

HIV/AIDS IN THE NATION'S CAPITAL

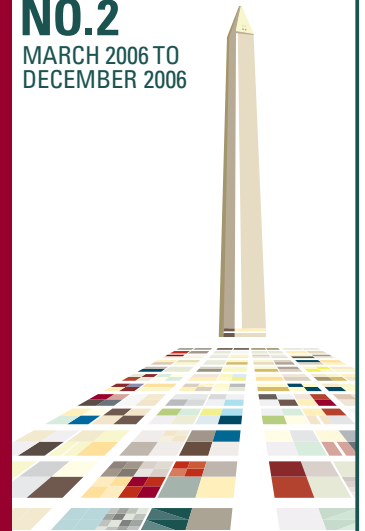
In the 16 months since DC Appleaseed released its August 2005 report—*HIV/AIDS in the Nation's Capital: Improving the District of Columbia's Response to a Public Health Crisis*—progress has been made in implementing numerous of the report's recommendations. As a result, DC Appleaseed has significant hopes about the future of the District's response to HIV/AIDS—but also has significant concerns.

This is DC Appleaseed's *Second Report Card* monitoring the District's progress in its response to HIV/AIDS. The grades, and a description of the areas graded, appear below. An Executive Summary and detailed explanations for each grade are attached.

REPORT CARD

NO.2

MARCH 2006 TO
DECEMBER 2006



GRADES (A-F)

LEADERSHIP

MAKE **HIV/AIDS** A TOP PUBLIC HEALTH PRIORITY IN THE DISTRICT.

B-

INTERAGENCY COORDINATION

IMPROVE COMMUNICATION AND COLLABORATION ON **HIV/AIDS** ISSUES BETWEEN KEY DISTRICT AGENCIES, INCLUDING DOH, DMH, DOC, AND DCPS.

C-

HIV SURVEILLANCE

FULLY AND APPROPRIATELY STAFF THE OFFICE RESPONSIBLE FOR TRACKING THE SPREAD OF **HIV AND AIDS**. PUBLICLY REPORT DATA ON **HIV** INFECTIONS IN THE DISTRICT.

B

GRANT MONITORING

IMPLEMENT COMPREHENSIVE MONITORING SYSTEM TO ENSURE THAT GRANT FUNDS ARE BEING USED APPROPRIATELY.

B-

QUALITY ASSURANCE

IMPLEMENT COMPREHENSIVE SYSTEM OF PROGRAM OUTCOME MONITORING AND QUALITY ASSURANCE STANDARDS, UTILIZING DATA TO ASSESS THE EFFECTIVENESS OF GRANT-FUNDED **HIV/AIDS** PREVENTION AND CARE PROGRAMS.

B-

HIV TESTING

DEVELOP CITYWIDE STRATEGY FOR ROUTINE **HIV** TESTING IN ALL MEDICAL SETTINGS. OFFER RAPID **HIV** TESTING AT DISTRICT-RUN FACILITIES (INCLUDING STD CLINIC, D.C. JAIL, TB CLINIC, AND SUBSTANCE ABUSE TREATMENT FACILITIES).

B

CONDOM DISTRIBUTION

SIGNIFICANTLY EXPAND CONDOM DISTRIBUTION IN THE DISTRICT.

D+

D.C. PUBLIC SCHOOLS

ADOPT SYSTEM-WIDE HEALTH EDUCATION STANDARDS, INCLUDING **HIV/AIDS** PREVENTION. ESTABLISH SYSTEM FOR MONITORING IMPLEMENTATION OF STANDARDS. DEVELOP AND IMPLEMENT A PLAN FOR ENHANCING **HIV/AIDS** POLICY FOR DCPS.

C-

SYRINGE EXCHANGE SERVICES

FUND COMPLEMENTARY SERVICES (E.G., **HIV** TESTING & COUNSELING AND DRUG TREATMENT REFERRALS) PROVIDED BY THE PRIVATELY-FUNDED SYRINGE EXCHANGE PROGRAM.

B-

SUBSTANCE ABUSE TREATMENT

INCREASE THE AVAILABILITY OF SUBSTANCE ABUSE TREATMENT PROGRAMS IN THE DISTRICT.

D+

HIV/AIDS AMONG THE INCARCERATED

IMPLEMENT ROUTINE **HIV** TESTING. IMPROVE COLLECTION OF **HIV AND AIDS** DATA IN D.C. DETENTION FACILITIES. IMPROVE DISCHARGE PLANNING SERVICES AT D.C. DETENTION FACILITIES.

B+

EXECUTIVE SUMMARY

In the 16 months since DC Appleseed released its August 2005 report, *HIV/AIDS in the Nation's Capital: Improving the District of Columbia's Response to a Public Health Crisis*, progress has been made in implementing numerous of the report's recommendations. The District has begun to improve its response to HIV/AIDS, and the disease has received far more public attention in the District than in prior years. Yet, in this time of transition in the District, as the city prepares for the inauguration of a new Mayor, DC Appleseed has both significant hopes about the future of the District's response to HIV/AIDS—and significant concerns.

This is DC Appleseed's *Second Report Card* monitoring the District's progress in its response to HIV/AIDS. The *First Report Card*, released in March 2006, noted a "surge of constructive energy in the District—within and outside the government—devoted to addressing the HIV/AIDS epidemic." The grades in the *First Report Card* showed varying degrees of progress, ranging from B+ to D. On balance, the *First Report Card* was positive.

Below is a chart showing the grades from both the *First Report Card* and this *Second Report Card*.¹ The areas graded in this *Second Report Card* differ slightly from the areas graded in the *First Report Card*.

GRADES FROM THE <i>FIRST REPORT CARD</i> (March 2006)		GRADES FROM THE <i>SECOND REPORT CARD</i> (December 2006)	
LEADERSHIP	B-	LEADERSHIP	B-
HIV DATA	INCOMPLETE	INTERAGENCY COORDINATION	C-
SURVEILLANCE STAFFING	INCOMPLETE	HIV SURVEILLANCE	B
GRANTS MANAGEMENT	B	GRANT MONITORING	B-
RAPID TESTING	B	QUALITY ASSURANCE	B-
ROUTINE HIV TESTING	C	HIV TESTING	B
CONDOM DISTRIBUTION	D	CONDOM DISTRIBUTION	D+
D.C. PUBLIC SCHOOLS	B-	D.C. PUBLIC SCHOOLS	C-
SYRINGE EXCHANGE SERVICES	B-	SYRINGE EXCHANGE SERVICES	B-
SUBSTANCE ABUSE TREATMENT	D+	SUBSTANCE ABUSE TREATMENT	D+
HIV/AIDS AMONG THE INCARCERATED	C+	HIV/AIDS AMONG THE INCARCERATED	B+
WEBSITE	B+		

In this *Second Report Card*, DC Appleseed again is pleased to report that progress is being made to address HIV/AIDS in the District. But the “surge” experienced in the months following the release of DC Appleseed’s August 2005 report has waned. The Mayor, City Administrator, and Deputy Mayor have not remained engaged leaders on this issue. And while Department of Health (“DOH”) Director Dr. Gregg Pane has made clear that HIV/AIDS is one of DOH’s top priorities, understandably he has delegated most responsibility for addressing HIV/AIDS to the Administrator of the Administration for HIV/AIDS Policy and Programs (“AHPP”), Dr. Marsha Martin. Dr. Martin has made great strides as Administrator of AHPP, but she cannot manage the District’s full response to HIV/AIDS alone. And, as described below, some of AHPP’s programs have made significant progress, but others are falling far short.

In our Report Cards, we attempt to grade what would be reasonable to expect the District to have accomplished in a given time period—as measured qualitatively and, where possible, quantitatively, and in all cases after receiving information from representatives of the District government and representatives from the community. In most cases, as more time passes, more progress is expected. We give some areas in the *Second Report Card* lower grades than the areas received in the *First Report Card*—e.g., the D.C. Public Schools (“DCPS”) went from a B- to a C- —because positive progress shown in the *First Report Card* was not sustained.

As noted, progress is being made. For example, this *Second Report Card* explains that one of the most alarming aspects of the District’s past response to HIV/AIDS—its historic failure to track new HIV infections and utilize data to plan effective prevention interventions—is now being addressed (Surveillance now receives a B grade). The District receives a B+ grade (compared to C+ in the *First Report Card*) for its efforts to test inmates routinely at the D.C. Jail—an area where the District has previously fallen short. And the District’s *Come Together D.C., Get Screened for HIV* campaign both brought significant local and national attention to the HIV/AIDS epidemic facing the District and has launched a citywide discussion about the need for routine HIV testing in all medical settings (HIV Testing receives a B grade).

1. The *First Report Card*, released in March 2006, may be viewed in full at www.dcappleseed.org.

However, as described in this *Second Report Card*, there are several areas with far too little progress. The District should be much further along in its efforts to distribute condoms in the city. In a recent *Washington Post* article about the District's condom distribution, Dr. Martin said, "We're failing on this one" (we give the District a D+). We also give the District a D+ for lack of access to substance abuse treatment. Because HIV is often spread through injection drug use and sexual behavior under the influence of drugs and alcohol, substance abuse treatment is a proven HIV prevention intervention. But insufficient measures are being taken by top District leaders to address the substance abuse problem. Further, the District receives a C- for DCPS's insufficient progress in implementing curriculum standards for HIV prevention education for the city's youth.

In this time of transition, DC Appleseed wishes to highlight two other areas graded in this *Second Report Card*: Leadership (B-) and Interagency Coordination (C-). These areas are related and should be reviewed with a fresh, keen eye by the new Administration.

Strong leadership from the Mayor and other top District officials is an essential element of the District's response to HIV/AIDS. However, leadership on HIV/AIDS in the District has been neither strong enough nor as sustained as it should be to make significant progress addressing HIV/AIDS. Almost all responsibility for the District's response to HIV/AIDS has been delegated to Dr. Martin. But we do not believe the District should rely on anyone who must manage a complicated government agency to also orchestrate the needed response from all the District agencies that must be involved in addressing this epidemic.

HIV/AIDS involves many issues and agencies, and therefore requires a comprehensive, coordinated response. For the District to improve its response to the epidemic significantly, all agencies—including DCPS, the Department of Mental Health ("DMH"), DOH, and the Department of Corrections ("DOC")—must collaborate toward the common goal of stopping the spread of HIV and caring for people living with HIV/AIDS. There are many different ways this coordination could be achieved—and sustained—but, if it is to be achieved, it must be orchestrated "from the top."

In the end, while progress is being made, much work remains to be done before we can stop quoting the statistics that we now all know too well: that the Nation's Capital has the highest rate of new AIDS cases of any major U.S. city; that one in 50 District residents is living with AIDS; and—most importantly—that as many as one in 20 District residents is infected with HIV.

REPORT CARD

DECEMBER 2006

LEADERSHIP: B-

Make HIV/AIDS a top public health priority in the District.

Although DC Appleseed's August 2005 report makes roughly 75 findings and recommendations, two sentences were arguably the most important in the report. The sentences read: "On numerous occasions, the authors of this report have asked key stakeholders in the District's system of HIV/AIDS care and prevention how the HIV/AIDS epidemic has reached such massive proportions in the nation's capital. The answer to this question was often the same: lack of effective, consistent leadership."

Following the release of the August 2005 report, leadership began to improve. As stated on our *First Report Card*: Mayor Williams pledged his personal involvement in making needed improvements to the District's response to HIV/AIDS; Dr. Pane replaced the former head of AHPP with Dr. Martin; the D.C. Board of Education directed the Superintendent to issue a plan for enhancing HIV/AIDS policy for DCPS; and the Mayor established an HIV/AIDS Task Force to advise him on needed reforms.

The *First Report Card* noted that there had been "a surge of constructive energy in the District—within and outside the government—devoted to addressing the HIV/AIDS epidemic." We noted that AHPP's leadership was taking innovative approaches to long-standing problems, and "new and meaningful discussions and collaborations within District agencies, among the community and providers, and with federal partners are taking place." We also noted that the D.C. Council Committee on Health and the Committee's Chair, Councilmember David Catania, played a large and important role in improving the District's response to

HIV/AIDS. For these and other developments, DC Appleseed gave the District a grade of B- for leadership.

In this *Second Report Card*, DC Appleseed has decided neither to raise nor lower this grade. Although the D.C. Council has continued to provide strong oversight of and assistance to AHPP (in particular, we note Councilmember's Catania's attention to health care at the D.C. Jail and the District's HIV surveillance program), and Congresswoman Norton has been the District's advocate for HIV/AIDS issues on Capitol Hill, the Mayor, City Administrator, and Deputy Mayor have not remained engaged leaders on this issue. And while Dr. Pane has made clear that HIV/AIDS is one of DOH's top priorities, understandably he has delegated most responsibility for addressing HIV/AIDS to Dr. Martin. Dr. Martin has made great strides as Administrator of AHPP (including the citywide testing campaign and the contract with George Washington University to overhaul the Epidemiology and Surveillance Division, which are both described in this *Second Report Card*), but she cannot respond to the District's HIV/AIDS crisis alone. The Fenty Administration's Pre-Transition team issued an HIV/AIDS Policy Paper that shows great promise, and we understand the Transition Team is focusing on this issue. However, unless the new administration gives HIV/AIDS the required attention at the highest levels, improvement will be difficult.

As noted elsewhere in this *Second Report Card*, a full response involves many issues (including mental health, access to health care, substance abuse, corrections, poverty, and education) and many District agencies other than AHPP. Continued improvements to AHPP alone will not suffice. Consistent, sustained focus on a coordinated response to HIV/AIDS is needed from the Executive Office of the Mayor—and the District currently does not have that focus.

Leadership "from the top" is needed to execute a citywide response. This leadership cannot be symbolic only (although symbolism plays an important role in alerting the public to the importance of the issue); it must actually manage and coordinate a

comprehensive response involving multiple agencies and issues.

INTERAGENCY COORDINATION: C-

Improve communication and collaboration on HIV/AIDS issues among key District agencies, including DOH, DMH, DOC, and DCPS.

Many of the biggest issues facing the District—including addiction, mental health problems, limited access to health care and support services, and poverty—complicate the HIV/AIDS epidemic facing the city and the District’s response to it. For this reason, one of the major recommendations in DC Appleseed’s August 2005 report was that the District’s response to HIV/AIDS requires significant improvement in the area of “coordination”—*i.e.*, improvement will require a coordinated, citywide, interagency response rather than the AHPP working alone to address HIV/AIDS.

AHPP is a central component of the District’s response to HIV/AIDS, which includes managing the grant dollars linked specifically to HIV/AIDS and being responsible for making sub-grants to organizations that provide an array of HIV/AIDS services for people in the District. But, here again, AHPP cannot bear sole responsibility for the HIV/AIDS epidemic in the District. AHPP is one of many agencies in DOH with responsibility for the delivery of services related to HIV/AIDS, including the Medical Assistance Administration (“MAA”), the Addiction Prevention and Recovery Administration (“APRA”), the Tuberculosis (“TB”) Clinic, the STD Clinic, and Maternal and Family Health Administration (“MHFA”). Further, several District departments are involved in the system of care and prevention for HIV/AIDS, including DOC, DMH, and DCPS. And, although the delivery of HIV/AIDS services is obviously a priority of AHPP, it is a lower priority for other agencies and departments.

In the wake of our August 2005 report, DC Appleseed recommended that Mayor Williams formally convene and lead an executive-level task force to provide leadership and improve coordination of the District’s management of HIV/AIDS policies and interagency and intergovernmental activities. Our recommended goal for the task force was to facilitate coordination among and make HIV/AIDS services a higher priority of all agencies responsible for delivering services to individuals living with HIV/AIDS or at risk for HIV infection—and consolidate in the Mayor’s office responsibility for the execution of a comprehensive response to HIV/AIDS.

On December 16, 2005, Mayor Williams signed an order establishing a Mayor’s Task Force on HIV and AIDS to advise the Mayor, the DOH Director, and the Administrator of AHPP on the District’s response to and coordination of programs and services related to HIV and AIDS.² Although the directors of other District departments are ex-officio members of the task force, interagency coordination has not been a focus of the Task Force. We think this has been a missed opportunity to improve interagency coordination in a forum convened and overseen by the Mayor.

Citywide coordination of HIV/AIDS services continues to be insufficient, although coordination between AHPP and some departments has improved. For example, AHPP has worked with DOC on its HIV testing program with great success. AHPP has collaborated with DCPS on its program that engages parents to assist teachers in addressing HIV prevention. And AHPP, through coordination with other agencies within DOH, has instituted routine HIV testing at APRA’s detoxification center, and the TB and STD clinics.

Meanwhile, however, DMH offers almost no HIV/AIDS prevention services, even though nationally it is estimated that 50 percent of those in care for HIV/AIDS have some form of mental illness. And, as described in this *Second Report Card*, the District fails to provide the necessary substance abuse treat-

2. DC Appleseed’s Executive Director, Walter Smith, is a member of the Task Force.

ment. Further, access to healthcare remains a large problem in the District. These are only a few examples of issues that are crucial to the District's response to HIV/AIDS—but these issues are clearly outside the purview of AHPP. For these reasons, responsibility for the District's comprehensive response to HIV/AIDS must be carried out with greatly increased coordination and collaboration across all agencies and issues.

HIV SURVEILLANCE: B

Fully and appropriately staff the office responsible for tracking the spread of HIV and AIDS. Publicly report data on HIV infections in the District.

DC Appleseed's 2005 report noted AHPP's Surveillance Bureau's lack of permanent leadership, staff vacancy rate of greater than 50 percent, and failure to collect or report data related to HIV infections. In the *First Report Card*, the District received an "Incomplete" in the areas related to data and surveillance. At that time, the District was in the process of creating a partnership with George Washington University's School of Public Health and Health Services ("GW") to address the data and surveillance issues. This partnership began in April 2006. Currently, AHPP leadership and GW staff are completing an extensive evaluation of the Surveillance Division and a review of "best practices" in the country, with the goal of implementing comprehensive organizational changes.

To date, AHPP has increased its staff by 50 percent, including hiring a new Bureau Chief for Surveillance, a MD/MPH Chief Epidemiologist and an Epidemiological Coordinator trained at the federal Centers for Disease Control and Prevention ("CDC"). DC Appleseed commends AHPP for the successful recruitment of highly qualified and dedicated professionals to the Surveillance Bureau.

AHPP reports that, although the reorganization and strategic planning process are underway, there are still significant deficiencies in HIV surveillance capacity that will take 18–36 months to address adequately. This

delay is attributed to the significant amount of required reorganization, the conversion from a unique identifier system to a name-based system and the need to assure that data released are complete and accurate. In order to gain the capacity to provide accurate and reliable data, AHPP is doing the following:

- The Surveillance Bureau is implementing GW staff's recommendations to enhance field investigation, data entry, data evaluation and quality assurance standards.
- The Surveillance Bureau is working with the CDC to ensure a smooth transition to confidential name-based reporting and is conducting extensive outreach to laboratories, hospitals, clinics, providers and other stakeholders to ensure timely and quality data.
- With the assistance of GW, the Surveillance Bureau will implement: core surveillance (the primary source of population-based data on persons living with HIV/AIDS); incidence surveillance (estimating the number of newly-acquired infections); and behavioral surveillance (examining behaviors that put people at risk for HIV infection).

We commend AHPP for the successful collaboration with GW and the scope and depth of the reengineering of the Surveillance Bureau. We urge AHPP to continue to pursue aggressively its data and evaluation efforts so that the District's community and policy makers will have the benefit of accurate and reliable HIV infection data at the earliest possible date. We also urge AHPP, at the appropriate time, to provide a public update on the results of GW's evaluation of the Surveillance Division so that the community is apprised of progress being made in this area.

Although the District has received a relatively high grade in this area due to the level of effort devoted to remedying this significant deficiency, it is imperative that continued efforts be pursued aggressively until AHPP has a Surveillance Bureau that can publicly report accurate and complete data on an ongoing basis.

GRANT MONITORING: B-

Implement comprehensive monitoring system to ensure that grant funds are being used appropriately

As noted in DC Appleseed's 2005 report, it is essential to the District's HIV/AIDS response that jurisdictions receiving federal funds monitor the compliance of its federal grant subgrantees with program and fiscal requirements. Monitoring mechanisms include progress reports, site visits, financial reports and audits. In the *First Report Card*, DC Appleseed gave a grade of B to the District for "Grant Management." However, the *First Report Card* dealt primarily with the payment of community-based organizations in a timely fashion. In preparing this *Second Report Card*, DC Appleseed specifically looked at the grant monitoring process of grant management.

In September 2005, the D.C. Office of the Inspector General ("OIG") conducted an audit of AHPP's grant monitoring process, finding significant deficiencies relating to the grant management process, including the failure to perform required subgrantee site visits, inadequately maintained subgrantee files, the failure to ensure that subgrantees were performing agreed-upon services, and inadequate supervision of grant monitors.

On October 20, 2006, the OIG issued a follow-up report to the August 2005 audit. The OIG audited seven of the 16 previously agreed-upon recommendations related to grant monitoring. The OIG report concluded that, although there is evidence of organizational improvements made by AHPP management, AHPP failed to implement five of the seven recommendations. Specifically, the OIG found that AHPP's grant management specialists failed to perform the required number of site visits, failed to document site visits in a uniform manner and failed to maintain complete and updated files of grant recipients adequately. Furthermore, AHPP management failed to ensure that monitors performed their duties and failed to provide appropriate training to grant monitor specialists.

The OIG's recent re-audit of 15 subgrantees during FYs 2004, 2005 and 2006 to determine if site visits were performed properly revealed that only one of 15 subgrantees received the required number of site visits. In fact, in each of the three fiscal years, the OIG found instances when a subgrantee had not received any site visits by AHPP staff, even though the OIG determined that there was more than sufficient time for the grant specialists to perform the required site visits. Additionally, there was no indication that supervisors regularly reviewed site visit reports, and the OIG found serious deficiencies in the content and completeness of the grant management specialists' files. Furthermore, the OIG visited one subgrantee on two occasions and questioned the validity of the services provided. The OIG's re-audit of the grant award process also revealed deficiencies in the management controls to ensure that grants were awarded to qualified subgrantees. Grants were awarded to subgrantees that did not have appropriate or valid licenses, and AHPP did not always identify subgrantees that were eligible for Medicaid certification. The OIG concluded that the District lost \$455,835 by not using available Medicaid funding.

In response to the OIG's report, on November 30, 2006, DOH provided a comprehensive plan to address the deficiencies in the OIG's October 2006 report. The plan notes, among other things, that: a protocol and schedule have been developed to assure the required four site visits to each subgrantee; a uniform form to document site visits has been created; training sessions for grant monitor specialists have occurred; new monitoring protocols have been developed; and, all subgrantee licensing and certification requirements have been confirmed and internal protocols have been developed to assure proper licensing and certification. In addition, on December 13, 2006, AHPP provided to the D.C. Council Committee on Health an update on efforts to address the 16 deficiencies identified in the August 2005 OIG report.

AHPP has recently hired an experienced manager of the Grants Management Division, and Supervisory staff has established bi-weekly supervision sessions with each

grant management specialist. DC Appleseed is hopeful that the comprehensive plan, new staff, and new protocols and procedures will improve the operation of the Grants Management Division.

QUALITY ASSURANCE: B-

Implement comprehensive system of program outcome monitoring and quality assurance standards, utilizing data to assess the effectiveness of grant-funded HIV/AIDS prevention and care programs.

Quality assurance was not an area graded on DC Appleseed's *First Report Card*. However, in our August 2005 report, we noted that AHPP had not established and implemented comprehensive program outcome monitoring requirements to evaluate whether funded prevention programs are effectively meeting the needs of District residents. Further, with regard to care services, we noted that AHPP had begun the process of developing more outcome measures and standardization across its service areas due to a mandate by HRSA to implement a "Quality Management Plan." We also noted, however, that as outcome measures were still being developed, AHPP had not begun the process of implementing a quality assurance program.

What is sometimes described as "quality assurance" actually involves three issues that often overlap substantially: program management, outcome monitoring, and quality assurance. AHPP distinguishes these three issues in this way: program management addresses primarily the processes of providing the services supported by a grant or other service agreement; outcome monitoring attempts to describe the overall health benefit from the provision of a particular service; and quality assurance assesses the extent to which the service is provided in ways consistent with established standards.

As of this writing, AHPP is making steady progress in implementing quality assurance programs for both prevention and care services. At the same time, AHPP acknowledges that these programs have a long way to go. On this basis, we have decided to assign a

B- grade. We hope that this grade is not interpreted to suggest that AHPP's quality assurance efforts are, at this moment, either a failure or a success. Rather, we want the grade to reflect AHPP's work in this area and its stated desire to push for further improvement. Its work covers both care and treatment as well as prevention.

HIV/AIDS Care and Treatment. AHPP has made substantial progress towards clarifying expectations of providers funded to provide HIV care and treatment programs. The bulk of its funds—an expected \$14 million in Ryan White CARE Act Title I ("CARE Act") funds—is currently undergoing a re-solicitation. The Request for Application requests very specific information for each service area on the number of clients proposed and the number and range of service components. If successfully implemented in grant agreements and monitored closely, this approach should provide valuable information into the actual delivery of HIV care and treatment services.

AHPP has an established quality management program responsible for the oversight and management of quality assurance activities through the D.C. Eligible Metropolitan Area ("EMA"), which works in collaboration with the Quality Management Improvement Committee ("QMI Committee") of the CARE Act Planning Council ("Planning Council"). The purpose of the program is to ensure that all CARE Act clients are provided a consistently high standard of medical and related health care services. The CARE Act envisions quality management programs as a partnership among the grantee, the administrative agents, providers and the Planning Council (in this case, its QMI Committee), but has not always offered clear guidance as to the various roles and responsibilities, resulting in some tension among the partners. AHPP and the QMI Committee have agreed to develop a memorandum of understanding that both groups believe will facilitate a more effective working relationship.

Quality assurance programs began in primary medical programs, and are increasingly emphasized by the federal Health Resources and Services Administration ("HRSA") for CARE Act grantees and administrative agents. Substantial work has been done to

develop standards of care for services supported by CARE Act funds, and we recommend that AHPP review those standards thoroughly for applicability to services provided in the District.

Implementation of the quality assurance program in the District has been plagued, however, by problems related to the collection, quality, availability and reliability of data. Data are routinely collected through the Cross Program Research and Evaluation System (“XPRES”), a system with significant and persistent challenges that threaten the reliability of, and undermine confidence in, the data it collects. We are pleased to learn that AHPP is aware of the many difficulties associated with XPRES and is assessing alternative systems for feasibility. We look forward to a speedy resolution of this assessment.

The annual Quality Assurance Comprehensive Site Visits are a second source of data. These site visits are conducted by outside contractors to maximize objectivity, but the contractors are not always familiar with the variable procedures and processes of service providers. Therefore, AHPP has found that the data they collect are not consistently as useful as they should be.

HIV Prevention. It is important to note that quality assurance standards for HIV prevention services are relatively new concepts for health departments nationwide. Although the concept remains in formative stages, AHPP has now developed program management indicators to guide the delivery of HIV prevention services by AHPP subgrantees that can be reviewed by AHPP staff. These program management indicators measure, for example, whether AHPP-funded providers are achieving their service targets according to their approved work plans, and whether AHPP-funded providers require increased resources.

AHPP has reported difficulty integrating use of the indicators into its staff’s routine program monitoring. We believe this difficulty is to be expected as AHPP works to implement this important program. Although AHPP program officers have integrated some quality assurance activities into routine site visits (e.g., chart reviews and activity observations), AHPP expects its quality assurance

program for HIV prevention services to continue to be refined and improved.

AHPP should consider modeling its quality management program for prevention on its quality management program for care services. Although the service activities are inherently different, and the quality management indicators would differ dramatically, we believe that the approach used for HIV care services offers some valuable guidance for HIV prevention. Included in this approach should be the creation of a committee of the Community Planning Group (“CPG”) that could parallel the QMI Committee of the Planning Council. As the CPG prioritizes populations and interventions, this committee could assist in the development of quality management indicators for each intervention and population. AHPP should consider the implementation of a site visit specifically to assess the quality of funded HIV prevention services.

HIV TESTING: B

Develop citywide strategy for routine HIV testing in all medical settings. Offer rapid HIV testing at District-run facilities (including STD clinic, D.C. Jail, TB clinic, and substance abuse treatment facilities).

HIV testing presents the opportunity to educate individuals about HIV prevention practices and, if necessary, to refer HIV-positive individuals to care services. Individuals who know their HIV status are more likely to modify their behavior to reduce the risk of transmitting the infection. The District received a C grade for routine testing on our *First Report Card* because, although the AHPP staff was making a concerted effort to develop a citywide strategy for routine testing, the strategy had neither been unveiled nor implemented.

DC Appleseed can say without hesitation that the District has made significant progress in the area of routine HIV testing. However, for reasons described below, more progress is needed.

In June 2006, AHPP announced an HIV testing campaign—*Come Together D.C., Get Screened for HIV*. The campaign has two

laudable goals: to urge District residents between the ages of 14 and 84 years old to know their HIV status, and to make HIV testing a routine part of all medical care. AHPP's primary means to meet these goals was raising public awareness through an education campaign and engaging the medical community to routinize HIV testing. AHPP allocated approximately \$1.3 million for the campaign during fiscal year 2006—\$500,000 for a publicity contract and \$800,000 for 80,000 rapid HIV test kits. The campaign was announced several months before the CDC declared its own new nationwide recommendation to routinize HIV testing in all medical settings.

The District launched the testing campaign on June 27, 2006—National HIV Testing Day—at an event on Freedom Plaza, attended by Mayor Williams, federal and city elected officials, and business and community leaders. The campaign launch received significant positive local and national media attention. In the weeks following, AHPP maintained a visible presence by offering HIV testing in mobile van units once per week at Freedom Plaza. To inform the public about the campaign and testing sites, AHPP distributed palm cards at 20 Metro stations in the District. The testing campaign's visibility was successful in raising public awareness of the need to know one's HIV status.

In addition to the events and publicity, AHPP has worked to engage the medical community regarding implementation of routine HIV testing in doctors' offices, emergency rooms, university student health services, and in other hospital settings. AHPP staff has met with six local hospital emergency room administrators in order to discuss the feasibility of testing and to provide support in developing an effective protocol. To date, George Washington University Hospital has launched a rapid testing program in its emergency room and Howard University Hospital has initiated free routine rapid testing to all patients in every clinical area—the first hospital in the nation to implement such a program. These hospital programs are exciting developments, but they should be reviewed regularly to ensure they are being implemented appropriately.

AHPP also has worked with other departments in DOH to facilitate routine rapid testing by providing rapid HIV test kits, programmatic guidance and technical training. DOH staff is performing rapid HIV testing at several health programs in the District: the STD Clinic, the APRA's detoxification center, and the TB Clinic. In addition, as discussed below, "automatic" rapid testing is conducted at the D.C. Jail. However, routine testing at the STD clinic, APRA's detoxification center and the TB Clinic is not performed on a full-time basis. Since these clinics primarily serve individuals who are at high risk for HIV infection, DC Appleseed encourages DOH to provide full-time routine HIV testing.

The results from the HIV testing campaign reported through September are as follows: from June through September 2006, 16,707 HIV tests were conducted in the publicly funded testing sites, including the community-based organizations, DOH facilities and the D.C. Jail. Of the 16,707 individuals tested, 580 or 3.4 percent of the preliminary test results were positive. Since this rate is much higher than the national average, the need for the testing campaign in the District in order to raise public awareness is evident. DC Appleseed commends AHPP for its bold testing campaign, including its excellent messaging and the positive attention it has received in the media; however, the execution of the campaign has had some problems.

Significant public funds were utilized to purchase 80,000 rapid HIV test kits (with expiration dates) before the District's health community had been engaged fully in discussions concerning either the testing campaign or a plan for distribution of the purchased test kits. Many of those test kits have been used for their intended purpose—*i.e.*, they have been used to administer HIV tests. However, it has been reported that some test kits have not been distributed yet; some test kits expired prior to their use; and, some were given to the Maryland health department because the kits were about to expire and could not be used in the District. In light of the fact that all tests kits could not be used prior to their expiration dates, DC Appleseed believes that AHPP should produce a plan designed to ensure that future test kits purchased are used efficiently.

DC Appleseed is encouraged by AHPP's expanded community based HIV testing locations (from 15 to 42) and its recent partnership with Unity Health Care, the District's primary care medical system, to institute routine HIV screening in all of their clinical settings. However, in order to maximize the number of residents tested, it is essential that AHPP creates a "blueprint" for implementation, especially with regard to the expedited testing of populations that are known to be at risk. While reports suggest that more HIV testing is occurring this year than in past years, DC Appleseed is not sure that the most at-risk groups are being prioritized. For example, testing at several public clinics that serve high-risk populations (TB, STD, and detoxification) is not being conducted on a full-time basis. Further, testing of the most marginalized injection drug users ("IDUs") in the city (believed to be contributing significantly to the District's HIV/AIDS epidemic) was conducted for a brief period in Ward 7, but it has not continued.

DC Appleseed has very high hopes for the future of routine HIV testing in the District, and this year's HIV testing campaign has been a spectacular start. But it is only a start. In order to bring measurable success in testing a significant percentage of the population, DC Appleseed hopes AHPP, in concert with other relevant District agencies and officials, will produce a detailed plan for sustained routine testing in the District—including strategies both for reaching the most high risk populations and areas on an urgent basis, and for ensuring that individuals who test positive for HIV receive appropriate counseling and are connected to care.

CONDOM DISTRIBUTION: D+

Significantly expand condom distribution in the District.

Widespread, regular condom distribution is a proven, cost-effective HIV prevention intervention. DC Appleseed's 2005 report noted that the District's condom purchasing and distribution efforts were inadequate and required expansion and improvement. When DC Appleseed issued its *First Report Card*, AHPP had

not taken any specific action toward increasing condom distribution in the District. In fact, community organizations had reported that requests for their condoms from AHPP had been ignored or they were told that condoms were not available. The District received a grade of "D" for condom distribution.

Even though AHPP has had condoms available to distribute, reportedly only 115,000 condoms have been distributed to date during 2006. And, since the DOH has distributed so few condoms, a coalition of providers organized to distribute 30,000 condoms in laundromats and 24-hour food establishments in the District's Wards 7 and 8. Dr. Martin has acknowledged recently that the District is "failing" in the need to provide condoms throughout the city.

Still, it should be noted that AHPP has initiated some measures to improve condom distribution in the District. An individual at AHPP has been designated to receive and process all requests for condoms from District agencies and community providers, and a condom request form has been posted on AHPP's website. Organizations can request condoms through this on-line process, which will allow AHPP to better track the areas and populations to which condoms are being distributed. This on-line process has been used on a number of occasions, and it appears to be working successfully. A purchase order to buy one million condoms has been approved, and the delivery of the first shipment of 250,000 condoms is expected on January 16, 2007. The proposed schedule is that an additional 250,000 condoms will be delivered each quarter. In light of the progress in purchasing and tracking distribution, we have given a D+ grade to the District in this area.

AHPP staff has initiated preliminary meetings with members of the provider and business communities and other District agency staff to plan a strategy for the distribution of condoms in the District. It is essential that a carefully designed strategy be in place so that condom distribution is widespread among all populations. DC Appleseed strongly encourages collaboration between AHPP and DMH so that condoms can be available to mental health providers for their clients.

The District has had an innovative condom distribution program at the D.C. Jail since the early 1990s. Currently, there are plans to increase condom distribution at the D.C. Jail. Previously, condoms were available to inmates only upon request to health care staff. The DOC Director recently testified before the D.C. Council Committee on Health that DOC's condom distribution policy is being expanded. In addition to condoms being available at the medical unit, upon request to health care staff, and at intake when HIV testing occurs, condoms will be issued to every inmate in their hygiene kit at intake and also will be provided at discharge. DC Appleseed commends the DOC for this progressive HIV prevention measure at the D.C. Jail.

DC Appleseed recommends that the District take prompt measures to remedy this continuing problem of insufficient condom distribution, which has been recognized universally as one of the most basic prevention interventions to reduce the transmission of HIV. Such measures should include the development of a distribution plan that prioritizes distribution to high-risk populations.

D.C. PUBLIC SCHOOLS: C-

Adopt system-wide health education standards, including HIV/AIDS prevention. Establish system for monitoring implementation of standards. Develop and implement a plan for enhancing HIV/AIDS policy for DCPS.

Developing curriculum standards is an important first step in ensuring that DCPS students have access to comprehensive, evidence-based health education that includes needed HIV prevention tools. Once standards are developed, educational programming must meet those standards, ensuring that both teachers and community-based organizations operating in schools provide effective evidence-based education.

In the wake of DC Appleseed's Report in August 2005, on September 21, 2005, the D.C. Board of Education passed a resolution to enhance HIV/AIDS policy for DCPS. That

resolution stated that "every student should receive age appropriate, medically accurate health education using scientifically proven methodologies which includes training on HIV/AIDS." It also stated that "the Superintendent is committed to addressing this important issue." And "in light of the urgency" of the issue, it directed the Superintendent within 90 days to develop an "implementation plan" ensuring that the needed student training would be implemented. In January 2006, at a hearing before the D.C. Council, Superintendent Clifford Janey testified that, "a full HIV/AIDS curriculum, including standards and lesson plans will be available for students by next fall."

In the *First Report Card*, in March 2006, we reported that although the full health education standards were not expected to be finalized until the 2007/2008 school year, DCPS planned to develop interim HIV curriculum standards for the 2006/2007 school year. Based on our understanding that HIV/AIDS curriculum standards were in the process of being developed, and relying on the Superintendent's January 2006 testimony, we gave DCPS a B- grade for its progress.

In April 2006, after considering a March 2006 written response from the Superintendent, the Board of Education adopted another resolution reconfirming its commitment to implementation of new curriculum standards. As Board President Peggy Cooper Cafritz stated in a press release announcing the Board's April 2006 action, their recommendations on the issue were "way overdue especially with the District having what is believed to be the highest rate of new AIDS cases of any major U.S. city." As she further stated, "A targeted and comprehensive HIV prevention program is imperative to provide our young people in D.C. schools with the skills and information to protect themselves."

Notwithstanding the Board of Education's September 2005 resolution, the Superintendent's January 2006 testimony, and the Board's April 2006 actions, system-wide HIV/AIDS curriculum standards were not ready to be adopted by the Board before the 2006 school year began. Instead, although DCPS officials and community groups held discussions concerning the HIV/AIDS curricu-

lum standards before the 2006 school year began, it now appears HIV/AIDS system-wide curriculum standards will be in place no earlier than fall 2007—a full two years after the school board expressly called for their development and implementation. In lieu of the adoption of system-wide standards, during the 2006/2007 school year, DCPS is using a CDC-approved HIV education curriculum that should ensure that many students receive HIV prevention education until the program mandated by the Board is in place.

In light of the District's HIV/AIDS epidemic and CDC's estimation that half of new HIV infections in the United States occur in youth under the age of 25, DCPS's delayed progress in developing and implementing the new standards should be considered unacceptable. This is so even though we understand and commend the fact that DCPS is now working to ensure that the new curriculum standards will be implemented by fall of 2007. We hope the newly constituted school board and the Superintendent will set prompt deadlines for completing and implementing the curriculum standards and address HIV/AIDS education as a priority of "life or death" importance.

SYRINGE EXCHANGE SERVICES: B-

Fund complementary services (e.g., HIV testing and counseling and drug treatment referrals) provided by the privately-funded syringe exchange program.

Syringe exchange programs ("SEPs") can play a critical role in an effective HIV/AIDS prevention and treatment program because they can engage injection drug users ("IDUs") at high risk for HIV infection. SEPs vary in their operation, but in addition to exchanging syringes, effective SEPs can provide a variety of other services, including referrals to addiction treatment programs; HIV testing and counseling; referrals to other medical and social services; condom distribution and HIV prevention counseling; and nursing services.

Although Congress has prohibited the District from using public funds to support the distribution of sterile syringes, the con-

gressional prohibition does not preclude using federal or local public funds to support complementary services provided by a SEP—a practice common in many other jurisdictions. Because of the District's large population of IDUs, and in light of the congressional funding prohibition, DC Appleseed supports the District's funding of complementary services to the District's large population of IDUs to the maximum feasible extent.

When DC Appleseed issued its *First Report Card*, the District was in discussions with the District's only SEP, PreventionWorks, about providing public funds for testing and counseling for IDUs. For that reason, we gave the District a B- in the *First Report Card*. In fact, following the issuance of the *First Report Card*, PreventionWorks received public funds for a demonstration project to provide HIV rapid testing to drug users in Ward 7. During a three-week testing period, over 9 percent of the individuals tested by PreventionWorks had preliminary positive results for HIV—a very high rate compared to the District's testing averages.

Following its work in Ward 7, which confirmed a high positive rate among IDUs, PreventionWorks submitted a proposal to AHPP for funding to provide HIV testing and counseling to IDUs citywide. That proposal was not funded. Although DC Appleseed does not question the decision not to fund that particular proposal, notwithstanding the clear need to provide HIV testing and counseling to the District's large high-risk population of IDUs, no organizations are funded specifically to provide this service.

Syringe exchange is a vital component of the District's HIV prevention strategy. While the District may not use public dollars to support the distribution of syringes, it can and should support complementary services provided to IDUs to the maximum feasible extent. The high positive rate of the recent HIV tests conducted with IDUs in Ward 7 suggests that HIV testing among IDUs citywide is essential.

We have neither raised nor lowered the District's grade in this area because, although progress has been made, the need for services among the District's IDUs suggests

much more attention is needed. DC Appleseed believes the status quo—the District both being prohibited from using public funds to support the distribution of sterile syringes and not funding complementary services for the District’s SEP—is unacceptable. AHPP and the community should think creatively about how to best serve the District’s population of IDUs.

SUBSTANCE ABUSE TREATMENT: D+

Increase the availability of substance abuse treatment programs in the District.

Substance abuse treatment is a proven HIV prevention mechanism for substance users who engage in high-risk behavior such as unsafe injection practices and/or unprotected sex. It is estimated that almost one-third of new AIDS cases in the District can be directly traced to a shared needle, and far more cases can be attributed indirectly to drug use through unprotected sex. Research has shown that the most effective approach for preventing the spread of HIV among drug users is a comprehensive strategy that includes community-based outreach, drug abuse treatment and syringe exchange services.

In the *First Report Card*, DC Appleseed gave a grade of D+ to the District for increasing substance abuse treatment services. This was due primarily to the lack of resources and attention that the District focuses on this serious problem. Although APRA has attempted to increase the attention to this issue through a Substance Abuse Town Hall Meeting, a Drug Summit meeting and a meeting of the Mayor’s Interagency Task Force on Substance Abuse, the District has received the same grade due to the continued insufficient funding.

The latest Household Substance Abuse Survey conducted in the District in 2000 estimated that 60,000—one in ten—District residents are addicted to alcohol or other drugs. This is 40 percent higher than the national average. This survey has not been updated due to a lack of allocated funds. Current and accurate data regarding substance users in

the District are vital. Reportedly, money is budgeted for a survey to be completed in 2007, and the contracting process is underway.

The funding for substance use treatment in the District is insufficient. Despite a January 2005 recommendation by the Mayor’s Interagency Task Force on Substance Abuse that a \$12 million increase to the FY 2006 budget for substance abuse treatment was needed for the District to begin addressing its substance abuse problem effectively, the increase has not occurred. Recently, Mayor Williams announced a plan to use \$245 million dollars of the District’s share of the 1998 national tobacco settlement to fund a number of health initiatives. Unfortunately, no funds were allocated initially for substance use issues. When future allocations of the tobacco settlement funds are expended, DC Appleseed hopes funding for substance abuse treatment receives appropriate consideration.

The substance abuse problem is particularly acute among the District’s inmate population, and the District continues to have insufficient substance abuse treatment at the D.C. Jail. Nearly 20,000, or about 94 percent of all individuals committed to DOC during the period October 1, 2004, through September 30, 2006, reported a history of alcohol and/or substance abuse to medical staff during their initial health screening as documented on the medical intake exam notes. Thus, the need to provide treatment to inmates while they are incarcerated is apparent. In the District’s two detention facilities, which house more than 3,000 inmates, there are only 20 beds for substance abuse treatment. The *First Report Card* noted that there were plans to establish a 290-bed treatment program at the District detention facilities. This has not occurred, and although DOC officials are engaged currently in discussions with community-based organizations to provide increased substance use treatment at the D.C. Jail, it is imperative that this be accomplished promptly.

Despite all the shortcomings, the District should be commended for a new outreach program, “Treatment without Walls,” initiated in August 2006 with funds from the

Enhanced Crime Prevention and Abatement Emergency Act of 2006. APRA coordinated the creation of outreach centers staffed by a community-based provider in three neighborhood collaboratives. The centers are designed to provide outreach services to the community in order to reduce barriers and increase access to drug treatment services. During a 30-day period, the outreach centers had contact with 1,300 residents and 50 entered some form of treatment. APRA has received a commitment for an additional \$250,000 to expand to three additional sites. DC Appleseed strongly recommends that the District continue to fund this important outreach program.

HIV/AIDS AMONG THE INCARCERATED: B+

Implement routine HIV testing. Improve collection of HIV and AIDS data in D.C. detention facilities. Improve discharge planning services at D.C. detention facilities.

Routine HIV testing—offering all patients, regardless of risk factors, the opportunity to be tested—has been recognized as an important component of public health efforts to control the spread of HIV, initiate treatment for HIV-positive individuals, and to gather data regarding HIV infections. Routine testing of inmates offers considerable benefits for the inmates and the community. The intake health care screening provided in most jails offers a unique opportunity for many inmates to be counseled about the risks of HIV infection and strategies for preventing the spread of the disease.

As noted in DC Appleseed's 2005 report, data regarding HIV infection in District detention facilities were lacking, and HIV testing had been minimal. In October 2005, the DOC instituted a pilot program to increase HIV testing at the D.C. Jail. The testing was successful in increasing the number of inmates tested upon intake. In June 2006, the D.C. Jail further increased HIV testing by initiating

“automatic,” but voluntary, HIV rapid testing to all inmates upon intake and discharge. From June 1 to November 2006, rapid testing was performed on 6,999 inmates, of whom 266 inmates or 4 percent were confirmed positive through blood testing. The confirmed positive group is made up of 1 percent who were unaware of their HIV status, and 3 percent who previously knew of their status. The substantial increase in the number of inmates learning their HIV status through this program is an important measure in the prevention of our community's HIV epidemic. DC Appleseed commends AHPP and DOC for the collaboration to make this testing initiative possible and encourages the continuation of this important testing initiative of high-risk inmates.

Although there have been recent discussions regarding mandating HIV testing at the D.C. Jail, the DOC has decided against implementing mandatory testing in favor of “automatic” testing. DC Appleseed commends this decision, which is in concert with leading public health organizations and experts who agree that any effective and ethical testing must be conducted with the inmate's consent and must be coupled with pre-and post-test counseling. Mandatory testing: (1) clearly violates longstanding medical ethics regarding informed consent; (2) is not more effective than voluntary testing; and (3) raises significant practical implementation concerns for correctional facilities.³ Furthermore, the DOC's voluntary, “automatic” testing program has proven successful with only 5 percent of inmates refusing HIV testing.

The importance of providing HIV prevention counseling to this high-risk population when the HIV testing occurs must be underscored. The jail has the opportunity to educate inmates who test negative about risk reduction to prevent future infection, allowing the benefits of routine testing to extend beyond the jail's walls to the communities to which the inmates will return. Although D.C. Jail's testing protocol mandates HIV prevention counseling at the time the test is performed, there have been some reports that preven-

3. DC Appleseed has prepared a briefing paper, available at www.dcappleseed.org, which discusses the issues related to mandatory HIV testing in jails.

tion counseling for inmates testing negative has been minimal or has not occurred. DOC reports that they will continue to evaluate and refine the testing process to improve efficiency. DC Appleseed encourages DOC to ensure that inmates who test positive for HIV receive appropriate counseling and treatment during their incarceration and that these individuals receive appropriate discharge planning services.

Recently, the DOC has instituted enhanced discharge planning services to the inmates at D.C. Jail. On October 1, 2006, Unity Health Care assumed the contract for the provision of comprehensive health services under a community correctional health care model at the District's detention facilities. Ten discharge planners have been hired to

facilitate the discharge planning process so that inmates will receive necessary health care upon release. Besides assuring linkage to health care upon release, it is imperative that the discharge planners facilitate the provision of medication to inmates upon discharge. This has been a long-standing problem at the D.C. Jail, and DC Appleseed has learned of recent instances when inmates have been discharged without medication. In addition, the Income Maintenance Administration is providing a full-time discharge planner on site at the D.C. Jail in order to assist inmates eligible for federal and District-funded assistance programs. It is too early to determine the efficacy of these additional resources; however DC Appleseed commends the DOC for this innovative approach.