

HIV/AIDS IN THE NATION'S CAPITAL

In the three years since DC Appleseed issued our 2005 report, *HIV/AIDS in the Nation's Capital: Improving the District of Columbia's Response to a Public Health Crisis*, the government has made important strides in combating the disease. The Fenty administration continues to take significant steps to implement many of the recommendations in our 2005 report.

Our generally positive assessment in the *Fourth Report Card* is tempered by a harsh reality: the HIV/AIDS epidemic still poses an ominous threat to District residents. The city has a vital role to play in targeting prevention measures to high-risk populations and in eliminating the stigma associated with HIV/AIDS. Although there has been progress in addressing the epidemic, sustained and increased efforts are necessary to curtail the epidemic.

This *Fourth Report Card* evaluates the District's progress in implementing the recommendations in DC Appleseed's 2005 report. The grades, and a description of the areas graded, appear below. An Executive Summary and a detailed explanation for each grade are attached.

REPORT CARD

NO. 4
JANUARY 2008 TO
SEPTEMBER 2008



GRADES (A-F)

LEADERSHIP

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

INTERAGENCY COORDINATION

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

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.

GRANTS MANAGEMENT

IMPROVE GRANTS MANAGEMENT, MONITORING AND PAYMENT PROCESSES TO ASSURE THAT FUNDS FOR HIV/AIDS SERVICES ARE SPENT FULLY AND EFFECTIVELY.

MONITORING AND EVALUATION

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.

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, D.C. JAIL, TB CLINIC, AND SUBSTANCE ABUSE TREATMENT FACILITIES).

CONDOM DISTRIBUTION

SIGNIFICANTLY EXPAND CONDOM DISTRIBUTION IN THE DISTRICT.

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.

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 ADOPT ADDITIONAL MEASURES TO ADDRESS PREVENTION WITH SUBSTANCE-USING POPULATION.

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, IMPROVE DISCHARGE PLANNING SERVICES, AND ENSURE THAT HIV-POSITIVE INMATES RECEIVE MEDICATION AT DISCHARGE.

B+

B

A

B

B-

A-

B

C

A-

B

A

EXECUTIVE SUMMARY

The District of Columbia has made substantial progress in confronting its HIV/AIDS epidemic since 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*. At that time, it was clear the District was failing in its efforts to address what we called "a modern epidemic" in our city. In our report, we called on government leaders to make HIV/AIDS the top health priority in the District and noted that with strong leadership the District could significantly improve its response to the epidemic. DC Appleseed has issued periodic "report cards" in an effort to provide the public with a continuing assessment of the District's progress in responding to the HIV/AIDS crisis. This is our *Fourth Report Card*.

DC Appleseed's *First Report Card*, released in March 2006, recognized the government's strong push to confront the HIV/AIDS challenge. 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.

In the *Third Report Card*, released December 2007, we pointed to significant, but uneven progress in the District's efforts to address the epidemic. The District made an important breakthrough by releasing its long-awaited HIV/AIDS Epidemiology Annual Report that for the first time provided a specific breakdown of HIV and AIDS cases in the city. That report provided a much-needed fundamental foundation for *targeting* the District's response to the epidemic. But we also noted inconsistencies related to certain important aspects of the District's response. The new administration of Mayor Adrian Fenty earned high marks for leadership, but a fundamental failure on the part of the D.C. Public Schools ("DCPS") to address the epidemic was a matter of deep concern that called for a much more aggressive response.

This *Fourth Report Card* again shows substantial progress in the District's response to the epidemic and highlights continuing efforts by the government to implement key recommendations in our 2005 report. Overall, the District's grades for the 11 assessed subject areas increased or stayed the same. Eventually — assuming the documented plans and successes can be sustained — we anticipate that these government initiatives will begin to have a substantial impact that should reduce the incidence of HIV/AIDS in the District.

But before that can happen, the District must take aggressive action to address the remaining obstacles to rolling back the epidemic. We of course welcome Mayor Fenty's call for HIV/AIDS to be his top health priority, but sustained, highly visible government efforts to broadly raise awareness of the severity of the epidemic have been absent and reflect a lack of urgency. HIV/AIDS has not been a consistent, routine part of the government's public conversation.

This engagement is particularly necessary as the most recent data make clear that the tragedy of the District's HIV/AIDS epidemic is far from over. Between 1997 and 2006, 68.7 percent of newly-identified AIDS cases in the District were "late testers." That is, they first learned of their positive HIV status less than one year before being diagnosed with AIDS, which is typically long after they initially would have tested positive for HIV. The CDC reported a national rate of "late testers" of 40 percent for 2007. The city's high late tester rate reveals that too many District residents living with the HIV virus are not aware that they are HIV positive and are potentially infecting others. The compelling need for increased HIV testing is plainly evident.

As the medical community, the government and service providers begin to improve the focus of testing efforts on the highest risk groups, we are finding the epidemic is changing and continues to pose a dire threat. As reported in the District's HIV/AIDS Epidemiology Annual Report, in 2006, although African Americans were estimated to comprise 55 percent of the District's population, they represented 79 percent of the new HIV cases and approximately 81 percent of those living with AIDS. The Kaiser Family Foundation recently reported that the District has the highest African-American AIDS case rate in the country (277.5 per 100,000) and the highest Hispanic rate of new AIDS cases in the country (109.2 per 100,000). Despite the efforts of government, community activists, and service providers, the epidemic is still very much with us and is making fresh inroads.

Our *Fourth Report Card* shows that, for the most part, the D.C. government has fashioned the basic building blocks needed to address its most important public health crisis. Considerable effort has been directed at reaching young people. But the remaining challenges require new solutions and stepped-up efforts. The District must find creative ways to reduce the stigma associated with HIV/AIDS — particularly in the African-American and Latino communities. HAA's push for HIV testing in all medical settings is commendable — and efforts by Howard University and other hospitals to routinize testing represent great progress — but many private physicians do not conduct routine HIV testing, or report testing data to HAA.

The District has made progress in recruiting a top-flight leadership team at HAA and in developing the fundamental government infrastructure essential for confronting the epidemic. HAA's surveillance efforts and the HIV testing program and other prevention measures at the D.C. Jail both received an "A" for the second straight year. The data released in the District's 2007 HIV/AIDS Epidemiology Annual Report are now driving HAA's efforts to reach the highest

risk populations. The District’s efforts to expand HIV testing into all medical settings earned an “A-,” and the government’s strong support for syringe exchange services drew another “A-.”

In our *Third Report Card*, DCPS was given the lowest grade — a “D.” Shortly after the release of that report, the D.C. State Board of Education adopted health standards that had been on the table for three years. DCPS also adopted an HIV/AIDS curriculum envisioned in the standards for all grades and began training teachers this year. The DCPS grade has been raised to a “C.” This progress is obviously welcome, but just as obvious, the progress is not what it should be if the school system is to reach the District’s young people concerning this epidemic.

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

In summary, DC Appleseed is encouraged by the District’s progress in addressing the HIV/AIDS epidemic. However, these efforts will need to be increased, as well as sustained, before the District can expect to see any significant drop in new HIV infections. This is particularly true given the most recent data which reflect the gravity of the epidemic within certain population groups. The city has the knowledge base, the professional staff and the infrastructure in place to better target those most at risk of being infected with HIV. The future gauge of success for the District in the fight against this epidemic should be the reduction in actual new HIV/AIDS cases.

DC Appleseed would like to acknowledge and thank the Washington AIDS Partnership and its Steering Committee for its initiation of and continued support for this project. We would also like to thank Hogan & Hartson for its continued, invaluable pro bono work on the project and Terrapin Studios for its pro bono production of this report. Finally, we would like to thank the District government for its cooperation as we prepare these report cards.

FOURTH REPORT CARD

SEPTEMBER 2008

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 elevated the profile of the disease inside and outside of the government, as well as strengthened the government response to the epidemic.

Our *First Report Card* noted that then-Mayor Anthony Williams supported the recommendations in the 2005 report. The HAA director was replaced, long-time vacancies at the agency began to be filled, and the D.C. State 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.

In our *Third Report Card* released in December 2007, we noted steady progress at HAA and a resurgence of energy and commitment at the mayoral level. The Mayor also

made HIV/AIDS a major focus of his transition plan and hosted an HIV/AIDS Summit, bringing together more than 120 leaders from the government and community organizations. During several events over the course of his first year in office, the Mayor stated publicly that HIV/AIDS is his number one public health priority. The grade was raised to a "B+" in the *Third Report Card*.

Since that time, the Fenty administration has enabled an improved performance and professional culture at HAA and helped foster a government-wide approach to confronting the epidemic. At the same time, the number of forceful messages about the epidemic from the top of the District government has decreased.

In the *Third Report Card*, DC Appleseed noted the Mayor's choice to lead the agency — Dr. Shannon Hader — had not served long enough for us to adequately assess her performance. Based on interviews with staff and service providers, and considering actions taken within the agency, we believe Dr. Hader is providing strong and focused leadership. Dr. Hader has effectively used the November 2007 HIV/AIDS Epidemiology Annual Report ("2007 Epidemiology Report") and subsequent surveillance data as a road-map for guiding new programmatic initiatives. Service providers and activists report that Dr. Hader has been accessible to the community, and she is perceived widely as providing energetic and competent leadership at an agency that has experienced considerable leadership turmoil. Dr. Hader also appears to have strong support from the Mayor, City Administrator and the D.C. Council.

The Fenty administration also has begun implementing several major initiatives it proposed in 2007. In January 2008, Mayor Fenty announced that the government would provide \$650,000 in new funding to expand syringe exchange programs ("SEPs") in the District. It was the first time since 1999 that the District was able to allocate local tax dollars to the enhancement of syringe access, which previously had been prohibited under a congressional ban that was lifted in late 2007. As will be highlighted later in this report, the initial phase of the expansion is producing promising results. The administration also has committed to fund continued expansion of SEPs. DC Appleseed believes the Mayor's

public support for SEPs is vital to the long-term success of this initiative.

The Fenty administration and HAA staff also should be commended for implementing a major multi-agency youth initiative that was crafted in 2007. The Mayor directed that HIV/AIDS education and testing be conducted in a systematic way by the Department of Parks and Recreation (“DPR”), the Department of Youth Rehabilitative Services (“DYRS”) and the Department of Employment Services (“DOES”). HAA staff report that approximately 15,000 young people received HIV prevention education during the summer jobs program initiative alone.

The administration also has pressed forward with a plan to institute HIV/AIDS education in DCPS at the start of the 2008-2009 school-year. The system-wide program is being put in place as part of a health curriculum less than a year after new health standards were finalized. These standards focused on a wide range of health concerns including HIV/AIDS.

Several promising developments initiated by the administration have increased the visibility and accessibility of HIV/AIDS services provided by the city. The Mayor directed the Department of Health (“DOH”) to make more information about the epidemic available through the new “311” city-wide call center. Also, DOH’s advertising campaign to promote the availability of free HIV/AIDS drugs under the federal AIDS Drug Assistance Program (“ADAP”), which serves eligible residents of the city, has resulted in a significant increase in the program — tripling the monthly enrollment since 2007. Furthermore, HAA also demonstrated initiative by forming a public-private partnership with a local foundation to expand the medication safety-net and improve advanced planning for ADAP. Without such an agreement, the District would have forfeited \$5.8 million in federal funding for this HIV/AIDS medication program, and would have lost the opportunity to maximize antiretroviral treatment stability as a fundamental basis for increased enrollment in ADAP.

The Mayor has directed HAA to engage the faith community more actively. This has led to the formation of the Faith-Based Advisory Board and triggered an assessment by HAA

of how best to serve this important community resource.

DC Appleseed is hopeful that a pattern of rapid turnover in leadership at HAA and at DOH has come to an end. At the beginning of this reporting period, DOH was led by an interim director. In February 2008, Mayor Fenty appointed Dr. Pierre Vigilance as the new Director of DOH. We are encouraged that Dr. Vigilance has a strong background in HIV/AIDS prevention. Several activists have noted, however, that DOH has not undertaken a major public relations campaign that focuses substantial attention on the threat posed by the HIV/AIDS epidemic. Furthermore, the administration has not yet conducted a follow-up to an April 2007 “CapStat” evaluation of the District’s overall efforts to address the epidemic. That session produced specific action items for DOH. The hiring of Dr. Vigilance would have seemed an appropriate time to assess the progress that has been made in implementing those action items.

While Mayor Fenty and his administration deserve recognition for the continued support of initiatives launched last year, his public appearances and statements about the epidemic have been noticeably sparse. After announcing the syringe exchange initiative in January, the Mayor participated in a February event kicking off the Test for Life campaign. The Mayor also appeared in television and radio public service announcements associated with that effort. The campaign was intended to encourage local residents to obtain free HIV screening. During the Mayor’s March State of the District speech, the Mayor reiterated his statement that HIV/AIDS is his top public health priority, but the epidemic was not a major focus of press reports on the speech. In June, the Mayor served as “host” at a wellness event for young people sponsored by a local radio station that included a discussion about HIV/AIDS prevention. In order to address the epidemic effectively, it is essential that there be consistent and regular messaging to District residents by the District’s leaders about the state of the epidemic and prevention measures. This has been much less consistent and forceful during the past year.

Due to the progress that has occurred at HAA during the past year, the District’s leader-

ship grade has been maintained at “B+.” Leadership is demonstrated both by speaking and doing, consistently and forcefully over time. DC Appleseed strongly encourages the Mayor, DOH Director and HAA director to take every possible opportunity to publicly speak about the fact that HIV is 100 percent preventable, and that resources to support prevention, testing and care are available in order to educate and assist residents on a continuing basis.

INTERAGENCY COORDINATION: B

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

DC Appleseed’s August 2005 report cited as a serious problem an absence of collaboration among District agencies to support the response to the District’s HIV/AIDS epidemic. At that time, we found that a coordinated, government-wide effort was essential to provide a comprehensive response to the 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 Community Health Administration (“CHA”).

In our *First Report Card*, the coordination between District agencies and within the DOH was not graded. In our *Second Report Card* in late 2006, DC Appleseed reported little to no coordination between HAA and either the Department of Mental Health (“DMH”) or DCPS, although there was coordination between HAA and the Department of Corrections (“DOC”). Other agencies within DOH had little contact with HAA. At that time, the Mayor’s Task Force on HIV/AIDS was not providing a vehicle to facilitate interagency coordination. The District therefore received a “C-” for its performance.

Our *Third Report Card* credited the Fenty administration with placing a greater emphasis on a coordinated effort to address

the epidemic, tapped by the mayor as his top public health concern. Several initiatives raised the prospect that government-wide solutions to the epidemic were being developed, including: a multi-agency effort aimed at HIV prevention among young people, a dialogue involving HAA and DMH regarding improvement in addressing those dually diagnosed with mental illness and HIV, and a Memorandum of Understanding (“MOU”) related to housing for those under the care of several city agencies. The grade was raised to a “B-” on the *Third Report Card*.

During the past year, we have seen an increase in collaboration among District agencies related to youth prevention. The Youth HIV Prevention Plan is a three-year initiative that attempts to address, in a systematic way, youths’ primary and secondary HIV/AIDS prevention and intervention needs. The youth project involved collaboration among 30 agencies and resulted in an Interagency Workgroup on Youth, Young Adults and Health. This workgroup convenes monthly to focus on improving the coordination and collaboration on youth and health services programming.

The initial activities associated with the youth plan that were implemented over the past several months reached hundreds of young people and should be maintained and expanded. DPR incorporated HIV education into several of its summer programs and offered a summer workshop in conjunction with DOH, MetroTeen AIDS and Planned Parenthood titled: *HIV 101, Pregnancy Prevention*. DPR reports that 13 sessions of the workshop were conducted reaching 330 participants. Of those, 100 participants were tested for HIV and 250 for STDs. Additionally, HIV/AIDS prevention education was offered to about 15,000 young people who attended training for the DOES summer jobs program. While the summer jobs program has experienced serious administrative failures, HIV education should be continued in the program and expanded to include testing and individual counseling.

Over the past year, HAA also has helped to guide an expansion of HIV services and prevention programs at DYRS. The youth agency has integrated HIV screening into its clinical services. HAA also identified local funding to support a program that provides education on

HIV, STDs and sexual health to residents of Oak Hill Youth Center.

The leaders of three city agencies critical to addressing the HIV epidemic — HAA, DMH and APRA — now meet monthly to explore ways in which individuals dually or triply diagnosed with mental illness, drug addiction and HIV can be better served. DMH and HAA are currently operating under an MOU, which establishes a partnership to provide affordable housing for patients who are dually-diagnosed with HIV and mental illness. Since the last report card, HAA is exploring the use of DMH's mediation services to intervene in housing challenges that confront individuals living with HIV or AIDS.

St. Elizabeths Hospital staff and HAA continue to consult on ways to improve HIV education and discharge planning for HIV patients. The HIV Planning Council has developed a screening tool that is now being used on a pilot basis to identify mental health and substance abuse problems. Also, since the last report card, staff has identified HIV service providers that do not have DMH certification. As those providers become DMH certified, they will become eligible for mental health funding.

HAA and APRA continue to play an integral joint role in the fight against the epidemic. All APRA sites now conduct HIV testing, distribute condoms and provide information about syringe exchange services in the District.

HAA also has entered into an MOU with the Mayor's Office of Partnerships and Grants Services (OPGS) for the Effi Barry HIV/AIDS Program. HAA has engaged OPGS to provide capacity building workshops and one-one-one consultation services that are helping improve the administrative and programmatic infrastructure of small, ward-based community organizations.

HAA's prevention bureau is working with the Metropolitan Police Department ("MPD") to educate officers about the District's expanding SEPS. Individuals in the exchange programs are issued an official card identifying them as a program participant and explaining the District laws that allow for the distribution and possession of sterile needles. The development of this tool has sparked further

dialogue between HAA and MPD about drug paraphernalia laws and public health.

Progress also has been made on issues related to reimbursing costs associated with HIV testing conducted by MAA. Previously, many clinics faced difficulties in receiving reimbursement due to billing complications. Since our last report, the American Medical Association and the American Academy of HIV Medicine issued a complete compendium of bill codes for HIV testing, and HAA has distributed that information and helped educate service providers.

The Children and Family Services Agency ("CFSA"), with HAA's assistance, has instituted a program to incorporate HIV education as part of its comprehensive health standards. In an effort to better equip foster parents, HAA released a Request for Applications ("RFA") which seeks to fund a local organization to administer the Centers for Disease Control and Prevention ("CDC") family intervention called *Parents Matter*, a program designed to promote effective parent-child communication about sexuality and sexual risk reduction.

DOC continues to collaborate with HAA to provide HIV testing, HIV education services and HIV medication and condoms upon discharge to the District's incarcerated population.

In our 2005 report, DC Appleseed cited a lack of coordination among various agencies within DOH as an obstacle to effectively addressing the HIV/AIDS epidemic. One major component of the District's efforts to better coordinate services — the 2007 integration of the District's STD clinic, TB clinic, and the Adult Hepatitis Program into HAA — should facilitate improved coordination of services, including prevention and testing.

In 2007, the Fenty administration initiated an ambitious agenda for improving coordination among various city agencies in responding to the HIV/AIDS epidemic. While not all of these plans have been implemented, an impressive number of them have been put in motion. DC Appleseed sees this improved coordination as providing an expansion of prevention and treatment efforts directed at particularly vulnerable populations, including young people, the addicted and the mentally ill. As a result, the District's grade has been increased

from a “B-” to a “B.” The increase is slight, since many of the initiatives are in the early stages, but further improvement in this grade is expected as these initiatives are sustained and expanded.

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.

In 2008, HAA’s Strategic Information Bureau (“Bureau”), formerly called the Surveillance Bureau, has sustained the remarkable turnaround of the previous year and has built upon its success. Last year, a revamped Bureau solidified its partnership with George Washington University’s School of Public Health and Health Services (“GW”). Together, HAA and GW successfully overcame significant data backlogs and issued a much anticipated report releasing data on the state of HIV/AIDS in the District. This impressive effort earned the District an “A” on the *Third Report Card*. While the Bureau had clearly exceeded expectations, a number of measures still were needed going forward. In particular, additional staffing and the need for the Bureau to follow its long-term plan to sustain its successes were recognized as essential to maintaining the District’s “A” grade. HAA has met these challenges successfully.

In the past year the Bureau has filled a number of staff vacancies with experienced personnel and has continued to expand its collaboration with GW. Four senior level managers have been hired, including a Field Investigator Coordinator, a Surveillance Coordinator, an Epidemiology Chief and a Manager for Monitoring and Evaluation. In addition, field investigators, a data manager and two staff epidemiologists have been hired. This expanded staffing is needed to assure accurate information on the District’s HIV/AIDS epidemic, which is especially vital in light of the epidemic’s disproportionate toll on certain high-risk groups in the District. Reaching these groups requires a large and well-trained investigation team. The newly hired individuals bring substantial new professional and educational experience and expertise to the Bureau.

In addition to adding qualified personnel to the Bureau, HAA has expanded its relationship with GW. This relationship was vital to the development of the District’s 2007 Epidemiology Report and has allowed the Bureau to clear its backlog of files. Since the report, the Bureau is now responsible for the core surveillance on adult Hepatitis, which is being performed with the assistance of GW. In addition to the work performed at the professorial level, substantial involvement of students at GW and other schools has allowed the Bureau to maintain routine surveillance and design new HIV/AIDS projects.

The Bureau has fortified its surveillance efforts by supplying material for HIV/AIDS, STD and TB reporting to over 5,500 providers. These packets provide information to physicians on how to report HIV/AIDS cases and contain easy-to-complete reporting forms. In 2008, the Bureau provided monthly training sessions regarding reporting and trained approximately 150 providers. In addition, the agency has continued to refine the analysis presented in the 2007 Epidemiology Report by adding additional cases identified from Medicaid records. The Bureau has initiated electronic data forms to assist in data collection at two area labs and intends to expand electronic data reporting in the near future. It is hoped that electronic reporting will relieve the Bureau of some difficult review and de-duplication work and will be easier for physicians to complete, thereby encouraging reporting. As a general matter, the Bureau is increasingly successful at gathering data on new cases and ensuring the accuracy of data.

Through its contract with GW, the District has successfully completed its work under the National Health Behavioral Surveillance (“NHBS”) study for the high-risk heterosexual population. This work will provide vital information on the demographics and behavioral patterns underlying the HIV/AIDS epidemic in the District. Findings from this study are expected to be released in the fall. The next phase of the NHBS, a study of behavioral patterns among men who have sex with men (“MSM”), has begun. The MSM study has involved extensive community involvement and a commitment to perform venue testing. The use of non-traditional settings for testing and interviews provides a better opportunity to assess the behavioral and social factors

affecting the HIV/AIDS problem in the MSM population.

HAA has now taken responsibility for the District's Hepatitis surveillance in coordination with GW. The work on Hepatitis is in early development, but HAA and GW are leveraging their previous experience with HIV. New professorial and student resources are being used to clean the data and design studies for Hepatitis research. This expanded focus of the Bureau and GW will provide a better understanding of the STD threat in the District, as well as the behavioral underpinnings of both the Hepatitis and HIV epidemics.

The most important change since DC Applesseed's *Third Report Card* is HAA's increased focus on utilizing surveillance data to drive policies. To this end, the Bureau is conducting community service assessments designed to provide a picture of the resources available and the gaps in care for the communities with the greatest need. Combining the findings from this assessment with the surveillance efforts will help HAA to meet the needs of HIV/AIDS patients and care givers.

The Bureau also should serve as an important resource for interpreting data collected by community service providers. For example, the Whitman-Walker Clinic recently released testing data for the first half of 2008, which reported 266 new HIV diagnoses, compared with only 80 for the previous period in 2007, without an appreciable increase in testing. The Bureau's rigorous examination and valid assessment of what these data reveal about the epidemic, as well as an examination of data collected by other community based organizations ("CBOs"), is vital to providing the public with a clear, accurate and scientifically sound evaluation of the epidemic.

At the conclusion of the *Third Report Card* period, the primary question was whether the progress made by the Bureau could be sustained. Since that report card the Bureau has not only sustained its progress, but has built upon it. To maintain this high grade of an "A" for surveillance the Bureau will have to continue its efforts, such as the annual release of surveillance data and carry forward its new projects.

GRANTS MANAGEMENT: B

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

Over the past year, HAA has continued to make some progress in improving the management and monitoring of grants awarded to service providers. Past problems have included slow payments to subgrantees and inefficient processes for monitoring grantees, two areas that have shown significant improvements, particularly since the *First Report Card*. In fact, for this *Fourth Report Card* period, the subgrantees that we contacted uniformly reported timely payment. However, progress appears to have been slowed somewhat during the last year as a result of personnel changes, and HAA is operating under essentially the same set of procedures and practices that we reviewed and addressed in the *Third Report Card*. That said, several significant changes are in draft form with planned implementation starting with the new fiscal year on October 1, 2008, including a revamping of subgrantee monitoring processes. Thus, the District is in a good position to improve its grade in the grants management area during the next review cycle.

HAA last revised site visit protocols for fiscal monitoring in November 2006, and newer policies on site visits and monitoring plans are still in draft form, with an October 1, 2008 target date for implementation. According to HAA's Bureau of Grants Management/Fiscal Monitoring ("Grants Management") staff, HAA convened a focus group to review the protocols for site visits in August 2008, with the objective of finalizing protocols by mid-September 2008. HAA also plans to convene a mandatory subgrantees' forum and is in the process of formulating an agenda for this forum, which will include an information session on grant fiscal requirements, an introduction to new forms, as well as a question and answer session. The last such forum was held four years ago and reportedly was well received.

In terms of monitoring of performance, HAA plans to place more emphasis on program

outcomes, i.e., whether or not the grant project is having a measurable impact on the community. Future funding reportedly will be contingent upon performance against predicted outcome objectives. This initiative should be advanced by HAA's decision to modify its RFAs for subgrants to include a "Statement of Needs" of the community. This initiative should help to focus grant applications on maximizing the impact on the local community.

HAA hopes to measure performance against fiscal indicators (e.g., elimination of unallowable costs from invoices, actual cost performance against budget, and rate of expenditures) as well as programmatic indicators (e.g., what percentage of the targeted population has been reached and completion of program goals relative to expenditures). Subgrantees earning passing scores on 85 percent or more of the measurement criteria will be labeled "Satisfactory," while those who do not will be rated "Needs Improvement." As part of a department-wide effort, HAA will work with all its subgrantees to support increased performance and functioning. Subgrantees who receive a rating of "Needs Improvement," will be provided technical assistance to increase the organization's capacity in the area(s) of weakness. If the additional HAA support and/or guidance do not improve the subgrantee's performance, then the subgrantee will experience a reduction in or withdrawal of funding. In the last evaluation cycle during March 2008, one subgrantee reportedly was unfunded. In the next funding cycle, HAA will examine past performance as measured above to decide what level of funding will be awarded on a going-forward basis.

By October 1, 2008, HAA plans to implement a "capacity-assessment system" to determine the number of required site visits, as opposed to a preset number of site visits for all subgrantees. This concept was discussed in the *Third Report Card*, and the details for Agency Capacity Assessment and Monitoring ("ACAM") now have been fleshed out both in terms of draft policy guidance and a detailed post-award ACAM Worksheet and Interview Guide. The number of site visits conducted per year will range from one to three depending on a subgrantee's performance assessment, which will be accomplished jointly by

fiscal and programmatic monitors. This new process appears to be well-documented and logical, but is yet untested.

Site visits also will involve two evaluation tracks, fiscal and programmatic. HAA reported that it historically has concentrated more on fiscal oversight aspects, and now is focusing more heavily on programmatic oversight. HAA plans to integrate the two monitoring processes and institutionalize regular meetings of fiscal monitors and program monitors. Reference resources and policy and procedure manuals are being developed to provide guidance for both fiscal and program monitors (with the one for fiscal monitors somewhat further along). On the program side, HAA wants to focus on outcome data and define "indicators" of performance expectations. Although it is inherently difficult to measure changes in human behavior, which is the objective of many HIV/AIDS programs, there nevertheless will be an effort to quantify and evaluate the impact of subgrantee activities on the HIV/AIDS epidemic. Key HAA staff has been selected to develop valid measurement methodologies.

As noted above, there appears to be progress in the timely payment of subgrantee invoices. However, HAA still lacks an established system for tracking the status of invoices. The spreadsheet HAA provided tracked invoices only from the date received at HAA to the date the invoice was sent to the Office of the Chief Financial Officer ("OCFO") for payment. However, subgrantees surveyed were satisfied with actual payment times for invoices. According to HAA, the OCFO has promised a 10- to 12-day turn-around time for issuing checks after receipt of invoice approval paperwork from HAA, and OCFO reportedly has been meeting this payment schedule. Still, subgrantee monitors currently have had no easy way of determining when (or if) a check has been issued. HAA reported that by October 1, 2008, all fiscal monitors will be trained in the District's System of Accounting and Reporting ("SOAR") so that they may access the system to determine when checks are issued. The intent is to have the grant monitors routinely check the SOAR system to verify timeliness of payments.

As noted in the *Third Report Card*, HAA has been cited in the past for not having an adequate training program, and in response

HAA implemented a formal training and certification program for fiscal monitors (via an established private firm that offers contracts and grants training). Although HAA had intended that all subgrantee monitors would be fully trained by February 2008, at the time of our interview in July 2008 there were three staff members needing to complete one course before becoming certified grant monitors. Although the courses in this program are geared toward fiscal and administrative management of grants, programmatic monitors also have started to attend this training, which is a positive development.

In the *Third Report Card*, we discussed HAA's on-going efforts to make sure all subgrantees meet all program eligibility requirements. The documentation we reviewed this year indicates across-the-board compliance. HAA has taken a close look at the list of certifications, assurances, and licensing requirements to make sure that all are either statutorily mandated or make good business sense. This review may result in a reduction in the administrative burden on HAA and the subgrantees. HAA also appears committed to assisting grantees to comply with eligibility requirements.

Finally, HAA has changed and clarified its grant budget submission process by providing a budget structure with electronic instructions to applicants in the recent RFA process. It is anticipated that this process also will streamline the budget construction process during the post-award phase, because the same electronic budget and structure will be used for the grant year once an award is made to an organization. To reduce the administrative burden on its subgrantees, HAA also has begun to accept negotiated federal indirect cost rates to support budgeted indirect costs. Those subgrantees without negotiated rates, however, still must provide supporting data to substantiate their proposed indirect cost rates.

Overall, the management of the Grants Management Bureau continues to improve, although more slowly as a result of personnel and management turnover. The policies and procedures in place today are largely the same as those that were in place a year ago. Although HAA's new initiatives, including the ACAM compliance rating, improved site monitoring, new policy/procedure manuals,

and more emphasis on programmatic results are all quite promising, most are in draft form and none have been fully implemented. Therefore, the District's grade continues to be a "B" in this section.

MONITORING AND EVALUATION (FORMERLY TITLED 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.

Despite the commitment and enthusiasm of senior leadership to the implementation of quality assurance ("QA") programs for HIV prevention and treatment services, the grade of "B-" in this area remains the same as on the previous two report cards due to limited progress. As the District expands its human resources and makes long-debated decisions on several key systems issues, we hope that noticeable progress will follow.

HAA's focus on QA starts at the top of the organization. Dr. Hader is actively involved in organizing plans in this area, and we expect that her leadership will start to have a more visible impact on QA outcomes in the near future.

Recently, Dr. Hader hired three individuals in monitoring and evaluation positions in epidemiology, care, and prevention who will play key roles in implementing QA programs. Dr. Hader is confident that these new team members will bring much-needed expertise and energy to the implementation of rigorous QA programs at the agency.

Despite success in expanding human resources, HAA's progress on QA continues to be hampered by several systems issues. Most notably, the data collection programs for both prevention and treatment continue to present problems. Providers and the agency alike find the existing systems cumbersome and unable to generate the types of data necessary to evaluate quality. We hope the

agency will address remaining systems issues by the end of this year.

Further, HAA reports that it needs to better synthesize data that it collects. This will be crucial to the overall success of the QA program. We are pleased that HAA has conducted internal reviews to identify data needs and superfluous variables, which will culminate in a HAA indicator guide listing all measures, definitions, and limitations. HAA expects to start implementing a streamlined set of indicators by October 2008 and plans to have the indicator guide ready by September 2009. We hope the guide will continue to be updated regularly as implementation of new systems moves forward. We strongly support HAA's planned use of the data to set grant performance targets and to make funding decisions.

HIV Prevention

HAA has made some progress on its QA program with respect to prevention. The agency reports that the initial rollout of the Program Evaluation & Monitoring System ("PEMS") began in January. In September, HAA plans to add a number of local fields to augment the data that the CDC-developed program captures.

HAA also has taken steps to build capacity of prevention providers. In particular, HAA conducted the CDC training for providers in the appropriate adaptation and implementation of evidence-based interventions in May 2008. Also, HAA conducted a two-day training on quality assurance for community providers on health education and risk reduction prevention interventions in December 2007. We hope these trainings improve the quality of prevention programs in the District.

HIV/AIDS Care and Treatment

With regard to care and treatment, HAA has yet to put a QA program firmly in place. HAA continues to explore different systems in order to identify one that would better suit current data collection and management needs. A system that would permit aggregation of data across different providers would be ideal. A number of systems have been reviewed, and the internal assessment is now being finalized. HAA plans to share its assessment with providers in September, and expects to need a 12- to 18-month transi-

tion period once the system selection is finalized. However, HAA does have an ongoing contract with Houston and Associates, which does an annual review of care and treatment provider quality measures. The contractor reviews approximately one-third of all providers each year.

In addition to system selection and implementation, HAA has identified other areas for improvement and action. For example, the District needs to update its current guidelines in order to incorporate recent changes in CDC standards. HAA staff are confident they can do this successfully.

HAA is also working to resolve ongoing issues with the Planning Council. For example, the agency continues to work with the Health Resources and Services Administration ("HRSA") to more clearly delineate the role of the Planning Council Quality Management Improvement Committee. In the last report card, we noted that HAA was making progress in implementing a screening tool for mental health and substance abuse, which was reportedly identified by the Planning Council Committee on Mental Health and Substance Abuse. This screening tool was implemented on a trial basis and recommended for full-scale use pending available funding. Since no new funding has been identified yet, HAA and the Planning Council are considering alternatives.

We commend the District for continuing its capacity-building efforts for providers. HAA reportedly conducts monthly case management and treatment adherence training. These case-based training programs cater to both new and experienced staff. We hope similar training can continue to improve the quality of care and treatment available in the District.

We look forward to HAA's use of its expanded staff to address these long-standing issues and to build an effective QA program.

HIV TESTING: A-

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

The District received a “B+” for routine testing on our *Third Report Card* because the District had taken a number of significant steps to implement routine testing in the District and was at the forefront nationwide in this endeavor. However, the report also noted that continued work was necessary to engage physicians and hospitals to routinize HIV testing.

Although the District has gone further than most jurisdictions in increasing access to HIV testing, it can and should do better. Surveillance data show that almost 70 percent of new AIDS cases are “late testers,” or persons who were diagnosed with HIV within 12 months of their AIDS diagnosis, often concurrently with a life-threatening opportunistic infection. This is nearly twice the national rate of 40 percent. This is another compelling illustration of the importance of increased surveillance programs.

HAA has continued its efforts in support of National HIV Testing Day. Although HAA did not itself conduct any specific events, it coordinated and supported its community partners. Support at events across the city included providing test kits and having DOH staff present at events. In addition, in furtherance of its general community education efforts, the District selected a social marketing program vendor — Octane LLC — in June 2008 to develop a more effective social marketing campaign targeting populations disproportionately affected by HIV/AIDS.

Since the 2006 CDC recommendation to routinize HIV testing, HAA has encouraged

providers to furnish routine HIV testing. HAA has built upon its existing network of community partners to increase testing at diverse medical sites. Through partnerships with several hospitals, routine testing has been implemented in a variety of settings. HAA and other organizations also have increased outreach to physicians and other providers in an effort to overcome stigma and to have routine testing become “expected by patients as a standard of care.”

HAA has successfully competed for CDC’s HIV Testing Expansion Grant providing an additional \$1.4 million for 2008. Through this grant, HAA is seeking to establish best practice models to integrate HIV screening in various medical/clinical settings. Three health-care organizations are currently being funded by HAA through the grant to perform routine HIV screening: GW Hospital, Howard University Hospital (“Howard”), and Unity Health Care (“Unity”). These organizations were selected by HAA for this initiative because they had already piloted routine screening in their respective settings in response to CDC’s 2006 recommendation. GW and Howard have each run full-scale routine emergency department testing since 2006. Howard also has a dedicated HIV testing team which works with multiple departments, as well as a perinatal routine testing program in the Labor and Delivery (“L&D”) Department. Unity has incorporated HIV status as a “fifth vital sign” in all triage, and has hired new staff dedicated to HIV testing. HAA has disbursed grants to these organizations to support integrated HIV screening in their respective areas as part of routine medical care. The funding allows the service providers to furnish the HIV screening services at no cost to their patients. In addition, HAA has continued distribution of HIV rapid testing kits to these partners in support of the testing programs. With few other cities having such extensive routine testing programs, HAA considers these partners to be “pioneers” in following CDC’s guidelines.

The experience at Howard is unique since it is believed to be the nation’s first hospital-wide screening program. In its first 19 months, about 20,000 people, ages 14 to 84, who went to the hospital for emergency or routine care, have been offered the free tests. About 17,000 have agreed to take

the 20-minute oral HIV antibody test. So far, about 260 of the patients tested were HIV positive. This reflects a positivity rate of approximately 1.5 percent. At the time a patient is determined to be “preliminarily reactive” based on the results of the rapid testing kit, the program performs a confirmatory test immediately (i.e., before the patient is discharged). Howard completes the standard CDC PEMS form on HIV tests that are both negative and preliminarily positive; the form collects relevant demographic information. Patients who are confirmed HIV positive are reported to HAA and referred immediately to the hospital’s Center for Infectious Disease Management and Research to receive treatment.

The District also has taken steps to expand routine testing at sites not being funded under the CDC expanded testing grant. In this regard, Mayor Fenty has announced a goal of increasing hospital emergency room testing in District hospitals by 100 percent in 2009. Washington Hospital Center (“WHC”) is expected to establish an emergency room program in the fall of 2008. As is the case at GW and Howard, HAA will be providing rapid test kits to WHC for purposes of conducting this testing. HAA also has entered into discussions with Children’s Hospital and the Georgetown University Hospital Division of Infectious Diseases to establish routine testing programs at those facilities.

In addition, HAA has continued efforts to educate physicians about CDC’s recommendations. For instance, in the D.C. Medical Society’s recent edition of *Newsline*, DOH included an article explaining routine testing. HAA also developed a “provider packet” in December 2007, which was distributed to over 5,500 providers. The primary focus of the packet is name-based reporting, but the packet also includes information on counseling, as well as information sheets on routine rapid testing. A letter from DOH encourages testing regardless of risk, and a “Routine and Rapid HIV Screening Fact Sheet” lists testing recommendations from CDC and DOH. The packet also includes a June 2007 letter on universal perinatal testing.

According to recent surveillance data, the District accounted for 9 percent of all pediatric AIDS cases in the U.S. during 2005. Between 2001 and 2006, there were

56 children ages 13 or younger diagnosed with either HIV or AIDS in the District. Many states reported no new cases among children during the same time period. The District has taken steps to promote perinatal HIV screening to reduce the number of babies born with HIV. HAA has hired a perinatal coordinator, Dr. Anitra Denson, to increase outreach work on routine perinatal testing. WHC and Howard are leading the rollout of testing at L&D Departments. HAA is following their leadership and engaging the Pennsylvania MidAtlantic AIDS Education and Training Center to use the WHC and Howard model for other L&D Departments in the District. DOH continues to provide rapid HIV testing at some District-run facilities, including the STD clinic, substance abuse treatment facilities and the D.C. Jail. In addition, the TB Clinic has integrated HIV testing by reviewing each patient’s history and conducting an HIV test if no record exists of HIV status.

Overcoming reluctance on the part of providers to conduct routine testing and reporting has been a serious challenge. Part of this reluctance stems from the fact that third-party payer reimbursement for the costs of routine testing is often unavailable. State Medicaid programs, for instance, provide for HIV testing in 32 states, but only three states provide reimbursement for tests undergone at confidential or anonymous clinics. After the CDC recommendations were issued, some private insurers began to cover routine testing in the primary care provider setting, but they are not required to do so, and generally do not cover tests administered in emergency rooms. Effective January 1, 2008, providers were able to bill for performing an HIV test with a rapid test kit and the American Medical Association created a coding modifier that allows providers to identify that they performed an HIV test with a rapid test kit. This coding modifier could help providers receive payment from insurers that cover rapid testing.

The District is developing legislation to ensure that the costs of HIV screening are covered by third-party payers and a public hearing on this issue was held in June 2008. This proposed legislation appears to be the first of its kind in the nation. The bill would require health plans to cover the cost of voluntary opt-out HIV screening tests for patients

visiting hospital emergency rooms. The bill also prohibits health plans from raising rates or terminating clients who use the benefit. Doctors are required to inform patients that HIV testing is a covered benefit. Having solicited public comment, the Committee on Public Services and Consumer Affairs has not yet recommended the bill for approval by the D.C. Council.

As noted above, GW and Howard currently offer routine HIV screening in their emergency departments. The costs of these programs are currently covered by a grant from the CDC and by free test kits provided by HAA. Reimbursement from insurance companies may make these programs more sustainable, and may ultimately encourage other hospitals to follow the lead of GW and Howard.

Overall, the District continues to make significant progress in promoting and providing support for routine HIV testing. But despite the described efforts and successes the goal of universal, routine HIV testing remains distant. Obstacles to routine testing — a continuing lack of acceptance by the medical community and financial challenges — continue to slow implementation. The District can now be counted among the national leaders in pressing and instituting routine testing, but even more must be done before HIV testing can be deemed routine in medical settings across the city. The District's grade has been raised to an "A-."

CONDOM DISTRIBUTION: B

Significantly expand condom distribution in the District.

Condom use is regarded universally as a safe and effective HIV prevention measure. Over the past few years HAA has expanded its condom distribution program from only 115,000 condoms in 2006 to one million in 2007. Dr. Hader pledged to expand the program to at least three million condoms per year by 2009. HAA had initially supplied "DC brand condoms," but the public rejected them due to what proved to be the erroneous belief that the condoms were defective. In spite of findings that the DC brand condoms were effective, HAA opted to provide brand

name condoms to allay fears and assure usage in the community. HAA selected condom brands and sizes based upon input from community groups. In recognition of major improvements in HAA's condom distribution program, DC Appleseed's *Third Report Card* raised the District's grade from a "D+" to a "B."

While HAA had clearly made substantial progress, the *Third Report Card* identified a number of significant issues with the District's condom distribution program. Coordination with other District agencies to assure that distribution reached high-risk populations was recommended. The *Third Report Card* also suggested implementing the District's condom distribution plan to reach non-traditional locations, facilitating efforts for the public to become informed as to condom use, creating a full-time condom distribution position and creating better methods for verifying condom distribution and assuring inventory control.

In the past year HAA's Prevention Bureau has had limited expansion of the condom distribution program due to the solicitation and award of a new contract for condoms and lubricants and the development of a new distribution plan. However, the program will be given a "B" based upon what appear to be solid plans for the future and continuation of a reasonable scale of distribution during the transitional period.

For 2008, HAA plans to distribute between one and 1.5 million condoms. HAA has expanded its distribution to include new groups of non-traditional providers such as DC Snacks, an organization delivering late night food to a primarily collegiate audience. In addition, condoms have been delivered to a number of other District agencies and offices, including the Mayor's Office on Latino Affairs, DOH, APRA, Court Services and Offender Supervision Agency ("CSOSA"), STD clinic, D.C. Public Lab, Job Corp Center, DPW, DMH, and CFSA, for the further distribution to targeted populations. Monitoring the performance of the condom recipient groups, however, has proven difficult, since HAA does not have a unified approach to its monitoring.

HAA is continuing to aim for a distribution of three million condoms by 2009 and is developing a plan to assist in this massive

scale up. These plans are expected to go into effect this fall. HAA is modeling much of its program on New York's substantial and successful HIV/AIDS condom distribution program. The District's new program will no longer provide a breadth of brand options, but will provide a variety of condom sizes and lubricants. The ordering plan will be revised to allow shipment directly from the manufacturer to provider and will work on an as-needed basis, rather than bulk purchasing and delivery by HAA. HAA anticipates that the revised purchase program will facilitate distribution to organizations and minimize delays. In addition, the new ordering system will provide a mechanism for assessing the frequency and volume of condom distribution by community partners. HAA also plans to launch public awareness outreach to increase non-stigmatized/non-traditional venues and will distribute promotional materials on condom use. HAA intends to work more intensively with community partners to identify new community venues.

The grade for condom distribution on this report card is influenced by the fact that there is no mechanism in place to assess whether the condoms that are distributed to CBOs reach those most at risk. While HAA has not made significant progress in that respect, it has maintained its distribution programs and has positive plans going forward. Accordingly, the grade for the distribution will remain a "B" for this year. However, for HAA to maintain or improve its grade in the next year, it will have to execute its planned program to reach its target distribution of three million condoms annually. HAA also should consider increasing its efforts to verify condom distribution by recipient organizations as part of its new program.

D.C. PUBLIC SCHOOLS: C

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

DC Appleseed's August 2005 report called for DCPS and the State Board of Education to develop content standards for HIV/AIDS education. The report identified four components of a good HIV/AIDS education program: a comprehensive curriculum, good professional development to train teachers in that curriculum, a plan to provide coordination between and within school and with community organizations that are working in schools, and a system to assess the impact of the curriculum.

In September 2005, the State Board of Education adopted a resolution that made 16 recommendations for HIV/AIDS education. In March 2006, the Superintendent said that "Health and Physical Education [curriculum] reforms [were] scheduled for [School Year] 2006-07." And in April of 2006, the State Board of Education adopted another resolution identical to the September 2005 resolution.

In our *First Report Card*, published in March 2006, DCPS received a grade of "B-" based on our understanding that standards were under review, standards 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 standards had not yet been published, and there were no interim standards in place. And in our *Third Report Card*, published December 2007, the grade dropped further to a "D" because, while proposed standards existed, the standards had still not been approved, and there had been very little additional progress toward the recommendations DC Appleseed made in our 2005 report.

Since the last report card, DCPS and the Office of the State Superintendent ("OSSE") developed plans to implement many of the

components of a strong HIV/AIDS education program in the 2008-2009 school year. This progress is promising. However, there are still no concrete plans to assess student understanding or teacher performance. And until the DCPS and OSSE plans are implemented, it will be difficult to determine their effectiveness. The long delay between our initial report and the plans in place today has not only left many children without information that could potentially save their lives, it also raised questions about the strength of the District's commitment to HIV/AIDS education. We are hopeful that the progress made over the last few months will be the first step in restoring confidence in the school system's HIV/AIDS prevention efforts.

In December 2007, shortly after our *Third Report Card* was released, the State Board of Education approved new health standards that included HIV/AIDS content standards. This was a major step forward, but it is important to note that these standards were not approved until *more than three years* after the first board resolution.

Since those standards were approved, DCPS's Office of Teaching and Learning ("OTL") has approved three age-appropriate curricula to implement the HIV/AIDS content standards for elementary, middle and high schools. These evidence-based, privately developed, prepackaged curricula have been recognized by the CDC. One curriculum has been utilized by DCPS's biggest nonprofit partners — Metro TeenAIDS and City Year — to deliver content to middle school students for the past several years. Additionally, OTL has expressed their intent to examine the three curricula during this school year to determine if and how they should be modified for the following school year. According to OTL, this examination likely will take place by evaluating surveys distributed to teachers, students, and parents.

OTL completed two days of mandatory professional development on HIV/AIDS and sexuality education for all Health and Physical Education teachers in August 2008. One of those sessions was specifically focused on the three HIV/AIDS curricula. Certified trainers from CBOs and HAA led the Elementary and Middle School breakout sessions. Seventy-nine percent of the expected teachers attended the training, representing 70

percent of the schools, with 100 percent attendance from middle school teachers. OTL also has scheduled a meeting during a professional development day in October where the secondary schools' health department heads and one representative from each elementary school will meet to evaluate how the curricula are being implemented. OTL plans to distribute surveys at these sessions to help gauge how well teachers have been able to implement the curricula. DOH staff will also be available during the school year to assist teachers who are facing difficulties. Throughout the school year, OTL also plans to identify strong teachers who may also be able to assist their colleagues with the curricula.

Adopting mandatory curricula and content standards will address consistency across schools. Teachers who attended the August professional development received standardized materials for each curriculum at the training. The teachers who did not attend will receive follow-up curricula training, though no make-up training date has been set. OTL suggested that there would be "check sheets" for principals to reference when observing health lessons; these check sheets would allow principals to determine quickly and easily whether key components of the curricula were being addressed.

OSSE requires schools to follow content standards, including the HIV/AIDS standards within the health standards, but it has no means to ensure that those schools are using uniform curricula or that students are receiving the necessary instruction. Although OSSE is encouraging charter schools to use a curriculum that will meet the HIV/AIDS standards in the health content standards, and OSSE has produced guides to the standards for teachers and parents, OSSE has no authority to require charter schools to use a particular curriculum. OSSE has indicated that it is developing a new monitoring tool for charter schools that will include HIV/AIDS education as a component; but this has not been completed, and it is not clear how the tool will impact the schools. Even if there were a way for DCPS or OSSE to measure either student mastery or teacher delivery, it is not clear that there are any consequences for schools or teachers that do not adequately deliver this important, life-saving information.

Additionally, the means by which OTL intends to monitor whether and how teachers are implementing the curricula — informal observations by principals and other administrators — should be more thorough. For example, we believe this is one of the most important components of a good HIV/AIDS curriculum, and it is something that the District should address in the future.

In addition to the work that DCPS has done towards developing a well-rounded HIV/AIDS educational program, both DCPS and OSSE also have taken additional steps to help students prevent HIV.

At the request and in partnership with DOH, Chancellor Michelle Rhee and State Superintendent Deborah Gist recently sent letters to all public schools — including charter schools — reinforcing the need for nurses to abide by DOH's condom availability policy. Under the revised policy, students will receive instruction on the use of condoms, and condoms will be made available on a nearly unlimited basis for students. All DCPS school nurses are under contract with DOH, and there had been some confusion as to whether all nurses were required to abide by this policy that has been in place since 1992. These letters should end the confusion around condom availability by clarifying that any nurse with a DOH contract should abide by this policy. Charter schools can opt into this program and hire DOH contracted nurses, or can secure nursing services through an alternate means.

HAA also funded Metro TeenAIDS to train school nurses on risk assessment and interviewing for interventions with young people on HIV/AIDS and sexual health.

Additionally, Chancellor Rhee recently agreed to support a new DOH program for voluntary testing for STDs, making the District one of only three school systems in the country to undertake such an initiative. A pilot program in charter schools identified both high rates of students volunteering to be tested, and a high infection rate among those students. This is troubling because a person infected with an STD is much more likely to acquire HIV if exposed to the virus and indicates high-risk sexual behavior, such as unprotected sex. Under the new program, students who

test positive for any STDs would be referred for additional STD and HIV counseling.

In addition to the plans DCPS has adopted, OSSE intends to revamp its HIV/AIDS education program at the state level. OSSE is expanding its nutrition services department to include “student wellness” for the DCPS and charter schools that participate in the federally funded National School Lunch and Breakfast Program. As part of the grant, DCPS and each charter school are required to set up a wellness council to develop a local wellness policy. These new policies will include an expansive range of healthy lifestyle practices, including HIV/AIDS prevention. It is intended that an HIV Program Specialist will join OSSE, though this has not occurred yet. This plan is in the very early stages, so it is not clear what impact it may have.

Overall, the school system has made more progress in the 10 months that have passed since our *Third Report Card* than it had in any other period since we issued our original report in 2005. This progress demonstrates that HIV/AIDS education was not a priority for the prior school administration, and we applaud the new administration for making these efforts. At the same time, the District has much further to go.

We look forward to monitoring the implementation of the many plans that DCPS and OSSE have to improve HIV/AIDS education, and we hope to rate their performance more favorably once we have seen the plans in action. We also urge DCPS and OSSE to develop a rigorous and standardized system to assess student understanding of HIV/AIDS prevention and teacher delivery of the content. There must be strong incentives to ensure that teachers are delivering this information to students at all schools in the District. Principals should make delivering this content a priority for their teachers and it is not clear that the current assessment system ensures that this will happen. The grade on the *Fourth Report Card* has been raised to a “C.”

SYRINGE EXCHANGE AND COMPLEMENTARY SERVICES: A-

Continue to fund complementary services (e.g., HIV testing and counseling and drug treatment referrals) provided by the privately-funded syringe exchange program and adopt additional measures to address prevention with substance-using population.

Injection drug use continues to play a significant role in HIV transmission in the District. Although syringe exchange is a crucial HIV prevention intervention for injection drug users (“IDUs”), the District was prevented by Congress from using its own funds for that intervention from 1999 until this year. In the wake of congressional action enabling funding of SEPs, the District’s leaders swiftly demonstrated their support for this important intervention. In recognition of their rapid and vocal response, we have raised the grade in this area from a “B+” to an “A-.”

This year marks the first time since 1999 that Congress permitted the District to use its own funds to support syringe exchange activities. Previously, Congress barred such activities through an appropriations rider. In December of 2007, however, Congress passed an omnibus appropriations bill that lifted this spending ban. Eight days after the President signed the bill, Mayor Fenty, Dr. Hader, and several Council members announced \$650,000 in local funding for SEPs.

The District has allocated its investment among the one existing SEP, PreventionWorks, and three other CBOs, Bread for the City, Helping Individual Prostitutes Survive (“HIPS”), and Family and Medical Counseling Services (“FMCS”). In addition to making grant awards, HAA provided two days of training for the staff of these providers soon after awarding them funding. HAA also provided funding so that select staff from all four providers could attend the North American Syringe Exchange Convention in Takoma, Washington earlier this year. We commend these efforts to maximize the use of District funding by training and building the capacity of these

providers. We also believe the selection of a diverse group of organizations will help in the expansion of syringe exchange in the District. The four organizations reach different target populations, which will help broaden access to clean syringes, as well as expose various parts of the community to the accompanying complementary services. Further, providers report that the new programs are using common identifiers for clients, so that clients could potentially be tracked across different providers. We think this will be particularly useful in evaluating the reach of the programs, because it will permit identification of duplicate clients who access multiple providers.

HAA will provide the bulk of its new SEP funding to PreventionWorks, the only SEP operating before the lifting of the funding ban. Through a substantial contract, PreventionWorks will establish a neighborhood harm reduction center in a recently identified site and will provide technical assistance to new SEPs as needed. In addition, PreventionWorks has re-opened a previous syringe exchange site on Georgia Avenue and will open a new site in Trinidad to expand its mobile health unit services. Both PreventionWorks and HAA staff expect the new harm reduction center to facilitate provision of integrated services, including medical treatment, HIV, STD and Hepatitis C screening, referral to drug treatment and mental health counseling to IDUs, a population in much need of attention.

In addition to supporting expansion of PreventionWorks’ existing operations, HAA also funded three additional providers to implement new SEPs in the District. Initially distributed as six-month grants, HAA plans to extend the grants for another year if the programs meet expectations.

FMCS, which received a grant from HAA, has integrated syringe exchange with primary care services and has connected individual clients effectively to complementary services. It has far exceeded grant targets by reaching 261 new clients and exchanging 15,272 syringes in its first two months. FMCS reaches clients through six mobile sites, and believes that it would be able to expand operations with additional funding. If FMCS can maintain its current level of success in terms of outreach, we urge HAA

to provide additional funding for it to provide services to its target population east of the Anacostia River.

Two other SEPs, Bread for the City and HIPS, also received grants. Bread for the City has continued the SEP, which previously was funded through private resources, at its clinic. However, as a result of the District's grant, they have been able to enhance the program to provide more exchange hours, resulting in increased encounters and services to IDUs. HIPS had some initial delays in starting its SEP, but it now has a mobile unit that distributes clean syringes to its sex worker clients two nights per week. After enrolling over 60 clients since July, HIPS expects to surpass its target of 100 clients.

In addition to providing financial support, HAA has taken other steps to facilitate expansion of SEPs. The District's drug paraphernalia laws require that all syringes exchanged as part of an official SEP be appropriately labeled. To assist the SEPs compliance with this requirement, HAA has prepared standardized labels for adhesion to the packaging of all syringes. In addition, HAA has created a plastic card for SEP clients that identifies them as SEP participants and includes the relevant legal provisions. SEP clients can produce these cards as proof that they are participants in an SEP if confronted by police officers. Perhaps most importantly, HAA has engaged in an outreach campaign to educate police officers about SEPs and the syringe labeling requirement. All three measures are designed to encourage greater participation by IDUs in SEPs.

We applaud HAA and the District government for progress in expanding access to clean syringes. We hope that HAA will stay informed about national trends and research on syringe exchange so that the city can implement successful strategies to reach this high-risk population. In addition, changes to paraphernalia and other laws may be necessary in the future to permit greater access to clean syringes.

The District should remain committed to other reforms that would further improve prevention services for IDUs. We urge the District to continue to support provision of integrated services, including condom distribution, by SEPs. Last year, HAA hoped to begin

a Comprehensive HIV & Substance Abuse Initiative, which would have created a comprehensive HIV prevention plan for substance abusers. Unfortunately, the initiative has been delayed. We recommend that the initiative be revived or its goals reached through other means as HAA continues to address the need for HIV prevention measures aimed at substance abusers.

SUBSTANCE ABUSE TREATMENT: B

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

The District's alarmingly high rate of substance abuse and dependence has been documented extensively, both in DC Appleseed's original report, the previous report cards, and in the 2000 District of Columbia's Household Survey. Studies in 2006 by the Substance Abuse and Mental Health Services Administration ("SAMHSA") demonstrate that this public health emergency remains severe, with the most recent figures suggesting that more than one in 10 District residents abuse or are dependent on alcohol or illicit drugs. In previous report cards, we noted that an effective substance abuse treatment and prevention program is a critical piece in an effective response to the HIV/AIDS epidemic. Recent surveillance data suggest that 14 percent of new HIV cases in the District can be attributed to a shared needle, and many more may be attributed to high-risk sexual behavior associated with substance abuse. Due in large part to the District's failure to commit adequate funding, leadership, or planning toward substance abuse treatment, DC Appleseed's *First* and *Second Report Cards* gave the District a "D+" grade.

In our *Third Report Card*, we raised the District's grade regarding substance abuse services to a "C+" in light of the efforts by Senior Deputy Director Tori Fernandez-Whitney and APRA's staff to access additional funding and expand outreach services. For our *Fourth Report Card*, DC Appleseed raises the District's grade regarding substance abuse services once again, to a "B." During this time period, we have been impressed with the commitment by APRA and DOC to

reduce barriers to substance abuse treatment; however, the forward momentum and any future increases in the District's grade will depend heavily on its willingness to match the level of funding for such services to the level of unmet need throughout the community.

DC Appleseed continues to be encouraged by the commitment at APRA and DOC to increase access to substance abuse treatment programs. Most notable among these programs is the Progress Towards Empowerment ("PTE") therapeutic community that has been operating in the D.C. Jail. DC Appleseed's original report and subsequent report cards identified substance abuse treatment at the D.C. Jail as a key component in preventing HIV infection in high-risk populations and noted serious deficiencies in this area. In our *Third Report Card*, we were pleased to report that DOC received a \$223,000 Residential Substance Abuse Treatment ("RSAT") grant from the U.S. Department of Justice to operate a therapeutic community for up to 60 inmates at one time (40 males and 20 females), with an annual treatment goal of 500 inmates.

The PTE community began screening potential participants in November 2007 and providing treatment services in December 2007. With 30-, 60-, and 90-day treatment programs available for convicted misdemeanants and parole violators, the PTE program provides substance abuse treatment, life skills training, discharge planning, and educational programming. The program also has developed a network of community partners to assist with technical and clinical planning as well as with discharge and transition for individual offenders. DOC reports that the PTE has received certification from APRA as a substance abuse treatment provider and is working to receive accreditation as a therapeutic community from the American Correctional Association. The program has hired five full-time staff members (one clinical director, three clinicians, and one administrative assistant/outreach worker).

Although participation in the PTE program is voluntary, DOC reports that the facility is operating at full capacity, with 40 male inmates living in two adjacent therapeutic communities in the D.C. Jail and 20 female inmates living in a separate community in

the Correctional Treatment Facility. Since December 2007, DOC reports that approximately 250 inmates have entered the PTE program and approximately 62 inmates have either graduated from the 90-day treatment program or received certificates for completing the 30- or 60-day treatment programs. Without question, DOC's implementation of the PTE program is extremely promising. What is even more encouraging, however, is the overwhelmingly positive comments that DC Appleseed heard from participants in the PTE program. During our visits, the offenders in the program spoke very highly of the program and the clinical and correctional staff assigned to the unit. They also expressed a strong sense of relief that DOC was able to provide a separate environment for treatment. Many participants reported that the PTE program was their first experience with residential treatment in the correctional setting, and those who were incarcerated previously at the D.C. Jail reported that the program is a long-overdue addition to the services provided by the D.C. Jail.

In addition to DOC's accomplishments at the D.C. Jail, DC Appleseed continues to be encouraged by APRA's efforts to design new outreach and treatment programs. Our *Third Report Card* highlighted several programs, such as the New Communities Initiative (formerly Project Threshold) and a collaboration with the D.C. Superior Court, to place intake counselors and clinicians in community settings. We also noted that the agency was targeting specific high-risk populations and substance abuse trends through programs, like Project Recovery in Supportive Environments ("Project RISE") and the Rapid Detection and Early Intervention ("RDEII" or "Ready") Initiative. Initial reports from the agency suggest that these programs are having a positive impact on reducing barriers to substance abuse treatment. For example, APRA reports that the New Communities Initiative conducted over 13,000 screening interviews for substance abuse and dependence between January and June of this year, resulting in over 400 individual referrals to the District's detox facility. Furthermore, since January 2008, the four APRA staff at D.C. Superior Court have screened 4,663 clients and facilitated treatment placement for 271 individuals.

Not only has APRA continued to fund these existing programs, but the agency also has undertaken new efforts to address the District's unmet treatment needs. At the administrative level, APRA has taken several steps to improve its working relationships with the District's treatment providers. The agency reports that it is in the process of reconciling its accounts payable to community partners and educating providers on billing and reimbursement procedures. Senior Deputy Director Fernandez-Whitney has instituted meetings twice a month with treatment providers and supported the formation of the D.C. Addictive Service Provider Consortium. APRA also reports that it is working with the DMH and MAA to provide coverage and payment for substance abuse treatment services for children through the Medicaid program. Our conversations with members of the provider community suggest that the agency's efforts have not gone unnoticed. Although some providers seemed concerned with the continuity of program funding once the three-year, \$10.7 million Access to Recovery ("ATR") grant term expires, the treatment community appears to be supportive of Director Fernandez-Whitney's work to refocus APRA.

At the clinical level, the agency is using funds from the ATR grant to provide additional vouchers for treatment and recovery support services through the Choosing Options for Recovery and Empowerment ("DC CORE") program. This program, operational since May, has enrolled approximately 918 clients and has partnered with almost 30 community organizations to provide these services. The agency also reports that it is developing a limited housing benefit through the DC CORE program of up to six months for ex-offenders who are actively participating in treatment, with an enhanced benefit for women with dependent children. At the same time, APRA has continued to address methamphetamine and other emerging drugs of abuse, and also to train substance abuse counselors in the use of the Oraquick rapid HIV test.

APRA also has improved access to adolescent treatment services. Over the past six months, APRA has expanded its network of certified adolescent substance abuse treatment providers from two to 10. Approximately half of this expanded network

has the capacity to treat adolescents with co-occurring substance use disorder and mental illness. In addition, the APRA-supported continuum of care now includes integrated recovery support services such as job skills training, education training, life skills training, recovery coaching, and other services designed to promote and sustain recovery from substance abuse. These services are supported by APRA's ATR Program. In addition, in partnership with DMH, APRA actively recruited adolescent mental health providers to become certified substance abuse providers. Three adolescent mental health providers have been certified.

Despite these accomplishments, the District still faces significant challenges that may limit its further improvement in this key area. Most notably, the District's proposed budget for FY 2009 does not appear to include any meaningful increases in funding for substance abuse services. Specifically, APRA's proposed budget of roughly \$13.4 million for the Drug Treatment Choice Program ("Choice Program") includes only a modest \$625,000 increase over FY 2008. Furthermore, it has been reported that the first year annual costs for a proposed (and much needed) residential treatment program for women and children potentially opening in FY 2009 is greater than \$2 million, which raises concern about whether and how other services may need to be cut. Although we are encouraged by the District's willingness to maintain funding for the Choice Program at the levels established in FY 2008, it seems doubtful that this level of funding will permit APRA to provide needed expansions in access.

Without question, the District has taken several important steps toward increasing the availability of substance abuse treatment services. Due to these significant programmatic improvements by both APRA and DOC, we have raised the District's grade to a "B." Continued underfunding of outreach and treatment services, however, will limit needed improvement in this area if not addressed in future budget proposals. Because of the impact that substance abuse has on HIV/AIDS transmission, the District must do more to fund a wide range of easily accessible treatment services. As always, DC Appleseed will look forward to continuing

our work with APRA and DOC on this pressing issue.

HIV/AIDS AMONG THE INCARCERATED: A

Implement routine HIV testing, improve collection of HIV and AIDS data, improve discharge planning services, and ensure that HIV-positive inmates receive medication at discharge.

In DC Appleseed's 2005 report, we recommended 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 the *Third Report Card*, DOC had made substantial progress toward implementing the recommendations from DC Appleseed's 2005 report, which was reflected by the "A" grade in this area.

The *Third Report Card* noted that DOC had continued its "automatic" HIV testing program for over one year, had contracted with Unity to provide comprehensive health services, including discharge planning at the District's detention facilities under a community correctional care model, had made significant progress toward ensuring that HIV-positive inmates receive their medications upon discharge, and had started to use ADAP funding to provide an increased supply of medications to inmates at discharge. This *Fourth Report Card* finds that DOC has continued its progress on all of these measures, providing critical health services to inmates in the District detention facilities.

On June 1, 2008, DOC's "HIV Automatic Testing Program" reached its two-year anniversary, and the success of the program was featured in the June 2008 issue of *Corrections Today* magazine. Under DOC's HIV testing program, all inmates are offered voluntary rapid HIV testing upon intake. Inmates are also counseled before they are tested, and once staff learns the results of the preliminary HIV rapid test, inmates are counseled and referred for additional care, if needed. Again, the DC Appleseed commends the District for this HIV testing program,

which has received national attention and has helped to shape policies in other jurisdictions.

Between June 1, 2006, when DOC implemented "automatic" HIV testing, and May 31, 2008, 22,515 inmates have been tested at intake. This figure represents 68 percent of all intakes. Of those not tested, 14 percent refused to be tested, and 18 percent were not tested for other reasons, such as having been tested recently or having a known positive result. Of those tested, 3 percent were confirmed positive through a follow-up blood test, and less than 1 percent were newly identified as HIV positive. This program continues to provide critical data on the rates of HIV infection among the incarcerated and helps DOC provide opportunities for treatment and prevention to this historically underserved population. To make the data more precise, DC Appleseed recommends that DOC revise the electronic medical record to capture data on the specific reasons inmates are not tested. For example, inmates who serve their sentences on weekends generally need to be tested once, and should not be counted as separate intakes each time they return to the Jail.

At the time of the *Third Report Card*, a nine-month contract extension was granted to FMCS staff to continue HIV testing in the Jail until October 1, 2008. The plan was that DOC would assume the administration and funding of the program, rather than DOH. On September 19, 2008 a contract modification between DOC and Unity was finalized so that Unity will assume responsibility for the HIV testing program at the Jail on October 1, 2008. Although it is evident that the District is committed to continuing this valuable program, in the future, DOC should strive to ensure the continuity of this program in a more timely fashion so as to avoid potential disruption.

DOC's discharge planning program and continuity of treatment model recently was selected by the National Commission on Correctional Health Care ("NCCCHC") as the recipient of the "NCCCHC 2008 Program of the Year." Under this program, Unity's 11 discharge planners and a discharge planner stationed at the Jail by the Income Maintenance Administration ("IMA") assist inmates with their transition back to the community by addressing their health

care and social service needs. Upon intake, inmates receive a discharge-planning packet which contains contact information for local social service agencies, Unity Clinics, and the discharge planners. A discharge planner meets with inmates within five days of intake to assess their needs, including medical insurance, food stamps, appointments with primary care and mental health providers, housing assistance, employment and vocational training, and substance abuse counseling services. Inmates also may request to meet with a discharge planner through the sick call request process. Before the inmate is discharged, the discharge planner will coordinate any necessary appointments with health care providers in the community. The discharge planner also arranges for a supply of medication upon discharge. If an inmate is released before meeting with a discharge planner, the inmate may contact a discharge planner by phone to receive information. By addressing the needs of District inmates as they return to the community, this program helps to improve the health of the whole community.

DOC continues to use ADAP funding to provide a 28-day supply of medication to HIV positive inmates at discharge. From January 2008 through June 2008, 84 inmates received HIV medications at discharge totaling approximately \$90,000 of ADAP funds. Through additional collaboration with HAA, DOC provides condoms and educational materials about STDs to inmates upon discharge from the Jail.

DC Appleseed also commends DOC on its recent accreditation of its health care program by NCCHC and the American Correctional Association. Furthermore, HAA has formed a new partnership with CSOSA, which includes a new HIV information fact sheet to be used by CSOSA in information sessions with ex-offenders who have returned to the District from the Federal Bureau of Prisons and presentations by HAA staff. In light of the continued success of DOC and HAA's programs related to HIV services to the incarcerated, the District's grade remains an "A."