

HIV/AIDS IN THE NATION'S CAPITAL

Eight years ago, DC Appleseed issued its 2005 report, *HIV/AIDS in the Nation's Capital: Improving the District of Columbia's Response to a Public Health Crisis*. Since that time, the District government has made significant progress toward implementing many of the recommendations in the report.

Reflecting on the progress made in addressing HIV/AIDS in the District since our 2005 report, we cannot avoid the stark reality that the epidemic continues to have a profound impact on the District of Columbia. Although significant progress has been made in addressing the epidemic, there are continuing challenges, and several grades have decreased since last year.

This *Eighth Report Card* assigns grades for the first time in Housing and in HIV Treatment and Care, and includes an initial assessment and recommendations regarding implementation of the Affordable Care Act.

REPORT CARD

NO. 8

JULY 2012 TO
NOVEMBER 2013



GRADES (A-F)

B-

A-

B

SURVEILLANCE: B+
M&E: C+

A

A

OSSE: C
DCPS: B+
CHARTER: C

A-

B+

A

B

C+

LEADERSHIP

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

PARTNERSHIPS & COLLABORATIONS

Improve District government partnerships and collaborations on HIV/AIDS issues with District agencies and with other community partners.

GRANTS MANAGEMENT

Improve grants management, monitoring, and payment processes to ensure that funds for HIV/AIDS services are spent effectively and appropriately.

HIV SURVEILLANCE; MONITORING & EVALUATION

Fully and appropriately staff the office responsible for tracking HIV and AIDS. Publicly report data on HIV infections in the District. Implement a comprehensive system to monitor outcomes and maintain quality assurance standards in grant-funded HIV/AIDS prevention and care programs.

HIV TESTING

Continue to support and expand routine HIV testing in all medical settings, targeted areas in the community, and in non-traditional settings.

CONDOM DISTRIBUTION

Continue to expand condom distribution in the District.

PUBLIC EDUCATION IN THE DISTRICT

Establish mechanisms for ensuring compliance with system-wide health standards. Provide data-driven information to the public about compliance with standards. Develop a plan for enhancing HIV/AIDS policy for public education in the District.

SYRINGE ACCESS SERVICES

Continue to fund syringe access and complementary services and adopt additional measures to address prevention with substance-using populations.

SUBSTANCE ABUSE TREATMENT

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

HIV/AIDS AMONG THE INCARCERATED

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

HIV TREATMENT AND CARE

Provide quality HIV treatment and care and improve health outcomes.

HOUSING

Increase the availability of housing support for people with HIV/AIDS in the District.

EXECUTIVE SUMMARY

BECAUSE THE NEED IS STILL SO GREAT, MORE IS EXPECTED

Eight years ago, DC Appleseed published its report, *HIV/AIDS in the Nation's Capital; Improving the District of Columbia's Response to a Public Health Crisis*. Initiated at the request of the Washington AIDS Partnership and with the support of then-Mayor Anthony Williams, DC Appleseed and Hogan Lovells US LLP examined how the District government was managing the city's HIV/AIDS epidemic. DC Appleseed took on this role with the hope that, as an independent investigator and monitor, it could bring attention to the epidemic and the reforms needed to address it. As part of that ongoing effort, DC Appleseed releases periodic report cards to assess the District's progress.

The 2013 Epidemiology Report Makes Clear that the City is Making Progress

DC Appleseed applauds the District and the community for the progress made in addressing the HIV/AIDS epidemic. The District's 2013 *Annual Epidemiology & Surveillance Report* ("Epi Report") highlights that progress. Between 2007 and 2011, the District has seen a 47 percent decline in new AIDS cases, a 46 percent decline in new HIV cases, and an increase to 79 percent of people newly diagnosed being linked to care within three months. There also has been a dramatic 80 percent reduction in the proportion of new HIV cases associated with injection drug use — a signal of the success of the District's investment in and support of syringe access and complementary services. DC Appleseed notes that the percentage of people dying from HIV-related causes also has declined significantly. At the release of the Epi Report, Mayor Vincent C. Gray and his administration rightly stated that these positive trends are indications that the District is "turning the corner" in addressing HIV/AIDS.

But The City Still Has a Long Way to Go

DC Appleseed agrees these data show that the District is making substantial progress. At the same time, other data in the Epi Report, and our assessments in this report card, show that the District still has much further to go to end the epidemic.

For example, on one of the most important measures of reducing the number of new HIV cases — the transmission rate — the city has shown almost no progress with 718 newly reported HIV infections in 2011. In 2010, the transmission rate was 5.1, meaning that there were 5.1 newly reported infections for every 100 known HIV/AIDS cases in the District. In 2011, the transmission rates moved down only .2 percent, to 4.9 newly reported cases per 100 existing cases.

DC Appleseed also is concerned to see alarming data on HIV and sexually transmitted diseases ("STDs") among youth in the District. Data on new HIV cases show that the highest percentage of new HIV cases is among those 20-29 years old. The Epi Report also shows an increase in new chlamydia and gonorrhea cases with the largest number of cases in the 15-19 age group and the vast majority of all cases in the 15-24 age group. These data highlight the importance of age-appropriate HIV and sexual health education for District youth. While DC Public Schools ("DCPS") has made great progress in this area, DC Appleseed urges the Mayor and the Office of the State Superintendent of Education ("OSSE") to ensure that this critical education also is available to the 44 percent of public school students who attend public charter schools. As the grades for OSSE and the Public Charter Schools in the report card show, we believe the steps taken so far are not sufficient to protect the young people of this city.

The District Is "Turning the Corner," But Must Continue to Focus on What's Around the Corner

At a time when there have been changes in the Department of Health ("DOH") and HIV, AIDS, Hepatitis, STD, and Tuberculosis Administration ("HAHSTA") leadership, DC Appleseed is encouraged by the interim appointments of Dr. Joxel García to lead DOH and Michael Kharfen to lead HAHSTA. However, their interim status illustrates a theme that cuts across this *Eighth Report Card* — the District has made progress in addressing HIV/AIDS, but areas of uncertainty remain about the District's plans for the future.

For example, as detailed in the Grants Management section of this report card, there are concerns about the implementation and impact on services resulting from the District's restructuring of the Ryan White program and the new oversight structure. With many services provided through subcontracts under agencies funded by HAHSTA, there is some confusion and concern about the impact of these changes on program administration and, more importantly, service delivery and quality oversight.

The District is also navigating the implementation of the Affordable Care Act ("ACA"), which will vastly change how health services are delivered. And these changes could prove challenging for providers and people living with HIV/AIDS. At this time of transition, the District must

be more transparent and communicate to the community its plans for the future, so that the process is systematic and predictable, rather than reactive and unexpected.

Without permanent leaders in place, there is also some uncertainty about the commitment of potential future District leadership to efforts that have been successful in the past, such as syringe access services, testing, and condom distribution. The creation of the Department of Behavioral Health (“DBH”) from the merger of the Addiction Prevention and Recovery Administration (“APRA”) and the Department of Mental Health (“DMH”) raises questions about the possible impact on substance abuse services that are a critical component of a comprehensive response to HIV/AIDS. In addition, the repeated short-term renewals of contracts for medical services at the DC Jail bring concern about stability of HIV screening and the quality of care provided to inmates with HIV/AIDS.

DC Appleseed is concerned that all these changes and uncertainties — if not well addressed, and communicated — could stall the District’s progress and hamper necessary efforts to continue combating the epidemic at this critical time.

The Future of the Epidemic in the District

The District’s January 2013 *Ending the Epidemic: The District of Columbia HIV/AIDS Implementation Plan* (“Implementation Plan”) articulates values DC Appleseed fully supports:

“This is the beginning not the end of a process. We must continue to work together to engage the community, the agencies of the District government, the Federal government, and the diverse partners in the District to maintain a dynamic and evidence based approach. With this document in hand, now is the time to act. Together we can end HIV/AIDS.”

The Implementation Plan stresses the long term nature of this work, the importance of data, and the need for the involvement of all sectors in the comprehensive response. It makes clear that the Mayor and his administration are committed to fighting — and ending — the epidemic in the District. To do this, the city needs the best and most current data, so it can plan accordingly and use resources effectively and appropriately. And the District needs to communicate with the community — its partner in this endeavor — so that all stakeholders understand and are prepared for what’s coming around the corner. DC Appleseed looks forward to working with the District and the community to help make this vision a reality.

Eighth Report Card Grades

Since our original 2005 report, the District has made steady and significant improvements in its overall response to HIV/AIDS. Through follow-up report cards, DC Appleseed has tracked this progress and offered further recommendations when there has been a lack of progress or the opportunity for further improvements.

- **Leadership (decreased grade from “B” to “B-”):** Mayor Gray remains committed to fighting HIV/AIDS as a priority of his administration. But there has been unstable leadership at DOH and HAHSTA at a time of transition to the ACA and restructuring of the District’s Ryan White program, and the impact of the Mayor’s Commission on HIV/AIDS (Commission”) is not apparent. There also is a perceived lack of vision and communication to providers in addressing HIV/AIDS. DC Appleseed is encouraged that the Mayor quickly appointed interim leadership after recent resignations — Dr. Joxel Garcia to head DOH and Michael Kharfen to head HAHSTA. DC Appleseed is encouraged by their commitment to fight HIV/AIDS and their openness to engaging and communicating with service providers and the community.
- **Partnerships & Collaborations (maintained grade of “A-”):** The District has developed and sustained strong interagency collaborations and developed partnerships with other stakeholders in the community. HAHSTA continues to expand collaborations among city agencies and implement an ambitious Youth HIV Prevention Plan.

- **Grants Management (decreased grade from “B+” to “B”):** HAHSTA has made efforts to continue its past progress in training and oversight of its grants. However, DC Appleseed is concerned about its decline in timely payments, because without timely payment of invoices, the quality and stability of critical services and care are in jeopardy. This year, HAHSTA revised the structure of the Ryan White Request for Application (“RW RFA”). Although we commend HAHSTA’s forward-thinking approach, the revised structure has caused some concern among service providers and has yet to be truly tested. DC Appleseed believes that the changes will have the most impact in areas such as invoicing, reimbursements, and quality of care. Monitoring the successes and challenges of implementation in these areas will provide valuable feedback regarding the impact of these changes for future program years.

HIV Surveillance (decreased grade from “A-” to “B+”): HAHSTA’s academic partnership with the George Washington University School of Public Health (“GW”) continues to be strong, and the work of the surveillance staff is recognized nationally. Though not as useful as HIV incidence data might be, HAHSTA’s reporting of newly diagnosed HIV cases helps provide some basis for understanding transmission trends in the District. However, DC Appleseed is concerned that HAHSTA does not provide more current data. DC Appleseed also is concerned about lingering vacancies in surveillance leadership.

- **Monitoring & Evaluations (“M&E”) (decreased grade from “B-” to “C+”):** Since 2009, HAHSTA has been developing a comprehensive M&E software program intended to simplify and improve data collection, analysis, and reporting for HIV/AIDS, hepatitis, STDs, and tuberculosis (“TB”). Though the system seems to be making progress, the DC Public Health Information System (“DCPHIS”), formerly called Maven, is still not operational for HIV.
- **HIV Testing (increased grade from “A-” to “A”):** The District continues to expand its HIV testing program and has been collaborating with Gilead FOCUS Program (“Gilead”) and United Medical Center (“UMC”) to offer fourth generation antigen testing to detect acute HIV infections. DC Appleseed hopes that improvements in test kit availability and training schedules continue in the future and that HAHSTA develops a strategy to address late testers and starts recording the proportion of people testing who are first-time testers.
- **Condom Distribution (increased grade from “A-” to “A”):** HAHSTA reports that the District distributed almost six million condoms in FY 2012 (a 25 percent increase over FY 2011) and has been better able to manage supplies, distribution, and communication with community partners. It also has continued its successful and innovative public service messaging campaign on the importance of condom use.
- **Public Education in the District**
 - **OSSE (decreased grade from “B-” to “C”):** While OSSE has continued to refine health curricula, testing, and programs, it has not addressed the glaring deficiency of HIV/AIDS education within public charter schools. OSSE must properly incentivize public charter schools to provide adequate HIV/AIDS education, whether through official rules pursuant to the Healthy Schools Act (“HSA”), testing data disclosures, or funding measures.
 - **DCPS (maintained grade of “B+”):** DCPS continues to make progress in curriculum development, student programs, hiring practices, and professional development. DCPS should continue to develop this holistic approach to sexual health education, in combination with continued, effective integration of nationally-recognized best practices and fast-developing technologies.
 - **Charter Schools (maintained grade of “C”):** As before, little transparency and accountability exist with respect to sexual health education across charter schools. DC Appleseed visited several charters with respected HIV/AIDS education programs to better understand the barriers, challenges, and opportunities they face. Given that 44 percent of public school children in the District now attend charter schools, DC Appleseed remains concerned about the lack of transparency and progress.

- **Syringe Access Services (“SAS”) (increased grade from “B” to “A-”):** HAHSTA reports that in FY 2012, SAS programs exchanged 598,000 syringes, an increase of 57 percent from the previous year. After maintaining funding at \$580,000 in FY 2011 and FY 2012, in FY 2013 HAHSTA awarded \$667,430 for SAS, including funding a fourth provider organization. It also awarded an Enhanced Harm Reduction Grant to organize service providers working with drug users, to better coordinate services and referrals, and to increase retention rates among program participants.
- **Substance Abuse Treatment (maintained grade of “B+”):** The District is carefully and gradually merging APRA and DMH into the new DBH, which was established October 1, 2013. This merger is taking place at the same time as the expansion of the District’s Medicaid program under the ACA. DC Appleseed will monitor the implementation of these changes and their impact on access to and quality of care available to District residents.
- **HIV/AIDS Among the Incarcerated (maintained grade of “A”):** The District continues to offer HIV screening to inmates, as well as treatment and discharge planning for HIV-positive inmates. Between October 2012 and September 2013, the Department of Corrections (“DOC”) tested 7,068 inmates, and in 2012, 89 percent of HIV-positive inmates incarcerated more than 180 days had an undetectable viral load. DC Appleseed will monitor any impact of the new medical services Request for Proposal (“RFP”) and the construction of a new intake center on HIV services provided to inmates.
- **HIV Treatment and Care (received grade of “B”):** With technical assistance from Robert Greenwald and his team at the Harvard Center for Health Law and Policy Innovation, DC Appleseed examined the District’s early implementation of the ACA and made recommendations for better addressing the needs of people living with HIV/AIDS. We look forward to working with the District and monitoring progress and impact in the future. We also examined trends in key indicators to monitor progress in linkage to care, retention in care, viral load suppression, and recapture/re-engagement.
- **Housing (received grade of “C+”):** Though the Mayor has made affordable housing a priority of his administration and HAHSTA has slightly increased the number of slots available through the Housing Opportunities for People with AIDS (“HOPWA”) program, the District must do much more to have an impact on stabilizing housing and improving health outcomes of people with HIV. Prioritizing the HOPWA list, investing local dollars to supplement HOPWA funding, and offering priority access to recipients who have transitioned out of HOPWA would go a long way in addressing unmet housing needs for people living with HIV/AIDS (“PLWHA”).

Below is a chart showing the grades on our past and current report cards:

	FIRST REPORT CARD	SECOND REPORT CARD	THIRD REPORT CARD	FOURTH REPORT CARD	FIFTH REPORT CARD	SIXTH REPORT CARD	SEVENTH REPORT CARD	EIGHTH REPORT CARD
LEADERSHIP	B-	B-	B+	B+	B+	B	B	B-
PARTNERSHIPS & COLLABORATIONS	N/A	C-	B-	B	A-	A-	A-	A-
GRANTS MANAGEMENT	B	B-	B	B	B+	B	B+	B
HIV SURVEILLANCE	Incomplete	B	A	A	A	A-	A-	B+
MONITORING AND EVALUATION	N/A	B-	B-	B-	B-	B-	B-	C+
RAPID TESTING	B	B	B+	A-	A	A	A-	A
ROUTINE HIV TESTING	C	B	B+	A-	A	A	A-	A
CONDOM DISTRIBUTION	D	D+	B	B	B+	A-	A-	A
PUBLIC EDUCATION IN THE DISTRICT	B-	C-	D	C	C+	OSSE: C- DCPS: B+ CHARTER: Incomplete	OSSE: B- DCPS: B+ CHARTER: C	OSSE: C DCPS: B+ CHARTER: C
SYRINGE ACCESS SERVICES	B-	B-	B+	A-	B+	B	B	A-
SUBSTANCE ABUSE TREATMENT	D+	D+	C+	B	B	B+	B+	B+
HIV/AIDS AMONG THE INCARCERATED	C+	B+	A	A	A	A	A	A
HIV TREATMENT AND CARE	N/A	N/A	N/A	N/A	N/A	N/A	N/A	B
HOUSING	N/A	N/A	N/A	N/A	N/A	N/A	N/A	C+

DC Appleseed would like to acknowledge and thank the Washington AIDS Partnership and its steering committee for the initiation of and continued support for this project. We also would like to thank Hogan Lovells US LLP and Paul, Weiss, Rifkind, Wharton & Garrison LLP for their continued invaluable pro bono work on this project and Terrapin Studios LLC for its donated design and production services. Finally, we would like to thank the District government for its cooperation in this effort and community stakeholders for their assistance.

EIGHTH REPORT CARD

NOVEMBER 2012

LEADERSHIP: B-

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

Strong leadership and commitment to fighting HIV/AIDS has been central to the progress the District has made in addressing the epidemic. In the *Seventh Report Card*, DC Appleseed commended Mayor Gray for prioritizing and focusing attention on HIV/AIDS and establishing a Commission to guide his administration's response. The District's grade for leadership was kept at a "B," awaiting evaluation of results and impact of the Commission's work. This year, in light of the unstable leadership at HAHSTA and DOH, the lack of a positive impact of the Commission, and the perceived lack of vision and communication to providers in addressing HIV/AIDS, the District's grade for leadership is reduced to a "B-."

Mayor Gray remains committed to HIV/AIDS and has brought public attention to the issue in the District by speaking publicly and participating in events related to HIV/AIDS, as reflected in local media coverage. This includes holding a press conference to mark National Gay Men's HIV/AIDS Awareness Day, public commemoration of World AIDS Day through a food drive and a candlelight vigil, and participating in the release of HAHSTA's Epi Report. The Mayor also spoke at and led the 2013 AIDS Walk Washington. While DC Appleseed applauds the Mayor for bringing attention to HIV/AIDS, overall the Mayor's public statements and appearances have slowed since the *Seventh Report Card* was released. Because the Mayor's visible, sustained commitment is a significant factor in ensuring the successful implementation of the city's coordinated response to the

epidemic, we encourage the Mayor to bring more attention to the issue.

In discussing HIV/AIDS, the Mayor calls attention to the efforts of his Commission on HIV/AIDS. Established in March 2011, the Commission was charged for two years with developing recommendations on HIV/AIDS policy in the District. For the *Seventh Report Card*, we researched the minutes, committee reports, and outcomes of the Commission's work and noted that it was not clear that there had been any solid results in terms of defining a mission, issuing new reports, or planning future actions. The Commission produced a list of nine recommendations to the Mayor, which he accepted. The recommendations address important issues on improving care, coordination and planning, and focusing attention on the needs of special populations. The Commission requested that DOH unify the plans of government agencies within and beyond DOH — including agencies working on schools, housing, and criminal justice — on addressing HIV. As a result, HAHSTA released a District-wide HIV/AIDS Implementation Plan in January 2013. DC Appleseed applauds this consolidation of HIV planning efforts effort across the District government. However, it is difficult to assess or even monitor the implementation of the Commission's other recommendations or the impact of this Implementation Plan on District efforts because minutes and implementation progress reports for Commission and subcommittee meetings have not been made available on the Commission's public website since January 2012. The initial two-year authorization for the Commission expired in March 2013, at which time the Mayor indicated that he would reauthorize the Commission in the coming months. The Mayor reauthorized the Commission in July. DOH and the Mayor's office are scheduling the first meeting of the Commission.

A greater concern than the Commission, because it is vital to the day-to-day, hands-on fight against the epidemic, involves the significant turnover in leadership at key District agencies with HIV/AIDS services oversight. This summer, the leadership of both DOH and HAHSTA changed. These changes occurred just as the District faces the challenge of implementing health care reform and making corresponding and related changes to

how it approaches HIV/AIDS services. At this crucial time, the turnover of key leadership positions poses significant challenges to the development and effective implementation of policies to make vital reforms and remain a leader in responding to the HIV/AIDS epidemic. It is important that the District make efforts to reduce turnover and fill the interim and acting positions with individuals who are committed to providing the leadership and direction necessary to make the transition to a new service paradigm successful. Leadership positions were not vacant for long, as the Mayor quickly appointed interim leadership — Dr. Joxel García to head DOH and Michael Kharfen to head HAHSTA. DC Appleseed is encouraged by their commitment and dedication to the HIV fight. We hope that this leadership transition does not disrupt progress and instead provides the leadership, direction, continuity, and stability required to steer the District-wide response to HIV/AIDS through this time of transition and beyond.

There is a perception among many service providers that over the past couple of years HAHSTA has not communicated effectively with providers and has not been able to clearly articulate its vision. While the District should be commended for having promptly started to prepare for and implement changes in health care precipitated by the ACA, HAHSTA has not communicated well its vision for the future or how the changes it is implementing further that vision. This parallels HAHSTA's generally poor ongoing communication with service providers. The *Seventh Report Card* noted that providers reported that major changes were made to testing and condom distribution programs without proper or timely communication. Recently, providers reported a lack of communication regarding changes in Ryan White funding for this year's funding cycle. Effective communication of both vision and policies is essential to ensuring community support for and effective implementation of District initiatives on HIV/AIDS. DC Appleseed recommends that HAHSTA develop a clear communication strategy to keep grantees, the Council, and the public informed of leadership changes, policy changes, and their plans and vision. DC Appleseed is encouraged that Dr. García and Mr. Kharfen are willing to engage with the community and seem to seem to

value the importance of good relationships with the community.

The Council of the District of Columbia, and the Committee on Health ("COH") in particular, influence the direction of HIV/AIDS efforts in the city. Since the *Seventh Report Card*, Councilmember Yvette Alexander replaced COH Chair Councilmember David Catania, who was a leader in focusing attention on HIV/AIDS. Councilmember Alexander has identified HIV/AIDS and teen pregnancy as two of her priorities. Under her leadership, COH facilitated the transfer of funds to HAHSTA to specifically address the problem of mother-to-child transmission. Attention on the multiple issues related to HIV/AIDS is crucial given the changing landscape of health care and HIV/AIDS service delivery due to the ACA and the new model for Ryan White grants discussed later in this report card. DC Appleseed was encouraged to hear Councilmember Alexander stress the importance of addressing housing, appropriate HIV and teen pregnancy education in schools, HIV incidence among senior residents, and concern about continuity of care for inmates after discharge. We look forward to monitoring her leadership in addressing these and other HIV priorities.

As Mayor Gray's administration moves forward, DC Appleseed hopes to see greater stability, leadership, vision, and communication. This is critical if the District hopes to continue the progress it has made in addressing HIV/AIDS over the last ten years. Because of the recent leadership instability, poor communication from HAHSTA, and the inability to see impact of the Commission, the District's grade for leadership is reduced to a "B-."

PARTNERSHIPS & COLLABORATIONS: A-

Improve District government partnerships and collaborations on HIV/AIDS issues among District agencies and with other community partners.

Improved interagency coordination has been a priority for DC Appleseed since our original report, when we noted the near absence of collaboration among District agencies in supporting HAHSTA's response to the District's

epidemic. Since then the District has made great progress in improving collaboration and communication among District agencies. Evidence of this can be seen throughout most sections of this report card. We summarize below the partnerships and collaborations described in other sections of this report card in addition to some of the District's youth initiatives.

Leadership

- The Commission on HIV/AIDS included representatives of key agencies that play a major role in the District's response to HIV/AIDS: DOH, HAHSTA, DCPS, DMH, and DOC.
- DOH released a citywide HIV/AIDS Implementation Plan, unifying goals and activities of government agencies within and beyond DOH — including agencies working in schools, housing, and criminal justice.

HIV Surveillance and Monitoring & Evaluation

- HAHSTA continues the academic partnership with GW that has played a central role in the strengthening of surveillance in the District, research projects, and collaboration on the National HIV Behavior Study Series.
- HAHSTA is participating in HIV Prevention Trials Network Testing, Linkage to Care Plus Study through the National Institutes of Health ("NIH").
- HAHSTA participated in the "Regional Sharing of Infectious Disease Data in the DC Metropolitan Region" conference coordinated by Georgetown University.

HIV Testing

- HAHSTA partners with seven of the District's eight hospitals, providing testing kits and funding for testing programs.
- In collaboration with Gilead, HAHSTA continues to provide testing at the Anacostia Economic Security Center.
- Under the 12 Cities Minority AIDS Initiative Technical Capacity Expansion grant, HAHSTA partnered with APRA and DMH to establish universal substance use, mental health, and HIV screening sites.

- HAHSTA is collaborating with Gilead and UMC to offer fourth generation antigen testing to detect acute HIV infection.
- HAHSTA is collaborating with the Alosa Foundation, whose representatives visit physician's offices to inform and update practitioners on HIV/AIDS diagnosis and treatment management.

Condom Distribution

- HAHSTA and the MAC AIDS Fund continue the Female Condom Project providing female condoms to community partners and training medical providers, young people, and youth-serving organizations.

Public Education in the District

- OSSE's Youth Advisory Committee partnered with HAHSTA and Advocates for Youth to pilot a student-version of Wrap M.C. condom distribution program in schools.
- DCPS partnered with DOH to pilot a HIV testing program — as part of the ongoing STD screening program — that includes a short mandatory video and voluntary screening.
- DCPS continues to work with the Gay, Lesbian & Straight Education Network.
- DCPS professional development efforts include partnerships with organizations like Metro TeenAIDS, which host the annual Health Summit, and Be Dramatic, which utilizes dramatic performances to teach about health.
- Several public charter schools provide HIV education through partnerships with community organizations such as Metro TeenAIDS and Peer Health Exchange.

Syringe Access Services

- HAHSTA funded Helping Individual Prostitutes Survive ("HIPS") Enhanced Harm Reduction Grant to lead a working group of service providers to share resources, better coordinate services and referrals, and encourage retention rates among program participants who use drugs.

Substance Abuse Treatment

- APRA manages the "12 Cities Project" — a component of National HIV/AIDS Strategy

(“NHAS”) that aims to better coordinate HIV prevention, treatment, and care. APRA works in partnership with HAHSTA and DMH.

- APRA continues its collaboration with the Psychiatric Institute of Washington (“PIW”) to conduct screenings at DC Superior Court.

HIV/AIDS Among the Incarcerated

- DOH, DOC, and Unity Health Care (“Unity”) collaborate to provide medical care, conduct routine rapid HIV testing at the DC Jail, and provide medications and discharge planning upon inmate release.
- The Court Services and Offender Supervision Agency (“CSOSA”) holds quarterly “resource day” video conferences where speakers from government agencies and organizations provide information and resources including HIV services for inmates at several BOP and contract facilities.
- CSOSA is working with service providers to obtain videos describing their services as well as printed information that can be made available in the waiting rooms of its field offices.

Housing

- HAHSTA expects to work with US Department of Housing and Urban Development (“HUD”) to consider the District’s current HOPWA program design, to compare with other jurisdictions, and to explore program changes to optimize HOPWA funding to increase housing availability.

Youth Initiatives

- This year HAHSTA began implementing its 2012-2015 Youth HIV Prevention Plan, which DC Appleseed commended in last year’s Report Card for being a more aggressive and expanded continuation of the previous plan.
- In FY 2012, HAHSTA hosted several workers from the Mayor’s Summer Youth Employment Program and trained them as peer educators. They worked through the Mayor’s One City Summer initiative to engage peer educators at activities where

they provided sexual health information, connections to youth-serving organizations for STD and HIV screening, and distributed condoms.

- HAHSTA plans to examine new approaches for expanding peer education in the future.
- In FY 2012 HAHSTA unveiled a new Peer Education Program to recruit and train youth peer educators, identify and form partnerships with other youth-serving organizations, schools, and other youth-serving government agencies to integrate peer education into their programs and support peers in those setting.

Interagency collaborations and partnerships with other sectors of the community continue to play a key role in the District’s efforts to address HIV/AIDS. Such strategies improve communication, efficiency, and effectiveness of interventions, which are especially critical in times of limited resources. Because of this continued attention to improving collaborative work, the District’s grade for Partnerships & Collaborations remains at “A-.”

GRANTS MANAGEMENT: B

Improve grants management, monitoring and payment processes to ensure that funds for HIV/AIDS services are spent effectively and appropriately.

Despite furloughs and some position vacancies, HAHSTA has made efforts to continue its past progress in training and oversight of its grants, but has lapsed in the area of timely payments. In addition to continuing to implement existing policies, HAHSTA expects to benefit from the ongoing development by the DOH Office of Grants Management of an operational system to oversee grants across all DOH recipients.

A significant change in HAHSTA’s grants management program is the revised structure of the 2013 RW RFA. The new RW RFA reflects HAHSTA’s commitment to the continuum of care for persons living with HIV and the changing landscape of medical care in DC — both as it relates to implementation of the ACA and changes to the approach in HIV/AIDS care — and how it may result in

reducing some of HAHSTA's administrative and oversight burden. As with anything new, there are pros and cons to the new structure. While the new structure has the potential to improve the standard of care and make more efficient use of available funds, there are questions surrounding the transition; in particular, the potential impact to the provider community and patients while any kinks are resolved. For example, although HAHSTA did provide training programs and transitional services to educate the community on the new RW RFA, many providers feel that the new RW RFA was rolled out with insufficient time for grant recipients to fully prepare for the new system. Confusion surrounding the new application process and RW RFA structure by some longstanding members in the provider community has resulted in providers missing out on funding for this year. Despite the changes and transition, one thing remains clear: program success rests on the ability of the provider community and HAHSTA to more effectively communicate about these changes and work together to implement them.

Because HAHSTA has declined in some areas, but taken steps forward in others, the District's grade for Grants Management was reduced from a "B+" to a "B."

PAYMENT PROCESS

Over the last year, HAHSTA has regressed in the area of timely invoice payments. In the *Seventh Report Card* we noted an improvement from 72 percent of on-time payments in FY 2010 to 84 percent in FY 2011. However, for FY 2012, only 75 percent of invoices were paid within the 30-day time frame. This is likely due to several factors. First, HAHSTA uses a manual system internally to track invoices in addition to the District's Procurement Automated Support System ("PASS") and the System of Accounting and Reporting ("SOAR"). Although HAHSTA expected that it would change to an Oracle-based system in the summer of 2013, the process has been delayed and a realistic updated timeline for this change is still unknown. HAHSTA has no control over the timing, as the upgrade will be a citywide effort managed through the Chief Financial Officer.

Second, there have been changes to the invoice tracking system and inconsistency in invoice accounting. To remedy this, the grants manager is providing additional training on maintaining the invoice tracking database, and more reports are sent to a supervisor for review. HAHSTA also has revised the PASS process that supports the approval of invoices. Additionally, the overall internal report architecture for invoice tracking is being redesigned so that grant and program monitors can proactively forecast the expenditure rate of vendors and take steps as necessary to encourage timely billing for services. HAHSTA expects that these changes will reduce the cycle time for invoices to accounts payable and provide proper checks and balances in the system for audit purposes. DC Appleseed is concerned about the apparent regression in timely payment, because without secure timely payment of invoices, the quality and stability of critical services and care are in jeopardy.

It is worth noting that the new RW RFA structure should reduce the number of invoices that HAHSTA must pay, thus assisting HAHSTA in this area until finalization of the Oracle-based system. Regardless, it is clear that this process needs to be updated.

GRANT MONITORING AND OVERSIGHT

Grantee Performance Ratings

As described in the *Seventh Report Card*, HAHSTA continues to monitor and track its awardees using its prioritized three-prong approach to site visits based upon its Agency Capacity Assessment Monitoring ("ACAM") Policy. Under ACAM, HAHSTA conducts an initial capacity assessment of a sub-grantee as low, moderate, or high capacity and tailors the number and frequency of site visits accordingly. In response to audits over the last year, the DOH Office of Grants Management is developing an operational system for oversight of grants that will be consistent across the entire DOH. There also is a new quality improvement position within HAHSTA with responsibility to provide oversight on all aspects of grants — including the handling, tracking, and reporting of site visits. Additionally, site-visit information

now is entered into a calendar that tracks this information for all grants and is transparent to everyone at DOH.

Through the ACAM approach, two corrective actions were initiated in FY 2012 and six in FY 2013 for a variety of program and fiscal issues. Of these, four were remedied successfully with ongoing support and monitoring while the other three were not, and one subgrantee lost funding entirely. There also have been 57 technical assistance sessions provided during FY 2012 and FY 2013 to date. Furthermore, all of the providers have received an additional copy of the HAHSTA Providers Manual. HAHSTA continues to analyze the site visits and provide subgrantees with Grantee Performance Ratings.

A-133 Audit Policy

There is little to report regarding HAHSTA's A-133 audit policy in FY 2012, which is the latest data available for review. A-133 audits are mandated by the federal government for entities expending \$500,000 or more in federal funds. HAHSTA continues to require grant applicants to certify whether they are required to be A-133 compliant. Self-certification with follow-up is the standard method of tracking compliance of subgrantees by agencies. As in the *Seventh Report Card*, there are no grant management-related findings for FY 2012. However, where previously HAHSTA reported difficulties identifying subgrantees required to complete an A-133 audit, it reported no such difficulties in FY 2012 and appears comfortable with the effectiveness of its current system. Under the new RW RFA, HAHSTA's oversight role with respect to A-133 audits will also be limited as discussed in greater detail below.

License and Certification

HAHSTA continues to improve its quality control over the required licenses and certifications of its subgrantees by requiring both pre-award and post-award certifications/assurances. First, a DC Clean Hands report is run by the Office of Grants Management. Then, the Office of Grants Management obtains and confirms the assurances and certifies the grantee to DOH. HAHSTA performs a check on the individual grantees as well. Additionally, HAHSTA tracks these requirements and the date of renewal/expiration of

all grantees on a grant-by-grant basis. Regular quality control checks are performed and notices are sent when those certifications/licenses/assurances are set to expire.

Under the new RW RFA, HAHSTA will not be managing this information for subcontractors, thereby further reducing its administrative burden. Rather, the applicant entities will certify on behalf of themselves and their subcontractors. It will be incumbent on the applicant to ensure that the licenses/certifications/assurances of both its subcontractors and itself are up to date. DC Appleseed will monitor the effectiveness of this transfer of responsibility.

GRANT AWARDS AND RENEWALS

In 2013, HAHSTA released the new RW RFA, with applications due May 23, 2013, which presents a new application structure that effectively reduced the number of applications for direct funding, but not the overall level of funding. HAHSTA hosted information sessions with follow-up time for questions and answers to introduce the program changes. The 2013 RW RFA combined the approximately 20 existing categories of HIV/AIDS care into five "Tiers," each "Tier" encompassing multiple facets of HIV treatment and care. Essentially, where service providers previously applied for direct funding in their specialized area, many will now receive grant money through a sub-contract negotiated with an applicant entity. If awarded funding, the applicant will have a direct relationship with HAHSTA and will manage the administrative aspects of grant management for itself and its subcontractors.

Under this new structure — which is common for government grants — HAHSTA will make awards to fewer direct grantees, and those grantees will be tasked with providing the full spectrum of HIV/AIDS services. This will allow HAHSTA to reduce the number of invoices it collects, tracks, and pays; the number of site visits it must perform; and its overall monitoring responsibility for program compliance. Instead, award recipients will be responsible for managing the administration of their subcontractors and will be accountable to HAHSTA to ensure that

subcontractors remain in compliance with the program terms and related financial and administrative requirements. In other words, HAHSTA will pay grantees to administer programmatic functions. One certain result of this change is that service-providing entities who apply directly for grant funds must now be equipped with the necessary internal systems for managing the resulting business relationships. This can be a great challenge for many organizations because it requires that they create the necessary infrastructure for invoicing, subcontractor oversight, and compliance, without additional funding to cover the added administrative burden.

HAHSTA believes this structure will more accurately reflect the continuum of care, providing patients with better services and promoting the ability of care providers to track patients through different aspects of care. However, the new RW RFA has created great concern, if not outright panic, among current award recipients about their ability to continue providing services. Because providers in the sub-tiers are no longer able to apply for funding directly, success or failure in the granting process depends on the ability of the top tier grantees to administer programs while also providing services. Some providers may lose funding if the top tier grant fails. Additionally, although HAHSTA is communicating with partners throughout the program roll-out, it is possible that while in transition, the combined pressures of the shift of administrative burden to the top tier service providers and the uncertainty in funding for sub-tier providers could have an impact on patients' ability to receive care across the District.

Finally, HAHSTA initiated the Effi Barry HIV/AIDS Capacity Building Program, using FY 2013 appropriated funds to provide individualized technical assistance and consultation services to eligible organizations to help ease the transition. In tandem with the Effi Barry RFA, HAHSTA invited all clinical and non-clinical providers funded, as well as all then-current RW grantees, to attend a three-day training to discuss provider collaboration and care coordination, which was the primary theme in the RFA. In these trainings, HAHSTA set out a framework that a new approach for the RFA was forthcoming and promoted strategic partnerships between clinical and non-clinical providers. Although this training

was voluntary, almost all providers were in attendance. Regardless, there still seems to be some concern among community-based providers that these changes were not adequately explained by HAHSTA.

DC Appleseed is very concerned about the new RW RFA on several fronts. First, it is not clear that first-tier grantees have the necessary infrastructure to administer large grants with critical intricate subcontracts. In coming years, DC Appleseed will assess the success of the transition, and the training and other support HAHSTA provides to enhance agency capacity. Second, it seems clear that any cost savings that HAHSTA might experience due to decreased administrative duties will not be passed on to grantees. Any reduction in resources previously engaged in direct administrative oversight by HAHSTA will be deployed to strengthen internal compliance and support the restructuring efforts underway in the agency. We urge HAHSTA to carefully evaluate this transition and to establish guardrails for first-tier grantees. DC Appleseed will carefully monitor subgrantee performance and service stability as the program rolls out. Finally, there are certain sub-populations who traditionally only received care from one local provider. These sub-populations are always at risk of losing access to care entirely if those providers are unable to secure funding, whether under the old RW RFA structure or the new one. Over the next year, HAHSTA should continue to track not only whether an appropriate amount of services in the spectrum of care are funded (and whether those services are funded adequately), but also whether those who receive funding are able to reach and provide care for the entire patient population.

CONCLUSION

Improving timely payment of invoices is paramount. This had been an area of substantial deficiency in past years, which we identified in our initial report and early report cards. The District cannot afford to go back to that era, especially in light of the anticipated changes. If grantees will be expected to do more, they must have confidence that they will be paid on time.

Grants Management will be an area in major transition over the next few years in the

District. Although we applaud HAHSTA's efforts to change with the times, successful change requires planning and buy-in by those whose collaboration is essential for success. In particular, we understand the concern of providers that they lack the capacity that the new RFA requires. We therefore recommend that HAHSTA continue external training and education efforts and monitoring of the community's reaction to the changes, as well as the administrative impact of the new grant structure, to ensure that these changes do not negatively impact the care provided by grantees. HAHSTA also must not relax its own internal training and compliance efforts. In recognition of HAHSTA's forward-thinking approach, but given some regression in other areas, the District's grade is reduced to a "B."

HIV SURVEILLANCE; MONITORING & EVALUATION

Fully and appropriately staff the office responsible for tracking HIV and AIDS. Publicly report data on HIV infections in the District. Implement a comprehensive system to monitor outcomes and maintain quality assurance standards in grant-funded HIV/AIDS prevention and care programs.

In this year's report card, DC Appleseed has combined the Surveillance section and the Monitoring and Evaluation ("M&E") section because these two topics are interrelated in terms of data gathering, reporting, and staffing. Despite this overlap, DC Appleseed will continue to grade the activities separately.

DC Appleseed remains concerned about lingering HAHSTA staff vacancies affecting both surveillance and M&E. The ongoing vacancy issue was compounded this year by new vacancies in Strategic Information Division ("SID") management positions. Within SID, three key staff positions have been vacant for most of the year; thus, the already overtaxed staff has assumed even more responsibilities. These vacancies include the Division Chief, the Deputy Division Chief, and the

Systems Administrator. At the time of publication of this report card, HAHSTA reports that they expect to interview candidates soon for the first position, are reviewing the responsibilities of the second, and are replacing the third with a new Health Informatics position that combines IT and data analysis. DC Appleseed urges HAHSTA to post and fill these vacancies as soon as possible. These positions are critical if the District hopes to maintain the progress it has achieved in measuring and monitoring HIV and AIDS.

HIV SURVEILLANCE: B+

In the *Seventh Report Card*, we kept the Surveillance grade at an "A-" because of concerns about the impact of continued staff vacancies on sustaining the improvements within HAHSTA, as well as the national leadership that HAHSTA has provided in the preceding few years. Because of ongoing staffing vacancies, the uncertain future of HAHSTA's academic partnership with GW, and delays in reporting on key HIV indicators, the District's grade this year is a "B+."

As DC Appleseed reported in previous report cards, HAHSTA's academic partnership with GW has been central to the progress that SID has made in surveillance in recent years. The partnership focuses on surveillance protocols, the NHBS studies, epidemiological technical assistance, research projects, and learning opportunities for students. The GW contract has been extended through 2014, the final option year for the contract. HAHSTA has seen tremendous benefits from the partnership, especially in building internal capacity for core surveillance activities. DC Appleseed strongly recommends that the District continue to prioritize this relationship and allocate resources to ensure the next phase of an academic partnership at HAHSTA.

SID and GW continue their work on important research projects:

- In the second phase of the Enhanced Comprehensive HIV Prevention Planning ("ECHPP II") project they are identifying factors associated with retention and continuity of care.

- They are collaborating with NIH on the DC Cohort Study, which is enrolling outpatients from 12 clinics in DC and collecting clinical data in order to evaluate the quality of HIV/AIDS care provided in the District. Study data also are being used to strengthen surveillance accuracy and identify individuals receiving care in multiple places. The data were used to conduct a recapture blitz to identify persons who previously have been in treatment but who had since fallen out and to re-engage them into care.
- SID conducted a larger scale recapture blitz with HAHSTA Care Division and Ryan White providers to identify clients who may have fallen out of care for re-engagement by providers.
- SID participated in the “Regional Sharing of Infectious Disease Data in the DC Metropolitan Region” conference coordinated by Georgetown University to build cross-jurisdictional and interdisciplinary relationships in the effort to control HIV/AIDS in the region.
- HAHSTA has begun using social network testing to find new positive cases of HIV, an effort which HAHSTA believes places it at the cutting edge of data collection.
- HAHSTA participated in the NIH funded HPTN 065 Testing, Linkage to Care Plus Study, whose study period ends in December and whose data will be available in 2014.

SID and GW continue to work on the NHBS. In 2012, NHBS work included publication of the 2012 report on the second injection drug user (“IDU”) cycle; analysis and reporting on the heterosexual cycle; and completion of data collection for the men-who-have-sex-with-men (“MSM”) cycle. This year, the third MSM cycle data were published. Of the study participants, 12 percent tested HIV positive and about 23 percent of the persons who tested HIV positive were unaware of their diagnosis, an improvement from the 41 percent in the 2008 study. The 2014 report will focus on the third cycle of heterosexual data.

SID staff continue to participate in national conferences and work groups, including:

- Presentations at the 2013 Conference on Retroviruses and Opportunistic Infections on the prevalence of syndemics among newly diagnosed HIV infections in DC; and on early HIV infections among MSM in five US cities.
- Presentations at the 2013 Surveillance Grantees Meeting on the prevalence of syndemics among newly diagnosed HIV infections in Washington, DC; on utilizing surveillance data to confirm newly identified positive test results for social network testing of HIV; and on novel use of data dashboards in HIV surveillance and analysis.
- Presentation at the November 2013 annual meeting of the American Public Health Association on retention in care among young black and Latino MSM in the District of Columbia, 2005-2009.
- Participation in the CDC’s work group updating surveillance guidance on how to integrate incidence into core surveillance.

HAHSTA continues to use CDC’s Serologic Testing Algorithm for Recent HIV Seroconversion (“STARHS”) which has been used at the national level and in several other jurisdictions to estimate HIV incidence. However, as reported in last year’s report card, this algorithm has been found to be inaccurate in small populations, and CDC discourages its use for estimating incidence in local populations. Accordingly, HAHSTA supplements the STARHS data with available information on testing and treatment history in order to measure and monitor incidence. DC Appleseed is discouraged that HAHSTA monitors HIV incidence but still does not report it publicly. In the absence of incidence reporting, the Epi Report presents — for the second year in a row — information on new HIV cases separate from AIDS cases. Though not as useful as HIV incidence data might be, HAHSTA’s reporting of newly diagnosed HIV cases helps to provide some basis for understanding transmission trends in the District. The difference is that new HIV cases refers to cases diagnosed in a year (i.e., positive HIV test results), while incidence refers to the transmission of HIV, which may have occurred long before testing and diagnosis.

DC Appleseed also is concerned that HAHSTA does not provide current data. The 2013 Annual Report provides data through December 2011. Other jurisdictions report much more current data in their reports. California's most recent *HIV/AIDS Surveillance in California* report, includes data through June 30, 2013, and in April 2013 the Minnesota Department of Health published reports on new HIV infections during 2012. DC Appleseed recommends that HAHSTA report promptly on the most current data available, so that timely data are available to assess the District's response to changes in the development of the epidemic.

HAHSTA reports that it will initiate a pilot program at its STD Clinic in late November and currently is providing support to UMC with a fourth generation HIV test, which can detect acute HIV infection, as reported in the Testing section of this report card. DC Appleseed applauds this as an important step forward for the District in the monitoring and reporting of incidence, and we recommend that HAHSTA expand the availability of this technology.

Along with the 2013 Epi Report, HAHSTA released a *Supplemental Report: Clinical and Care Dynamics* ("Supplemental Report") and launched an Interactive Data Dashboard. The Supplemental Report used laboratory data to show trends in HIV care utilization and health outcomes among persons living with HIV in the District. The dashboard, available on HAHSTA's website, is a tool that allows visitors to filter HAHSTA data and produce customized charts and graphs. DC Appleseed applauds this initiative by HAHSTA to make data more accessible to the community.

HAHSTA continues to make progress in measuring and reporting HIV/AIDS surveillance data and trends, and we hope to see HAHSTA regularly identifying challenges and developing plans for addressing them. However, because of repeated and ongoing staffing issues, the uncertain future of its academic partnership with GW, and the lack of timely publication of data on key indicators of HIV/AIDS infection, the District's grade is reduced to a "B+."

MONITORING & EVALUATION: C+

In the *Seventh Report Card*, the grade for M&E was kept at a "B-" because of concerns about staffing and continued delays in the implementation of Maven, an integrated data collection program. Because these concerns continue, the District's grade is reduced to a "C+."

Since 2009, HAHSTA has been developing a comprehensive M&E software program intended to simplify and improve data collection, analysis, and reporting for HIV and AIDS, hepatitis, STDs, and TB. The program under development is based on the Maven software platform and has been referred to as "Maven" in previous report cards. Since the last report card, HAHSTA has given the program the name DC Public Health Information System.. DCPHIS aims to be a secure, integrated database system replacing the myriad of current different databases across all disease areas used by providers to meet all federal and local reporting requirements. Despite the long-anticipated great promise of DCPHIS, funding difficulties have delayed its launch, and although HAHSTA has reported in the last two report cards that its launch was imminent, the use of the DCPHIS for HIV and AIDS is still not operational. HAHSTA reports that the HIV, STD, and hepatitis modules progressed recently from the software developer environment to the DOH testing environment. HAHSTA aims to have the HIV module in use by the end of 2013. HAHSTA also reports that it is working with DOH IT to initiate limited Electronic Lab Reporting, which it expects will more efficiently update real time clinical lab data.

HAHSTA reports that DCPHIS needs additional user testing and program refinement before it can be launched and implemented. HAHSTA reports that it has identified funding for the Health Informatics position (mentioned above) through its CDC Surveillance Grant and is waiting for the position central to this work to be filled. HAHSTA does not expect that extensive training will be needed, because HAHSTA will not be deploying the field user component of the system. HAHSTA will be using the system internally with community partner information. Community

partners will be submitting data electronically that will then be imported into DCPHIS.

While work on DCPHIS continues, HAHSTA is implementing a short-term solution, through CAREWare, to collect, monitor and evaluate, and report on projects that are funded by Health Resources and Services Administration ("HRSA") for HIV and AIDS. CAREWare, a HRSA-supported, scalable client-level data software for services funded by Ryan White, will be used for the centralized care and treatment system, and eventually for housing, as well. Because CAREWare is able to generate the provider- and grantee-level reports, as well as quality indicators, it satisfies the HRSA-funded component of the programs. HAHSTA also has identified Ryan White funding for a Health Informatics position to provide IT support and data analysis.

HAHSTA-funded prevention and testing programs are monitored through submission of monthly reports from providers. These reports contain quantitative information based on specific project goals established by HAHSTA by program area and testing, linkage, and treatment initiatives. They break down the number of persons targeted, tested, and linked to HIV care. These reports additionally contain qualitative information that allows providers to add programmatic detail showing the processes by which they achieve testing, linkage, and care goals. These processes are discussed with individual project officers and other HAHSTA staff who advise providers on any suggestions to program improvement. The project officer assigned to specific organizations reviews monthly reports and works with the providers to achieve the goals set forth in each sub-grant agreement. HAHSTA provides technical assistance as needed. The monitoring and evaluation team meet regularly with providers to train them on changes to policies and procedures for data reporting.

DC Appleseed is encouraged that HAHSTA appears to have identified funding for key vacancies, reports recent progress in the development of DCPHIS, and has implemented mechanisms to maintain monitoring and evaluation functions. However, because vacancies remain unfilled and DCPHIS is still not operational for HIV, the District's grade for M&E is reduced to a "C+."

HIV TESTING: A

Continue to support and expand routine HIV testing in all medical settings, targeted areas in the community, and in non-traditional settings.

To combat the HIV/AIDS epidemic effectively, it is critical that individuals be aware of their HIV status. HIV positive people can seek necessary care and treatment earlier, leading to better health outcomes and longer lives. In addition, those who know that they are HIV positive are more likely to take steps to prevent the transmission of HIV.

In our *Seventh Report Card*, the District's Testing grade was reduced modestly from an "A" to an "A-." Though the number of public-supported HIV tests increased, totaling 122,356 in FY 2011 (an 11 percent increase over FY 2010), providers reported shortages of necessary testing supplies and inadequate communication between HAHSTA and community testing partners for a second year in a row. In this report card the grade is raised to an "A."

In the past year, the District has continued to expand its HIV testing program. HAHSTA surpassed its 2012 goal of 125,000 publicly-supported tests by supporting 136,885 tests, an increase of roughly 13 percent over FY 2011. HAHSTA target numbers for FY 2013 were again 125,000 tests and the agency reports being on track to meet or exceed this goal in 2013. From October 2012 through July 2013, the agency received reports of 120,517 tests. Seventy-four percent of these tests were conducted in a clinical setting, and 26 percent were conducted in a non-clinical setting, with a total of 585 positive test results, 486 or 83 percent of which were new positives. HAHSTA aims to increase the number of tests delivered by clinical and non-clinical providers by five percent each year from 76,161 tests in 2011 to 92,574 tests by 2015. HAHSTA also seeks to increase the proportion of individuals in the general population who indicate they have been tested for HIV from 51 percent in 2013 to 90 percent by September 30, 2015.

In FY 2013, the District provided direct funding support in excess of \$2.3 million to 19 entities to implement HIV testing in 11 clinical and eight non-clinical settings. HAHSTA also

supports 56 programs and has spent more than \$1 million annually through its test-kit distribution and technical-assistance program, which provides free rapid testing technology (OraQuick Advance and Clearview) as well as training in areas including test administration and counseling to District organizations. In addition, HAHSTA continues to partner with seven of the District's eight hospitals, providing test kits and funding for testing programs.

In contrast to previous report cards, DC Appleseed has not received many complaints from providers this year regarding the availability of test kits or provider training for HIV testing. DC Appleseed applauds this progress, and hopes that in the future HAHSTA will continue to minimize delays in providing kits and scheduling trainings.

Over the past year, HAHSTA was involved in many testing and outreach initiatives. In collaboration with Gilead, it continues to provide testing at the Anacostia Economic Security Center. In addition, HAHSTA currently provides testing at the Department of Motor Vehicles and at the Crew Club, both of which began as collaborations with Gilead. Under the 12 Cities Minority AIDS Initiative Technical Capacity Expansion Grant program, HAHSTA partnered with APRA and DMH to establish universal substance use, mental health, and HIV screening sites. HAHSTA also engaged in testing and outreach to senior citizens; faith-based communities; ethnic minority communities; lesbian, gay, bisexual, and transgender communities; youth; couples; incarcerated individuals; citizens returning from recent incarceration; and social networks among youth, sex workers, heterosexual men and women, and injecting drug users ("IDUs"). Through its outreach to youth, HAHSTA screened 5,870 youth for STDs through targeted outreach programs, surpassing its target of 5,000 and the 4,273 screened in FY 2011.

HAHSTA is collaborating with Gilead and UMC to offer fourth generation antigen testing to detect acute HIV infections. Fourth generation tests have greater testing sensitivity and can detect HIV before the body has begun to produce antibodies. If a blood sample comes back positive on the fourth generation test, a follow-up antibody test can be conducted to determine if it is an acute infection. With early detection, treatment

can start early and increase the likelihood of optimal health outcomes. In addition, an individual is most infectious when newly infected, so detecting someone's HIV infection early serves as a preventive measure. Gilead and HAHSTA are jointly funding this new form of antigen testing, which began at UMC on September 26, 2013. HAHSTA expects to start fourth generation testing at its STD clinic by the end of November 2013.

For many years, HAHSTA has sought to shift HIV screening from a targeted public health program to a routine medical standard of care. Among other efforts to make HIV testing more routine, HAHSTA has urged medical providers to make HIV tests a standard part of patient care and a test that is routinely billed. The agency also has encouraged providers to train all relevant staff members to perform HIV tests, rather than use dedicated employees for the purposes of HIV testing, because research has shown that HIV testing programs that implement HIV testing using existing staff are less costly than those that use parallel staffing models. HIV testing initiatives are more sustainable when incorporated into the regular practices of provider operations. HAHSTA reports that seven of the eight District hospitals currently provide routine HIV screening in their Emergency Departments. Testing efforts in six of these hospitals have expanded or will be expanded to inpatient and outpatient settings.

On November 20, 2012, the U.S. Preventative Services Task Force ("USPSTF") updated its recommendations on HIV screening, expanding its prior recommendation to include adolescents and adults aged 15 to 65 years who are not known to be at increased risk for HIV infection. Under the ACA, new health plans and policies must cover USPSTF-recommended preventative services, which now include HIV testing, without patient copayments. HAHSTA believes that the USPSTF's recommendations combined with providers' ability to now bill for HIV testing will help substantially to reinforce HAHSTA's message that HIV testing should be a routine part of providing health care treatment. HAHSTA believes these changes also will help to maximize third party reimbursement for the HIV screenings being performed.

HAHSTA has sought to reinforce its message to providers regarding routine HIV testing

through the District's collaboration with the Alosa Foundation, whose representatives have visited physician's offices to inform and update practitioners on HIV/AIDS diagnosis and treatment management. Through August 2013, representatives made 379 visits to private physicians' offices and provided educational sessions to 1,146 providers (physicians, nurses, physician assistants, and other practitioners) and staff. Of those 379 physicians, 308 (81 percent) agreed to implement routine testing. HAHSTA plans to continue this program through February 2014 and will add a Hepatitis C screening component in November 2013. HAHSTA is confident that HIV testing has increased as a result of this program. Unfortunately, the increase is difficult to measure, because providers are not required to report whether they conduct HIV testing. In order to better capture these data, HAHSTA hopes to establish a data-sharing agreement with the District's Department of Health Care Finance ("DHCF").

Because the ability to be reimbursed for HIV testing is new in the District, HAHSTA reports that some entities offering testing remain concerned about their ability to seek and receive third party payment. However, HAHSTA staff members have been collaborating with entities such as DHCF to become a resource for clinical HIV testing partners who wish to implement billable models. In addition, HAHSTA also is investigating whether the CDC may be able to provide technical assistance on billing practices for HIV screening programs.

Of concern is this year's Epi Report, which indicates that although the number of new AIDS cases has declined, the proportion of late testers has been rising since 2009. DC Appleseed recommends that HAHSTA develop a strategy to address this troubling trend and also start recording the proportion of people testing who are first-time testers.

DC Appleseed commends the District for the overall increase in HIV tests performed in the District, the expansion of routine screenings, its ongoing efforts to make HIV testing a routine part of patient care, and the collaborations that incorporate new testing technology to find the undiagnosed. To maintain this progress, DC Appleseed recommends that HAHSTA tracks first-time testers, continues to scheduling trainings, and continues to

support and expand routine HIV testing in all medical settings as well as in targeted areas in the community and non-traditional settings. This year the grade is an "A."

CONDOM DISTRIBUTION: A

Continue to expand condom distribution in the District.

Condom use is universally regarded as a safe and effective HIV prevention measure. In DC Appleseed's *Seventh Report Card*, the District's grade for Condom Distribution was maintained at an "A-." Although HAHSTA had distributed an impressive number of condoms, successfully continued its DC Female Condom Project, and enacted other social media campaigns, DC Appleseed raised concerns regarding ongoing supply issues and a failure to fully communicate supply issues to providers. Because these concerns have been addressed and HAHSTA's otherwise impressive performance on this issue has continued, in this report card, the grade is raised to an "A."

HAHSTA reports that the District distributed 5,747,000 condoms in FY 2012 (a 25 percent increase over FY 2011) and 2,414,000 packets of lubricant. HAHSTA's target for condom distribution for FY 2012 was 4.5 million, meaning that it exceeded its goal by 28 percent. HAHSTA's condom distribution network includes 598 community partners in the District, an increase of 26 percent over the number of community partners reported in the *Seventh Report Card*. The types of community partners include: businesses, college and university groups, schools, faith-based organizations, and government agencies. In FY 2013, again the District's goal was to distribute 4.5 million condoms. This goal was exceeded since HAHSTA distributed 6,577,500 male condoms and 76,720 female condoms ("FC2"). HAHSTA aims to distribute six million condoms in FY 2014.

As reported in the *Seventh Report Card*, HAHSTA partnered with a new condom vendor in FY 2011, Ansell Healthcare LLC. Ansell remains HAHSTA's vendor for the general condom program. Last year, we reported that HAHSTA had encountered significant supply



Know Your Rights



- » The MPD supports the distribution of condoms to help prevent the spread of HIV and other sexually transmitted diseases.
- » Individuals are allowed to carry as many condoms as they want. There is no “three condom rule.”
- » MPD officers cannot conduct a stop or conduct a search of a person or premises based on whether or not that person possesses condoms.

Making a Complaint Against a Police Officer

Office of Police Complaints

1400 I (“Eye”) St, NW, Suite 700, Washington, DC 20005

(202) 727-3838

OPC’s 24-hour, toll-free hotline: **(866) 588-0569**

For more information, visit policecomplaints.dc.gov

You may also obtain a form at any MPD district station

issues with Ansell. We are pleased to report that this year, HAHSTA has not reported similar issues. Furthermore, DC Appleseed has not heard about significant condom shortages or delays from any community providers. DC Appleseed applauds HAHSTA for addressing this important concern.

HAHSTA has continued its community outreach efforts to promote condom use, including efforts to promote FC2 use through a television advertisement. Furthermore, the Female Condom Project (“Project”) received a fourth year of funding from the MAC AIDS Fund. From February 2010 to October 2012, the Project educated 76,000 individuals, distributed 550,000 FC2s, trained over 600 peer educators, and enlisted more than 300 locations to distribute FC2. HAHSTA provided over 76,000 female condoms to community partners for distribution in FY 2013. The focus for this last year of the initiative was training medical providers, particularly OB/GYNs in both clinic settings and private practice, as well as young people and youth-serving organizations.

HAHSTA’s FC2 social marketing campaign, “DC’s Doin’ It,” held focus groups to develop educational and promotional materials for FC2 use among MSM. HAHSTA also translated these instructions into Spanish and updated the website’s Spanish content. Additionally, HAHSTA ran a television advertisement on local channels that was designed to de-stigmatize FC2 use by informing viewers that female condoms can fit comfortably and are easy to use.

HAHSTA also funded two condom distribution projects that targeted social networks of MSM. The programs were geared to Latino, African American, and white MSM. Between

January 2012 and March 2013, the two programs distributed close to 430,000 condoms.

HAHSTA continues its “Rubber Revolution” and “DC’s Doin’ It” social marketing campaigns, which DC Appleseed has reported on in previous report cards. Since the last report card, HAHSTA released a mobile version of the Rubber Revolution website on National Condom Day (February 14th) and made street pole banners for the International AIDS Conference. HAHSTA also developed the Rubber Revolution television advertisement that was broadcasted on WJLA, WDCW, and various cable networks. The Rubber Revolution Campaign also created advertisements featuring older adults. For example, HAHSTA created advertisements comparing condom use to a form of “Social Security.” The “Social Security” advertisement received a 2013 Gold Hermes Creative Award from the Association of Marketing and Communication Professionals for its creative achievement in the advertising/outdoor category.

Additionally, HAHSTA initiated a new program aimed at young adults called “#ShowOff.” The agency developed the idea from the use of focus groups. The program is designed to address peer norms among young adults. The agency determined that adolescents know how to use condoms but do not use them all the time and that they have multiple partners. The agency has designed the campaign to address these issues. Currently, HAHSTA uses Instagram and Twitter as the platforms for this campaign.

DC Appleseed also applauds the Metropolitan Police Department for clarifying that they will not use possession of condoms as evidence of prostitution. They also produced and distributed educational cards with this

information and with information on how to report complaints against a police officer.

The District has continued to achieve ambitious condom distribution goals. This year HAHSTA has been better able to manage supplies, distribution, and communication with its community partners while maintaining active and, we believe, successful public service messaging about the importance of condom use. Therefore, the grade in Condom Distribution is raised to an “A.”

PUBLIC EDUCATION IN THE DISTRICT

Establish mechanisms for ensuring compliance with system-wide health standards, including HIV/AIDS prevention; provide data-driven information to public about compliance with standards; develop a plan for enhancing HIV/AIDS policy for public education in the District.

In the *Seventh Report Card*, DC Appleseed reported on the DC public education system’s continued efforts to comply with the HSA, which was passed by the DC Council in May 2010. The HSA requires all DCPS and public charter schools to meet benchmarks, such as providing a minimum amount of health education per week to students in grades K-8 and establishing a health education curriculum that complies with the Health Education Standards. D.C. Code § 38-824.02(b) (“Public schools and public charter schools shall provide health education to students . . .”); *id.* at § 38-824.02(d) (“The . . . health education required by this section shall meet the curricular standards adopted by the State Board of Education.”). OSSE, DCPS, and DC public charter schools are primarily responsible for providing and assessing HIV/AIDS education in the District. OSSE functions as the State Education Agency for the District. DCPS and each public charter school function as separate school districts or Local Education Agencies (“LEAs”). DC currently has 61 LEAs. Under the HSA, every LEA is required by law to meet the Health Education Standards, and OSSE is responsible for assessing and reporting on progress in meeting them.

To evaluate the respective roles of OSSE, DCPS, and the DC public charter schools, DC Appleseed provided separate grades for each in the *Seventh Report Card*. Due to its successful implementation of the Health and Physical Education Assessment (“Health Assessment”), OSSE received a grade of “B-.” DCPS received a “B+,” reflecting its continued achievement in providing HIV/AIDS education, including adjusting curricula and supporting professional development. The public charter schools received a grade of “C” due to a lack of information and transparency in HIV/AIDS education.

Now, over three years since the passage of the HSA, DC Appleseed finds that glaring inadequacies remain with respect to HIV/AIDS education in the District. While substantial progress has been made by DCPS in providing HIV/AIDS education to students in traditional public schools, the DC public charter schools and OSSE have fallen short in their responsibility to provide students in charter schools adequate HIV/AIDS education. This is particularly disturbing given the growing share of DC youth that public charter schools now educate. Despite their good intentions, DC public charter school leaders told DC Appleseed that they are subject to incentives that deemphasize sexual health education, and they have not received sufficient guidance from OSSE. For its part, OSSE needs to properly incentivize DC public charter schools to prioritize sexual health education. OSSE could, for example, promulgate official rules and regulations under the HSA, which would explain the specific HSA obligations that all DC public schools are subject to and how schools that do not meet such obligations will be held accountable. OSSE also could release Health Assessment scores on a school-by-school basis to increase transparency and balance schools’ incentives. With substantial concern for the health and well-being of the District’s youth, DC Appleseed urges OSSE to take action to ensure that DC public charter schools are properly educating students about sexual health education.

OSSE: C

In the *Seventh Report Card*, we praised OSSE for making significant progress in developing the Health Assessment, which is

comprised of 50 multiple-choice questions covering a range of health topics, including HIV/AIDS. The Health Assessment is administered as part of the DC Comprehensive Assessment System (“DC CAS”) testing in Grade 5, Grade 8, and one grade in high school. Notably, no other jurisdiction in the country conducts standardized tests for health and sexual education. In both 2012 and 2013, Health Assessment participation was very strong, with every school, including public charter schools, completing the 2013 Health Assessment. The Health Assessment results in both 2012 and 2013 are promising. Overall, students answered 63 percent of the questions correctly in 2012 and 64 percent of the questions correctly in 2013. For the most recent Health Assessment, 8th grade students answered 59 percent of human development and sexuality questions correctly and high school students answered 73 percent of questions correctly. Going forward, health teachers will continue to participate in content and bias review in order to refine the Health Assessment questions.

However, OSSE has elected for the second year to publish the Health Assessment results in the aggregate, rather than for each individual school. This approach lacks transparency, reduces accountability, and hardly serves the efforts to balance schools’ incentives to ensure proper resources are devoted to sexual health education. DC Appleseed strongly urges OSSE to publish future results of the Health Assessment on a school-by-school basis, as OSSE does for other sections of the test.

Similarly, OSSE has not adopted official rules pursuant to the HSA to properly incentivize schools to dedicate sufficient time and resources to health education. Under the HSA, OSSE is given the authority to promulgate official rules and regulations, including rules and regulations regarding required health education curricular standards. At present, OSSE only refers to the Health Education Standards as “guideposts” and acknowledges that there are “many ways or models” for the development of instruction and assessment. Without more, it will remain ambiguous as to how these standards should be implemented and monitored. This issue is especially pressing for the public charter schools, which do not enjoy the

same benefit as traditional public schools of a centralized office offering guidance. Section 38-828.01 of the HSA states that “[t]he Mayor . . . shall issue rules to implement the provisions of this act.” (Emphasis added). Under the DC Administrative Procedure Act, OSSE, as an executive agency of the Mayor, can promulgate rules following the same notice-and-comment process that is used to effectuate regulations on a variety of subjects in the District. By promulgating regulations as to the enforcement and scope of the HSA, OSSE could provide guidance to the public charter schools as to their obligations under the Act and could properly align public charter schools’ incentives with those of the District’s youth, who are entitled to an adequate health education.

Each year, OSSE collects data for HSA school health profiles, and every other year, OSSE collects data for CDC school health profiles. OSSE should be commended for the high participation rate of both profiles, including 90 percent participation for the HSA profiles. These profiles are used to ensure that schools are in compliance with minimum health requirements. However, aside from removing obvious outliers, OSSE does not have an auditing or verification system in place to monitor the self-reported information. DC Appleseed recommends that OSSE, either on its own or in collaboration with local organizations or universities, find a cost-effective way to audit the data it receives from the HSA profiles.

OSSE’s work with respect to professional development and training, special programs, and curricula refinement appears to be moving in a positive direction, as evidenced by the following:

- OSSE uses the Health Education Curriculum Analysis Tool to review sexual health curricula. OSSE inputs data based on how the curriculum meets national health standards, submits those data to a third-party vendor for review, and sends the results to an advisory board. After the health curricula are reviewed, OSSE shares example curricula with both DC public schools and public charter schools so that the schools can incorporate relevant material into their own sexual health programs.

- OSSE has improved their professional development programs in two ways. First, they are using the aggregate scores on the Health Assessment to determine areas that require increased training and are tailoring their professional development programs to meet those high-need areas. Second, they have worked to create more online training and web-based seminars.
- OSSE trains approximately 20 Youth Advisory Committee (“YAC”) members on issues of sexual health, mental health, and domestic issues. This year, the YAC partnered with HAHSTA and Advocates for Youth to pilot a student-version of Wrap M.C. in schools. Wrap M.C. is a condom distribution program that educates individuals on what condoms protect against, how to use them, and how to negotiate condom use with partners.
- OSSE has continued to receive funding through DC Personal Responsibility Education Program. As described in the *Seventh Report Card*, this funding is used to provide grants to five organizations to implement an evidence-based program designed to educate adolescents on both abstinence and contraception to prevent pregnancy and sexually transmitted infections, including HIV/AIDS. Due to their success over the past year, OSSE elected to fund the same five groups who received funding last year. These groups served approximately 885 youth from April 2012 to March 2013.

DC Appleseed commends these efforts and encourages OSSE to build on them.

OSSE receives a grade of a “C.” While OSSE has continued to refine health curriculum, health programs, and Health Assessment questions, DC Appleseed urges OSSE to properly incentivize public charter schools to provide adequate HIV/AIDS education. These efforts could include, but are not limited to, publicizing the Health Assessment scores on a school-by-school basis, so as to provide parents, students, and the public information about the quality of each school’s health program; auditing the school health profile data, so as to provide more reliable information to the public about the amount of health education each student receives; or adopting official rules and regulations pursuant to the

HSA, so as to create clear requirements for an even playing field among public charter schools with respect to health education. DC Appleseed exhorts OSSE to use these tools at its disposal to ensure that all DC youth, including those at public charter schools, receive adequate health education, and specifically HIV/AIDS education.

DCPS: B+

In the *Seventh Report Card*, we credited DCPS for its evidence-based interventions and use of strategic partnerships to bolster sexual health education curricula; its steady progress with respect to teacher accountability and professional development, which notably included the third annual health summit in March 2012; and its expanded pregnancy prevention programs, such as New Heights program for expectant and parenting students.

DCPS has continued many of the developments that were indicated in the Sixth Report Card and *Seventh Report Card*. In particular, DCPS made continued strides with curriculum development, student programs, hiring practices, and professional development. DC Appleseed remains encouraged by the multifaceted approach embraced by DCPS.

The health curriculum remains largely the same as in past years, in an attempt to maintain continuity. DCPS has instituted a web-based education program called Discovery Health, which is an easily updated teacher resource. DCPS also has developed an “Ed Portal” that allows them to better distribute information to teachers.

DCPS has utilized some promising student programs. This year, DCPS made condoms more available in the schools by expanding the Wrap M.C. program and the Student Wrap M.C. delegates. Additionally, students are able to obtain condoms from school nurses, as well as Wrap M.C. trained school staff and students. DCPS, in partnership with DOH, piloted an HIV testing program — as part of the ongoing STD screening program — which includes a short mandatory workshop and voluntary screening.

In addition, DCPS has maintained their other programs, including work with the Gay, Lesbian & Straight Education Network. DCPS

has received additional funding through a grant from the CDC Division of Adolescent School Health. This grant will be distributed over five years and will be used to further support teachers in delivering the sexual health curriculum, expand access to sexual health services in schools and referrals to community providers, promote sexual health policies, fund more web-based educational programs, provide additional training for school staff and expand DCPS's Lesbian, Gay, Bisexual, Transgender, and Questioning awareness programs.

DCPS conducts four to five mandatory professional development training days during the course of the year, with the collaboration of community-based organizations ("CBOs"). Reflective of other health developments, DCPS has changed the focus of professional development from print materials to other training methods. Partner organizations include Metro TeenAIDS, which hosts the annual Health Summit, and Be Dramatic, which utilizes dramatic performances to teach about health.

DCPS should be commended for hiring a Manager of HIV/STI Prevention, who is responsible for managing the five-year CDC grant, while developing and implementing evidence-based, youth development and school-based programming that address risk factors that negatively impact health and academic outcomes. Overall, DCPS has continued the strong programs that have been in place. DCPS also has made great strides with the new online curriculum and training programs and measures to facilitate condom distribution. DC Appleseed hopes to see further development of this holistic approach, in combination with effective integration of fast-developing technologies. For this continued strong effort, DCPS' grade is a "B+."

PUBLIC CHARTER SCHOOLS: C

In the *Seventh Report Card*, DC Appleseed concluded that although intentions among the public charter schools showed promise, their efforts to date did not reflect the sense of urgency and comprehensive planning needed to afford DC students necessary HIV/AIDS education. DC Appleseed also called on the Public Charter School Board ("PCSB"), which has primary oversight responsibility

for DC public charter schools, to take a more active role in encouraging and assisting public charter schools to improve their HIV/AIDS education. This included, among other ways, that PCSB integrate the results of the Health Assessment into its Performance Management Framework used to evaluate public charter schools.

The conclusion of the last report card, unfortunately, remains true. Little transparency and accountability exist with respect to sexual health education across charter schools. This is due in part to the nature of charter schools, which operate as independent LEAs with less oversight from DC government. But it also is attributable to other factors, such as pressures associated with testing and funding regimes, and relationships with OSSE and the DC State Board of Education. Nevertheless, the public charter schools are *required* to abide by the HSA and should make every effort to incorporate the Health Education Standards into their health curricula.

While there also is a dearth of data to evaluate the charter schools as a whole, partly because test scores have not been released on a school-by-school basis, the data that do exist show some progress. For example, all but one charter school participated in the Health Assessment, almost 98 percent of charter schools completed the HSA school health profile, and over 80 percent of charter school students receive some form of health education.

In light of the disparate nature of charter schools, DC Appleseed endeavored this year to meet with individual charter schools with respected HIV/AIDS education programs to better understand the barriers and challenges they face, and to generate possible solutions that could be adopted across schools on best-practices or other bases. The school administrators that DC Appleseed interviewed were overwhelmingly supportive of sexual health education and agreed that it is essential to ensure the health and wellness of their students. Nevertheless, they recognized a number of issues that make it difficult for charter schools to provide sexual health education.

Based on meetings with administrators, it is evident that the primary challenges charter schools face are twofold: lack of resources

and demands that do not account for sexual health education. Each school has limited funds by which it can support its programs. This issue is exacerbated, however, by testing and funding demands placed on schools which do not prioritize, or even account for, sexual health education. With limited funds and time, even despite the best of intentions, charter schools face undeniable disincentives to spend more time and resources on sexual health education.

Despite these challenges, DC Appleseed is encouraged that several charter schools have at least formed partnerships with community organizations, such as Metro TeenAIDS and Peer Health Exchange, that offer their own resources and staff to educate charter school students. These community partnerships have allowed charter schools to educate their students about HIV/AIDS and other STDs while imposing minimal burdens on the charter schools' resources. DC Appleseed also learned that many charter schools participate in national school-based surveys such as the California Healthy Kids Survey, which help schools understand the health behaviors of their students rather than relying on the Youth Risk Behavior Study "YRBS" data which are generalized data and only collected every other year.

DC Appleseed recommends that charter schools request that OSSE to release Health Assessment results on a school-by-school basis, as OSSE does for other subjects. This will at least allow for a minimal review of charter schools' health education programs, while maintaining an even playing field across all schools.

In terms of facilitating collaboration among schools, DC Appleseed strongly recommends that PCSB continue to take a more active role, which it seems to be embracing. For example, PCSB has hired a manager of intergovernmental relations, whose responsibilities include coordinating with and disseminating information to charter schools about available sexual health education resources; this will allow community organizations offering available resources to more easily contact charter schools. As before, DC Appleseed also recommends that PCSB integrate health education, including HIV/AIDS education, data from standardized testing into their Performance Management Framework, as

PCSB does for other subjects such as English and Math.

Given that DC public charter schools now educate 44 percent of public school children in the District, DC Appleseed remains very concerned at the lack of transparency and progress with respect to sexual health education in public charter schools. In the last report card, we gave a grade of "C" due to the minimal progress the charter schools had made with respect to HIV/AIDS education. Over the past year, DC Appleseed, through our meetings with individual charter schools, has gained greater insight into the challenges and obstacles facing charter schools, and recognizes that certain charter schools have made real progress in refining their sexual health education programs. However, once again, public charter schools as a whole have achieved only marginal improvement. And, while DC Appleseed does not discount the efforts of individual public charter schools that have made concerted efforts to educate their students about HIV/AIDS, the public charter schools, *as a whole*, receive a grade of "C."

CONCLUSION

The DC education system has achieved progress over the past year in rolling out the Health Assessment, improving professional development opportunities, and refining health education curricula, among other achievements. These achievements should be commended. However, a glaring gap in HIV/AIDS education still exists within the District's public charter schools. This is due to a variety of factors, including the lack of official rules and regulations under the HSA and the lack of publicly-available data about the quality of each school's health program. DC Appleseed exhorts OSSE to implement a plan of action that ensures public charter schools provide their students with proper health education, especially HIV/AIDS education. DCPS, OSSE and the public charter schools also must work together to develop a system-wide plan for improving HIV/AIDS education. Without a clear plan and proper coordination, DC will not achieve the system envisioned by OSSE in its 2009 Youth Sexual Health Project, nor provide adequate HIV/AIDS education to all DC youth.

It is worth mentioning that while the role of the Deputy Mayor for Education and the State Board of Education are not assessed here, there should be more accountability from both of these institutions. For example, the Deputy Mayor for Education could take a more active role in supporting OSSE, and the State Board of Education could work to update and refine the Health Learning Standards, which are now five years old.

HIV/AIDS education in the District remains lacking, and it is the legal, indeed moral, responsibility of all stakeholders in DC to remedy that deficiency as soon as practicable.

SYRINGE ACCESS SERVICES: A-

Continue to fund syringe access and complementary services and adopt additional measures to address prevention with substance-using populations.

Since our original report, DC Appleseed has urged the District to support and expand SAS to help prevent HIV transmission and link IDUs with treatment, care, and services. DC Appleseed has worked closely with the DC Syringe Access Working Group, a coalition of service providers, policy advocates, and community partners, to monitor District policies and funding and to advocate for expanded services. In the *Seventh Report Card*, the city's grade for SAS remained a "B" because the funding level was not increased in FY 2011 and 2012. DC Appleseed was encouraged by the announcement last summer that more funding would be made available for SAS in FY 2013 and that new funding for complementary services also would be available. In this *Eighth Report Card*, the District's grade is raised to an "A-."

HAHSTA's Epi Report continues to show the success of public funding and expansion of SAS in the District. The Report shows that the percentage of new HIV cases associated with injecting drug use decreased 80 percent (from 149 cases to 30) between 2007 and 2011. During the same period the largest decrease in deaths by mode of transmission was among IDUs, decreasing 52 percent from 128 to 62. DC Appleseed recognizes the role the SAS programs played in providing

the testing and facilitating the linkage to care that are important complementary services that improve the health of IDUs participating in the programs.

After maintaining funding at \$580,000 in FY 2011 and 2012, in FY 2013 HAHSTA awarded \$667,430 of \$720,000 available for SAS. Four CBOs were funded: Family Medical Counseling Services ("FMCS") (\$450,000); HIPS (\$180,000); Bread for the City ("BFC") (\$37,430); and, Transgender Health Empowerment ("THE") (\$50,000). DC Appleseed commends HAHSTA for increasing the funding available and for the first time since 2007 adding a new provider aimed at a population that historically has been underserved. Unfortunately, administrative difficulties at THE resulted in the District's inability to fund the organization as anticipated. HAHSTA currently is exploring options to continue to provide SAS services to the transgender population.

In addition to funding for SAS, in FY 2013 HAHSTA awarded a one-time two-year Enhanced Harm Reduction Grant of \$198,500 to HIPS. With this grant, HIPS has been able to expand testing for hepatitis C and has brought together a working group of a broad continuum of service providers that have met several times over the past year. The working group aims to share resources, better coordinate services and referrals, and encourage retention rates among program participants who use drugs. After the initial two years, HAHSTA hopes that this working group will sustain itself beyond the current one-time funding. DC Appleseed recommends that the District continue to support the important new services and collaboration made possible with this funding.

HAHSTA reports that in FY 2012, the three funded DC NEX programs exchanged 598,000 syringes, an increase of 57 percent from the previous year, despite no increase in District funding. Of this total, FMCS exchanged nearly 417,000 syringes, HIPS 167,000, and BFC 14,000. In total, the programs reported 6,900 exchange transactions (an increase of 17 percent from the previous year), 1,300 linkages to HIV testing (a slight decrease from the previous year), and 275 linkages to drug and treatment services (up nominally). In FY 2013, HAHSTA targeted 450,000 syringes exchanged, and

as of the end of September the goal had been surpassed with nearly 648,000 syringes exchanged. By provider, the numbers are: FMCS 505,799 syringes, HIPS 133,954, and BFC 8,265. HAHSTA currently maintains its performance goal of 500,000 syringes exchanged in FY 2014.

One of the goals in HAHSTA's 2013 Implementation Plan is to "[s]ustain integrated service delivery within needle exchange programs" by the fall of 2015. HAHSTA expects to see the number of SAS participants receiving screenings for HIV, hepatitis, and STDs increase by 10 percent each year. Sustaining progress and achieving these goals requires steady and appropriate funding and support.

DC Appleseed is pleased that SAS programs continue to expand, that the data are showing the impact of these programs, and that HAHSTA has increased the funding and broadened its support to include important complementary services. Because of this progress, the District's grade is raised to an "A-." We hope that leadership continues to support these services and that a plan for conducting a needs assessment occurs in the near future to better understand the appropriate level and type of services needed to address HIV among substance users.

SUBSTANCE ABUSE TREATMENT: B+

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

Substance abuse treatment is an essential component of a successful response to the HIV/AIDS epidemic. People with substance abuse disorders are at heightened risk for contracting and spreading HIV due to their propensity to engage in other high-risk behaviors, such as sharing needles, unprotected sex, and intercourse with multiple partners. In addition, they may encounter difficulties accessing and adhering to HIV treatment. Effective substance abuse prevention and treatment can help to reduce these risks. Since our initial report, the District has improved its substance abuse treatment services, and has expanded them despite regular changes in leadership. The District

received a grade of "B+" in the *Sixth* and *Seventh Report Cards*. At the time of this *Eighth Report Card*, as the District is restructuring its administration of these services and facing significant funding changes, DC Appleseed gives the District's efforts on substance abuse treatment a grade of "B+."

APRA continues to experience a lack of steady leadership, with four Senior Deputy Directors since April 2011. Although substance abuse treatment providers have not reported significant disruptions in the day-to-day delivery of services, DC Appleseed remains concerned that leadership disruptions can cause uncertainty for providers and consumers. And consistent leadership is essential for the District's successful navigation of two major changes in the delivery of substance abuse treatment services: (1) the creation of DBH that combines DMH and APRA, and (2) implementation of key components of the ACA by January 2014. DC Appleseed does not have a position on whether the creation of the DBH is a good idea, but we believe that extra efforts are needed at this time of significant change to assure that the District continues to make progress in improving the substance abuse treatment efforts that are critical to fighting HIV/AIDS.

The DBH was established on October 1, 2013. The goal for the combined agency is to improve care across the full range of mental health and substance abuse treatment services. A substantial number of the approximately 32,000 individuals who sought treatment for mental health or substance abuse disorders in FY 2012 reported co-occurring disorders. Senior officials at DMH and APRA hope that the merger of the two agencies will help the District implement a "no wrong door" policy for these individuals. For example, one of DBH's first priorities will be to train both DMH and APRA providers to use a common screening tool, Global Appraisal of Individual Needs — Short Screener ("GAIN SS"), to screen patients for both mental health and substance abuse disorders.

DMH and APRA have reported that they are implementing the merger slowly and deliberately over the six to 12-month period following October 1, 2013, to allow providers to understand and adjust to changes in certification requirements, billing procedures, and

the like. For example, DBH has retained the separate certification standards and covered services for providers of substance abuse and mental health treatment previously administered by APRA and DMH, respectively. DBH also has continued DMH's moratorium on certifying new mental health providers in the District, which was based on DMH's conclusion that there were enough providers certified to serve the District's needs. DBH will establish a working group to examine streamlining and integrating these requirements and will use standard notice and comment procedures to announce any changes. DBH also plans to assess the potential interoperability of a new electronic medical records and billing systems started under DMH, called iCAMS, with APRA's District Automated Treatment Accounting ("DATA") system. iCAMS will potentially function as DATA's claims processing component beginning June 1, 2014. Other areas of common functionality will be evaluated in order to maximize use through a shared provider network. DC Appleseed will be following these next steps with interest to evaluate whether the two agencies will become truly integrated so that DBH can in fact deliver better-coordinated services.

At the same time, DMH and APRA have launched a number of new programs and initiatives related to mental health and substance abuse treatment services in the months leading up to, and immediately following, the effective date of the merger. It is not yet clear how DBH will assign responsibility for these initiatives or monitor their implementation. The combination of a new agency and new programs presents the risk of significant confusion among providers about the impact of the merger on the provision of services in the future. We urge the DBH Planning Committee to improve the transparency of its planning process and to provide more frequent and more detailed communications to providers as the Committee continues to implement the transition.

The second major transition is the expansion of the District's Medicaid program under the ACA, and the related changes in federal funding for substance abuse treatment services. APRA expected that a significant percentage — perhaps as high as 85 percent — of District residents who obtain substance

abuse treatment from APRA providers will be eligible for Medicaid under the expanded program. DBH hopes that Medicaid will be a sustainable source of funding for covered services, consequently freeing up monies for non-Medicaid services, such as transitional housing and other recovery support services. Achieving this goal will depend on the District's ability to expand the population and services covered by Medicaid while assuring an adequate number of treatment providers for Medicaid recipients and maintaining a steady funding source.

Throughout these changes the District continues to receive funding to support important programs described in previous report cards. The District Medicaid program pays for Adult Substance Abuse Rehabilitation services and DBH plans to work with Centers for Medicare and Medicaid Services ("CMS") and DHCF to further expand Medicaid-covered services in 2015. Under the National HIV/AIDS Strategy ("NHAS") "12 Cities Project" targeting jurisdictions most heavily impacted by HIV/AIDS, APRA continues to use federal grant funding to support its services for patient with HIV/AIDS under the Minority AIDS Initiative Capacity Expansion: Integrated Behavioral Health/Primary Care Network Cooperative Agreement. And APRA has continued to use federal funding from the Strategic Prevention Framework State Incentive Grants and the Access to Recovery Grant to support general treatment and prevention services which help reduce the risk of HIV infection and transmission — both these grants are set to terminate in 2014. APRA has continued to operate the Adolescent Substance Treatment Expansion Program allowing youth enrolled in Medicaid to participate in the treatment program of their choice. APRA also has continued to increase the number of individuals assessed for treatment. During FY 2012, APRA's "Assessment and Referral Center ("ARC") assessed 7,893 individuals, compared to 7,714 in FY 2011 and 6,643 in FY 2010. In July 2013, APRA launched the Rapid Project at the ARC to test the impact of a brief questionnaire-based assessment and intervention on reducing behavioral risk factors for HIV. In addition, APRA has continued its collaboration with PIW to conduct screenings at the DC Superior Court.

Detoxification services continue to be provided under contracts with two private entities, Providence Hospital Seton House and PIW. In FY 2012, 7,893 individuals received assessments through the ARC and 1,538 patients were referred for detoxification services in 2012.

The substance abuse treatment units at the DC detention facility, which are funded through the DOC local budget, Department of Justice Residential Substance Abuse Treatment ("RSAT") grant, and the DC Office of Justice Grants Administration, continue to serve a particularly vulnerable population. The RSAT men's unit serves approximately 60 inmates with four staff members. The female unit currently serves 13 women with one staff and a joint program assistant shared with the men's unit. The shared program assistant position was grant funded and is no longer funded. RSAT reports that they have a full-time permanent administrative position that remains unfilled secondary to the hiring freeze from the Mayor's office.

DC Appleseed continues to be impressed by the inmates' overwhelmingly positive comments about the program. During our visit to the RSAT units, inmates in the men's unit said they appreciated the opportunity to address their substance abuse and mental health needs and to receive effective treatment and education, including peer-to-peer counseling and GED courses. Inmates also praised the staff's dedication. However, inmates expressed a need for continued treatment and support after their release from the Jail.

The RSAT program has the capacity for 75 men and 25 women, but funding limitations have restricted the program's ability to hire additional staff needed to treat more inmates. Restricted funding, especially in light of increased uncertainty about the availability of federal funds in the next fiscal year, has limited inmates' options for continuing care after they leave the Jail. RSAT had funding from the Department of Justice through September 2013 for four peer specialists who help inmates adhere to treatment plans in the six months after their release. Due to the lack of appropriations for these positions for FY 2014, RSAT had to let its federally-funded peer specialists go. RSAT hopes to be able to hire one peer specialist for FY 2014 if

funding becomes available. Without additional staff, RSAT will be able to serve a fraction of the inmates released into the community. DC Appleseed recommends that the District provide sufficient resources to allow inmates to complete their recovery.

DC Appleseed supports the District's plans to provide better coordinated, integrated care across all mental health and substance abuse treatment services through DBH. We also are encouraged by the recognition among leadership at DMH, APRA, and now DBH, of the challenges posed by the changing funding landscape and its focus on the longer-term financial sustainability of substance abuse treatment programs. However, because so many of the changes needed to make progress towards these two objectives have yet to be implemented, the impact of those changes on access to vital substance abuse treatment services remains to be seen. We are eager to see how DBH navigates these transitions to expand access and improve the delivery of efficient, high-quality care to District residents. The District's grade for Substance Abuse Treatment is kept at a "B+."

HIV/AIDS AMONG THE INCARCERATED: A

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

The District continues to make steady progress on testing, treatment, and discharge planning for HIV and AIDS among the incarcerated. The District's grade was an "A" in the *Seventh Report Card*, for its commitment to the care and discharge planning needs of those with HIV and AIDS in the Jail. In this report card the grade remains an "A." The District continues to reach a large number of inmates through its testing methods and offers discharge planning and other services to HIV-positive inmates.

The DOC continues to offer rapid HIV testing to inmates. Unlike in prior years, DOC did not experience any problems in obtaining test kits. DOC inmates initially are offered testing

at the time of intake and are provided pre and post-test counseling. Intake testing is available to all newly incarcerated individuals who do not have a documented HIV test within the last six months. Additional testing options are available to inmates incarcerated at DOC detention facilities, including requesting an HIV test at sick call, and routinely during an inmate's annual health screening.

The RFP for the provision of medical services seeks to increase the testing frequency from the current six month standard to three months. The DOC's current HIV testing program exceeds Centers for Disease Control and Prevention ("CDC") guidelines, which recommend that inmates who are at high risk for HIV should be offered opt-out HIV testing on an annual basis. From a public health perspective, resources needed to perform HIV testing for those who haven't been tested within the last three months upon entering the Jail could be better utilized in other prevention efforts. During the time DOC was doing repeat testing within 30 days of the prior intake, it has been reported there were no new diagnoses for those with a negative test in the preceding three months. In light of this, and the fact that an inmate may request HIV testing at any time, DC Appleseed feels that the six month standard is appropriate.

A question was raised by a member of the DC Council whether mandatory testing of all inmates at discharge should be required. The DOC, DOH, and Unity recently conducted a joint assessment in response to the DC Council question. The agencies concluded that mandatory testing upon discharge was not needed. The joint assessment noted that DOC discontinued testing at discharge in 2010 when DOC and Unity determined that the Jail did not appear to be a vector for transmission and that testing at discharge did not identify new diagnoses. DC Appleseed agrees with this assessment. The DOC's current frequency of testing appears to be sufficient, and based on statistics included in the assessment, it does not appear that mandatory testing at discharge would serve an otherwise unmet need.

DOC's automatic testing program continues to reach a large number of inmates. From October 2012 to September 2013, 9,550 inmates were eligible for testing at intake to the medical unit at the DC Jail. A total of

7,068 inmates were tested, including some inmates who chose to be tested although they had been tested within the last six months. DOC data identified 845 individuals (nine percent of eligible inmates) who were eligible for testing but declined or inadvertently were not tested at intake. This percentage of inmates is a decline from last year's report card. These numbers demonstrate that the DOC's automatic testing program continues to show improvement and is reaching almost all inmates who should be tested. DC Appleseed applauds DOC and Unity and encourages DOC to maintain its commitment to HIV/AIDS testing.

As in last year's report card, the number of HIV-positive inmates with undetectable viral loads also remains high. For 2012, 89 percent of HIV-positive inmates incarcerated more than 180 days had an undetectable viral load.

The DOC discharge planning services are largely unchanged from prior years. Unity has allocated four discharge planners to serve the DOC chronic care patient population, including HIV-positive individuals, as well as other individuals with chronic conditions such as diabetes and mental health issues. Outside of its DOC contract to run the health services, since the *Seventh Report Card*, Unity has used Ryan White funding to place a community health worker at the Jail to facilitate coordination of care with patients' community providers and to link individuals newly diagnosed with HIV to a community provider. Prior to release, discharge planners meet with inmates to assist in scheduling treatment appointments with providers in the community, particularly as needed to obtain refills of prescription drugs. Discharge planners do not have problems obtaining follow-up appointments with providers at Unity and non-Unity providers and clinics, but it remains difficult to confirm continuity of care when an inmate goes to a provider other than a Unity clinic.

HAHSTA's 2013 Implementation Plan identified increasing pre-release planning and linkage to care for HIV positive inmates released from DC correctional facilities as one of its goals with respect to eliminating HIV in the District. To achieve this goal HAHSTA identified action steps, including increasing the availability of HIV providers that are affiliated with the District's participating providers'

network. The Plan also sets specific targets for the percentage of HIV positive inmates who should be linked to care. DC Appleseed supports the District's efforts to improve access to care. We note that in past years, tracking follow-up care provided to recently released inmates (particularly outside of the Unity system) has been difficult due to privacy concerns. We are interested in learning about the progress made toward these goals.

Also, as part of the discharge process, DOC provides a 30-day supply of medications to HIV-positive inmates upon discharge. In the *Seventh Report Card*, we reported that DOC did not request reimbursement from the AIDS Drug Assistance Program ("ADAP") for all of its expenses related to HIV/AIDS medication provided at discharge. DOC confirmed that it requested and has subsequently received reimbursement for all eligible expenses and has not had any issues with this process. DOC received approximately \$200,000 in ADAP funding for HIV/AIDS medication during the current ADAP grant period.

DOC also continues to make condoms available to inmates both upon release and in the detention facilities. Inmates being released to homes, as opposed to a halfway house, are provided with condoms and instructions on usage.

Unity continues to provide comprehensive medical services to DOC inmates, and is currently operating under a contract extension through March 31, 2014. The District issued an RFP for the continuation of medical services. DC Appleseed will continue to monitor the contracting process in order to assess the provision of HIV/AIDS services provided to inmates in any future contract.

DOC also is in the process of building a new intake center, scheduled to be completed in March 2014, which will include a medical holding unit. Medical intake is to take place in the new intake center and there is a room designated for HIV testing. DC Appleseed looks forward to monitoring the progress of the new facility and reporting more about its services in future report cards.

Although the District's grade remains an "A" in this *Eighth Report Card*, we encourage the District to continue to make progress in

its HIV and AIDS testing, treatment, and discharge planning for the incarcerated. We will monitor what, if any, effect the medical services RFP and construction of the new intake center may have on HIV services provided to inmates. We also will closely monitor the District's progress in areas such as pre-release planning and linkage to care, particularly in light of the targets set by HAHSTA in these areas.

Federal Correctional Facilities

As a continuation to last year's report card, DC Appleseed reviewed the HIV testing and treatment of DC inmates housed in or released from federal correctional facilities. As of June 2013, 5,358 male and female DC inmates were housed in Federal Bureau of Prison ("BOP") facilities. For the most part, DC inmates were housed in the following facilities — Rivers Correctional Institution, USP Hazelton, FCI Petersburg, FCI Gilmer, and FCI Fairton. Approximately 28 percent of DOC inmates reside in one of these five facilities.

We attempted to obtain information from the BOP regarding its specific HIV prevention efforts and initiatives, but were informed almost two months after submitting questions to BOP that we would need to file a Freedom of Information Act request in order to obtain additional information. Therefore, in this report card we are unable to report on the BOP's specific testing procedures and efforts.

CSOSA continues to work with the BOP to facilitate offenders' reentry into the community. CSOSA holds quarterly "resource day" video conferences with inmates at some BOP facilities and contract facilities, including Rivers Correctional Institution, FCC Allenwood, FCI Fairton, and FCI Otisville. During these conferences, speakers from government agencies and organizations provide information and resources to inmates on a variety of topics, including health care, education, housing, and occupational training. At the May 14, 2013 program, representatives from health care agencies and organizations such as HAHSTA, DMH, Unity, U.S. Department of Veteran's Affairs, D.C. , and Rehabilitative Services Administration, were present. CSOSA records the video conferences and provides copies of the video and reference materials to other BOP institutions.

CSOSA also provides a “best of” fact sheet to the wardens at prisons where the video is not available.

CSOSA is a member of the D.C. Criminal Justice Coordinating Council’s Reentry Steering Committee, which is currently considering a new educational initiative to better inform inmates: the production of a quarterly newsletter sent to reentry coordinators where DC prisoners are housed. CSOSA also is working with service providers to obtain videos describing their services as well as printed educational information that can be made available in the waiting rooms of its field offices. DC Applesseed applauds CSOSA for its continued efforts and new ideas. We strongly support the implementation of these programs.

On average, CSOSA had approximately 14,000 individuals under its supervision on any given day in FY 2013, and services were provided to a total of approximately 20,300 people that year. As part of its intake process, CSOSA completes a risk and needs assessment of each client that identifies individual needs and helps the agency develop a supervision plan. The assessment process allows individuals to self-report their HIV status. CSOSA does not provide any direct health-related services; however, the agency assists offenders in registering for health benefits and makes referrals to service providers. CSOSA contracts with external providers, some of which focus on providing HIV/AIDS treatment related services. Although sequestration has affected the agency’s finances, resulting in reduced program funding, CSOSA believes that the ACA will provide opportunities to connect participants with expanded health care services. DC Applesseed encourages CSOSA to pursue these additional opportunities. We also encourage CSOSA to ensure that inmates released from correctional facilities continue to have access to an adequate number of treatment providers and services upon their release.

We understand that some CBOs that link inmates with necessary health care services are experiencing budgetary limitations or are closing. For example, Our Place DC, which provided services to women in several federal prisons, recently closed due to a lack of funding. Our Place DC served as a key resource in helping incarcerated women with

their transition out of correctional facilities, including obtaining health care services.

CSOSA has been working closely with the BOP regarding continuity of care for offenders returning to the District with behavioral health or other medical challenges. Procedures are now in place to facilitate information sharing and pre-release case conferencing so that needs are identified and addressed. In most cases, CSOSA is only able to receive medical records for individuals with severe and persistent behavioral and health issues, such as individuals with substance abuse, behavioral issues, or an urgent physical need identified by the BOP. DC Applesseed recommends that CSOSA and the BOP agree to a mechanism to exchange medical information, such as obtaining authorization from inmates for the release of their information. The distribution of this information is vital to ensuring continuity of care and services for offenders.

Though grading federal entities is outside the scope of this report card, assessing the District’s response to HIV/AIDS including, the testing, care, and discharge planning inmates receive while in prison, are important factors affecting HIV in the District. DC Applesseed will continue to monitor CSOSA’s and the BOP’s efforts to maximize health outcomes of inmates with HIV and to ensure linkage and retention in care.

HIV TREATMENT AND CARE: B

Provide quality HIV treatment and care and improve health outcomes.

In the *Seventh Report Card*, we laid the groundwork for a new section on treatment and care and we promised to monitor the District’s progress in providing treatment options and improving health outcomes, and efforts to integrate HIV care and funding with its overall health care reform efforts. In reaching our grade, we considered the District’s progress in healthcare reform implementation, funding, and treatment indicators compared to previous years and to other jurisdictions. DC is doing a good job in working with the community to provide treatment and care to HIV-infected individuals, but there are

several areas where improvement is needed. To reflect this, the District has earned a “B.”

HEALTHCARE REFORM IMPLEMENTATION

The ACA intends to improve access to health care for people living with HIV/AIDS, but also may present challenges regarding continuity of care depending upon the District’s implementation of major provisions of the ACA, particularly the Medicaid expansion and the Health Benefit Exchange. We are grateful to have received technical assistance from Robert Greenwald and his team at the Harvard Center for Health Law and Policy Innovation in addressing and evaluating the District’s implementation of the ACA.

Medicaid Expansion:

Under the ACA, states may expand Medicaid eligibility to individuals below 133 percent of the federal poverty limit (“FPL”) beginning in 2014. As described below, the District has already expanded its Medicaid eligibility criteria. However, there are several uncertainties regarding the ongoing Medicaid expansion that could significantly impact access to care and treatment for people living with HIV/AIDS (“PLWHA”).

As part of its Medicaid expansion, the District obtained a Section 1115 Waiver to insure adults up to 200 percent FPL — a benefit that provides PLWHA, who would not qualify under the lower 133 percent FPL standard, access to vital medical services and prescription drugs. Section 1115 waivers give states flexibility to design and improve their Medicaid programs through experimental, pilot, or demonstration projects. DC’s waiver expires on December 31, 2013. Although coverage up to 200 percent FPL is expected to continue, the request to extend the benefit through a State Plan Amendment has not been approved yet. In the event the Amendment is not approved, individuals between 133 and 200 percent FPL would be able to purchase insurance through DC Health Link and receive ADAP funds to cover the cost-sharing for which they might otherwise be responsible. Nevertheless, a reversion to the 133 percent FPL standard is likely to result in disruptions in care if persons previously covered under Medicaid are no longer eligible for Medicaid.

Additionally, the ACA requires the District to define the extent of covered benefits for its expanded Medicaid population. The benefit package for the expansion population may differ in some respects from the services provided under traditional Medicaid — although it must cover certain essential health benefits, including, for example, chronic disease management services, hospitalization, prescription drugs, mental health and substance use disorder services, maternity care, and preventive wellness services. Through early expansion, the District simply extended the same package of services it offers to traditional (fee-for-service) Medicaid recipients to the expansion population. In the future, it can choose to offer a different, less generous package of services to the new population, and create a special package of more comprehensive services for a specific category of newly eligible people, like people living with HIV/AIDS. Even if the District were to cover the expansion population with this different benefit package, the District is required to give newly eligible individuals who are considered to be “medically frail” a choice between enrolling in traditional Medicaid coverage or the new package of covered services. The District has the ability to define “medically frail” to include all PLWHA, thus ensuring that they will be able to elect the most comprehensive package of Medicaid coverage even if they are childless adults and considered to be part of the expansion population.

At the time of this report card’s release, DC had not released enough information to evaluate how well the District is taking into consideration the needs of PLWHA as it continues to implement Medicaid expansion. We urge the District to maintain or improve upon the benefits currently offered to PLWHA who are enrolled in Medicaid.

Health Benefit Exchange:

On October 1, 2013, the District successfully launched DC Health Link, the District’s web-based insurance exchange marketplace. Through DC Health Link, PLWHA who previously may have been unable to purchase affordable health insurance due to pre-existing conditions or other factors can select and enroll in one of over 30 private plans provided by five insurance carriers. Individuals who buy plans through the exchange may

be subject to premiums and cost-sharing. However, the District intends to use ADAP funds to cover insurance premiums, co-pays and deductibles for PLWHA who enroll in such plans, as it already does for people who enroll in other third-party health plans. The ability to purchase plans on DC Health Link, particularly with this premium and cost-sharing assistance, will increase access to insurance for PLWHA in the District. We commend DC for taking advantage of the opportunity to expand coverage by implementing a DC-based exchange, and applaud DC for its achievement in having a functioning online exchange by October 1st.

The District's implementation of the Assister Program has been a promising step to ensure that the exchange marketplace is accessible to PLWHA. Assisters provide in-person assistance to DC residents in need of help navigating the exchange marketplace. This assistance will be critical in helping PLWHA to enroll in exchange plans that meet their health needs. We commend the District for providing Assister funding to a wide range of CBOs that are knowledgeable about the particular needs and concerns of the HIV/AIDS population. Eleven of the 35 funded organizations provide services to PLWHA. In addition, DC contracted with a prominent local HIV/AIDS provider organization to train the District's Assisters. Much of the training focused on the importance of identifying factors that matter to individuals living with chronic conditions, including HIV/AIDS, and how to best assist these individuals in identifying plans that work for them. The District could further improve its Assister system by including a searchable listing on Health Link of all organizations with individuals approved as Assisters. This would enable individuals to easily identify Assisters at organizations that regularly work with PLWHA. Additionally, the District should continue to educate Assisters on how to select plans that match individuals' health needs, and should provide Assisters with information beyond that available on Health Link (e.g., the availability of wrap-around secondary coverage), in order to improve their effectiveness in assisting individuals.

The exchange also can make a variety of improvements that would greatly enhance access for this unique and often

difficult-to-reach population. In particular, the District should improve Health Link's transparency and user-friendliness, and should provide better mechanisms for monitoring and enforcing complaints against exchange carriers. The DC Health Benefit Exchange Authority has indicated that they opted to launch a relatively basic online exchange to ensure that the launch went smoothly — as it did — and that they are planning to make improvements to the site. Based on our interactions with them in developing this report card, we are impressed by their receptivity toward working with stakeholders to identify ways to improve the usability of the site, and we look forward to continuing to work with them to do so.

Additional functionalities could enhance the ability of PLWHA to access information necessary to make an informed plan-election decision. For example, Health Link lacks a functionality to compare plans' drug formularies. Instead, consumers must search carriers' websites for formularies. For PLWHA, this lack of information could severely hamper their ability to identify plans that cover medications that are part of their ongoing treatments. We understand the Exchange Authority is exploring ways to make formulary information more directly accessible to consumers. We encourage the District to require that plans post their complete prescription drug formularies on the exchange, thereby providing PLWHA with an easy way to determine the plans' coverage of their medications.

Likewise, the DC Health Link website currently does not allow consumers to determine which plan networks a provider belongs to. Such information is highly beneficial to PLWHA, who often see numerous specialists with whom they hold long-standing patient/provider relationships. Inadvertently enrolling in a plan that does not include one's regular providers could result in disruptions in care with serious negative health consequences. We recommend the District follow the example of Minnesota and California, whose exchanges provide a more streamlined experience by allowing consumers access to electronic search tools or directories that allow them to easily determine whether specific physicians or hospitals are available in different marketplace plans.

Finally, DC Health Link should make it easier for consumers to register complaints about marketplace operations and create an open and transparent process for resolving complaints or disputes with insurance carriers. Prior to the release of this report card, DC Appleseed suggested a first step to greater transparency would be to offer more guidance about when and how consumers should make complaints about discrimination by health insurance carriers. In response, the District is planning to update the site to more prominently include information about filing complaints. Although the ACA forbids discrimination in health care programs, in practice people living with HIV/AIDS may find themselves facing both subtle and overt discriminatory treatment by insurers, and the District system should allow consumers to easily report infractions. Additionally, the District should be required to log and retain discrimination complaints, in order to track and analyze aggregated complaint information to better identify patterns of discriminatory treatment by carriers. Lastly, the Department of Insurance, Securities and Banking should increase the frequency of its monitoring of commercial carriers — as its current policy of monitoring on an annual basis may fail to adequately detect and address malfeasance in a timely and efficient fashion.

The opening of DC Health Link is a positive step forward in increasing access to private insurance for PLWHA in the District. DC Appleseed will continue to monitor District efforts to address the needs of PLWHA as the District's marketplace continues to build its infrastructure and grow its plan options. DC Appleseed will monitor the District's success in providing effective differentiation among plan types. DC has elected to utilize a passive "clearinghouse" approach to its exchange, and if the number of plans offered increases significantly over the coming years — the number of options available to consumers may prove overwhelming for uninsured persons trying to make an informed plan decision.

In future report cards we intend to consider the following factors related to health reform implementation in grading the District on Treatment and Care: (1) the extent to which the percentage of individuals with health insurance coverage increases as a result of

ACA implementation; (2) the comprehensiveness of the package of services offered through Medicaid to those eligible as a result of Medicaid expansion; (3) the transparency and user-friendliness of DC Health Link with respect to ability to assess plans for coverage of services used by PLWHA, prescription drugs, inclusiveness of provider networks, and a clearly articulated process for making complaints; and (4) the extent of continuing, robust Ryan White program funding that enables the Ryan White program to be a payor of last resort to PLWHA, and to support the service providers that people in the District rely on for essential and non-medical services.

FUNDING

In the latest report from HRSA, in 2010, among DC HIV-positive individuals served by Ryan White funds, approximately 11 percent were covered by private insurance, 53 percent were covered by Medicaid, 14 percent were covered by Medicare, 13 percent were covered by other public insurance, less than one percent had other insurance, and eight percent lacked insurance coverage.

These numbers show an increase in public insurance since 2008, with the percentage of Ryan White-served clients holding public insurance growing from 76 percent in 2008 to 80 percent in 2010. This corresponds with the 2010 Medicaid expansion. Additionally, clients in 2010 were more likely to be served by Medicaid or Medicare and less likely to have insurance through other public insurance programs. Percentages served grew in both Medicaid (47 percent in 2008 to 53 percent in 2010) and Medicare (9 percent in 2008 to 14 percent in 2010), while the percentage insured by other public insurance fell from 20 percent in 2008 to 13 percent in 2010. Encouragingly, the number of clients without any insurance coverage fell from 12 percent in 2008 to 8 percent in 2010. Also, the reduction in other public insurance is largely in the number of people covered by DC Healthcare Alliance (a local health insurance program that is currently serving nearly 15,000 people). A majority of people with HIV who were enrolled in Medicaid under the expansion had been served through the Alliance.

Ryan White

DC currently receives Parts A and B Ryan White Funds. In Grant Year 22 (2012-2013), DC Care Act funds were approximately \$37.6 million. In 2012, six non-profit entities in DC also received direct Part C grant funds to support HIV/AIDS services (e.g., to fund AIDS education and training center services, and outpatient early intervention services to populations with or at risk for HIV/AIDS).

Twenty-one entities within DC have received Part A funding for Grant Year 22 and provide services ranging from core medical treatment such as ambulatory outpatient care and case management to support services such as child care. These providers include community healthcare centers, hospital clinics, AIDS service organizations, grassroots nonprofits targeting specific communities, and faith-based organizations. In 2011, out of the approximately 15,000 people in DC living with diagnosed HIV, almost 11,700 received HIV/AIDS assistance through Ryan White funding. Thus Ryan White funding touches more than 75 percent of PLWHA in the District. As described in more detail in the Grants Management section of this report card, HAHSTA has made significant changes in the way it awards Ryan White Part A grants. These changes are just beginning to be implemented and while they are intended to provide more continuity of care through a medical home-like approach, some people are concerned they also may limit service provision. DC Appleseed will monitor the implementation of these changes and any impact on service delivery and health outcomes.

Included in the Part A funds are Minority AIDS Initiative (“MAI”) funds, which target minority populations. In Grant Year 22, these totaled \$1,925,981. The Part A MAI funds were distributed to five service providers to support a cluster of services to high-need people of color, using MAI dollars to supplement other resources. DC’s Part B funds include \$15,234,729 for ADAP and \$250,038 for MAI. In FY 2011 (the most recent data available) Part C funding in the District totaled \$2,546,165.

To supplement federal funding and cover some services not allowed under Ryan White, local funding provided \$300,000 for food bank and home delivered meals;

\$125,000 for burial and bereavement services; and \$200,000 for housing assistance through the Bridges Fund.

CARE AND TREATMENT INDICATORS

To focus on health outcomes and treatment as prevention, in the *Seventh Report Card* DC Appleseed proposed four indicators to assess and monitor HIV/AIDS treatment and care in the District: (1) Linkage to Care; (2) Retention in Care; (3) Viral Load Suppression; and (4) Recapture/Re-engagement. These indicators are in part based upon the National HIV/AIDS Strategy (“NHAS”) Objectives and Key Performance Indicators and are a way to represent the treatment side of the HIV/AIDS continuum of care or treatment cascade. There are a few ways to evaluate these indicators — DC’s progress against itself, its progress toward the NHAS goals, and its progress against other urban jurisdictions with a large number of people living with HIV/AIDS.

Linkage to Care. For 2011, the District reports 574 (80 percent) of newly diagnosed patients linked to care within three months, which is a small increase from 2010 (79 percent). Although calendar year data for 2012 have yet to be released, for FY 2012, the District reports 87 percent of newly diagnosed individuals linked to care within three months, which exceeds the District’s original 2015 target of 85 percent. The District-wide implementation of the Red Carpet Entry Program is likely an important factor in achieving faster linkage to HIV/AIDS care for more patients. It provides expedited intake and a quick appointment with medical professionals for individuals with newly-diagnosed HIV. DC Appleseed encourages the District to continue the Red Carpet Entry Program, making any needed adjustments with the changes arriving to conform to the ACA.

Retention in Care. In assessing retention in care, we looked both at the specific NHAS goals of newly diagnosed cases receiving RW funding and the total number of PLWHA diagnosed from 2007 through 2012 receiving continuous care in 2012. The District reports for 2011 that 55 percent of RW clients were in continuous care (two medical visits at least

three months apart), up from 35 percent in 2010. Another 45 percent were in sporadic care, with at least two visits less than three months apart.. With a 2015 objective of 80 percent, the District still has a way to go. Taking a different perspective, for individuals diagnosed from 2007-2012, only 42 percent were in continuous care in 2012, but 72 percent of those that had received any care in 2012 were receiving continuous care. Thus not surprisingly, retention in care is a reflection of linkage of new cases, re-engagement, and treatment support.

Viral Load Suppression. Viral load suppression is the ultimate goal of treatment and also a key ingredient of prevention. No data for the 2011 cohort overall were reported. However, the targeted populations for reducing health disparities have a viral load suppression around 40 percent. The District should be commended for exceeding both its own and the NHAS goals for 2015 for these sub-populations. However, we note that the District has not updated its original 2015 goals, giving the impression it is satisfied with its progress. We encourage the District to increase its viral load goals for these subpopulations and to continue to strive to achieve higher rates of viral suppression. Viral load suppression for the 2007-2012 cohort is 34 percent of total, 58 percent of those that received any care in 2012, and 80 percent of those in continuous care in 2012. This illustrates how closely viral load suppression is dependent on receiving care.

Recapture/Re-engagement. There are no NHAS targets or standard metrics for re-engaging patients. “Recapture Blitz” programs, developed in collaboration with the District continue to be executed by community providers. These require identifying and locating out-of-care patients, and providing them support for returning to care. Many people believe DC could further reduce unmet need by focusing more on Early Intervention Services and peer-based models. Given that the District currently does well at linkage to care for new diagnoses and that viral load suppression is most successful when people are in continuous care, it makes sense that getting patients lost to care back in care is essential for the District to bridge the gap in viral load suppression. We give credit to the District for their re-engagement efforts, but

we could find no data on “successes.” We encourage the District to keep this focus, but would also like to see outcomes data, so that the most successful outreach techniques may be identified and intensified. We also understand that DC is working on distinguishing patients that are truly lost to care and those that have left the jurisdiction or are deceased because this is probably inflating their number of out-of-care patients.

Comparisons to Other Jurisdictions

Direct comparisons to other jurisdictions are difficult due to reporting differences as well as local differences in the epidemic. With those caveats, we looked at epidemiological reports from San Francisco, Los Angeles County, Chicago, and Baltimore to get a sense of how the District’s performance in controlling the HIV/AIDS epidemic compares to other urban areas based on the available data. From a qualitative look at the limited comparison data that are available, the District is doing as well or better than others in linking newly diagnosed patients to HIV/AIDS care; and for those in continuous care, viral load suppression is fairly comparable. Although all jurisdictions struggle with this, DC’s overall percentages of PLWHA receiving continuous care and with suppressed viral load need improvement. But the District realizes this and has focused resources on getting people into care with the objective of improving their health and achieving viral load suppression.

Overall

In the 2013 Epi Report, the District stated it has “[m]aintained ‘Treatment on Demand’ with universal access to HIV medical care with no waiting lists for treatment and medications,” which is an important foundation for combating the HIV/AIDS epidemic. Overall, the District is doing well at linking new diagnoses to care and achieving viral load suppression for those individuals receiving care. It is the middle of the cascade where the District needs to improve — care retention in care and re-engagement of those who have dropped out of care. The District recognizes this, and DC Appleseed encourages their efforts in both these areas.

CONCLUSION

In this *Eighth Report Card* this section is focused on the District's progress in ACA implementation, funding treatment options, and improving health outcomes. The District is doing a good job in working with the community to provide treatment and care to PLWHA, but there are areas where improvement is needed. Concerns about the transition to the new Ryan White structure described in Grants Management and unanswered questions about the implementation of the ACA will need to be addressed. The District's grade this year for Treatment and Care is a "B."

HOUSING: C+

Increase the availability of housing support for people with HIV/AIDS in the District.

In the *Seventh Report Card*, DC Appleseed introduced a new section on Housing and provided a general overview of housing resources for low-income individuals living with HIV/AIDS in the District. Stable housing is critical to HIV/AIDS prevention and care because it positively influences access to care, treatment adherence, maintenance in care, and improved health of people living with HIV/AIDS. Homelessness and housing instability are also associated with increased risky behavior and poor health outcomes. Since the last report card, Mayor Gray has made affordable housing a priority of his administration, and HAHSTA increased slightly the number of long-term slots available through the HUD HOPWA program. Despite these efforts, there has not been significant progress in stabilizing the housing of low-income residents living with HIV/AIDS and the District's grade for Housing is "C+."

The primary funding source supporting housing for low-income people living with HIV/AIDS is the HOPWA program. The amount of funding the District receives for HOPWA has been gradually decreasing: \$14.1 million in FY 2011, \$13.8 million in FY 2012, and \$13.6 million in FY 2013. HAHSTA expects a substantial decrease in FY 2014 due to a combination of Congress's budget sequester and HUD's adjusting the formula used to calculate the

funding level a jurisdiction receives. HUD is expected to start using living AIDS cases instead of cumulative AIDS cases in its calculation in the near future. HAHSTA expects that FY 2014 funding could be approximately \$12.5 million, which is a reduction from the FY 2013 funding of approximately \$13.6 million.

The bulk of HOPWA funds in the District are used for the Tenant-Based Rental Assistance ("TBRA") Program. Through this program, HAHSTA is able to support about 300 people in long-term rental housing in the community. The goal of TBRA is to support clients' housing until they transition to permanent housing through the Housing Choice Voucher Program (formerly Section 8) or when they are able to return to work. However, very few people are able to make that transition and few persons are dying from AIDS, thus they remain on HOPWA, and the HOPWA waiting list grows. The waiting list grew from 612 in 2009 to 1,026 in 2012, and had already reached 1,088 with three months left in 2013. HAHSTA estimates that only 10-12 slots open up each year, generally when a client dies or moves to another state. Over the past one-and-a-half years, HAHSTA was able to add 25 additional vouchers, bringing the total to 325 at any one time. DC Appleseed commends HAHSTA for finding opportunities to support more individuals and families, but much more is needed. The gap between need and funding is vast and widening. DC Appleseed recommends that the District develop a system to prioritize the waiting list based on health status, comorbidities, or other important factors to replace the current first-come, first-served system.

Other housing assistance HAHSTA provides includes:

- Short-term assistance to ensure the housing stability of 213 persons;
- Transitional housing for persons requiring support services but not ready to enter permanent housing;
- Emergency housing for persons in an immediate state of homelessness; and
- The Metropolitan Housing Assistance Program which provides a single point of counseling to persons — including ongoing engagement with persons on the

HOPWA waiting list — and has leveraged other housing assistance programs for persons living with HIV such as the federal Homelessness Prevention and Rapid Re-Housing Program

Research shows that providing housing to homeless and unstably housed people with HIV/AIDS can be a cost-effective means to prevent HIV transmission, increase treatment adherence, improve health outcomes, and reduce medical costs. To stabilize housing and improve health outcomes, the District should stop relying solely on federal funding sources for this critical need, think creatively, and invest District monies to supplement HOPWA funding.

In his State of the District address this year Mayor Gray made affordable housing a priority of his administration and pledged to invest \$100 million of District funds. He followed through on this pledge by increasing the funding for affordable housing in both the FY 2013 supplemental budget and the FY 2014 budget, for a variety of affordable housing programs. Between the Mayor's investment in affordable housing, and the DC Council's work to find additional funds for affordable housing programs, the overall local funding for affordable housing in the FY 2014 budget increased to \$125 million (a 30 percent increase over 2013). DC Appleseed commends Mayor Gray and the DC Council for prioritizing this important issue. We are disappointed that we are unable to confirm that the District has set aside any of these funds to address the housing needs of PLWHA and recommend that the District include people living with HIV/AIDS as a priority as they plan for budgeting and implementation of this initiative.

Especially vulnerable are PLWHA who are homeless or living in shelters. Such environments pose many challenges to adherence, including nutrition, safety, and the security of medications. The Fair Budget Coalition ("FBC") advocates for budget and public policy initiatives that address poverty and human needs in the District. Using estimates from the 2012 Point in Time count on HIV among homeless adults in the District, FBC calculated that with an annual investment of \$3.75 million, the District could fund enough tenant-based vouchers to end homelessness

for all PLWHA living on the street or in shelters — approximately 250 households.

As mentioned above, a major obstacle to HOPWA's ability to meet housing demand in the District is that there is very little turnover in HOPWA that would make vouchers available to support others. DC Appleseed brought this issue to a small focus group of consumers to get their perspective. From this we heard that as treatment and care improve, people with HIV/AIDS are living longer and healthier lives, especially with appropriate stable housing. HOPWA beneficiaries, whose health allow it and who have skills to earn a salary to support themselves comfortably, are generally willing to pay their share. However, if their health should decline, they would not have easy access to HOPWA support again, and this insecurity deters them from considering independence. DC Appleseed recommends that HAHSTA and the District consider options to allow HOPWA recipients who transition out of the program to receive prioritized access should their health decline again and they need the support. HAHSTA has reported that it will be receiving technical assistance from HUD in the near future to consider the current HOPWA program design, to compare other jurisdictions, and to explore program changes to optimize HOPWA funding to increase housing availability. DC Appleseed hopes that the above recommendation can be incorporated into the discussion.

DC Appleseed applauds the Mayor for making affordable housing a priority of his administration and is pleased that HAHSTA was able to increase slightly the number of HOPWA slots available. However, the District must do much more to address this critical issue. Prioritizing the HOPWA list, investing local dollars to supplement HOPWA funding, prioritizing people living with HIV/AIDS in the Mayor's affordable housing initiative, and offering priority access to recipients who have transitioned out of HOPWA would go a long way in addressing unmet housing needs for PLWHA in the District. The District's grade for Housing is a "C+."