condom use, removal of stigma) through media, industry partnership, and social networks;
• Where is the conversation on post-exposure prophylaxis (nPEP; e.g., role of dialogue), not in PrEP?
Breakout Group VI: Approaches to Handling Cross-jurisdictional Prevention and Treatment Issues in Metropolitan Washington

Facilitators: Bradley Boekeloo, Elspeth Cameron Ritchie, Reverend Dana Mitchell Tolliver

What are the syndemics in Metropolitan Washington impacting the issues to be discussed in this Breakout Group?

- Unstable housing can lead to movement from one jurisdiction to another and care can be hit and miss;
- Gentrification of DC neighborhoods triggers migration to other jurisdictions where the required services may not be available or may be different;
- Persons who are returning from prison need to be re-integrating into community; 80% do not transition into care or access services in any jurisdiction;
- Correctional system crosses jurisdiction in Metropolitan Washington area and privatized prisons in other states;
- Systems distribute funds on basis of AIDS cases and this may underfund prevention and co-occurring health conditions;
- Stigma leading individuals to seek services in jurisdictions where they do not live and are not known and therefore it may not be as consistent;
- Services are provided from 9 am to 5 pm, but risky behavior often occurs after 5 PM; there is a need for round-the-clock outreach programs;
- Transient populations that are not integrated into the community (e.g., university students, embassy employees, political appointees, entertainers).

What are key questions that need to be addressed in future research?

- Conduct a rapid policy assessment to capture policies and linkages among substance abuse, housing, and mental health; each has its own case management system, and therefore, an individual may be “managed” by 3 or more systems;
- What services are individuals living with AIDS accessing and where are they obtaining these services?
- What is the experience of individuals living with AIDS in accessing services in different jurisdictions and what recommendations do they have to improve the system?

What methods do service providers use to keep informed about the latest research findings?

- Meetings, e-lists, and newsletters;
- Sexually Transmitted Infectious Community Coalition (STICC) which meets regularly;
- Point about EMA (Eligible Metropolitan Area) – addresses cross jurisdictional needs;
- Clinical del Pueblo; and
- Needs Assessment and Services.
What other concerns need to be addressed?

- Service fragmentation because of border and stigma
  - Some counties in the DC metropolitan area have less resources and low infrastructure (e.g., Prince George’s country) for HIV care, and therefore might impact services offered in DC;
  - Border is a political designation and is a potential barrier that creates fragmentation of services; jurisdictional issues impacts services that are restricted by border;
  - University of Maryland is trying to facilitate a coalition to foster coordination among the various jurisdictions.
  - Individuals must not be discouraged from seeking services from any of the jurisdictions; people may not want to receive services where they live because of stigma.

- Lack of cross-jurisdictional database
  - Ethnic issues and gentrification contribute to migration out of DC to border communities. There is no cross jurisdictional database to record and describe patterns so it is not clear which populations are leaving and what services are needed.
  - Several issues associated with testing and treatment would also benefit from a better database.

- Intervention is needed at a structural level
  - It takes too many resources at the lower levels to make any headway, and therefore changes at the structural level are needed.

- Providing services and collecting and sharing data
  - Need tracking system to track where patients are coming from and going to. What do cross-jurisdictional policies and statues look like? Can they work together and facilitate providing services and collecting data?
  - Work with Planning Council – plans and allocates Ryan Caucasian funds to 4 jurisdictions. Need systems that facilitate active exchange of information;
  - Collecting client level data that is submitted to the government (Who was treated during which year?) What kind of data is needed?
  - Artificial distinction between health and mental health that is arbitrary;
  - HIV surveillance – tracking of data mandated by law. Data is shared in Metropolitan DC (Who is in care and what is the viral load?); however, CD4 counts are not reported even though it is required as part of treatment;
  - What part of what data is shared? Are services being duplicated? This may be putting an undue burden on the system for service. Rooting out duplicated services may be a way of reducing some effort and re-allocating those funds where they are needed – excellent way to improve services and to be cost effective;
  - Understanding where services are and who is getting them would permit analyzing what is really needed and narrow the services;
Where one acquire services is important. Trying to develop a system that informs people what is offered where (e.g., do not understand about services in Prince George’s County);
People move because they do not have continuous housing (word is out that DC has most services).

- Distribution of funds
  - Which jurisdiction can claim an AIDS case if that individual receives services in different jurisdictions?
  - How will funds be allocated as health care providers shift to treating more chronic disease which requires different wrap around services;
  - Currently devising a health care system based on where people live; need to devise an integrated health care system so that individuals can get services anywhere they want; create new funding streams; be creative in developing a funding portfolio;
  - Needs new pool of funds that recognizes cross-directional services;
  - Examine core service agencies (CSA) to find out about treatment services (Pathway, Green Door).

- Communication and Sharing
  - STICC is important because it convenes representatives from each health department; as part of their job, they coordinate health effort, and examine health concerns by zip codes (e.g., low birth weight babies);
  - Hospitals need to be more involved in the jurisdictional discussions about providing prevention and treatment services.

**Recommendations Reported to the Panel for Breakout VI (Kelly O’Bryant)**
- Need cross-jurisdictional policy analysis;
- Need to identify and address treatment barriers due to jurisdictional issues (e.g., when individuals move across the border, they lose services),
- Need a formal body to establish service policy for cross-border initiatives because systems of care are fragmented due to multiple service providers and jurisdictional fracturing.
Panel Comment on Breakout Group Reports

Mohammad N. Akhter, M.D.
Director, DC Department of Health

Dr. Akhter applauded the efforts of the conference speakers and participants. He was impressed with the recommendations that had been developed in such a short period of time. He stated that every recommendation discussed during the meeting will be evaluated in accordance with the DC Department of Health priorities and, if resources are available, will be implemented. He admitted that HIV care is fragmented and all clinical and nonclinical providers need to coordinate and cooperate to deliver optimum care. To address this problem, the Department is initiating HIV-centered medical homes with mental health providers, substance abuse counselors, and community providers. He indicated that this meeting was another way to encourage this process because individuals from different health care sectors were working together on a report. In addition to fragmentation in DC, the problem is complicated by the cross jurisdictional issues because of the proximity to Maryland, Virginia, and West Virginia. Because patients travel across these borders seeking optimal care, health policy makers need to develop some policies that handle the complex reimbursement problems this creates.

For a program to be successful, four things are required. First, you need robust research that provides evidence-based answers, not only about which treatments are successful but which one are appropriate for an individual client. Dr. Akhter expressed appreciation for the participation of the National Institutes of Health and local universities in partnership with DC health care providers. Second, you need qualified staff to be on the front line and deliver the best programs. The District is fortunate to have excellent staff in the Department of Health and in AIDS-focused community-based organizations. While researchers examine issues through a microscope, community-based activists look at issues using a telescope. While both perspectives are important, activists frequently cannot wait for the researchers to develop ideal efficacy-based prevention programs before providing services to their clients. The third important component of developing an integrated HIV prevention and treatment program is political leadership that provides the resources and the cover under which health care providers can act. The District is fortunate to have Mayor Gray and prior mayors who provided support so that services could be delivered to persons at risk for or living with a stigmatized disease. After the research, service, and political leadership, the fourth component is the activists. Community activists in the community play a crucial role—not only do they agitate, they advocate. They are instrumental in procuring adequate resources for research and programmatic implementation.

Because all four of these components have been represented in this conference, we expect that these recommendations will contribute to development of an optimal program in the District.
**Stephen T. Baron**  
Director, DC Department of Mental Health

Mr. Baron applauded the work of the conferees and was pleased to see that mental health issues were integrated into the recommendations. He agreed that cross-jurisdictional issues pose many challenges to keeping HIV-positive subjects in treatment, especially with respect to their mental health care and long-term adherence to treatment. He advocated greater use of technology to create and maintain uniform records of care across state lines as one way to facilitate cooperation among providers to provide better care. He advocated that policy and community leaders in the region convene regular dialogues on health care to seek solutions for cross-jurisdictional prevention and treatment issues so that the needs of all populations are being met.

**Alan E. Greenberg, M.D., M.P.H.**  
George Washington University

Dr. Greenberg expressed his pleasure at being at the conference with such a diverse group of participants. He said that the DC D-CFAR (District of Columbia Developmental Center for AIDS Research) is part of a network of 21 C-FARs in the US that address the NIH C-FAR mission of supporting a multidisciplinary environment that promotes basic clinical epidemiologic behavioral and translational research in the prevention, detection, and treatment of HIV infection and AIDS. Most C-FARs are based at major US universities and the District is unique because the C-FAR represents the whole city. The DC D-CFAR is inclusive of all community groups, care providers, and academic institutions. There are six institutions: George Washington, Georgetown, Howard, and American universities as well as Children’s National Medical Center and the Veteran Affairs Medical Center. The overarching goal is to reduce HIV transmission and disease in Washington, DC. He stated that research is being conducted on all aspects of HIV, from prevention to treatment resulting in reduced viral load (‘cascade research’). The Center is focused on moving research from academia to practice (‘bench to bedside').

Dr. Greenberg indicated that he serves as the director along with Dr. Gary Simon, who is the head of infectious diseases at GW. The Center has established four working groups consisting of researchers and clinical and community care providers to define and collaborate on future research areas: (1) HIV malignancies, (2) mental health, (3) criminal justice-affected communities, and (4) men who have sex with men.

The Center has been active for two out of five years for which we have received funding of about $3.7 million. There are 154 investigators who have received 16 new NIH awards. DC D-CFAR has awarded 15 pilot research awards totaling $580,000 to investigators within the Centers and investigators have been fortunate to compete successfully for administrative supplements that have brought in an additional $2.5 million in research funding. These are important community-based studies that have laid the foundation for understanding the epidemic in DC. Prior to 2006, there was little community-based prevention HIV research. Without understanding a community, it is difficult to develop
effective strategies to address the epidemic. Important data can be derived from non-clinical settings, specifically with regard to behavior and seroprevalence information about people who are not served by clinics. The community focus which is represented in this Conference is critical in fostering community engagement rather than designing a prevention program from an ivory tower.

Closing Remarks

Anthony K. Wutoh, Ph.D.

Dr. Wutoh concluded the meeting discussions by thanking the participants for their attendance and contributions of ideas. He indicated the DC D-CFAR, the DC Department of Health and NIH, have collaboratively contributed to the development of excellent data on the epidemic in the District. Now they are working on rapid dissemination of that information and translating the findings into important research studies to test combination prevention and treatment programs.

He ended by sharing a quotation that one of the community members had shared with him during the meeting of the HIV Prevention Trials Network study 061. He had a Maya Angelou quote which said "Do the best you can until you know better. Then when you know better, do better." I think that aptly expresses what the public health community in the District is doing in collaboration with CBOs, the DC Department of Health, universities, and NIH.
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