HIV/AIDS IN THE NATION's CAPITAL

REPORT CARD NO.3

JANUARY 2007 TO DECEMBER 2007

Nearly two and half years ago, DC Appleseed released 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 city has made significant progress in implementing many of the recommendations in that report.

But data recently released by the District's HIV/AIDS Administration show that despite the efforts of the government and community service providers to respond to the epidemic, the disease remains a dire public health threat across the city. DC Appleseed is pleased by the progress, but the new data and this report card show that much more needs to be done.

This is DC Appleseed's *Third Report Card* grading the District's response to HIV/AIDS. The grades, and a description of the areas graded, appear below. An Executive Summary and detailed explanation for each grade are attached.

	GRADES (A-F)
LEADERSHIP MAKE **HIV/AIDS** A TOP PUBLIC HEALTH PRIORITY IN THE DISTRICT.	**B+**
INTERAGENCY COORDINATION IMPROVE COMMUNICATION AND COLLABORATION ON **HIV/AIDS** ISSUES AMONG KEY DISTRICT AGENCIES, INCLUDING DOH, DMH, DOC, AND DCPS.	**B-**
HIV SURVEILLANCE FULLY AND APPROPRIATELY STAFF THE OFFICE RESPONSIBLE FOR TRACKING THE SPREAD OF **HIV AND AIDS**. PUBLICLY REPORT DATA ON **HIV** INFECTIONS IN THE DISTRICT.	**A**
GRANT MANAGEMENT IMPROVE GRANT MANAGEMENT, MONITORING AND PAYMENT PROCESSES TO ASSURE THAT FUNDS FOR **HIV/AIDS** SERVICES ARE SPENT FULLY AND EFFECTIVELY.	**B**
QUALITY ASSURANCE IMPLEMENT COMPREHENSIVE SYSTEM OF PROGRAM OUTCOME MONITORING AND QUALITY ASSURANCE STANDARDS, UTILIZING DATA TO ASSESS THE EFFECTIVENESS OF GRANT-FUNDED **HIV/AIDS** PREVENTION AND CARE PROGRAMS.	**B-**
HIV TESTING DEVELOP CITYWIDE STRATEGY FOR ROUTINE **HIV** TESTING IN ALL MEDICAL SETTINGS AND OFFER RAPID **HIV** TESTING AT DISTRICT-RUN FACILITIES (INCLUDING STD CLINIC, DC JAIL, TB CLINIC, AND SUBSTANCE ABUSE TREATMENT FACILITIES).	**B+**
CONDOM DISTRIBUTION SIGNIFICANTLY EXPAND CONDOM DISTRIBUTION IN THE DISTRICT.	**B**
D.C. PUBLIC SCHOOLS ADOPT SYSTEM-WIDE HEALTH EDUCATION STANDARDS, INCLUDING **HIV/AIDS** PREVENTION. ESTABLISH SYSTEM FOR MONITORING IMPLEMENTATION OF STANDARDS. DEVELOP AND IMPLEMENT A PLAN FOR ENHANCING **HIV/AIDS** POLICY FOR DCPS.	**D**
SYRINGE EXCHANGE & COMPLEMENTARY SERVICES CONTINUE TO FUND COMPLEMENTARY SERVICES (E.G. **HIV** TESTING AND COUNSELING AND DRUG TREATMENT REFERRALS) PROVIDED BY THE PRIVATELY-FUNDED SYRINGE EXCHANGE PROGRAM AND TAKE ADDITIONAL MEASURES TO ADDRESS PREVENTION WITH SUBSTANCE USING POPULATION.	**B+**
SUBSTANCE ABUSE TREATMENT INCREASE THE AVAILABILITY OF SUBSTANCE ABUSE TREATMENT PROGRAMS IN THE DISTRICT.	**C+**
HIV/AIDS AMONG THE INCARCERATED IMPLEMENT ROUTINE **HIV** TESTING. IMPROVE COLLECTION OF **HIV AND AIDS** DATA IN D.C. DETENTION FACILITIES. IMPROVE DISCHARGE PLANNING SERVICES AT D.C. DETENTION FACILITIES.	**A**

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EXECUTIVE SUMMARY

In DC Appleseed's August 2005 Report, *HIV/AIDS in the Nation's Capital: Improving the District of Columbia's Response to a Public Health Crisis*, we said that "the District's efforts to address HIV/AIDS have fallen far short, and addressing the epidemic must move front and center as a priority of the District government." We also said that "[w]ith the appropriate attention and commitment, the District can substantially improve its response to this urgent public health issue." To help provide continuing information to the public concerning the government's response to the epidemic, DC Appleseed has issued periodic "report cards" concerning that response. This is our third such report card.

DC Appleseed's *First Report Card*, released in March 2006, recognized a surge of government activity. Our *Second Report Card*, issued in December 2006, highlighted continued improvements at the HIV/AIDS Administration ("HAA"), but also noted a decline in the engagement of top government leaders.

While this *Third Report Card* assesses the government's performance in 11 different areas — all of them crucial to an effective response to the epidemic — three key points stand out.

The first is that the District's long-awaited and much-publicized November 26, 2007 Epidemiology Annual Report for the first time provides a specific breakdown of HIV and AIDS cases within the city's population. It is an important, commendable breakthrough, one that we specifically called for in our August 2005 Report. The 2007 Epidemiology Annual Report provides a baseline to develop a focused, data-driven response to the epidemic and allows Mayor Adrian Fenty and new HAA Director Dr. Shannon Hader to move forward on their public commitments to attack the epidemic. It is such a significant milestone that the District's efforts in producing it earned one of the two "A" grades on this report card — the first and only "A's" given on any of our three report cards.

The second key point is that while the 2007 Epidemiology Annual Report is a crucial step forward, it does not by itself advance the city's response to the epidemic. Rather, that report provides the District a much needed new tool for *targeting* that response. As we said in our own August 2005 Report, "[t]imely epidemiological data provide the foundation for public health agencies to allocate funding and develop effective prevention and treatment strategies."

Third, and most important, is how the District is doing in developing and implementing the necessary prevention and treatment strategies. In our opinion, while the District continues to make progress on that front, the progress is not as strong and uniform as it needs to be, given the urgency of the issue. Two grades in particular illustrate this point, one grade quite good — a "B+" for leadership, and the other quite poor — a "D" for the lack of a coordinated HIV/AIDS education program in the District of Columbia Public Schools ("DCPS").

The "B+" is for the leadership shown by Mayor Fenty and Dr. Hader. DC Appleseed considers this to be a vital grade, because as we said in our August 2005 Report, only a clear, visible, and forceful commitment from the top of the District government "will help ensure that the necessary reforms occur and will galvanize support within the government and the community."

But there is one area where leadership has failed to make the necessary reforms occur — in the public schools. In September 2005, and again in April 2006, the Board of Education embraced the need to have appropriate, systematic, standardized HIV/AIDS education for the District's youth. And in both January and March 2006, the Superintendent promised that the necessary program would be in place by the fall of 2006. However, such a program still has not been developed, and it now appears it will not be in place until the fall of 2008, at the earliest. This delay is unacceptable, and this element of the District's response to the epidemic must be made a much higher priority. The District's response to date cannot be graded higher than a "D."

The other, generally positive grades in this report card reflect the District's success in creating the beginnings of an infrastructure of a properly functioning public health system to address the epidemic, something lacking in the District for quite some time. The continued HIV testing program and other HIV prevention services at the D.C. Jail earned an "A;" the new initiatives related to routine HIV testing resulted in a "B+;" and the new plans to expand HIV prevention services to injection drug users received a "B+." Other grades that were increased also are due to the city undertaking some promising new initiatives.

It will take a sustained effort to implement and administer these new programs and plans. Future assessment of the District's success must be based on their full and successful implementation, with resulting declines over time in the incidence of new HIV cases in the District. For in the end, it will be the actual results, not the programs that matter.

In DC Appleseed's report cards, the grades assigned are based on what we would expect the District to accomplish in that time period. Our assessments involved extensive conversations with representatives of the District government, those who provide services to people living with HIV and AIDS, and those who are living with HIV and AIDS. Relevant city agencies also provided information and documents to us.

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

	GRADES FROM *FIRST REPORT CARD*	GRADES FROM *SECOND REPORT CARD*	GRADES FROM *THIRD REPORT CARD*
LEADERSHIP	B-	B-	B+
INTERAGENCY COORDINATION	N/A	C-	B-
HIV SURVEILLANCE & DATA	INCOMPLETE	B	A
GRANT MANAGEMENT	B	B-	B
QUALITY ASSURANCE	N/A	B-	B-
RAPID TESTING	B	B	B+
ROUTINE HIV TESTING	C		
CONDOM DISTRIBUTION	D	D+	B
D.C. PUBLIC SCHOOLS	B-	C-	D
SYRINGE EXCHANGE SERVICES	B-	B-	B+
SUBSTANCE ABUSE TREATMENT	D+	D+	C+
HIV/AIDS AMONG THE INCARCERATED	C+	B+	A
WEBSITE	B+	N/A	N/A

In summary, progress continues, but there is still far to go. As recent press reports and the District's own data reports make clear, HIV/AIDS remains nothing less than a public health emergency in the Nation's Capital. The District continues to have the highest incidence of new AIDS cases in the nation, and the high incidence of new HIV infections in the city among African Americans is extremely troubling. These facts behoove the District to make all elements of the response to this epidemic an urgent priority.

DC Appleseed would like to acknowledge and thank the Washington AIDS Partnership and its Steering Committee for its continued support on this project.

THIRD REPORT CARD

DECEMBER 2007

LEADERSHIP: B+

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

DC Appleseed's 2005 report cited a lack of leadership at all levels of the District government as a significant cause for the District's failure to adequately address the HIV/AIDS epidemic. Since that time District leaders have taken steps to elevate the profile of the HIV/AIDS crisis inside and outside of the government, as well as to sharpen the government response to the epidemic.

Our *First Report Card* noted that then-Mayor Anthony Williams embraced the recommendations in the 2005 report. The HAA director was replaced, long-time vacancies at the agency began to be filled, and the DC Board of Education directed the school system to develop a health curriculum that included a major focus on HIV/AIDS. D.C. Council Committee on Health Chairman David Catania provided aggressive oversight of the agency and helped to force reforms at HAA. Those efforts earned a B- in leadership on the *First Report Card*.

The grade did not increase in our *Second Report Card* released in December 2006, primarily because the top leaders in the city government were content to delegate responsibility for addressing the crisis to subordinates. While the urgency of D.C. Council oversight continued, the former Mayor and City Administrator were not directly and systematically engaged.

During his 2006 campaign, Mayor Fenty produced a detailed position paper on the appropriate responses to the epidemic. Many of those recommendations mirror DC Appleseed's 2005 report. Prior to taking office, Mayor Fenty made HIV/AIDS a major focus of his transition plan and *First 100 Days and Beyond* initiative.

On April 4, 2007, Mayor Fenty hosted an HIV/AIDS Summit, bringing together more than 120 leaders from the government, provider, faith-based, and community organizations. The Mayor stated publicly that HIV/AIDS is his number one public health priority. The conference generated a significant level of feedback from the participants. On April 6, the Mayor held a CapStat session with HAA staff to focus on the prevention of HIV/AIDS. Subsequently, the Office of the City Administrator created a document packet outlining possible goals that could be achieved within the next four years, and methods for achieving them. This information was then mailed to each summit participant and posted on the D.C. government's website. The packet included reports on HAA achievements and the District's plan to develop a comprehensive strategic plan involving interagency collaborations.

In May, some community providers organized their own meeting or "Speak-Out" so that the public could voice their concerns regarding the District's response to the HIV/AIDS epidemic. Many participants made clear that they want the Mayor to show strong leadership in the area of HIV/AIDS and to implement action steps to address the recommendations of DC Appleseed.

During the first half of 2007, the Mayor lobbied Congress to remove an existing ban on the use of local DC tax dollars to fund syringe exchange programs ("SEPs"). The ban was not attached to the 2008 DC funding bill, which is still pending in the Senate. Despite the uncertainty surrounding the ban, District leaders publicly expressed their plan to spend $1 million to expand needle exchange efforts should the ban be lifted.

Under Dr. Gregg Pane's leadership as former Director of the Department of Health ("DOH") and Acting Director of HAA, the agency continued to make progress implementing many of the recommendations in DC Appleseed's 2005 report and subsequent report cards. Dr. Pane also issued a "Call for Action," designed to reenergize HAA's

HIV/AIDS response. He specifically called for completing the conversion to a confidential names-based data reporting system — an initiative that began during the previous administration. HAA issued a mid-year status report in August 2007, which sets forth a number of the accomplishments of HAA. HAA also crafted a plan for reaching youth at risk for contracting HIV; the plan relied on efforts of government agencies such as the Department of Parks and Recreation and the Department of Youth Rehabilitative Services ("DYRS").

On November 26, 2007, Mayor Fenty launched the release of HAA's 2007 HIV Epidemiology Report. The report itself includes a personal call-to-action from the Mayor, asking all members of the community to use the report's information to help change the future of the epidemic. Ongoing continued high-level visibility is critical to decreasing stigma and silence. The release of the report received widespread attention and was accompanied by the announcement of several new prevention programs. DC Appleseed commends the administration's initiative, and our grade reflects that effort. However, future grades will assess the implementation of those programs and their effectiveness in combating the disease.

While the programs undertaken by Mayor Fenty and the leadership at HAA have been applauded by the District's HIV/AIDS activists, many in the community also have voiced concern over the lack of consistency at the top leadership levels. Dr. Hader is the third HAA director in three years. She is well qualified and appears to be bringing new energy to the post. We hope that Dr. Hader's experience, knowledge and enthusiasm will provide the leadership needed at HAA to ensure a sustained and adequate response to the local HIV/AIDS crisis.

One obvious leadership failure of the District is addressed in a separate section of this Report Card: DCPS only now is preparing to publish health standards that include HIV/AIDS education more than two years after the school board first directed the superintendent to address the issue. The slow pace of moving these standards forward means that the very earliest DC students will receive systematic HIV/AIDS education is Fall 2008. Several policy makers suggest it is more likely that students will not receive the standards-based HIV/AIDS curriculum until Fall 2009.

Mayor Fenty has staked out an aggressive program for addressing the HIV/AIDS epidemic at a time when DOH and HAA are adjusting to major leadership changes. These recent changes offer both opportunities and challenges to the Mayor's agenda for combating the epidemic. In a time of transition at the agency level, a commitment to continuing the progress at HAA — from the highest levels of government — is more important than ever. We strongly commend and endorse the statements of commitment by the Mayor and other top officials. Due to the progress that has occurred at HAA during the past year and the resurgence of energy and commitment at the Mayoral level, the District's grade has been raised to a "B+."

INTERAGENCY COORDINATION: B-

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

A key recommendation in DC Appleseed's August 2005 report was increased collaboration among numerous District agencies in order to provide a comprehensive, coordinated response to the District's HIV/AIDS epidemic. We also recommended more coordination between HAA and other agencies within the DOH, including the Addiction Prevention and Recovery Administration ("APRA"), the Sexually Transmitted Disease Clinic ("STD Clinic"), the Tuberculosis Clinic ("TB Clinic"), the Medical Assistance Administration ("MAA"), and the Maternal and Family Health Administration ("MHFA").

In our *First Report Card*, the coordination between District agencies and within the DOH was not graded. In our *Second Report Card*, the District received a "C-" for its efforts related to interagency coordination. At that time, there was little to no coordination between HAA and either the Department of

Mental Health ("DMH") or DCPS, although there was coordination between HAA and DOC. There was also little coordination between HAA and other agencies within DOH. At that time, the Mayor's Task Force on HIV/AIDS was not providing a vehicle to facilitate this type of interagency coordination.

During the last year, there has been greater emphasis on the need for coordination and collaboration in many areas. Of particular significance is HAA's development and release of its Youth and HIV Prevention Plan, a three-year initiative that represents the first comprehensive, inter-governmental efforts in the District to systematically address youths' primary and secondary HIV/AIDS prevention and intervention needs. The project involved collaboration among 30 agencies and resulted in an Interagency Workgroup on Youth, Young Adults and Health, which convenes monthly meetings to focus on improving the coordination and collaboration on youth and health services programming. While it is too early to assess the effectiveness of this program, the initiative demonstrated by the plan is commendable.

Another significant step has been the start of a dialogue between HAA and DMH to develop ways in which individuals dually diagnosed with mental illness and HIV can be better served. HAA staff and DMH staff have met regarding testing at DMH provider sites, and HAA staff met with 30 DMH providers this summer to provide information on HAA's programs, particularly condom distribution, HIV testing and the HIV resource directory. Additionally, a Memorandum of Understanding ("MOU") has been entered into which establishes a partnership between HAA and DMH to provide affordable housing for patients who are dually diagnosed with HIV and mental illness. HAA and St. Elizabeths Hospital staff also has held discussions to improve HIV education and discharge planning for HIV patients. HAA facilitated technical assistance from the Health Resources and Services Administration ("HRSA") for the HIV Planning Council to develop a screening tool to identify mental health and substance abuse problems on a pilot basis. Finally, leadership at APRA, HAA and DMH recently has convened a meeting to discuss ways in which their agencies can work together to deal with dual and triple diagnosed individuals. These meetings will occur on a monthly basis. Although most of these steps are just beginning, DC Appleseed is encouraged that more extensive efforts are being made at coordination.

Changes within DOH also will facilitate greater coordination. Of primary significance is the realignment within DOH to integrate the STD clinic, the TB clinic and the Adult Hepatitis Program into HAA, which occurred in October 2007. This will allow integration of these programs within HAA, which should facilitate improved coordination of services. HAA and APRA also have held discussions regarding HIV testing, condom distribution and future syringe exchange services in the District. Currently, all APRA sites provide for HIV testing. In addition, MAA is attempting to facilitate Medicaid reimbursement for HIV testing. Furthermore, HAA has met with the Community Health Administration in order to integrate HIV education into the Healthy Start Program.

Other agencies have also coordinated with HAA to improve HIV prevention and care services. DYRS has a vendor at Oak Hill Youth Center that is providing HIV testing to the youths. Children and Family Services Agency ("CFSA") has had discussions with HAA staff regarding HIV issues related to foster children and adoptive children. The District's Department of Housing and Community Development has been in discussions with HAA to develop an MOU to assist in funding three construction and renovation projects to provide housing for persons living with AIDS and their families. And DOC continues to collaborate with HAA to provide HIV testing, HIV education services, and discharge planning services at the Jail.

While DC Appleseed is encouraged by the number of new initiatives that have been developed as a result of collaboration within DOH or due to coordination between HAA and other District agencies, most of these are in their early stages and have not yet produced significant substantive results. As a result, the District's grade has been increased from a "C-" to a "B-."

HIV SURVEILLANCE: A

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

During 2007, there has been a remarkable turnaround in the operations of HAA's Surveillance Bureau ("Bureau"). In 2005 the District received an "Incomplete" on the *First Report Card* in recognition of its attempt to form a partnership with George Washington University's School of Public Health and Health Services ("GW") to address significant surveillance deficiencies. The District received a "B" on the *Second Report Card* because of the improved surveillance through its partnership with GW. However, the Bureau remained understaffed, had significant data backlogs, and had not released any surveillance data. A genuinely successful operation seemed 18 to 36 months away.

In the past year, as a result of the successful partnership with GW and the enthusiasm and hard work of the HAA and GW staff, along with advice and direct assistance from the Centers for Disease Control and Prevention ("CDC"), operations of the Bureau have improved significantly, and the staff has developed a long-term plan for further development. Although staffing vacancies remain, the significant progress that has been accomplished by the current staff to further the mission of the Bureau warrants a grade of "A" for HIV surveillance efforts.

The Bureau has finalized an organizational structure to implement GW's and CDC's recommendations outlined through a comprehensive evaluation process. It has recruited and hired well-qualified individuals who possess the training and skills required to achieve its mission, including those in key leadership positions. The Bureau continues to seek individuals to fill six new surveillance positions, including a Data Manager Coordinator, a Field Investigator, a Public Health Analyst and a number of Epidemiologist positions. It is anticipated that these positions will be filled in the near future. However, the partnership with GW has provided substantial staff resources for the Bureau including expertise in HIV epidemiology, behavioral risk factors and biostatistics assistance. This affiliation also has allowed the Bureau to benefit from significant assistance from GW and other student interns this past summer.

Data collection efforts increasingly have focused on outreach measures to encourage primary care and infectious disease physicians to report HIV/AIDS cases. These efforts include the pending distribution of a provider toolkit intended to educate physicians about confidential name-based HIV reporting to facilitate passive reporting by all providers of newly diagnosed HIV cases. In accordance with CDC recommendations, the Bureau has revised its reporting forms to help facilitate complete and accurate reporting. HAA reports that providers will receive the revised forms by the end of the year. Additionally, the Bureau intends to employ electronic records to avoid duplication, errors and delays in reporting. Collectively, these efforts should lower burdens on providers and should improve reporting rates. DC Appleseed commends the Bureau's attention to supporting improved reporting within the community.

One major focus of the surveillance efforts is to confirm HIV/AIDS cases and to investigate new cases successfully within 30 days. Approximately 2100 laboratory reports are submitted quarterly, and more than 50 percent of these reports require an investigation. Field investigators have pursued these cases aggressively, and in so doing have sought to assure the medical community that data reported to the Bureau will be managed appropriately. The revised efforts have included integrating incidence and prevalence data collection and partnering with local laboratories and CDC to test for viral resistance. In addition to these data collection efforts, the Bureau has utilized its partnership with GW to conduct National HIV Behavioral Surveillance, a CDC-funded on-going behavioral surveillance system being conducted in 25 U.S. cities. The current cycle of the study, which has been completed, focused on heterosexuals at high risk for HIV. Future studies to be conducted by GW staff will focus on men who have sex with men ("MSM") and injection drug users ("IDUs"). The focus on

these high-risk populations and the understanding of behavioral factors associated with infection in DC will be a vital component in the design of treatment and prevention programs.

The Bureau also has strived to improve the transparency and collaboration with the community regarding its surveillance efforts. The Bureau has sought community input through community advisory boards regarding the results of surveillance and study designs. Further, the Bureau has endeavored to provide better community service by fielding calls from the public regarding a broad array of HIV/AIDS questions.

Data analysis processes also have improved greatly. Most significantly, the Bureau has successfully completed the transition to the nationally recognized confidential name-based surveillance system and has resolved its backlog of cases. Additionally, the Bureau has de-duplicated records and is prepared for more detailed data collection. As a result the Bureau, on November 26, 2007, released a long-awaited epidemiologic profile for the city — the 2007 Epidemiology Annual Report.

The data for the report were rigorously gathered by extracting and de-duplicating information from previous code-based reports. The result has been a robust data set that allows the surveillance bureau to engage in the complex statistical analysis needed for a comprehensive HIV surveillance report. As a result, the report provides the first good look at the scale and diversity of the HIV/AIDS challenge facing the District.

The 2007 Epidemiology Report found that the current prevalence rate for AIDS in DC is 1,386 per 100,000 people. This prevalence rate is higher than the rates observed in Baltimore, Philadelphia, Chicago, New York and Detroit. However, the rate is not uniform throughout the demographic groups in the city. While comprising 57 percent of the District's population, African Americans represent 81 percent of all new HIV cases in the city. Likewise, while the number of men and women in the District is roughly equal, the prevalence is much higher in men than it is in women — 70 percent versus 30 percent. This uneven pattern appears to be continuing for new cases as well, and is consistent with national trends.

The likely source of new infections is changing. When assessing likely causes based on risk, 33.2 percent of all current HIV/AIDS cases are MSM, 29.5 percent are from heterosexual contact, and 20.8 percent are IDUs. By contrast, the new HIV cases are thought to be 37.4 percent from heterosexual contact, 25.8 percent MSM and 13.2 percent IDU with 21.8 percent unknown.

While the mortality rate has declined, the diagnosis pattern in the District is making successful treatment of the disease difficult. While nationally about 40 percent of diagnosed cases are late testers, in the District, over two-thirds of cases are among late testers. Late testers refer to individuals who transition to AIDS within a year of receiving an HIV diagnosis. Individuals who are diagnosed later have a much harder time managing their disease. Finally, perinatal transmission of HIV has occurred in the city — 140 cases since the beginning of the epidemic through 2006 — a phenomenon virtually absent now in the rest of the United States, because it is almost entirely avoidable through the use of antiretrovirals during pregnancy, childbirth and antenatally. Dr. Hader has set a goal of eliminating perinatal transmission by 2009.

The new surveillance results should provide the city with much needed guidance on how to commit its resources and will give a vital assessment of how well current interventions have affected HIV in the District. HAA also announced several new initiatives based on the report findings. As these programs are implemented, DC Appleseed will seek to determine how effective they are in stemming the spread of the epidemic.

The Bureau has created a long-term plan to sustain its successes of the last year. It hopes to expand its work in sub-populations, including assessing perinatal infection. The Bureau also will evaluate the surveillance tools to ensure that it is collecting accurate and comprehensive data. Further, the Bureau will seek to raise its profile by continued community outreach and epidemiologic studies.

The Bureau has made major advances during the last year and deserves the very positive grade presented here. The impressive performance of the Bureau is tempered, however, by questions of the sustainability of these successes. There remain understaffing concerns, and the terms of its contract with GW is subject to an annual negotiation. The lack of a multi-year contract creates difficult staffing decisions for both GW and HAA. To build on the success of the Bureau and continue the GW partnership, the District should consider extending the term of its contractual relationship with GW. The District also should continue to recruit actively to fill all vacancies in the Bureau.

GRANT MANAGEMENT: B

Improve grant management, monitoring and payment processes to assure that funds for HIV/AIDS services are spent fully and effectively.

Since DC Appleseed's 2005 report, HAA has made steady progress toward improving the management and monitoring of grants awarded to various service providers. Prior to 2005, there were significant delays in the District's payment to subgrantees, and HAA routinely failed to monitor systematically whether grant funds were spent in an effective manner.

The *First Report Card* noted improvements in HAA's grant payment process and found that providers reported significant improvements in the timely payment of invoices. That report card also noted that HAA had taken some steps to improve grant monitoring, but found that providers were continuing to have difficulty with delays in the grant renewal and extension process. The *Second Report Card* focused solely on grant monitoring. That report card referred to an October 2006 report of the D.C. Office of the Inspector General ("OIG"), which found some improvement in the area of grant monitoring and management, but also found that HAA had failed to implement the OIG's recommendations in five of seven grant-monitoring subjects covered by the report.

Since the issuance of the *Second Report Card*, HAA has continued to make improvements on issues identified by the OIG's report, as well as in other areas.

HAA has improved its process for ensuring that adequate grantee site visits are performed. The Grants Management - Fiscal Control office has developed a "Site Visit Protocol" specifying that four site visits (two on administration and two on program issues) must occur during each fiscal year. According to HAA staff, a centralized calendar tracks scheduled site visits. A management tool for tracking the completion of site visits also has been developed. Grants Management also has implemented regular periodic supervision sessions with grant monitoring staff who are responsible for site visits. Because four site visits may be more (or occasionally less) than is required for effective monitoring, HAA is in the process of developing a site visit plan under which the number of site visits for a particular subgrantee is keyed to risk factors and performance issues for that subgrantee.

The agency also has provided uniform documentation requirements for site visits. The Site Visit Protocol summarizes the steps that need to be taken before, during, and after each site visit, and provides forms for recording information obtained during the visits. Grants Management has developed an extensive, uniform Site Visit Report form covering financial, personnel, and facility management. Three sample Site Visit Reports that DC Appleseed reviewed appear to have been completed in a uniform manner in accordance with the requirements of the form and the Site Visit Protocol.

The OIG report recommended a policy to ensure that grant management specialists are properly trained to monitor subgrantees. Training for grants managers has been upgraded. The grants monitoring staff now are required to participate in a certification training program. The training appears to be appropriate and includes a module on monitoring subgrants. The Grants Management staff reports that as of November 2007 five grant specialists had completed the training, and six currently were taking courses. It is anticipated that all of its grants monitoring staff should complete this training by

February 2008. Additional training in related areas, such as courses on the use of electronic spreadsheets, is encouraged.

In addition, the Grants Management has taken steps to ensure that staff collects audit reports from grantees and subgrantees. Still, some subgrantees appear to have failed to file the required audits.

The October 2006 OIG report found that some subgrantees had received awards even though they had failed to obtain permits and licenses that were required in order to qualify as eligible awardees. The Grants Management staff has developed a template to record the receipt and review of the necessary certifications, evidences of insurance coverage, licenses, and other eligibility items required for each subgrantee operating under each Request for Application ("RFA"). A review of the completed template for two RFAs, covering 26 subgrantees, showed that necessary eligibility documentation had been obtained in almost all cases. HAA reports that no award was made to any subgrantee that had not submitted all required documentation.

While progress has been made on timeliness of payments to subgrantees, there continues to be evidence of significantly late payments to some subgrantees and some apparent anomalies in HAA's record keeping. HAA currently is using an 11-step tracking procedure that begins when invoices are date-stamped upon receipt and logged into the HAA/Invoice Tracking System ("ITS") database. Although HAA is working toward having the ITS system automatically generate summary level detail on days-to-payment, it currently must use an electronic spreadsheet with the ITS system.

Generally, it is considered good practice to pay subgrantee invoices within 30 days, but delays of a few days are not unreasonable. The spreadsheet that we reviewed contained information on approximately 150 invoices and reflected only 16 instances in which payments were made more than 35 days after receipt. In other words, based on the data in HAA's spreadsheet, about 90 percent of invoices appear to have been paid within five days of a customary 30-day period, and some payments were made well before 30 days. Although historical data are not available to compute the level of improvement, we presume this payment record is considerably better than the situation giving rise to the OIG findings.

The spreadsheet, however, also reflected some instances of delays of 70, 80 or even 90 days. Delayed payments can be caused by the subgrantee (e.g., submission of an improper or erroneous invoice) or by other causes beyond HAA's control. We contacted subgrantees with significant grant funding to ask about their recent experiences with timeliness of payments. Generally, these subgrantees confirmed that timeliness of grant payments has improved. However, we also heard of instances where payments have been delayed significantly. One subgrantee brought to our attention an unpaid invoice pending for 228 days that was not reflected on HAA's spreadsheet. HAA states that this instance was an "anomaly" and that situations of this sort will be avoided in the future through improved invoice tracking software and implementation of additional processing protocols. We conclude that there remains room for improvement in this area both with respect to the timeliness of payments and accurate recordkeeping.

The primary focus of this review has been on whether HAA has developed and implemented the grant management and monitoring policies and processes recommended by the OIG. In general, it appears that recommended policies aimed at correcting grant monitoring and management problems are in place, and are being used by grants management staff. In some cases the procedures have been instituted fairly recently, and it is not yet completely clear how faithfully the procedures are being followed, or whether they are achieving their intended result — better performance by subgrantees. Interviews with subgrantees support the conclusion that grant monitoring processes and grant management in general have improved, although one subgrantee reported that HAA had missed numerous site visits, and another reported that timely extensions of grant renewals continue to be a problem.

We understand that the OIG is in the process of conducting a further follow-up audit of grant management practices; this

may shed further light on whether the new procedures are being used to good effect. In general, however, since the last report card HAA has made important improvements in the tools and training provided to grants management staff and management. More broadly, it appears that the management of the Grants Management Office has improved materially since the issuance of the *Second Report Card*, and, therefore, the District's grade has been raised from a "C+" to a "B."

QUALITY ASSURANCE: B-

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

The District continues to work on implementing quality assurance ("QA") programs for both HIV prevention and treatment services. The grade in this area is the same as on the last report card because, despite the ongoing efforts being made, it appears that implementation is yet to begin in many areas. We encourage the District to take concrete steps forward and, at the very least, develop a QA strategic plan in the next few months.

In general, we believe the District deserves recognition for beginning to focus greater attention on QA over the past year. HAA's hiring of a Medical Director with responsibility for QA is a positive development. That said, agency leaders stress that HAA is pursuing QA as a broad, collaborative effort and is working to focus on quality across the agency's many bureaus. We commend Dr. Hader's reported goal of measuring linkages between prevention and care and developing indicators for such linkages. We also hope that through her leadership such indicators can be developed and integrated into program officers' efforts soon.

HAA has made attempts to better understand gaps in its QA program over the past year by conducting an interim program assessment. The assessment report, which is expected to be released by the end of 2007, is already being used as a quality tool and as a resource during the planning of agency QA activities. While we do think this is an important step, the draft report provides only limited information: an inventory of current QA activities, a discussion of best practices, a gap analysis, and some recommendations for building capacity at HAA. The report fails to set forth a QA plan or identify resource needs. We think it is time for HAA to move forward with such steps in order to begin implementing its QA program. HAA also recognizes the need for the service provider community to play a crucial role in the successful implementation of QA measures. One major provider expressed concern that community-based organizations ("CBOs") may need additional resources or technical assistance to effectively implement the QA objectives. HAA reports it will draw upon HRSA for technical resources. We hope to see more progress in this area for the next report card.

HIV/AIDS Care and Treatment. HAA has made limited progress with respect to QA for care services. The contractor assisting with QA data collection and evaluation has been changed, which HAA staff report to be a positive development; however, some community members expressed reservations regarding the technical capacity of the new contractor. We hope HAA staff will provide careful oversight of the contractor's activities and ensure they have access to the most recent clinical protocols and other tools with which to carry out their reviews of medical charts and other QA activities.

HAA reports that it is exploring replacing the much-criticized Cross Program Research and Evaluation System ("XPRES") with the HRSA-developed CAREWare system for data collection. The new HAA leadership, however, is not convinced that CAREWare would be the best replacement and is exploring several other program options. As HAA makes a transition to a new data collection system, we encourage the agency to solicit input from providers and also the D.C. Primary Care Association so as to maximize the system's ability to work with other data collection systems and electronic medical records.

HAA reportedly has made significant progress in the implementation of standardized screening for mental health and sub-

stance abuse, as recommended by HRSA. This important screening tool was identified by the Planning Council Committee on Mental Health and Substance Abuse, and HAA collaborated in obtaining technical assistance from HRSA for the tool's implementation. This is to be commended since mental health and substance abuse can be important barriers to adherence to HIV treatment regimens.

An area in which HAA has failed to make progress as expected is in clarifying the role of the Planning Council Quality Management Improvement Committee. The agency and the mayor's office are now taking several steps to address this shortcoming. HRSA is providing technical assistance that includes helping define the role and functions of the committee, as well as highlighting statutory requirements and best practices. HAA staff report that this effort is expected to take nine months to one year. The agency is also reviewing new committee nominees and will provide a full orientation for new and current committee members focusing on performance requirements. Community members have raised the concern whether clinicians should play a more integral role on the Committee and as part of the process of developing and vetting HAA's QA plan. We hope both HAA and the Committee will collaborate and accomplish their common quality goals.

HIV Prevention. HAA is poised to make progress on its QA program with respect to prevention services. A draft Program Monitoring Procedural Manual has been developed for program officers. Although it is not meant to be a training manual, this new manual should help address concerns about inadequate training of some program officers because it provides step-by-step tools for program monitoring during the lifecycle of HIV prevention grants. As HAA rolls out the manual, it should ensure that both staff and grantees are trained in data collection and evaluation to ensure that performance indicators can be properly employed.

We recognize that HAA does not have full control over all issues that are slowing progress in the implementation of its QA program. For example, it appears that implementation of the Program Evaluation & Monitoring System ("PEMS") has been held up due to delays with the CDC finalizing certain components of the system. Nonetheless, HAA expects that PEMS will be fully functional sometime next year, which should lead to additional data collection and more information for evaluation.

We hope that HAA will continue to make progress in implementing a QA plan and that more robust indicators will be incorporated into a functional system in the next year.

HIV TESTING: B+

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

Our 2005 Report described how individuals who know their HIV status are more likely to change their behavior to reduce the risk of contracting or spreading the infection and, if necessary, to seek appropriate care and treatment. The report also indicated that more people likely would undergo HIV testing and learn their status if HIV testing were offered routinely as part of medical care.

The District received a "B" for routine testing on our *Second Report Card* because the District had made significant progress in announcing and implementing a routine testing program, but full implementation and results were yet to be seen.

Since mid-2006, a concerted effort has been made by the District to address the need for a citywide strategy on routine testing at all public and private medical settings. In June 2006, AHPP announced an HIV testing campaign — *Come Together D.C., Get Screened for HIV*. The goals of the campaign were to urge District residents between the ages of 14 and 84 to know their HIV status through free testing services, and to make HIV testing routine in all medical settings. The DOH launched an education campaign to raise public awareness and to engage the medical community to routinize HIV testing. As a result of the campaign, at the end of 2006, HAA saw a 60 percent increase in overall HIV screening in the District, yielding a 2.4 percent positivity rate. In the near future, HAA

intends to release a progress and data report on the testing campaign, detailing accomplishments, challenges, and next steps.

Since the launch of the campaign, the District has worked to improve collaborative relationships between DOH and community providers to promote routine testing. HAA has built upon its existing network of community partners to increase testing at diverse medical sites, including hospitals, public health facilities, primary care centers, private physicians' offices and 23 CBOs. To date, there are a total of 49 testing partners throughout the District. HAA staff also has met with the D.C. Dental Society to brief the members on HAA's testing priorities and to explore options for implementing routine screening in dental offices.

As part of its outreach efforts, HAA has furnished educational materials, training and technical assistance to providers. For example, the Prevention Bureau has developed a new curriculum for HIV counseling and testing, which was finalized in April 2007. This curriculum-based training established the new standard for minimum training required for HIV testing counselors in the District. HAA also has organized a Counseling, Testing, and Referral ("CTR") Providers Consortium, which meets quarterly to receive updates on the HIV screening initiative and other CTR program areas. Participants have the opportunity to provide feedback and recommendations regarding ongoing HIV screening efforts. In the future, HAA will provide technical assistance to the providers in areas related to counseling and testing.

Partnerships have been established by HAA to monitor testing. Constant program monitoring and evaluation gives HAA and community stakeholders a means of tracking the effectiveness and outcomes of individual testing programs and services throughout the District. HAA has partnered with GW to provide technical assistance in monitoring and evaluation, database development, data analysis and qualitative analysis.

Overcoming reluctance on the part of providers, particularly private physicians, to conduct routine testing and to report the results has been a serious challenge. In April 2007, Dr. Gregg Pane, then Director of DOH, issued a policy directive to implement routine screening for HIV infection in all DOH-operated medical and clinical sites. All programs throughout DOH were asked to identify opportunities to offer HIV testing and/or build upon current efforts to offer HIV testing, including rapid testing, in appropriate settings. HAA staff has done extensive outreach to private physicians and local hospitals to encourage routine testing.

As a result of these efforts, some private physicians who had not previously reported test results have agreed to report. In the near future, the District will be providing private physicians with information on names-based reporting in an attempt to increase reporting. We encourage the new leadership at HAA to continue to reach out to this group. Nevertheless, a number of potential barriers to participation by providers and CBOs remain, including lack of funding for HIV screening, lack of trained staff to perform the screening or counseling of patients, and concerns about counseling and liability with regard to linkage to care.

During the initial testing campaign, HAA had experienced a problem with test kits expiring prior to distribution and use. In an effort to remedy this problem, HAA modified its purchases of kits by shipping larger monthly quantities (500+) directly to more providers, and by eliminating agency inventory responsibility. Additionally, according to HAA officials, one of the lessons learned from the first year of the testing initiative was the productivity of community providers. HAA is now able to project with more accuracy how many tests providers can perform monthly and annually. HAA also has coordinated test-kit ordering with selected high-volume service providers. According to DOH, its purchase of test kits since January 2007 has increased to 80,000, and it is aware of only 15 test kits having expired during that time period. As a result of these changes, expiration of kits has become much less of a problem.

The District has taken steps to promote perinatal HIV screening to reduce the number of babies born with HIV. Although nationally the number of perinatally acquired AIDS cases

has been dramatically reduced, HAA reports that the number of new cases in the District may be as high as double the national case rate. In response, in June 2007, the DOH director sent a letter to health care providers calling for universal perinatal HIV testing and treatment. DOH is prepared to work with health care providers to offer training and technical assistance to achieve universal HIV screening for pregnant women and may be able to offer free rapid HIV testing devices for use in labor and delivery rooms. In light of the high perinatal transmission rate, there is a need for continued focus on this population. Dr. Hader has pledged to hire a staff person dedicated to eliminating perinatal HIV transmission.

The DOH continues to be successful in providing rapid HIV testing at some District-run facilities, including the STD Clinic, substance abuse treatment facilities and the D.C. Jail. While the District has not been successful at the TB Clinic, the new integration of the TB Clinic into HAA should help to facilitate HIV testing at that facility.

During 2006, HAA also successfully competed for the CDC's HIV Testing Expansion Grant, obtaining an additional $1.4 million for 2008. It is expected that this grant will be renewed for two additional years.

In summary, HAA has taken a number of significant steps to implement routine testing in the District and is in the forefront nationwide in this endeavor. At the same time, continued work is necessary to engage physicians and hospitals to routinize HIV testing. Therefore, we have raised the District's grade to "B+."

CONDOM DISTRIBUTION: B

Significantly expand condom distribution in the District.

Condom use is universally regarded as a safe and effective HIV prevention measure. In DC Appleseed's *First* and *Second Report Cards*, the District's condom distribution efforts were identified as areas of particular concern. As reported in DC Appleseed's *Second Report Card*, HAA had distributed only 115,000 condoms during 2006 and as a result received a grade of "D+." However, at the time of that report card the District had initiated a condom distribution program, whereby community providers could request free condoms on line from HAA to be distributed to the community. Although there is continued room for growth and expansion in the program, the District has made significant strides and the program has been well received and utilized by community providers. Moreover, the District has recently assessed the program's effectiveness, outlined specific steps for continued improvement, and made public these internal findings.

During 2007, HAA purchased one million condoms to be distributed primarily by CBOs to District residents. The condoms were packaged in custom-made wrappers in both English and Spanish affixed with artwork related to the District's HIV testing campaign. The condoms were to be purchased in quarterly quantities for a total cost of $107,000.

The program was premised on HAA providing condoms to CBOs free of charge as part of prevention activities after the agencies demonstrated how and to whom the condoms would be distributed. In addition, HAA noted that resource and referral centers in Wards 7 and 8 would act as condom distribution centers. HAA also stated that it would reach out to District agencies, such as DOC, DMH, Department of Human Services and other DOH agencies providing health and social services, to serve as condom distribution points. Finally, HAA sought to facilitate street outreach in Ward 7 and 8, and to work with health care provider members, DOH school nurses, and bar and club owners to promote condom distribution.

To date, HAA's CTR Division has managed the distribution of the condoms, which includes intake of requests, inventory control, and delivery and pick-up arrangements. Requests are made primarily through an Online Condom Distribution Form on the DOH website, but also by telephone or email to CTR. CTR committed to monthly surveys of the agencies that track the quantities of condoms handed out and to determine whether the agencies are reaching their target populations and geographic

areas. To date, 60 different organizations have received a total of 890,000 condoms, and HAA anticipates that one million condoms will be distributed by the end of the year.

HAA recently conducted an assessment of its condom program after media reports concerning complaints about the integrity of the packaging of the condoms distributed. Specifically, there were suggestions that the packaging could easily be damaged and that expiration dates were illegible. After the reports, HAA convened a meeting with the CBOs participating in condom distribution and other stakeholders to share information and seek recommendations regarding the District's program. Testing and analysis of a sample of DC brand condoms by an independent, nonprofit international public health organization concluded that the condoms in fact complied with all applicable Food & Drug Administration and other package seal integrity standards. Follow-up conversations involving CBOs and HAA resulted in HAA's decision that it will no longer distribute the DC brand condom, but instead will distribute brand-name condoms. The District should be commended for this thorough and prompt response and for involving the community in efforts to determine how best to protect the integrity of the city's condom distribution efforts.

For FY 08, HAA has budgeted $150,000 for safe sex products, comprised of approximately 750,000 male condoms, 20,000 female condoms and 250,000 individual lubricants. However, as noted in HAA's condom distribution policy, to meet projected demand for condoms, additional funds may be needed. DC Appleseed considers spending additional funds for condom distribution an essential public health investment.

On November 26, 2007, HAA Director Hader pledged to expand the condom program three-fold, saying that by 2009 the city will distribute at least three million condoms per year.

Although the various grant agreements provide a passive mechanism for coordination with other district agencies servicing high-risk populations (e.g., drug users, the mentally ill and the incarcerated), DC Appleseed recommends increased coordination among all city agencies as well as CBOs and the development of joint strategies for distributing condoms to at-risk populations. In addition, DC Appleseed recommends that the District support the various "next steps" identified in the HAA's revised Condom Distribution Plan, developed at the request of the Office of the City Administrator, which include increasing non-HIV community partners, increasing distribution at non-traditional/non-stigmatized locations, making information on obtaining condoms easier to access, developing a full-time employee position dedicated to condom distribution and logistics, creating a practical instrument to record condom utilization data, and improving inventory control.

DC Appleseed commends HAA for the significant progress made during the last year in the distribution of condoms and raises the District's grade to a "B" in this area.

D.C. PUBLIC SCHOOLS: D

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

DC Appleseed's August 2005 report called for DCPS and the Board of Education to develop content standards for HIV/AIDS education. In September 2005, the Board of Education adopted a resolution that made 16 recommendations for HIV/AIDS education, including: "The Superintendent should recommend for Board approval comprehensive… Health Education standards and evidence-based evaluation standards for all health education programs including HIV education provided by DCPS." In January 2006, at a hearing before the D.C. Council, the Superintendent testified that "a full HIV/AIDS curriculum, including standards and lesson plans, will be available for students by next fall." And in April 2006, the School Board adopted another resolution identical to the September 2005 resolution.

In our *First Report Card*, published in March 2006, the DC Public Schools received a grade of "B-" based on our understanding that HIV/AIDS standards were under review, would be in place by the 2007 - 08 school year at the latest, and that interim standards would be in place for the 2006 - 07 school year. In our *Second Report Card*, published in December 2006, the grade dropped to "C-" because HIV/AIDS standards had not yet been published, and there were no interim standards in place.

Based on our conversations with DCPS officials, the only resource currently in place for HIV/AIDS education is an eight-hour, optional curriculum supplement that teachers can use as part of the greater health curriculum. So far this year, there have been no training sessions on this supplement. And while the latest data available from the School Health Education Profile indicate that 100 percent of educators in schools that require a health education course self-report having taught HIV prevention, there is no assessment tool in place to monitor what information teachers are presenting to students and whether instruction is consistent across schools — or even within schools.

Since our last report card, the HIV/AIDS Education Program Director and the DCPS Executive Director for Health, Physical Education, and Athletics have worked to produce HIV/AIDS standards within broader health content standards. The Board of Education finally published Health Education Standards that included HIV/AIDS standards for comment in June 2007, and the comment period closed in August 2007. DC Appleseed and numerous community advocacy groups expressed satisfaction with the HIV/AIDS content, and expected the Health Standards to be approved soon after the comment period closed. But in November 2007, the newly reformulated Office of the State Superintendent reopened the comment period, and the State Board of Education held a hearing on the Health Standards on November 28, 2007. Now, the *earliest* that HIV/AIDS standards — as part of the Health Standards — could be approved is December 2007 — 27 months after the Board of Education first recommended that the school system adopt comprehensive HIV/AIDS education standards. And even that date is not certain.

In our view, these circumstances are unacceptable. The Board of Education's 2005 resolution recognized the urgency of the HIV/AIDS crisis in the District. Indeed, in May 2006 Peggy Cooper Cafritz, then the President of the School Board, recognized that the changes proposed in the School Board resolutions were "way overdue especially with the District having what is believed to be the highest rate of new AIDS cases in any major U.S. city." HAA's recent Epidemiology Annual Report confirms that there are still more people living with HIV and AIDS in the District than in other large cities with similar demographics. In the midst of this crisis, students should be getting information in school that will help prevent infection for the rest of their lives. But during the District's delay in adopting standards, fewer and fewer students report having received HIV/AIDS education — information that could actually save their lives.

The 2007 Youth Risk Behavior Survey shows that 78.4 percent of middle school students in the District reported receiving instruction on AIDS or HIV infection in school; that percentage has decreased every year that the survey has been given since a high of 88.6 percent in 2001. Similarly, the percentage of high school students who report having received HIV/AIDS education has decreased from a high of 91 percent in 2001 to a ten-year low of 85.7 percent in 2007. This disappointing decrease has occurred at a time when the need for comprehensive HIV/AIDS education plainly has increased.

Some District officials have cited the change in school leadership — especially the division of responsibilities between the new Chancellor's office and Office of the State Superintendent — as a reason for delay in adopting HIV/AIDS standards. DC Appleseed recognizes that school officials have a long list of pressing matters that require attention. But the District, by its actions, must demonstrate that providing HIV/AIDS education is a priority. That has not happened during the two years since the Board of Education's resolution called for immediate action.

And even after the standards are approved, DCPS must develop both a curriculum to implement the standards and tools to assess the impact of the HIV/AIDS program, and then train teachers throughout the District to implement the curriculum and assessment tools. All of the District officials that we spoke with told us that there are already plans for a multi-agency work group to begin development of the curriculum as soon as the standards are adopted. And they expressed hope — but not certainty — that a curriculum *could* be in place and teachers *could* be trained by the beginning of the 2008-09 school year if appropriate resources are engaged.

We urge the Chancellor, the State Superintendent, and the rest of the District government to (1) ensure that HIV/AIDS education standards are approved in enough time to develop an accompanying curriculum and train teachers on that curriculum by the beginning of the 2008-09 school year; (2) devote the resources necessary to ensure that curriculum design and training are completed before the 2008-09 school year begins; and (3) examine the coordination between DOH, DCPS, OSSE, and the Mayor's office as it relates to HIV/AIDS education in the new configuration of school leadership. The District's young people are entitled to nothing less.

SYRINGE EXCHANGE SERVICES: B+

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

Injection drug use continues to account for a sizable proportion of new HIV infections in the District. DC Appleseed commends the D.C. government for recognizing that providing services to this group of high-risk individuals can and should be a major effort in the battle against HIV/AIDS.

Through a combination of privately-funded syringe exchange and publicly-funded complementary services, the District has been making progress in addressing the various needs of the high-risk population IDUs. The District has earned a higher grade in this area because the government has demonstrated increased commitment to expanding services to IDUs in a number of ways, including planning for the possibility of funding syringe exchange programs ("SEPs") with local money.

Recent political developments leave open the possibility that the District soon may be able to fund syringe exchange directly. Since 1999, Congress has barred the District from using federal or local public funds to support SEPs. Earlier this year, however, the concerted efforts of the District government and community members led the House of Representatives to take action to remove the ban on spending of District funds on SEPs. Upon the request of Delegate Eleanor Holmes Norton, Mayor Fenty sent a letter to all members of Congress before the floor vote on the SEP ban, highlighting the importance of needle exchange in the city's HIV/AIDS prevention efforts. The floor amendment introduced by Representative Souder (R-Ind.), which would have prevented the District from using its local funds for SEPs, was defeated on June 28, 2007. The Senate subcommittee with jurisdiction over the District's budget marked up the House bill on July 11, 2007 and passed no amendments to restrict local spending on SEPs. While we are hopeful that the ban will finally be lifted this year or early next year, prospects for city funding of SEPs remain uncertain until final passage of the DC appropriations bill.

In anticipation of the potential elimination of the ban, various District government officials have been actively engaged in planning for the possibility of spending local funds on SEPs. In June 2007, Dr. Pane presented a memorandum to the City Administrator recommending $1 million in funding for SEPs in the event of the removal of the congressional ban. In addition to recommending additional funding, the memorandum outlined the components of successful SEPs and suggested possible approaches to important issues such as the location for services and community relations. As a follow up to these recommendations, the Office of the City Administrator held a meeting in September with DC Appleseed repre-

sentatives and senior staff from HAA and APRA to discuss potential approaches for funding one or more SEPs if the ban is lifted. HAA staff report that they are continuing to strategize with regard to potential SEP funding. Thoughtful planning to expand and strengthen needle exchange in the District is crucial. The government's actions are commendable, particularly since the planning has engaged a number of agencies.

In addition to taking steps to prepare for the possibility of funding SEPs directly, the District is making progress in publicly voicing its support of SEPs as a prevention method and as a way to address a wide range of health challenges confronting IDUs. Earlier this fall, Dr. Hader indicated that syringe exchange should be a "tool" to be used even in face of the ban on public funding. Like the Mayor's letter to Congress, this comment indicates the willingness of the District's leaders to employ this proven method for preventing HIV transmission in a high-risk population.

Consistent with the ban, the District continues to fund complementary services by PreventionWorks, as permitted under current appropriations restrictions. As mentioned in the last report card, PreventionWorks previously received funding for HIV testing and counseling for IDUs in Ward 7. More recently, the organization received a treatment adherence grant of $200,000, which is an important step towards providing a broader range of services to its target population. Although it is unclear whether such funding will be made available to PreventionWorks again, the organization's Director Ken Vail is committed to using SEP as a tool to engage clients initially in what he hopes will be a full continuum of care as the organization develops its capacity to provide additional services to IDUs.

The District also has been making progress internally to advance prevention efforts with the IDU population independent of the SEP funding issue. In order to maintain this momentum, we urge the Office of the City Administrator to provide funding for the Comprehensive HIV & Substance Abuse Initiative that has been under development since May 2007. The initiative first will assess the risk of HIV infection among substance users and their sexual partners. The assessment then would be used to develop a strategic plan for the District to decrease HIV incidence among residents who use illicit drugs. The plan is expected to include a new focus on harm reduction practices for IDUs and to provide additional counseling, testing and referral services. In crafting this strategic plan, HAA should solicit the input of other agencies, including APRA, DMH, and DOC, and seek guidance from community representatives and organizations. The plan should set forth a long-term vision with regard to services and prevention with IDUs, and establish benchmarks by which to measure progress. HAA staff estimates that approximately $150,000 in funding is needed to support the development of the strategic plan, with an additional $1 million needed for implementation. The Office of the City Administrator should seriously consider funding this worthwhile effort to ensure that IDUs are not neglected in HIV prevention services.

DC Appleseed commends the District's interagency efforts to explore possible funding of SEPs in the future. More importantly, we are pleased at the increased attention being paid to the provision of services to IDUs and hope that the new initiative will lead to integrated prevention and care for this population. The District's grade has been raised to a "B+."

SUBSTANCE ABUSE TREATMENT: C+

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

According to the most recent District of Columbia Household Survey, conducted in 2000, the rate of substance abuse in the District remains alarmingly high — fully 40 percent higher than the national average. Recent surveillance data indicate that 14 percent of new HIV diagnoses in the District can be attributed to a shared needle, and many more may be attributed to high-risk sexual behaviors associated with substance abuse. These numbers provides a stark example of the interrelationship between substance abuse and the District's continuing HIV/AIDS crisis.

DC Appleseed's *First* and *Second Report Cards* determined that the District had been largely ineffective in providing adequate substance abuse treatment services, and therefore warranted a "D+" grade. Both *Report Cards* noted that the District had made some progress in this critical area, but its efforts have been hamstrung by long-standing shortfalls in funding. Recently, a highly experienced individual with wide community support, Tori Fernandez Whitney, was hired as the Director of APRA. Largely because of efforts by the new director and her staff, APRA has accessed additional funding, and expanded its outreach and assessment services. As a result, DC Appleseed has raised the District's grade regarding substance abuse services to a C+.

DC Appleseed is encouraged by the increase in APRA's budget to address substance abuse issues, which, as noted, are so interrelated with HIV prevention efforts. APRA's budget for substance abuse treatment services remained stagnant at $34 million from FY 1998 to FY 2006, but increased to almost $44 million in FY 2007. The District's proposed operating budget for FY 2008 requested over $45 million for APRA. Of this total, the budget proposal requested almost $13 million for the Drug Treatment Choice Program — a $5 million increase from FY 2007. In addition, APRA received a $10.7 million Access to Recovery ("ATR") grant from the federal Substance Abuse and Mental Health Services Administration ("SAMHSA") to implement clinical treatment and recovery supports throughout the continuum of care during the next three years. Since this is the first time the District had received such a grant, APRA is commended for achieving additional access to needed funds outside of the DC budget.

In addition to the increased funding, the District has developed new community-based programs to make substance abuse treatment services more accessible by expanding its outreach efforts and targeting high-risk populations. APRA has stationed two outreach workers at the D.C. Superior Court and intends to add a third worker in the near future. It also has increased its screening, assessment and intervention capabilities in five economically distressed communities through the New Communities Initiative (formerly Project Threshold). Although some providers have reported organizational difficulties with this initiative, and recent data must be collected and analyzed to evaluate its success, APRA's initial reports suggest that the program is meeting its outreach and assessment goals.

APRA also has established substance abuse treatment programs that target specific high-risk populations. For example, Project Recovery in Supportive Environments ("Project RISE") provides a continuum of treatment, training, and housing services for homeless men with substance abuse disorders. The Rapid Detection and Early Intervention Initiative ("RDEII" or "Ready"), another example, has been in operation since 2006, and provides mobile outreach and rapid assessment to substance abusers living with or at-risk of contracting HIV/AIDS or viral hepatitis. APRA has stated that a portion of the funds received through the ATR grant has been earmarked for methamphetamine treatment services.

In DC Appleseed's *Second Report Card*, substance abuse treatment at the D.C. Jail was identified as a key component in the District's systemic approach to preventing HIV infection in high-risk populations. The DOC reports that over 90 percent of individuals in its custody report a history of alcohol and/or substance abuse. The DOC received a $223,000 Residential Substance Abuse Treatment (RSAT) grant from the U.S. Justice Department. The DOC intends to use these funds to implement a comprehensive assessment program at intake and also to operate a therapeutic community at the D.C. Jail to accommodate up to 60 inmates at one time (40 males and 20 females), with an annual treatment goal of 500 inmates. It is expected that this program will provide 90 days of substance abuse treatment during incarceration, along with linkages to community providers upon release. The DOC intends to operate this program internally and efforts to recruit a program director are ongoing. It is projected that the treatment program will open in late December 2007. The operation of an effective substance abuse treatment program at the D.C. Jail is essential. Many other neighboring jurisdictions have successfully

accomplished a comparable goal. As the program is in early implementation, ongoing monitoring and assessment will be necessary in order to determine its impact.

The District has taken several important steps towards increasing the availability of substance abuse treatment services since the *Second Report Card*, and the ongoing attention paid to this area of particular vulnerability remains encouraging. As a result, the District's grade has been raised to a "C+." Even so, because of the significant impact substance abuse has on the District's HIV/AIDS crisis, more must be done to fund a wide range of easily accessible substance abuse treatment services. The District should also move forward to update its monitoring and surveillance data in order to create an accurate picture of the substance abuse crisis and to develop targeted interventions for new drugs of choice. We look forward to working with APRA's new leadership to further improve substance abuse services in the District.

HIV/AIDS AMONG THE INCARCERATED: A

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

As noted in DC Appleseed's 2005 Report, the incarcerated are impacted disproportionately by the HIV/AIDS epidemic and have an increased need for HIV education and prevention services. They also are well situated to benefit from targeted prevention and care services. The intake health care screening provided in most jails offers a unique opportunity for many inmates to be tested and counseled about the risks of HIV infection and to benefit from strategies for preventing the spread of the disease. Even a short period of incarceration can give an HIV-positive inmate a chance to begin a treatment regimen, and effective discharge planning can link inmates with care in the community upon their release. In addition to improving the health of individual inmates, these steps can help to prevent the spread of HIV to others upon the inmate's release. To help D.C. reap the benefits of these opportunities, the DC Appleseed's original report recommended, among other steps, that the District improve collection of HIV and AIDS data among the incarcerated, implement routine HIV testing, ensure that HIV-positive inmates receive medications upon discharge, and improve discharge planning services.

At the time of DC Appleseed's *Second Report Card* in December 2006, DOC in cooperation with HAA, had implemented "automatic," voluntary, HIV rapid testing to all inmates upon intake. In this program, inmates receive counseling before they are tested, and once staff learns the results of the preliminary HIV rapid test, inmates receive counseling and referral for additional care, if needed.

Since the last report card, the success of this HIV testing program continues. The program provides critical data and expands opportunities for treatment and prevention among the incarcerated. A significant number of District residents have learned their HIV status through testing at the Jail. From June 2006 through September 2007, 16,853 inmates, or 74.9 percent of those inmates entering the Jail were tested at intake. The remaining inmates refused testing (9.5 percent) or were not tested for other reasons (15.9 percent), such as previously known HIV status. Of those tested, 3.1 percent were confirmed positive through blood testing, and less than 1 percent were newly identified as being HIV-positive.

Currently, Family and Medical Counseling Services ("FMCS") staff performs HIV testing in the Jail under a grant from HAA that covers testing through December 2007. Shortly before this *Report Card* went to press, HAA and FMCS negotiated an extension to this grant providing for FMCS to continue the testing at the Jail until September 30, 2008. This nine-month extension will allow DOC and Unity Health Care ("Unity") time to finalize their plans to consolidate HIV testing services with routine corrections medical services.

Since the *Second Report Card*, Unity assumed the contract for the provision of

comprehensive health services at the District's detention facilities under a community correctional care model. These services include discharge planning both to identify the inmate's health care and social needs and to help address those needs when the inmate returns to the community. Unity employs ten discharge planners, and the Income Maintenance Administration ("IMA") provides an additional discharge planner.

According to the Jail and Unity staff, Unity's discharge planners meet with inmates who have known chronic illness, including HIV, within 24 hours of the inmates' intake to the Jail to collect information regarding the inmates' medical and social needs. Prior to discharge, Unity discharge planners make appointments for inmates with HIV/AIDS to see infectious disease specialists in the community and arrange for them to receive medications at discharge. According to Unity's records, in December 2006 and January 2007, 30 percent of inmates with HIV who were discharged from the D.C. Jail were seen by a Unity Health Care provider. Whether other inmates were seen by non-Unity providers is not known and is difficult to research under the medical privacy laws. The IMA discharge planner's role is to identify benefits the inmates are entitled to and enroll them in those programs. We were unable to get in contact with the IMA worker to discuss her responsibilities. DC Appleseed commends the District for initiating a program to address the medical needs of inmates upon discharge. However, it has been reported to us that housing is an area of discharge planning that is clearly needed and lacking, especially for HIV/AIDS inmates. We encourage the District to incorporate housing discharge planning into the current program.

In addition to referrals to health care in the community, inmates with HIV/AIDS must have unbroken access to their medications. DC Appleseed's *Second Report Card* identified the failure to provide medications on discharge as a long-standing problem at the D.C. Jail. In recent months, Unity and DOC have shown significant progress toward solving this problem. According to DOC's audit, from May through September 2007, 92 to 95 percent of inmates who required medication received them upon release. DC Appleseed commends Unity and DOC for addressing this problem, and we encourage the continuation of these efforts.

DOC currently provides seven days of HIV medications to inmates upon discharge. In its 2005 report, DC Appleseed recommended that DOC use AIDS Drug Assistance Program ("ADAP") funding to provide a 28-day supply of HIV medications upon discharge. At the end of fiscal year 2007, the District's ADAP program had a surplus in the amount of $7 million. This surplus provides the District with a great opportunity to expand the supply of medications provided to HIV-positive inmates upon discharge from the Jail. HAA and DOC recently have collaborated to facilitate the transfer of ADAP funds between HAA and DOC to pay for drugs provided to inmates at discharge in 2007, including medications provided to 174 inmates between January and September 2007, at a cost of $39,909.50. These figures indicate that the cost of significantly expanding the supply of drugs provided at discharge would equal only a small fraction of the ADAP surplus.

DC Appleseed is pleased to report that DOC intends to increase the supply of medication provided to inmates with HIV/AIDS at discharge to a 28-day supply of HIV medications, paid for through ADAP funds. We applaud the District for taking this important step to facilitate HIV positive inmates' uninterrupted treatment regimens. Through additional collaboration with HAA, DOC recently agreed to provide condoms, lubricant, and educational materials about STDs to inmates upon discharge from the Jail.

In the *Second Report Card*, the District received a "B+" for its HIV/AIDS services to the incarcerated. In recognition of the District's substantial progress in this area, the District's grade has been raised to an "A." The District's automatic testing program and its agreement to provide 28-days of medication and condoms at discharge from the Jail put the District at the forefront of the Nation in identifying and treating HIV-positive inmates. We applaud the District's efforts and encourage them to continue these programs.