PUBLIC HEALTH CHALLENGES IN THE NATION'S CAPITAL

UNITED STATES SENATE

COMMITTEE ON HOMELAND SECURITY AND GOVERNMENTAL AFFAIRS

SUBCOMMITTEE ON OVERSIGHT OF GOVERNMENT MANAGEMENT, THE FEDERAL WORKFORCE AND THE DISTRICT OF COLUMBIA

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Chairman Akaka, Ranking Member Voinovich and members of the Subcommittee, I am Shannon Hader, senior deputy director of the HIV/AIDS Administration in the District of Columbia Department of Health. I appreciate the opportunity to present testimony for your hearing -- "Public Health Challenges in the Nation's Capital" -- on the HIV/AIDS epidemic in the District of Columbia. My testimony will cover the highlights of our new statistics on HIV/AIDS; our current strategies and initiatives to prevent HIV transmission, make HIV testing routine and provide care and treatment for persons living with the disease; our partnerships with the community, including faith-based organizations; cooperation among government agencies; and the challenges and next steps to achieve our goal of reducing the burden of HIV and other sexually transmitted infections among District residents.

On March 15, 2009, the nation read the banner headline in *The Washington Post*: "HIV/AIDS Rate in D.C. Hits 3%; Considered a 'Severe' Epidemic, Every Mode of Transmission Is Increasing, City Study Finds." This was startling news to the public and truly a wake up call—information that empowers us to build and raise the District's response to match the scale and complexity of our "modern" HIV epidemic.

The *District of Columbia HIV/AIDS Epidemiology Update 2008* provides the most current statistics on the District's modern HIV/AIDS epidemic. Overall, 3 percent of all District residents are currently known to be living with HIV/AIDS. To put that in context, the U.S. Centers for Disease Control and Prevention (CDC) and the World Health Organization (WHO) have historically defined an HIV epidemic as generalized

and severe when the overall percentage of disease among a population exceeds 1 percent. The numbers, however, reflect only the persons diagnosed with HIV/AIDS in the District. Other targeted studies show between one-third and one-half of residents who are already HIV-infected may be unaware of their infection. The true number of residents currently infected and living with HIV is certainly higher. In the District, nearly every population group, age and ward is experiencing a substantial epidemic.

Some populations are particularly impacted. Over 7% of persons between 40 and 49 years old are living with HIV/AIDS. Nearly 7% of African-American men have HIV. Every ward but one has HIV exceeding 1% of that ward's population. African-Americans are disproportionately affected, comprising 55% of our District's population but 78% of all HIV/AIDS cases. Though men still represent the larger proportion of cases at 70%, the number of women infected is increasing. In some wards of the city, the proportion is nearly half and half. Contrary to common misperception, HIV is not strictly a young person's disease. Over 70% of living HIV/AIDS cases are currently 40 or older. This number represents the combination of both people who are aging with HIV as well as those who are newly infected at older ages. In fact, we see nearly as many new diagnoses among persons who are 50 years old and older as among those who are under 30 years old.

The District also has one of the most complex epidemics in the world. Where most of the world may see one or two principal modes of transmission of HIV, in DC, all three major modes of transmission are at high levels. Among new cases, heterosexual contact is the

highest at nearly 40%, followed by sex between men who have sex with men at 25% and injection drug use at 15%.

The report not only presents the new findings on the impact of HIV/AIDS on District residents, it also highlighted the promising results of the District's efforts to reduce disease. The District's HIV testing programs have greatly increased early diagnosis among residents and reduced the number of babies born with HIV. In 2005, 10 babies were born with HIV. By 2007 only one baby was born with the infection. The report also confirms that the District has seen a 70-percent increase in the number of people tested with publicly supported testing from 40,000 in 2007 to over 70,000 in 2008. In fact, the District was just recognized by the CDC as one of the top three jurisdictions in the country in expanding HIV testing. DC nearly equaled New York City and the entire state of Florida in absolute numbers of persons tested and new HIV cases identified.

These achievements are not random; they are the mark of true committed leadership to reverse the epidemic in our city and it is truly a 'new day' in the District. Our Mayor Adrian Fenty released those new HIV/AIDS statistics as one demonstration of his leadership. No other mayor announces HIV/AIDS statistics. Mayor Fenty's leadership is not only shown in public events, such as holding the first ever Mayoral Summit on HIV/AIDS, but especially behind the scenes, in supporting new initiatives and directing interagency cooperation to achieve results. After 25 years of the epidemic, our Mayor is leading a new day with new opportunities.

In addition to new leadership, we have real data to drive our response to the epidemic. The 2007 Epidemiology Report and its 2008 Update boasted the most comprehensive and highest quality data ever collected and compiled on HIV/AIDS in our city. This data is already in practice in retooling our prevention strategies, routinizing HIV testing as part of a standard of health care and accelerating people entering care and treatment. The data has also galvanized our community, expanding traditional and non-traditional partnerships. The Effi Slaughter Barry Program, named in honor of our late First Lady, has provided technical assistance and start-up funding to more than 50 small community-based organizations to build their capacity to reduce HIV/AIDS in their neighborhoods.

We have described the complexity and breadth of the District's HIV/AIDS burden as a modern epidemic. Our modern epidemic requires a modern response. I can summarize this in Mayor Fenty's directives to me since I started in this position: go fast, go far and don't go it alone.

Go fast. The Mayor has repeatedly emphasized a clear urgency for our response. This urgent response must be marked by actions that are not just a flash in the pan, but are focused for a sustained and impactful response. For example, the District started an HIV testing campaign in 2006 to raise more awareness of HIV as well as new technology with a rapid oral test. The rapid test was easy to administer and gave a preliminary result in 20 minutes. This initiative has transitioned into a true, city-wide policy of routine HIV testing in our medical and community settings. Ultimately, we aim to make HIV as regular a test as blood pressure, blood sugar, cholesterol and other vital signs. One of our

major clinical partners, Unity Health Care, calls HIV the fifth vital sign. In our city where HIV is a common disease, the test must be a standard vital sign for every residents' health. And one test is not enough. We promote an annual HIV test.

Go far. The Mayor has directed us to bring the District's response to scale and impact. We are building on a strong foundation of sustainable systems that address HIV regularly and repeatedly as a major overriding health issue for the District. We are also putting the tools in place to monitor and evaluate that system to track our achievements over time. We are accountable for impact and effect.

Examples of core programs and results include the expanded testing achievements I mentioned earlier – making the District one of nation's leaders in HIV testing. We are also ramping up enrollment in our care and treatment programs. Through marketing and outreach, we increased enrollment in our AIDS Drug Assistance Program by 50% over an 18 month period to the highest level ever. Recently, through support of the Minority AIDS Initiative, our partners implemented a re-enrollment campaign to return people into primary medical care, medical case management, substance abuse services and mental health services. One provider was able, in a 4-month period, to re-enroll nearly 70% of clients who had been lost to follow-up over the previous 5 years.

We have substantially enhanced our youth services through our Youth and HIV Prevention Initiative. This year, we have increased four-fold the number of prevention programs funded focusing on young people.

We are reaching more residents with the tools to prevent transmission. The District is one of only two cities with a large public sector free condom distribution program. We have distributed over 1 million condoms in the past 6 months with a goal to reach 3 million free condoms each year. In addition, following the end of the Congressional ban on the use of our own local dollars to support needle exchange, we have implemented comprehensive harm reduction programs. The Mayor has committed nearly $700,000 to support community programs that in the first 6 months already enrolled 900 people into services, linked nearly 40% of them to detox and treatment services, and removed 130,000 needles from the street.

The District is breaking new ground in the country with innovative new programs. We funded the first couples testing initiative. For years, people who want to get tested with their spouse or partner have been told no. Now, in DC, we are planning to expand couples testing throughout the city as one strategy to promote further dialogue on relationships. Further, Parents Matter, an evidence-based intervention that trains parents to communicate with their pre-sexual initiation children, has been successful overseas but sadly un-utilized domestically. We are supporting Parents Matter among our foster parents and are training more community partners to expand the effective program. We have modeled these particular efforts on lessons learned from the PEPFAR program.

Don't go it alone. One of the cornerstones of our Mayor's directive is to build strong partnerships. Partnerships by definition recognize that an effective response to the HIV

epidemic requires mobilization of all community members. In terms of community partnerships and outreach, we have—as mentioned earlier—engaged more than 50 small organizations, many of which do not have HIV as their primary mission, to mainstream HIV/AIDS activities in their daily programming. We are expanding our faith-based partnerships through a Places of Worship Advisory Board, by recruiting more faith communities to include HIV in their day to day faith activities and by providing technical assistance and capacity building support, and have funded an umbrella organization to work with faith leadership of multiple denominations to take on the mantle of HIV. We are doing similar 'mainstreaming' of HIV knowledge and skills with non-health related youth serving organizations by providing capacity building and skills training assistance.

In terms of partnerships within government, our interagency collaborations have been expanded and formalized, and range among population and service need. With the DC Public Schools, we are partnering to develop new curriculum on sexual health and by training school nurses to counsel students. Though the number of young people with HIV/AIDS has doubled from 2001 to 2007, the prevalence rate is still lower compared to older populations. However, STD rates – namely chlamydia and gonorrhea – are very high. The District is one of only three cities to roll-out a voluntary school-based STD screening and treatment program designed to reach students who may not know they have an infection and to interrupt transmission. We offer sexual health information and urine-based testing for chlamydia and gonorrhea to high school students. To date, we report infection rates between 8% and 20%. The screening program is working. We went back to a few public charter schools in 2009 that we tested in 2008 and found a 34%

drop in infections. We have also collaborated with the Department of Employment Services to be the first city to offer free information and STD/HIV screening and treatment to young people in the Summer Youth Employment Program. Last year, we tested nearly 1,500 young people. This summer, we aim to expand that number to 5,000. One of the keys to this success has been partnerships among District Government agencies, including screening at Recreation Centers and with other agency sites. We are also working with the DC Department of Mental Health and the Addiction Prevention and Recovery Administration to address the critical co-morbidities of mental health and substance abuse services.

Our partnerships extend to innovations at the federal, academic and private levels. We are partnering with the National Institutes of Health, to increase local HIV prevention trials, build HIV sub-specialty capacity and services, and to better understand the successes and complications of persons in care and treatment in the District. We have also formed academic partnerships between our epidemiology bureau and The George Washington University, as well as the University and the Veteran's Administration with our TB Control Program. We also have formed new public-private partnerships with the Washington AIDS Partnership to develop an AIDS drug safety net, with the Gilead Foundation on school health curriculum development, the MAC AIDS Fund on female condom use and couples testing, and with the Global Business Coalition to make Washington, DC a model corporate partnership city.

This hearing also gives us the opportunity to engage your subcommittee on ways to improve the coordination between the federal government and the District to enhance impact on this epidemic. One extremely helpful action would be the coordination of federal supports for the local HIV response. Currently, in a given year, we receive between 10-14 core non-competitive public health grants for our HIV/AIDS, STD, TB and Hepatitis programs that span 5 to 7 different fiscal years. Each funding stream has a different application cycle, reporting cycle, reporting indicators, and none takes into account the overall impact and portfolio of activities in the District. The result of this fragmented system of federal management is an inordinate amount of time and duplicative paperwork to implement a non-fragmented response, and prevents our federal partners from seeing what it takes to achieve overall community-level impact. PEPFAR presents a model of federal coordination for impact and efficiency that preserves specific agency competencies and funding streams while ensuring that, taken as a whole, the overall funded portfolio makes sense.

Another opportunity to improve our coordination would be in sharing vital information. For example, the federal prison system does not convey health information on offenders returning to the District. In our correctional system, we have coordinated discharge planning among the DC Jail and our jail and community based health care provider. This coordination ensures continuity of care for persons living with HIV as well as appropriate prevention interventions for both returning individuals who are HIV positive and HIV negative. We lack this coordination with the federal system and are missing an opportunity to address important health needs of our returning residents.

We are not making this a platform for new federal funding for the District. However, there are clearly some opportunities through new investments to not just accelerate scale-up of our programs, but to 'catch up' and make up for lost time that brought us to the epidemic we have now. We have made specific supplemental requests to federal agencies that include the following:

- **Expanded HIV testing**. As mentioned earlier, the District was a high performer with expanded HIV testing, which was supported with CDC funding. The District has pending a request for a one-time investment of $4 million that would allow us to double the amount of testing in an 18 month period and maintain that performance afterwards.

- **Extended partner services**. The District was one jurisdiction that received funding from CDC that we used to begin to expand partner services for persons recently diagnosed with HIV and STDs. The District has been informed that we are ineligible for renewed funding of $825,000, as new restrictions have been applied to limit eligibility for the support to one year only.

- **Special Project**. The District currently has a pending request for a $500,000 Special Project of National Significance with HHS targeted to increasing care and treatment outcomes among HIV-infected women of color. These are available dollars and the District hopes that it can be one of the recipients.

- **1115 Medicaid Waiver**. The District has an 1115 Medicaid waiver that enables us to extend medical care and treatment to persons living with HIV/AIDS with matching local dollars. There are hundreds of persons eligible for coverage yet denied because the District has not to date received approval to raise the cap.

- **Needle Exchange**. The District does not seek additional funding from the federal government for needle exchange and harm reduction services, but lifting the federal ban would go far to allow community programs to eliminate the current burdensome administrative firewalls between federal and local funding sources that prevents relatively small investments of local funds build on current infrastructural investments from federal funds.

- **HOPWA formula**. The funding for the Housing Opportunities for People with AIDS (HOPWA) program is based on an outdated formula. HOPWA provides short-term and long-term rental assistance and housing supports. The formula is based on the total number of persons ever diagnosed with AIDS, including those who are no longer living. This approach disadvantages jurisdictions, such as DC, with larger numbers of living persons than deceased ones resulting in currently over 300 people on a waiting list for housing assistance. Formula reform would be very helpful in moving people from insecure to stable housing, which is crucial for maintaining their health.

The District may have the most complex epidemic in the country, but the current state of our epidemic is now emerging in other urban areas across the country. The increase in heterosexual contact is now surfacing in cities like Atlanta and Miami. Even within cities, there are communities where the epidemic is diversifying. Many urban areas have 'hot spots' within them that reflect similar patterns and challenges to what is seen city-wide in DC. So, turning the tide in the District is important as a model for other hot spots within urban areas.

In conclusion, we have reached that proverbial fork in the road. For years, the United States has been a leader overseas in reversing the course of the HIV/AIDS epidemic, while lacking in leadership for the domestic response. We can take the inspiration from international successes and model strategic plans designed to reach scale and impact in our cities, states, and rural areas. And we hope that the federal government will start in its backyard, here in our nation's capital. The District of Columbia assures you that its leadership, innovation and capacity are present to return the federal investment in our city and turn the corner for District residents on the HIV/AIDS epidemic.