

# HIV/AIDS IN THE NATION'S CAPITAL

Almost exactly four years ago, 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*. Since that time the government has made significant progress toward implementing many of the recommendations in the report.

While our *Fifth Report Card's* generally positive grades reflect that progress, the HIV/AIDS epidemic continues to devastate our city. What is needed now is not only a sustained, superior performance by the government, but also a strong commitment from non-governmental organizations like businesses, places of worship, civic organizations and the entertainment industry.

This *Fifth 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 and a detailed explanation for each grade are attached.

## REPORT CARD

NO. 5  
OCTOBER 2008 TO  
SEPTEMBER 2009



### GRADES (A-F)

B+

A-

A

B+

B-

A

B+

C+

B

B+

B

A

#### 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.

#### PUBLIC EDUCATION IN THE DISTRICT

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.

#### YOUTH INITIATIVES

Establish and implement a youth HIV education and prevention program that involves all District agencies that have regular contact with or programming for young people.

#### SYRINGE EXCHANGE & COMPLEMENTARY SERVICES

Continue to fund needle exchange programs and complementary services (e.g., HIV testing and counseling and drug treatment referrals) 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.

# EXECUTIVE SUMMARY

DC Appleseed published its report, *HIV/AIDS in the Nation's Capital: Improving the District of Columbia's Response to a Public Health Crisis*, almost exactly four years ago. Since that time the government has made important strides in putting into place the public health practices vital to combating the disease. Yet the District still is in the grip of an HIV epidemic.

In this *Fifth Report Card*, the generally positive grades reflect the progress made by the Fenty Administration toward building the basic infrastructure essential to combat the epidemic. Many of the recommendations DC Appleseed proposed four years ago are being implemented. That is the good news.

The bad news is that the epidemic continues to devastate our city. As a result, generally positive grades for the District government are no longer enough, given the persistence of the epidemic and the gravity of the harm that it is causing to people in our neighborhoods and in every walk of life. The epidemic is the tragic outgrowth of the

failures of private and public community leadership to address the epidemic effectively, for about 20 years. What is needed now is not only a sustained “straight A” performance by the District government, but also a strong commitment from the non-governmental community.

In future report cards and for the benefit of the community as a whole, it will be vital for HAA to assess whether the steps being taken are effectively reducing the spread of the disease. Ironically, better data collection and increased targeted HIV testing by the HIV/AIDS Administration (“HAA”) will generate more sobering numbers related to the overall HIV/AIDS rate. And, progress in treatment fortunately means that people are living longer with both HIV and AIDS. Despite advances in prevention, testing, treatment, and other vital tools, the reported levels of HIV and AIDS in the community will likely remain high for some time.

Nevertheless, one key measurement of eventual success will be a measurable reduction in newly-acquired HIV infections. Yet, developing accurate data on trends in new HIV infections historically has posed major challenges, in part because many HIV infections are not diagnosed until years after they occur. DC Appleseed is aware of the difficulties associated with the current Centers for Disease Control (“CDC”) method for estimating numbers of recently-acquired HIV infections. We recognize that the existing tools used to estimate recent infections are imperfect, may not be suitable for the District and are still being refined.

At the same time, given the extent of our HIV/AIDS epidemic, DC Appleseed believes the District should be on the leading edge of the ongoing, national effort to refine and improve the tools for estimating new infections. HAA is participating with the CDC in its current efforts to implement these tools. In the coming years, it is crucial that District residents have a quantitative measure of progress in actual reductions of new infections.

HAA now uses various behavioral health surveys of District residents to help gauge progress. Over time, these surveys can show trends in behavioral changes that would be expected to reduce the spread of HIV. DC Appleseed believes these reports can be a useful measure of program success and encourages HAA to revise or expand the HIV-related questions as needed.

In addition, while the grades point to steady improvement by the government, our *Fifth Report Card* also highlights several key areas where the District should be doing a better job:

- Top public officials, including the Mayor, have not consistently made HIV/AIDS part of their public dialogue. They have occasionally expressed support for fighting the epidemic, but we urge them to do so more frequently and consistently, especially at events and to audiences that are not specifically targeted to HIV/AIDS issues. The routine discussion of the epidemic is an important element in reducing the stigma associated with HIV/AIDS. This continuing stigmatization frustrates effective education efforts, testing and condom distribution, and hinders the changes in personal behavior that will be required to reduce the spread of the epidemic.
- HIV/AIDS education programs in DC’s charter schools are uneven and poorly monitored. The DC government has no system of accountability to determine whether health education standards are being met in these schools. Furthermore, DCPS has not implemented a tool for assessing what DCPS students are actually learning about HIV/AIDS prevention, or whether those lessons are changing sexual behavior.
- A comprehensive, government-funded social marketing campaign that has been under development for nearly two years has yet to be initiated. In September 2008, shortly after the release of our *Fourth Report Card*, Mayor Fenty announced that such a campaign was being crafted. The latest DC report from the CDC’s National HIV Behavioral Surveillance (“NHBS”), *Heterosexual Relationships and HIV in Washington, DC*, shows that many District residents at high risk for HIV infection continue to engage in dangerous sexual behavior. The message that HIV/AIDS poses a real risk to everyone and that the disease is 100 percent preventable is clearly not getting through.

- Syringe exchange services can and should be expanded. Research of other jurisdictions conducted by DC Appleseed reveals that in several cities with intravenous drug user populations similar to the District, significantly more needles are distributed. Further analysis of the potential level of unmet need for these services in the District will be important as the District gains experience with these relatively new programs (started after the lift of the Congressional ban on use of District funding for syringe exchange).

These improvements would enhance the government's HIV/AIDS prevention effort, but given the scope of DC's epidemic, government actions alone will not turn the tide. Real progress will require a strong commitment from the entire community. DC Appleseed believes such broader action is so critical that future HIV/AIDS report cards will assess the contributions made by major hospitals, academic institutions, civic organizations, the media, the entertainment and sports industries and the federal government.

DC Appleseed calls on leaders in each of these entities to make development of a strategy to combat HIV/AIDS a higher priority. HIV/AIDS should be a routine topic of discussion in non-traditional settings like places of worship, civic organizations, businesses and sports and entertainment venues. Our community leaders – the mayor, the clergy, athletes, entertainers, and others – have an important role to play in reducing the stigma surrounding HIV/AIDS and making known to all the information and resources that are available to prevent its spread.

We call on the business community to bring its substantial resources to bear. For instance, HAA's planned social marketing campaign will be severely limited if the message is spread only through paid advertising in broadcast outlets and other mass media venues that reach large numbers of people. The effectiveness of this campaign would be enhanced greatly by donations of prime air time and advertising space by private media outlets.

We anticipate that there may be reason to applaud as we examine the extent of coordinated involvement by some members of the community. For example, DC Appleseed has taken a preliminary look at the level of involvement of District hospitals and universities in the HIV/AIDS effort. This snapshot revealed an emerging commitment by these institutions. Several District hospitals – led by Howard University Hospital and George Washington ("GW") University Hospital – have adopted routine HIV testing as part of their emergency room standard procedure. GW's School of Public Health has partnered with the city to strengthen HAA's HIV/AIDS surveillance efforts. Several academic institutions, including Howard University, GW University and Georgetown University, have a strong HIV/AIDS presence in both the academic and research arenas. We will consider whether these are models that others should follow.

Other non-governmental entities also have stepped forward. Recently, the Global Business Alliance pledged private funds to support HAA's efforts. And for the last eight years, radio host and television personality Darius "Big Tigger" Morgan has hosted an annual celebrity basketball game and street festival for the express purpose of encouraging HIV education, testing and stigma reduction in the District.

DC Appleseed looks forward in future report cards to highlighting other positive contributions or challenging key institutions and leaders among us to do more and better. While there is no question that the DC government shows improved performance in addressing the HIV/AIDS epidemic, government action is an indispensable but insufficient element of a successful community war against HIV/AIDS. The District's HIV/AIDS rates remain the highest of any community in the nation. That sobering distinction will not change until the entire DC community makes preventing HIV/AIDS a high priority.

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

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

*DC Appleseed would like to acknowledge and thank the Washington AIDS Partnership and its steering committee for the initiation of and continued support for this project. We would also like to thank Hogan & Hartson LLP for its continued invaluable pro bono work on the project. Terrapin Studios donated design and production services for the Fifth Report Card. Finally, we would like to thank the District government for its cooperation in this effort.*

# FIFTH REPORT CARD

AUGUST 2009

## 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 major reason for the District's failure to adequately address the HIV/AIDS epidemic. Since that time District leaders have significantly elevated the profile of the disease inside and outside of the government, as well as strengthened the government response to the epidemic.

In our *First through Fourth Report Cards*, we applauded the support of Mayor Anthony Williams, and later Mayor Adrian Fenty, for embracing the recommendations in the 2005 report and for making the fight against HIV/AIDS a public health priority. Mayor Fenty's public statements that HIV/AIDS is his number one health priority have set the right tone for the DC Government's efforts in the last two years.

The leadership at HAA has improved markedly, from an era of management turmoil to the appointment of Dr. Shannon Hader, a strong selection for the agency. Other HAA vacancies have been filled, and DC Council Committee on Health Chairman David Catania has provided aggressive oversight of the agency and helped to force reforms at HAA. The use of epidemiology reports and subsequent surveillance data as a roadmap for guiding new programmatic initiatives was a key step forward that rectified a fundamental deficiency found in the 2005 Report. The funding provided to expand DC needle exchange programs ("DC NEX") following the lifting of the federal spending ban, the implementation of a multi-agency youth

initiative, and institution of an HIV/AIDS curriculum in DC Public Schools ("DCPS") were positive developments brought about through the new energy at HAA and in the DC Government more generally.

While DC Appleseed has continued to recommend that the Mayor and other leaders give even higher priority to using their public platforms to deliver regular messaging to District residents about the epidemic and available prevention measures, these effort have earned leadership grades that have improved from a "B-" to a "B+" over the four report cards.

Over the past year, the Mayor continued to call HIV/AIDS his top public health priority. We commend him for headlining the recent release of the DC *HIV/AIDS Epidemiology Update 2008* and the NHBS, *Heterosexual Relationships and HIV in Washington, DC*, – the highest profile city-sponsored event designed to highlight the epidemic. While numerous cities produce similar reports, we know of no other mayor that has played such a key role in releasing and explaining the basic facts about the epidemic.

DC Appleseed also is encouraged by Dr. Hader's leadership at HAA. Leadership instability has severely hampered the government's ability to undertake and sustain efforts to address the epidemic. Dr. Hader is viewed as a competent and forceful administrator who is moving rapidly to implement new initiatives. Mayor Fenty can be credited with providing top-level support for Dr. Hader's efforts to make the District's fight against HIV/AIDS a government-wide effort. HAA's budget has essentially remained steady even though city revenues have dropped significantly.

The Mayor's top appointees outside of HAA, with coordination from Dr. Hader, also have demonstrated strong leadership regarding HIV/AIDS and youth. Despite facing many competing priorities, DCPS Chancellor Michelle Rhee directed that a new HIV/AIDS curriculum be taught during the 2008-2009 school year. As detailed in other sections of this *Fifth Report Card*, numerous DC agencies are now playing more significant roles in addressing the epidemic since Dr. Hader's arrival. The DC Department of Corrections ("DOC") now is considered a national leader

in HIV testing and discharge planning. HAA and the Department of Parks and Recreation (“DPR”) have formalized an agreement that will provide expanded HIV/AIDS awareness programs as part of public education offerings. The Department of Employment Services (“DOES”) has fully integrated HIV/AIDS awareness into its training program, including for the roughly 20,000 participating in the summer jobs program.

Dr. Hader also led the effort that resulted in HAA assembling information from CDC to implement a prevention intervention called *Parents Matter*. The program was developed specifically for African American families in the U.S. and is aimed at the parents of fourth and fifth graders, but had previously only been used internationally. *Parents Matter* is supported by local funding and is being presented to foster care and adoptive parents involved with the DC Child and Family Services Administration (“CFSA”).

Under Dr. Hader’s direction, several key initiatives have been sustained and expanded. Local funding for DC NEX has led to the establishment of three new programs designed to prevent HIV infections and reduce high risk behavior among intravenous drug users (“IDUs”). A major youth HIV/AIDS prevention plan is being implemented. The District’s HIV/AIDS surveillance efforts are considered among the best in the country, and HAA continues to employ top talent. The city now has solid data to guide its actions to address the epidemic. Dr. Hader has played a key role not only in establishing these improvements, but in assuring they are sustained at a high level.

Since the *Fourth Report Card*, Dr. Hader also has forged a new partnership with the National Institutes of Health (“NIH”) to craft a first of its kind local/federal joint venture aimed at reducing new HIV infections in the District and improving the care and treatment of HIV/AIDS patients. This new partnership may lead to the expansion of HIV prevention trials and a better understanding of care and treatment challenges in the District, and should accelerate HIV subspecialty care and HIV treatment.

Dr. Hader also has engaged the foundation community. The Gilead Foundation has provided funds to the Washington AIDS Partnership for the District to develop a

monitoring and evaluation system to assess whether the new HIV/AIDS curriculum at DCPS is improving students’ understanding of the risks posed by HIV and sexually transmitted diseases (“STDs”). Dr. Hader is working with the Global Business Coalition on AIDS, a group of large multinational companies based in the U.S., which recently launched a new domestic HIV/AIDS prevention initiative in DC, New York City and Oakland, California. The inclusion of the District in this initiative is an important signal to the wider non-governmental community in the city that it, too, can and should play a role in the fight to prevent HIV/AIDS. DC Appleseed encourages HAA to continue to foster such relationships.

HAA, with the Mayor’s support, has committed to expanding the reach of HIV/AIDS messaging. Immediately after the September 2008 release of our *Fourth Report Card*, Mayor Fenty announced that the city was crafting a new ad campaign to raise awareness of the disease and promote testing. DC Appleseed was told on several occasions that the social marketing campaign was nearing release, but the campaign has yet to be launched. HAA again stated publicly that a new ad campaign was forthcoming in a June 2 *Washington Post* article. Given the severity of the epidemic, we believe the administration should move forward with this public awareness effort as soon as possible. HAA also has created a Places of Worship Advisory Board, is undertaking a major outreach effort to the faith community and funded one faith-based organization to build HIV/AIDS capacity among congregations in the District.

While Mayor Fenty and his administration deserve recognition for the continued support of these numerous HAA initiatives, his public appearances and statements about the epidemic have fallen short of his enthusiasm for action inside the government. While the Mayor’s involvement with the release of the 2008 epidemiology report and update is encouraging, three days after the release, while the District’s HIV/AIDS crisis was getting international media attention, the Mayor failed to mention HIV/AIDS during his second annual *State of the District Address*. This omission is illustrative of an HIV/AIDS messaging strategy by the Mayor’s office that is



not sufficient to keep a consistent, continuous focus on what the whole community can do to combat the epidemic.

The list of the Mayor's public appearances or statements related to HIV/AIDS also remains sparse. Since the *Fourth Report Card*, the Mayor has announced the release of the new epidemiology report, given remarks at an HIV/AIDS event on Capitol Hill, and conducted a CapStat on HIV/AIDS in January 2009. He has on two occasions responded to questions about HIV/AIDS from the media and participated in the annual AIDS Walk. The mayor appeared in a public service announcement around National HIV Testing Day at the request of U.S. Department of Health and Human Services Secretary Kathleen Sebelius. Given the continuing severity of the epidemic, we believe the Mayor should take a more frequent, proactive, visible role in the community educating the public about the epidemic and the need to change behavior.

We have maintained the leadership grade at a "B+." Despite the strong performance of HAA on many fronts, DC Appleseed urges the Mayor to seek out more opportunities to highlight the epidemic. A consistent message that HIV/AIDS affects everyone in the city, that it is 100 percent preventable and that testing, prevention and care resources are readily available, is essential to educating the public and reducing the stigma associated with the disease.

## INTERAGENCY COORDINATION: A-

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

A near absence of collaboration among District agencies to support HAA's response to the city's HIV epidemic was cited as a severe impediment to positive action in DC Appleseed's 2005 report. At that time, we recommended greater coordination between HAA and other agencies within DOH, including the Addiction Prevention and Recovery Administration ("APRA"), the STD Clinic, the tuberculosis clinic ("TB Clinic"), the Medical Assistance Administration ("MAA"), and the

Community Health Administration ("CHA"). DC Appleseed also has urged greater coordination of all relevant DC agencies outside of DOH in responding to the epidemic.

The coordination between District agencies and within the DOH was graded in the *Second through Fourth Report Cards*. The grades have improved steadily, from a "C-" to a "B-" to a "B." The earlier report cards describe progress from 2006 – when coordination between HAA and DOC – was the only evident coordination to implementation of several important interagency initiatives by 2008. The earlier report cards credited the Fenty administration with placing a greater emphasis on a coordinated effort to address the epidemic.

That goal started to be implemented through several initiatives that evidenced government-wide solutions to the epidemic, 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/AIDS; and a Memorandum of Understanding ("MOU") related to housing for those under the care of several city agencies. Significant developments included the youth plan and DPR's HIV education programs; expansion of HIV services at DYRS; and, better coordination with the Metropolitan Police Department ("MPD") on DC NEX. The administration also moved the TB and STD clinics under HAA. Top staff of DMH, APRA and HAA began meeting on a monthly basis to explore ways for better serving individuals dually or triply diagnosed with mental illness, drug addiction and HIV/AIDS.

Numerous DC agencies now play an important role in addressing the HIV/AIDS epidemic. The DC DOC is considered a national leader in HIV testing and discharge planning. HAA and the DPR have formalized an agreement that provides expanded HIV/AIDS education programming. The Department of Employment Services ("DOES") has integrated HIV/AIDS awareness into the training for those participating in the summer jobs program.

HAA's takeover of the STD clinic and increased collaboration with DCPS has resulted in a major new school-based STD testing



program. During this academic year, the District became one of only three cities to conduct widespread opt-out STD testing in schools. HAA screened students in six schools and has plans to test in all high schools during the 2009-2010 academic year. This testing program provides an opportunity to teach students about the connection between STDs and HIV infection. Furthermore, it is well known that the presence of STDs increases the likelihood of HIV transmission during sexual contact. This program also affords the opportunity to treat individuals with STDs. According to HAA, approximately 13 percent of students tested were positive for chlamydia or gonorrhea. These results illustrate the need for more consistent sexual health education and argue for greater condom accessibility for students. DC Appleseed commends HAA and DCPS for undertaking this important effort.

Since the *Fourth Report Card*, we have seen increased collaboration among numerous District agencies related to youth HIV prevention. A separate section of this *Fifth Report Card* addresses the youth initiative. We note it here because it does represent an outstanding example of interagency coordination that we urge District governmental officials and entities to replicate in other areas.

St. Elizabeths Hospital ("SEH") staff and HAA continue to consult on ways to improve HIV education and discharge planning for HIV patients. SEH conducts routine HIV testing, provides counseling, and treats inpatient HIV-positive individuals. Discharge planning at SEH now has an intensive focus on HIV-positive individuals including education about HIV, scheduling appointments with specialists, and managing drug therapy. Condoms are readily available and are distributed to most patients at discharge.

The HAA/APRA partnership plays an integral role in fighting the epidemic. Individuals involved in substance abuse are much more likely to engage in behavior that puts them at higher risk for HIV infection. The HIV prevention efforts of these two key agencies are now closely integrated. The directors meet on a regular basis. All APRA sites offer HIV testing, distribute condoms, and provide information about syringe exchange services in the District.

HAA continues to work with the Office of Partnerships and Grants to provide capacity building workshops and one-on-one consultation services to improve the administrative and programmatic infrastructure of small, ward-based community organizations that receive funds under the Effi Barry HIV/AIDS Program. HAA, along with its partner Metro TeenAIDS, is committed to helping community groups without an HIV/AIDS focus to recognize the need to address the epidemic as part of their work. These organizations will provide education, testing, and counseling in the neighborhoods they serve.

Efforts by HAA to coordinate with MPD on syringe exchange programs have allowed this vital HIV/AIDS prevention effort to operate across the city without significant police interference. Operators of DC NEX say their clients report few problems with the police regarding syringes. In 2008, HAA produced official cards identifying syringe exchange program participants and explaining that District laws permit distribution and possession of sterile needles.

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 has awarded the Consortium for Child Welfare a \$100,000 grant to administer the CDC's family intervention called *Parents Matter*, a program designed to promote effective parent-child communication about sexuality and sexual risk reduction. To date, 16 facilitators from six DC-based organizations have been trained and certified to administer the program.

Since the *Fourth Report Card*, HAA has sustained and expanded numerous initiatives aimed at creating a coordinated response to the HIV/AIDS epidemic. This progress has led to an expansion of prevention and treatment efforts directed at particularly vulnerable populations, including young people, the addicted, and the mentally ill. The District's grade has been raised to an "A-."

## 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 2009, HAA's Strategic Information Bureau ("Bureau"), formerly called the Surveillance Bureau, sustained the notable turnaround it had achieved in previous years and built upon its success in tracking HIV/AIDS in the District. The Bureau continued its partnership with GW's School of Public Health and Health Services, which helped the District earn an "A" on the *Fourth Report Card*. This year the Bureau faced further staffing demands, publishing goals, and operational challenges. HAA has met these goals successfully, and has earned another "A" for the *Fifth Report Card*.

Since our *Fourth Report Card*, the Bureau filled a number of staff vacancies with experienced personnel and continued to expand its collaboration with GW. With the addition of these personnel, HAA now has a strong surveillance team, and DC Appleseed believes that the data now being used to target the District's fight against HIV/AIDS are sound.

The Bureau has made great strides with respect to routine data collection and analysis. But data collection from some service providers remains a challenge, with providers still showing some resistance to reporting because of the time it takes to complete necessary forms. HAA staff hope that the current movement toward electronic data collection will reduce the burdens on providers and, of equal importance, improve the accuracy and reliability of submitted data. The Bureau continues its efforts to encourage reporting during the transition to electronic data collection and to work closely with community service providers.

To help obtain more reliable data, the Bureau created partnerships for information exchange with other government sources, such as law enforcement agencies, mental health agencies, and STD surveillance. The Bureau obtains data from these sources and in return provides HAA's surveillance, prevention and treatment information to them. The Bureau also intends to publish more mortality data as

well as assess treatment success and CD4 counts using public and private labs.

The collaboration between the Bureau and GW has been essential to the improvements seen in the District's HIV surveillance effort over the past few years. As part of the collaboration, the Bureau has continued its surveillance of adult Hepatitis. Expanded focus on this research provides a better understanding of the STD threat in the District, as well as the behavioral underpinnings of both the Hepatitis and HIV epidemics. The data from this work currently are being reviewed for reporting.

The District also continues conducting the National HIV Behavioral Survey ("NHBS"). The results of the first round of that study, which focused on at-risk heterosexuals, were released simultaneously with the *District of Columbia 2008 HIV/AIDS Epidemiology Update*. This year, the behavioral study focuses on men who have sex with men and the report should be released later in 2009. The Bureau also has initiated a community service assessment.

As the HIV/AIDS surveillance methods of the District improve, efforts are underway to raise the Bureau's profile nationally, including the preparation of abstracts for the annual CDC prevention conference. HAA also is seeking grants to expand the scope of its research. Proposed grants would fund tests for asymptomatic STDs and would also add electronic birth assessment studies to its database.

While the Bureau has made significant strides over the last several years, it continues to face challenges. The Bureau currently focuses more heavily on the prevalence of HIV/AIDS rather than the incidence of new HIV cases. The Bureau is missing important initial testing information, with the result that it is not possible to know precisely when a person was actually infected. Furthermore, there is currently no effective process to detect and record new HIV infections with precision. As testing data are improved through patient interviews by physicians and new reporting processes, the agency may be in a position to use the CDC's serologic testing algorithm for recent HIV seroconversion ("STARHS") to estimate new infections. STARHS may allow the District to approxi-

mate incidence, but requires the collection of data related to previous HIV testing. These testing data are coupled with CD4 counts to estimate which individuals are more likely to have contracted HIV/AIDS recently, thereby allowing the District to report incidence.

HAA raises several concerns about this current methodology for estimating new infections, particularly in the District. Because of previous weaknesses in the city's data collection program, DC began participating in the STARHS program later than other jurisdictions.

DC Appleseed recognizes that current methods for estimating recent HIV infections at a jurisdiction level are limited, and in the early stages of development. Still, we believe HAA should remain committed to participating with CDC and other jurisdictions to advance the effort to provide data on new HIV infections. Such data can provide an important measure of the overall success of the District's response to the epidemic. HAA's leadership has been pressing for a greater level of federal support for more comprehensive studies of urban HIV/AIDS "hot spots." These studies – which could produce data about newly acquired HIV infections – have been routinely conducted internationally, but have not been undertaken domestically.

Without a reliable tool for tracking newly-acquired infections, HAA relies on behavioral surveys to track changes in behavior that may provide some indication of the effectiveness of prevention efforts. The District, with the assistance of GW, conducts NHBS and recently released the survey results for heterosexuals at high risk of HIV infection. Each year, the city also conducts the Youth Risk Behavior Surveillance System ("YRBSS") survey, and the Behavioral Risk Factor Surveillance System survey. The results of these surveys related to sexual behavior can also be a valuable tool for assessing the effectiveness of HIV/AIDS prevention efforts.

The public should be educated to the fact that an increase in newly reported HIV cases is anticipated with the expansion of testing in the city. Unfortunately data related to newly reported HIV-diagnoses are not projected to be released by HAA until 2011. According to HAA officials, it takes up to five years – using CDC standards – to complete the transi-

tion from code-based to name-based HIV reporting.

At the conclusion of the *Fourth Report Card* period, the primary question was whether the progress made by the Bureau could be sustained through the annual release of surveillance data, the continued hiring of high quality staff and the and initiation of new projects. Since the *Fourth Report Card*, the Bureau has met those objectives. The grade is maintained at an "A."

## GRANTS MANAGEMENT: B+

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

HAA has made significant progress over the last year in fostering organizational and sub-grantee accountability, promoting transparency, and better tailoring its grant monitoring to the needs of service providers.

In the *Fourth Report Card*, DC Appleseed detailed several of the new draft initiatives and policies that HAA planned to implement in the new fiscal year beginning October 1, 2008. Over the course of the year, HAA has implemented most of the proposed reforms to its practices and procedures, including a subgrantee capacity and monitoring program and a modified invoice tracking system. In order to make subgrantees aware of its revised policies, HAA held a subgrantees forum in September of 2008. While HAA should develop additional subgrantee assessment protocols and standardize grant renewal and license tracking systems, it has taken positive steps since the *Fourth Report Card* to improve the objectivity and flexibility of its grant management processes. In acknowledgment of HAA's progress and continued self-assessment and improvement, its grade has been raised from a "B" to a "B+."

In the *Fourth Report Card*, we discussed HAA's proposal for a revised subgrantee capacity assessment system that would tailor monitoring and site visits to a community based organization's ("CBO") needs. After incorporating feedback from focus groups,

HAA implemented its Agency Capacity Assessment Monitoring (“ACAM”) system. Under ACAM, HAA conducts an initial capacity assessment of a subgrantee, and then classifies the subgrantee as low, moderate or high capacity. HAA then tailors the number of site visits and length between site visits based on the subgrantee capacity assessment. For low capacity CBOs, including all CBOs that have worked with HAA for fewer than two years, HAA will conduct a comprehensive visit, a follow-up visit, and a reassessment each year. The baseline number of site visits is lower for moderate and high capacity agencies, but ad hoc visits above the baseline amount can occur depending on specific circumstances.

ACAM is designed to enhance flexibility in HAA interactions with CBOs and to further open lines of communication between CBOs and HAA. CBOs submit a self-evaluation and a staff questionnaire to HAA prior to their capacity assessment, the timeliness of which can affect their capacity rating and the content of which informs discussions during HAA’s assessment. To promote transparency, ACAM specifies programmatic and fiscal “triggers” that can increase or decrease a CBO’s capacity rating and consequent monitoring. HAA also has created a matrix for its capacity assessments that itemizes the criteria used to evaluate a CBO’s organizational capacity, human resource management, fiscal implementation, and programmatic implementation. Recognizing that CBOs face differing fiscal demands, HAA varies the weight accorded to each CBO’s administrative, programmatic, and fiscal circumstances. HAA has committed to sharing its “outcome reports” with the evaluated CBOs within 30 days of a site visit.

Because ACAM is relatively new, limited data exist to measure the effectiveness of the program. However, on the whole, HAA reports that its subgrantees are quite satisfied with the improved objectivity, transparency, and flexibility promoted through the ACAM structure, and HAA believes that ACAM enables it to more effectively learn about its community partners. HAA is still in the process of developing objective protocols that will govern post-assessment site visits, which should ensure better coordination between

programmatic and fiscal monitoring visits and evaluations.

One area in which HAA needs to address is consistency of communication between programmatic monitors and fiscal monitors. To improve communication, HAA plans to institute quarterly meetings between the fiscal and programmatic groups. Additionally, HAA did not consistently meet its 30-day timeline for issuance of its ACAM outcome reports to the evaluated subgrantees, as 73 percent of the outcome reports were sent after 30 days. HAA is working to improve the timeliness of its reports. To ensure that the ACAM system remains an effective tool for grant monitoring, HAA has indicated a willingness to incorporate feedback on ACAM into future modifications or adjustments of the program.

In past report cards, DC Appleseed expressed concern over the timeliness of HAA’s invoice payments and the soundness of HAA’s invoice tracking procedures. For this *Fifth Report Card*, the subgrantees we contacted again confirmed that HAA has made great improvements in the timely payment of invoices and that payments are received within the stated 30-day period. At the time of the *Fourth Report Card*, HAA told DC Appleseed that by October 1, 2008 all fiscal monitors would be trained in the District’s System of Accounting and Reporting (“SOAR”), which provides fiscal monitors with the ability to track payments and verify agency funding balances. HAA now has confirmed that all fiscal monitors have been trained in SOAR. Moreover, current procedures require fiscal managers to indicate on invoices when payment is made and to place a copy of the paid invoice in the grant file.

HAA has implemented a new File Review Policy that standardizes maintenance of subgrantee files and provides for quarterly reviews of grant files by HAA management. HAA anticipates the new File Review Policy will assist in the orderly transition of grantee oversight in situations where grant managers leave the employ of HAA.

In the *Fourth Report Card*, we reported that HAA planned to convene a mandatory subgrantee forum. In September 2008, HAA held the forum, which introduced subgrantees to ACAM and provided information sessions on fiscal management, program monitoring

and evaluation, social marketing, and the District's efforts at HIV/AIDS prevention. HAA reported that feedback from participants was uniformly positive, and HAA concluded that the forum opened a useful dialogue, face-to-face, between the District and community agencies. HAA has planned another forum for this fall.

HAA has been cited in the past for not having an adequate training program for its fiscal monitors. In response, HAA implemented a training program through an outside private firm. Although HAA intended for all fiscal monitors to have completed training by February 2008, as of July 2008, three staff members had not completed the training, and as of May 2009, two staff members still had not completed the training.

In past report cards we discussed HAA's efforts to ensure that all subgrantees meet all program eligibility requirements. Although the majority of subgrantees currently have all appropriate licenses on file and up-to-date with the District, HAA does not have a standardized approach for knowing how and when updated licenses and certifications should be re-filed. HAA is developing a systematic approach to alert the District of deadlines for requisite agency licenses and permits. The system is intended to enable HAA staff to notify subgrantees of impending renewal requirements.

Finally, HAA plans to reconsider its approach to renewal and extension of existing grants. Currently, HAA has no formalized set of criteria for considering whether a grant to a CBO should be renewed, but does conduct regular evaluations to highlight concerns about grantee performance. Subgrantees are given performance ratings that are reported during DC Council hearings. Other factors involved in determining renewal include service area needs, availability of funding sub-grantee results, and fiscal performance. HAA is now working through its monitoring and evaluation group to create a uniform set of renewal criteria.

HAA's grant management efforts have undergone a period of growth and development since the *Fourth Report Card*, and we applaud its continued efforts at building efficient, objective grant management systems and working with its community partners. In

the coming year, HAA should ensure that its staff members are fully trained and operating consistent with the recently implemented policies and protocols. HAA should continue to solicit feedback from its community partners on the effectiveness of its new systems and remain flexible in responding to agency concerns. In recognition of HAA's progress, the District's grade has been raised to a "B+."

## MONITORING AND EVALUATION: 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.**

As DC Appleseed has reported in the past, the District has outlined plans for improving HIV/AIDS monitoring and evaluation ("M&E") efforts that have yet to be implemented. The plans appear more developed than in the past, but much work remains to be done to establish a comprehensive M&E program. Senior leadership and new staff are committed to improvement in this area, but progress has been slow. Due to the slow implementation of new systems and reporting requirements, we continue to give the District a "B-."

Dr. Hader has laid the foundation for advancement by hiring three staff members to focus on monitoring and evaluation. These staff coordinate with other HAA staff, including the Medical Director, to determine the types of indicators that HAA will examine and track across surveillance, prevention, and care.

Last year, the agency implemented the Program Evaluation & Monitoring System ("PEMS") for reporting to the CDC. This involved a major overhaul of HAA's core data collection and monitoring system and is more extensive than the system it replaced. PEMS provides program-level data, but insufficient client-level data. Despite this system limitation, HAA reports that it is able to inform clinics whether a newly reported HIV case is truly a new diagnosis or just new to that particular clinic. HAA believes it is the only



jurisdiction that provides such information directly to clinics.

Despite improvements in data collection and usage, HAA estimates that it needs an additional six to nine months to fully analyze its data and establish appropriate indicators for quality assurance. Although HAA collects and reports HIV/AIDS, Hepatitis, and STD data to the federal government, including CDC and the Health Resources and Services Administration (“HRSA”), it currently uses 15 databases for such functions. HAA plans to purchase and implement a new data system, called Maven, by May 2010 in order to replace the existing data systems. The consolidated, web-based system will: (1) allow HAA staff to transfer data directly into PEMS for reporting purposes; (2) mandate collection of certain data elements; and (3) be available to providers free of charge, permitting them to extract their own data, and, eventually, to compare their performance to the mean or aggregate data.

As part of its efforts to streamline data collection, HAA is collaborating with the DC Primary Care Association to promote use of integrated electronic medical records (“EMRs”). HAA applied for a grant from HRSA to support its EMR project and hopes that stimulus funding provided by Congress will also assist with these efforts.

In addition to strengthening quality assurance efforts related to HIV/AIDS prevention and treatment, HAA is planning to review STD and TB data now that the infectious disease programs have been consolidated at DOH. The ultimate goal of the M&E program is to facilitate the provider-level changes necessary to drive better clinical outcomes, both in reducing the number of new infections and improving treatment and care for all three areas of jurisdiction. As the District continues to build its capacity and resources in this area, we hope to see an impact on HIV, STD, and TB rates.

## 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, DC Jail, TB Clinic, and substance abuse treatment facilities).**

DC Appleseed’s 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 likely would undergo HIV testing and learn their status if HIV testing were offered routinely as part of medical care.

In our *Fourth Report Card*, the District received an “A-” for routine testing because the District was at the forefront nationwide in its efforts to implement routine testing. However, the report also noted that obstacles to routine testing – a continuing lack of acceptance by the medical community and financial challenges – continued to slow implementation.

Although the District has gone further than most jurisdictions in increasing access to HIV testing, it can and should do more. HAA seems to agree. In March 2009, the District released the DC *2008 HIV/AIDS Epidemiological Update*, which shows that three percent of adult and adolescent District residents are known to be living with HIV/AIDS. At the press conference accompanying the release of the report, Dr. Hader stated that the prevalence of the disease is probably worse than the reported figures, and that the District planned to increase testing and introduce a marketing campaign emphasizing the need for testing and the use of condoms, clean needles, and other forms of prevention.

Our *Fourth Report Card* noted that HAA was the recipient of CDC’s HIV Testing Expansion Grant for FY 2008, which provided funding to initiate routine HIV testing at GW Hospital, Howard University Hospital (“Howard”), and Unity Healthcare, Inc. (“Unity”). The CDC funding is intended to assist HAA’s partners in building capacity for opt out testing and eliminating cultural and institutional barriers to testing. HAA provides the rapid testing kits free to its partners. Since that time, Children’s National Medical Center

has instituted an emergency room testing program. HAA staff note that Washington Hospital Center has also approved a testing program that will begin operation in the very near future. In addition, HAA continues to have discussions with Providence Hospital, Georgetown Hospital, Sibley Hospital and United Medical Center regarding the implementation of a routine HIV testing program. We urge HAA to persist in those efforts.

A CDC Summary of Year One of the HIV Testing Expansion Grant – released on February 24, 2009 reflecting data collected from September 30, 2007 to September 29, 2008 – shows that the District is one of the top three jurisdictions in the country in the number of HIV tests conducted and the number of HIV-infected residents identified. Among more specific findings in the CDC report are:

- New York City, Florida, and the District conducted the most HIV tests and identified the greatest number of newly diagnosed HIV-positive individuals during the first year of the initiative (with the District conducting 72,864 tests and identifying 464 new HIV diagnoses).
- The District achieved 162 percent of its testing goals at the end of Year One, and showed a 936 percent improvement in the total number of tests performed during the second six months of the initiative as compared to the first six-month period.
- The District established a new quality standard that includes linkages to care as a critical function of the counseling, testing, and referral process, and HAA now tracks confirmed referrals into medical care for those identified as HIV-infected.
- The District is one of three jurisdictions that have initiated large-scale efforts to increase general awareness, availability, and efficiency of counseling services for partners of those who test HIV positive.

HAA's recently submitted Interim Progress Report for the HIV Testing Expansion Grant noted a number of ongoing difficulties with efforts to expand testing, including:

- Expansion into additional primary care centers and emergency departments can be slow, as sites experience start up issues;

however, HAA is providing technical assistance to assist in implementation.

- Hospitals report implementation delays resulting from staff resistance, including laboratory staff and administration. Much of the resistance to implementing routine HIV testing in hospitals and primary care centers stems from concerns about the ability to find treatment homes for all identified HIV-positive patients and the stigma related to HIV.
- Some providers report significant opt-out rates, and HAA discovered that the language used by testing staff was actually asking patients to opt-in to screening. HAA corrected this by providing technical assistance.

According to the Interim Progress Report, HAA will continue to encourage routine opt-out HIV testing in clinical settings throughout the District. From September 2008 through June 2009, HAA expanded the number of Unity community health care centers doing routine HIV testing as a "5th Vital Sign" from four to nine. HAA asserts that knowing a patient's HIV status should be as routine as checking pulse, blood pressure, respirations and temperature.

HAA partners with 20 CBOs to offer HIV testing and supports an additional 23 clinical testing sites. The CBOs offer a wide array of general and specialized services targeting African Americans, youth, transgender persons, substance abusers, and women at high risk of contracting HIV, as well as other special populations.

HAA is working with CBOs to make the transition from care access to care promotion. It partners with Howard University's AIDS Education and Training Center (AETC) to develop comprehensive training for all interested community partners to provide information on the array of services for HIV positive persons in the District. The District's Medical Society has focused attention on the HIV education resources available for providers in the District. Its March/April 2009 newsletter carried an article regarding AETC and encouraged providers to use the Center's lectures, case consultation, and other services.

The Interim Progress Report noted that 78 percent of the newly diagnosed HIV-positive



persons identified through expanded HIV testing efforts were linked into medical care. All of the HIV testing partners have protocols in place for linking HIV-positive persons to medical care and treatment. However, the report noted that the CBOs have “some room to grow” in this area. Their linkage relationships tend to be more informal; some HIV testers at CBOs lack confidence and familiarity with care systems.

The District has taken steps to promote perinatal HIV screening to reduce the number of babies born with HIV. The *2008 HIV/AIDS Epidemiological Update* noted that only one baby was born with HIV in the District in 2007, compared with 10 in 2005. Dr. Anitra Denson, HAA’s perinatal coordinator, continues to work with hospitals on routine perinatal testing. Washington Hospital Center and Howard have led the rollout of testing at Labor and Delivery (“L&D”) Departments for over a year. HAA has engaged the Pennsylvania MidAtlantic AIDS Education and Training Center to use the Washington Hospital Center and Howard model for other L&D suites in the District. At present, seven of eight hospitals in the District provide perinatal HIV screening during the first trimester.

Overcoming reluctance on the part of providers to conduct routine testing 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. The District has attempted to address this problem by enacting legislation to ensure that the costs of HIV screening are covered by third-party payers. Legislation requiring health insurers to pay for routine HIV screening tests went into effect in March 2009. The new law – the Insurance Coverage for Emergency Department HIV Testing Amendment Act of 2008 – requires third-party insurers to pay for the cost of a voluntary HIV screening test performed on an insured patient while that person is receiving emergency medical services at a hospital emergency department.

HAA has indicated it will soon announce a marketing campaign aimed at boosting HIV testing by encouraging all District residents to get tested when visiting their doctor. A second phase of the promotion will implore sexually active heterosexual couples to get tested and to know their partner’s HIV

status, explore whether there are only two people in the relationship and use condoms. Heterosexual sexual contact is the fastest-rising mode of HIV transmission in the city, particularly among black residents in wards six, seven and eight. DC Appleseed urges HAA to move forward with the social marketing campaign and to seek broad exposure for the message, including through ads contributed by local media.

Overall, the District continues to make significant progress in promoting and providing support for routine HIV testing. Although the District can now be counted among the national leaders in promoting routine testing, even more must be done. After four years of steady declines, the District’s rate of “late testers,” or persons who were diagnosed with AIDS within 12 months of their HIV diagnosis, often concurrently with a life-threatening opportunistic infection, jumped in 2007. These data show the need for continued improvement in the District’s HIV screening programs. Greater efforts must be made to expand testing to additional clinical and non-traditional settings across the District. The District’s grade has been increased to an “A.”

## CONDOM DISTRIBUTION: B+

**Significantly expand condom distribution in the District.**

Condom use is universally regarded as a safe and effective HIV prevention measure. Over the past few years HAA has greatly expanded its condom distribution program to meet Dr. Hader’s pledge to distribute three million condoms in the District by the end of 2009. Remarkably, given the limited distribution of 115,000 condoms in 2006, 1.3 million in 2007, and 1.5 million in 2008, HAA is on track to reach this goal, having distributed one million condoms through April 2009.

DC Appleseed’s *Fourth Report Card* recognized the progress HAA had made to improve and expand distribution efforts. The report noted, however, that the agency faced a number of challenges to achieve its goal of expanded distribution, including organizational and staffing issues. HAA has begun

to address these concerns by solidifying its management team and adding one full-time staff member, as well as a Capital City Fellow, to assist in its distribution efforts. In addition, the program has been restructured within HAA and is now a component of the Capacity Building Program. This reorganization, along with the improved staffing, will help to ensure that the program can reach its ambitious distribution goals and to satisfy one of the “next steps” identified in HAA’s revised condom distribution plan.

The District’s condom distribution program now provides only one brand of condoms, Durex, which is available in four sizes. Although the agency previously had distributed multiple condom brands, Durex was designated as the condom supplier through competitive process, and HAA believes a single brand system is the only affordable and manageable approach to broader distribution. While working with a single company facilitates distribution to community and governmental organizations, the Durex brand is not as well known in the community as some other condom brands. Accordingly, HAA has encouraged Durex to intensify advertising efforts in DC in an attempt to increase name recognition and boost the popularity of the brand. However, HAA is committed to providing other brands of condoms for targeted populations. For example, during the health and HIV/STD screening of youth in the Summer Youth Employment Program, HAA is distributing Trojan brand condoms in a custom designed matchbook to promote safe sex activity.

HAA has continued its efforts to identify new partners and retain current partners to assist in its condom distribution program. The *Fourth Report Card* noted that HAA had successfully delivered condoms to several District agencies and offices; it has continued and intends to formalize these partnerships. HAA also has expanded its efforts to identify new partners and retain existing partners in the broader community. The agency currently has 120 community partners who assist in the distribution of condoms. These community partners are responsible for activities ranging from identifying and arranging new distribution sites to operating mobile health units that provide HIV testing and HIV/AIDS literature. HAA has made substantial prog-

ress in collaborating with community partners and intends to hold quarterly meetings where these partners can coordinate and share their concerns and accomplishments with HAA.

In order to evaluate the progress of the condom distribution program, HAA has developed quantitative measures, including numbers of condoms, numbers of community partners and numbers of non-public health sites. In addition, HAA has added questions to population based surveys to measure condom use and utilization of free condoms.

Currently, community partners distributing condoms must complete an online condom distribution form to request condom delivery. However, the District hopes to take a more pro-active approach whereby HAA will reach out to the community to identify non-traditional distribution partners. HAA has made progress in this area by making condoms available in dispensers in non-public health locations, such as barber shops, as well as distributing palm cards that contain information about condom distribution locations. HAA intends to expand this program and make condoms available through 500 dispensers.

As part of its effort to expand distribution, HAA also is developing a direct ordering program allowing individuals to order free condoms through HAA’s website. HAA is modeling its program on a similar one in Los Angeles that has experienced initial success. In addition, HAA plans to start a pilot program to expand access to female condoms and dental dams. HAA also is identifying all condom distribution sites in the District. Once this information is available, HAA intends to collect data that would enable the agency and its community partners to identify geographic and demographic gaps that need to be addressed.

One noticeable gap that needs to be addressed is that of distribution to the prison population. The DC Jail currently distributes condoms upon request at sick call and provides each inmate with two condoms upon release. However, it was reported that condoms are not distributed at the Correctional Treatment Facility (“CTF”). The CTF, which houses approximately 1000 inmates, is managed by Correctional Corporations of America (“CCA”) and prohibits condom distribution.

The leaders of the DOC should discuss this issue with management at the CCA.

The *Fourth Report Card* stressed the need for HAA to increase efforts to monitor the performance of condom recipient groups. The agency has committed to conducting a qualitative assessment of community partners. For community partners that receive more than 10,000 condoms per month, HAA intends to perform audits twice a year. For partners that receive between 3,000 and 10,000 condoms per month, HAA intends to perform annual audits. These audits will focus on issues such as adequate storage and extent of actual condom distribution.

HAA has also indicated it will launch a public awareness outreach campaign to increase condom use in the District. HAA is in the process of developing a promotional program that it hopes will increase routine condom use. As a part of this promotional effort HAA intends to create partner materials, such as tote bags and shirts linked to the District's efforts bearing this symbol.



It is clear that in the past year HAA has made significant progress in its condom distribution efforts. To sustain the gains and enthusiasm within the program the agency will need to meet its 2009 distribution goal and continue its efforts to identify and retain partners – particularly non-traditional partners.

Significant challenges still remain. DC Appleseed recommends that HAA take further steps to assure widespread condom distribution, including increased coordination with community partners. The selection of Durex as the District's condom brand presents a challenge for the distribution efforts. While the condoms are functional and effective, the community's lack of familiarity with Durex means the District will need to focus efforts on exposing the public to the brand to assure widespread adoption. In the area of monitoring, the District should continue to pursue the current mapping method for assessing distribution, including some gauge of whether target populations and geographic areas are receiving adequate coverage.

The grade for condom distribution has been raised to a "B+" based on progress so far in

reaching the three million condoms per year distribution goal. Further improvement in the grade will depend on actually meeting the goal for 2009, and implementing an ongoing effective distribution program that reaches individuals who lack access to condoms and are at highest risk for HIV infection.

## PUBLIC EDUCATION IN THE DISTRICT: 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 ("the Board") to develop content standards for an HIV/AIDS curriculum. Four critical component areas were identified as elements of a good HIV/AIDS education program: a comprehensive curriculum, professional development to train teachers in the curriculum, a plan to provide coordination between and within schools and with community organizations that work in the schools, and a system to assess the impact of the curriculum.

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

Over the course of the past four report cards, the grades for public education have fluctuated. On numerous occasions, solid commitments to move forward with health standards and a health curriculum were not followed by action. Our *First Report Card* gave the schools a grade of "B-" based on an understanding that health learning standards were under review and that an interim curriculum would be in place during the following school year. The grade fell to a "C-" in our *Second Report Card* after the standards were not published and no interim curriculum was developed. Our *Third Report Card* gave yet

another declining grade of “D” since, though proposed standards existed, they had still not been approved.

Under the Fenty administration, substantial progress toward instituting an HIV/AIDS curriculum was finally made. The schools received a “C” in our *Fourth Report Card* based on the implementation of standards by DCPS, significant progress in bringing an HIV/AIDS curriculum into the classroom, and plans for further professional development.

In the original report, this section was devoted to DCPS. Given the changes in DC’s public education system that resulted from the Mayoral takeover and the complex relationship between the charter schools, DCPS and the new state education agencies, DC Appleseed has broadened this category to include the key institutions that are part of ensuring that DC’s youth acquire the information and skills they need to protect themselves from HIV.

## PROGRESS ON MEETING THE STANDARDS

### DCPS

With the health standards in place, in 2008 DCPS’s Office of Teaching and Learning (OTL) approved three age-appropriate curricula to implement the HIV/AIDS content standards for elementary, middle, and high schools for the 08-09 school year. These evidence-based, privately developed, prepackaged curricula are recognized by the CDC. Metro TeenAIDS and the local AmeriCorps program, CityYear DC, have provided *Making Proud Choices!* to students over the past few years. The other curricula are *Making a Difference*, for older elementary school youth and *Becoming a Responsible Teen* (BART), designed for teens in non-school, community-based settings.

This year DCPS transferred responsibility for student health and wellness to the newly created Office of Youth Engagement (“OYE”). This office focuses on issues related to health, nutrition and physical education and on how improved health outcomes are related to student attendance and behavior. HIV/AIDS education and prevention and STD screenings fall within the health and wellness initiative. While no specific outcome

is named for HIV/AIDS in the current OYE strategic plan, activities related to HIV/AIDS are included in OYE’s health and wellness milestones.

DC Appleseed commends DCPS for requiring that an HIV/AIDS curriculum be taught in schools during the 2008-2009 school year. OYE has worked with physical education and health teachers as well as Metro TeenAIDS throughout the year to ensure schools are providing instruction aimed at meeting the health standards and that teachers are being provided the necessary training and support. Metro TeenAIDS and City Year also have supplemented the HIV/AIDS programs in schools.

An evaluation of the DCPS program is expected to take place this summer. OYE plans to work with a select group of teachers, along with Metro TeenAIDS, to examine the “pacing” guides for the sexual education curriculum based on their teaching experiences. This evaluation is expected to focus in part on pacing out HIV/AIDS resources and adding model lesson plans on puberty, sexual health, and sexual orientation. OYE hopes to find overlap in content that will allow DCPS to combine lessons and condense the timeline of the pacing guide. School officials report that one of the biggest challenges teachers face is finding time to teach a health curriculum when so much emphasis is placed on boosting student performance in core academic areas like reading, math, and science.

While DCPS appears to be making progress and devoting more staff time and resources to implementing an HIV/AIDS curriculum, a lack of student assessment and limited teacher monitoring in both the public and public charter schools continues to raise questions about the effectiveness of the program. OYE does not keep data on student comprehension of HIV/AIDS prevention lessons. During the first year that the HIV/AIDS curriculum was taught in the schools, DCPS conducted no assessment of students to determine the efficacy of the curriculum and teaching methods. An assessment performed by Metro TeenAIDS following the 2007-2008 school year found that while there were statistically significant increases in student knowledge on sexual health and HIV/AIDS, there were no significant changes in safer behaviors. While these results focus

on a small sample of the students, such data demonstrate the need to ensure that classroom effort results in safer behavior.

We understand that DCPS is developing more comprehensive assessments to gauge the success of HIV/AIDS lessons that will be used in the coming school year. And, DCPS intends to institute stronger instructional support on developing student assessment as well. These plans to develop monitoring and assessment mechanisms are welcome and should be implemented expeditiously.

### **Charter Schools**

While DC Appleseed is pleased with the progress on HIV/AIDS education in DCPS, this momentum is not evident throughout the charter school system. Regrettably, our investigation reveals an uneven and uncoordinated effort among charter schools. With more than a third of District youth attending charter schools, ensuring that those students also receive adequate HIV/AIDS and sex education should be a high priority.

DC Appleseed recently conducted an informal survey of 22 charter schools that have students who are of the appropriate age to be taught sexual health education. Of the schools that responded to the survey, only five reported using the DCPS health curriculum. Two others employed a different commercially-available health curriculum. Two reported having no sexual health instruction at all. Of the remaining schools, 13 reported having some type of sexual health education – assemblies, presentations by teachers, or the use of external speakers – but no recognized curriculum. Several charter schools leave the issue completely up to physical education teachers or nurses and provide no guidance or oversight concerning what they teach.

### **Office of the State Superintendent of Education (OSSE) and the State Board**

OSSE and the Board are responsible for monitoring and ensuring all students' progress on the Health Learning Standards. However, neither OSSE nor the Charter School Board is currently monitoring charter schools' progress on meeting the standards or even whether the schools are teaching a curriculum designed to meet the health standards.

It appears that the issue of how charter schools should be monitored has not yet been clarified. While the DC Code and applicable statutes can be viewed as giving OSSE and the Board the authority to create standards for health education for both DCPS and charter schools, the enforcement capabilities of OSSE and the Board over charter school requirements are less clear. Clarity should be sought by all parties.

OSSE is taking steps in the coming year to assess current HIV/AIDS activities and help build capacity in ten DCPS and ten charter schools. This support for charter schools in particular will be welcomed. Many charter schools contacted as part of our survey indicated a strong interest in receiving training and information to help them build a health program. As an objective within its CDC grant, OSSE will provide the selected schools a "sexual health toolkit" to develop a sexual education plan. In addition, OSSE should utilize the CDC Health Education Curriculum Analysis Tool (HECAT) for charter schools that have elected to use curricula other than those used by DCPS.

### **Teacher Training**

Teaching HIV education to youth requires both a grasp of material and sensitivity to subject matter. While substantial progress has been made, all schools as well as OSSE should offer expanded professional development to school personnel teaching the HIV/AIDS curriculum and advising students on sexual health matters. Several community partners could be of great help in this area. As an example, during the year, outside trainers from community groups, like Sexual Minority Youth Assistance League ("SMYAL") and the Sexuality Information and Education Council of the United States ("SIECUS") were brought in to help teachers become more comfortable teaching sexual-health related issues. DCPS and the OSSE jointly invited SIECUS to run a gender sensitivity training for health teachers in the winter.

### **Additional Sexual Health Initiatives**

DCPS partnered with DOH to make substantial progress toward instituting a routine STD testing program for students during the 2008-2009 academic year. A DOH program for voluntary STD testing occurred in six DCPS high



schools. According to HAA, the pilot program screened 3,144 students. Of those, 350 were positive for an STD. Nearly all of those who tested positive received medical treatment by the District's STD program or by a private medical provider. The confidential procedure for testing and treatment provided students a secure and non-judgmental way to participate. This program is scheduled to expand to all high schools during the 2009–2010 school year.

Condom availability in DCPS has expanded, in part due to a joint letter sent by Dr Pierre Vigilance (DOH) Chancellor Rhee (DCPS) and then-State Superintendent Deborah Gist (OSSE) in 2008 clarifying the condom distribution policy in high schools. However, several issues have prevented the kind of expansion that would make condoms more widely available for sexually active youth. Currently, school nurses are the single point of contact for condom distribution in schools. However, not every charter school has a school nurse, and many say that the condom distribution should be expanded beyond the nurses' suites.

DCPS is collaborating with DOH on a new policy to allow additional school staff to distribute condoms. OSSE officials say this change to current policy could expand distribution to health teachers, coaches, and counselors.

OSSE and DCPS also have begun presenting CDC's *Parents Matter* program to advance parental and community involvement in sexual health education. Some DCPS staff members already have been trained to administer this evidence-based HIV prevention program for parents of pre-teens. The program is designed to enhance protective parenting practices and promote parent-child discussions about sexuality and sexual risk reduction.

Overall, the education system in the District has taken positive steps to implement a city-wide sexual health and HIV/AIDS prevention curriculum since our *Fourth Report Card*. DCPS has made progress toward providing comprehensive health education and has made HIV/AIDS prevention a priority in the classroom. We are encouraged by the dedication of staff and resources. The grade on the *Fifth Report Card* for the overall public

education in District schools has been raised to a "C+."

The grade increase is limited for two reasons: first is the lack of monitoring and assessment mechanisms to measure the effectiveness of the classroom HIV/AIDS curriculum at DCPS, the charter schools, OSSE or the Board; second is the concern over a lack of progress in instituting a health curricula for the more than 33 percent of students who now attend charter schools. Equally troubling is that the charter schools seem accountable to no government entity on this matter. While we commend OSSE for including charter schools in the pilot assessment program, and for offering assistance to those charters attempting to develop a health curriculum, no formal oversight mechanism for determining whether health standards are met has been established.

We acknowledge that DCPS has made strong progress in many areas important to providing HIV/AIDS education for students. Plans for assessing the effectiveness of programs are being developed and successful implementation of those plans will be a strong factor in determining grades in future report cards.

## YOUTH INITIATIVES: B

**Establish and implement a youth HIV education and prevention program that involves all District agencies that have regular contact with or programming for young people.**

DC Appleseed's report cards have not specifically addressed the District's efforts to reach young people outside of DCPS. In the past, we have focused primarily on efforts to implement a strong HIV/AIDS prevention program as part of the DCPS health curriculum. This new section is an assessment of other youth programs being undertaken by HAA, other District agencies, and community partners.

Reaching young people with effective HIV prevention messages is essential to the reduction of HIV/AIDS rates in the District. Youth are a particularly high-risk group. The 2007 DC Youth Risk Behavior Surveillance System indicated that among high school stu-

dents, 29 percent did not use condoms during their last sexual intercourse. Furthermore, according to HAA, many youth are not aware of their HIV status.

While DCPS and the charter schools play a vital role, meaningful ways of reaching young people must be sought outside the public schools as well. Young people have contact with the District government in many different settings. HAA and other District agencies have taken strong first steps to reach young people through its Youth HIV Prevention Plan. The initial year of the plan has been encouraging, but sustaining this progress is the key to achieving broad dissemination of the HIV/AIDS prevention message to youth.

The District's 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 project involved collaboration among 30 agencies and resulted in an Interagency Workgroup on Youth, Young Adults and Health. This workgroup convenes monthly to work on improving coordination and collaboration on youth and health services programming. The plan has focused on early intervention, STD and HIV testing, and on policy changes related to the availability of condoms.

The initial activities of the youth plan implemented over the past year reached thousands of young people and should be maintained and expanded. Some of these efforts involved DCPS. As mentioned previously in this *Fifth Report Card*, during the 2008-2009 academic year, DCPS and HAA undertook the first stage of a widespread STD testing program – screening students in five DCPS schools and two charter schools. These efforts required extensive coordination with principals, many of whom are already mandated to boost student performance on basic literacy, science, and math. Dr. Hader and Chancellor Rhee should be commended for making this testing program a priority.

As part of the youth initiative, HAA funded Metro TeenAIDS to provide additional training and support to DCPS nurses. Currently, only school nurses distribute condoms and for the last two years, they have been trained on providing a brief risk intervention with middle and high school students.

Outside of the schools, HAA also funded Metro TeenAIDS to conduct training sessions for DC government employees and CBOs. The focus of this program is to build core HIV competency in non-HIV focused youth organizations and to incorporate those new skills into their day-to-day activities. As part of this initiative, Metro TeenAIDS trained youth service providers at several CBOs that had not previously focused on HIV/AIDS prevention. Many of those organizations are located in communities that have very high rates of HIV/AIDS. Training also has been provided to all DPR youth "team leaders."

DPR has incorporated HIV education into several of its summer programs and now offers a summer workshop in conjunction with DOH, Metro TeenAIDS and Planned Parenthood titled: *HIV 101, Pregnancy Prevention*. Furthermore, HAA and its community partners report that they now are providing testing services, condom distribution, and communication and referral information to young people being served by DPR, DYRS, DOES, APRA and DMH.

Additionally, HIV/AIDS prevention education and testing information was offered to about 20,000 young people who attended the required orientation for the DOES summer jobs program. The orientation provides a unique chance to reach young people, but opportunities for expanding the HIV education program appear limited by the very short period young people are asked to spend at the orientation. Ideally, DOES should lengthen the orientation to accommodate more extensive HIV/AIDS education and counseling.

HAA 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 and provides education on HIV, STDs and sexual health to residents of the New Beginnings Youth Development Center, the District's facility which houses committed youth.

Significant funds were made available by HAA to launch a multi-media social marketing campaign directed at young people. The campaign, REALTALK, aims to encourage testing and reduce stigma related to HIV testing, and includes a text messaging component that links youth to HIV testing sites and HIV prevention services. A web-



site, [www.realtalkdc.org](http://www.realtalkdc.org), provides extensive information on HIV prevention and testing as well. Billboards for the campaign recently began running on Metro buses. The campaign, however, likely will be limited by the high expense of these advertisements. Billboards for REALTALK will run only twice for a few weeks over the next year.

Since the inception of the Youth HIV/AIDS Prevention Plan, many involved government agencies have incorporated HIV prevention, education and other resources into their routine delivery of care for DC youth. Reaching the young population outside of the school environment is essential to any successful plan to address the epidemic. The District should be commended for making great progress in the early stages of the youth initiative. Still, more can and should be done to incorporate testing, condom distribution and counseling into all of the youth programs. The District's grade in this area is a "B."

## SYRINGE EXCHANGE AND COMPLEMENTARY SERVICES: B+

**Continue to fund needle exchange programs and complementary services (e.g., HIV testing and counseling and drug treatment referrals) 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 IDUs, the District was prevented by Congress from using its own funds for DC NEX from 1999 until December 2007. In the wake of congressional action enabling local funding of DC NEX in late 2007, the District's leaders swiftly demonstrated their support for this important intervention. Eight days after the President signed the bill, Mayor Fenty, Dr. Hader, and several Council members announced that \$650,000 in local funding would be appropriated for DC NEX. In recognition of their rapid and vocal response, DC Appleseed raised the

grade in this area from a "B+" to an "A-" in the *Fourth Report Card*.

Since the ban was lifted, the District has expanded its NEX program by partnering with four CBOs that conduct syringe exchange. This effort has led to a substantial increase in the numbers of needles being exchanged. The importance of this initiative extends beyond fighting the transmission of HIV/AIDS by providing clean needles for injection drug users. Syringe exchange programs ("SEPs") also provide a safe, non-judgmental environment where IDUs are tested for HIV, referred to medical, mental health or substance use, treatment, and provided condoms. According to HAA, between October 2008 and June 2009, DC NEX has exchanged 209,048 needles, referred 1,490 clients for testing, referred 278 IDUs to drug treatment and detox, and distributed 214,000 condoms.

DC Appleseed commends the District's approach to integrate comprehensive syringe exchange services with ongoing ancillary services to substance users. Nevertheless, it is imperative that HAA, as part of its strategic plan development, determine if an adequate number of syringes are being distributed to IDUs in DC. While the District government deserves credit for expanding syringe exchanges to roughly 300,000 syringes per year, a review of SEPs in other cities indicates that cities of comparable size carry out substantially larger and more comprehensive exchange programs than the District provides. Until the current federal ban on expenditures for SEPs is removed, the District must commit scarce local resources to ensure the continued viability of these important DC NEX programs. IDUs still account for about 15 percent of HIV/AIDS cases in the District, which argues for a stronger focus on this high risk group.

Other SEPs in cities of comparable size are exchanging far more syringes than in DC. San Francisco exchanged 2.3 million needles in 2008. Along with syringe exchange, the San Francisco program distributes about 4,000 condoms per week. San Francisco relies heavily on volunteers and its effort has led to a substantial reduction in new HIV infections among IDUs.

Baltimore exchanged about 400,000 needles on a budget that was 30 percent higher than

the District's FY2009 budget. Philadelphia saw its IDU HIV rate drop from 33 percent to 16 percent between 1995 and 2005. The city currently is exchanging roughly 1.5 million needles per year. DC Appleseed believes a major expansion of the District's program will be required before we can expect to see a reduction in the HIV/AIDS rate among IDUs.

The DC NEX is comprised of four programs: PreventionWorks, Bread for the City, Helping Individual Prostitutes Survive ("HIPS"), and Family and Medical Counseling Services ("FMCS"). All programs are funded grants HAA. While FMCS and PreventionWorks account for 96 percent of the volume of exchanged syringes in the District, the rapidly expanding ancillary services being offered by the other programs make them important as well. Notably, the volume of syringes exchanged, as well as the enrollment numbers at all four of the programs, is expanding steadily.

HAA has reported that PreventionWorks, the largest program in the city, has a 91 percent return rate for dispensed needles, and has distributed a commendable 130,000 needles this past program year over the course of 6,140 transactions. Since the *Fourth Report Card*, Prevention Works has opened a new harm reduction center.

FMCS also is expanding its patient base and service offerings. The program has exchanged roughly 80,000 syringes since October 2008, referred 104 people to detoxification programs, and sent another 54 to drug treatment programs. FMCS does more than simply provide referrals; the program takes willing patients to the programs for treatment. We also note that FMCS is expanding its HIV service offerings, and has performed 724 HIV tests over the past year.

Bread for the City is making significant strides in offering comprehensive harm reduction services to District residents. The major strength of this program is its medical clinic, which provides general medical care and advice. Bread for the City medical professionals also have integrated into their general medical care program the distribution of Naloxone (overdose prevention medication) kits to patients determined to be candidates for overdose. Importantly, the other three SEPs can refer patients to the Bread for the

City program for a Naloxone kit, as well as other medical care services.

The HIPS program, like Bread for the City, has similarly made positive efforts in expanding the services offered to District residents; in HIPS' case, particularly to prostitutes. The HIPS program caters to a unique patient base, one that is necessarily transient and that operates primarily at night. Because of that, the syringe return volume is quite low.

The "B+" grade on this *Fifth Report Card* reflects the expansion in the DC NEX by CBOs that was made possible by District initial funding; however, the slight reduction in the grade is due to the need for further expansion and funding, in light of research related to other jurisdictions. The 2010 budget of dollars allocated to syringe exchange is the same amount initially allocated in 2007. A continued expansion of syringe exchange effort will be required if the District hopes to significantly reduce new infections among IDUs. Future grades will be strongly influenced by progress towards meeting this objective.

## SUBSTANCE ABUSE TREATMENT: B

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

In our initial report, DC Appleseed noted that a successful substance abuse program is a critical element of an effective response to the HIV/AIDS epidemic. A substantial portion of new HIV cases in the District are still attributed to shared needles and many more may be attributed to high-risk sexual behavior associated with substance abuse.

In DC Appleseed's *First* and *Second Report Cards*, the District received a D+ due to its inadequate provision of services related to substance use treatment. Since Senior Deputy Director Tori Fernandez-Whitney has assumed charge of the agency, the grades have steadily increased. We commend her on the progress made. On this *Fifth Report Card*, DC Appleseed again gives the District's efforts on substance abuse treatment a grade of "B."

APRA has continued to demonstrate its commitment to improving access to substance abuse prevention and treatment services. APRA recently received a Strategic Prevention Framework/State Incentive Grant (SPF SIF) award from the Substance Abuse and Mental Health Services Administration (SAMHSA) for more than \$2 million annually until June 30, 2013. The District will use the SPF SIG award to develop and sustain a culturally sensitive substance abuse prevention delivery system; develop and implement a data and evaluation system; conduct capacity building; and implement a substance abuse prevention planning process. As part of these efforts, APRA has already issued a request for application (“RFA”) for substance abuse prevention centers in the District. APRA expects to provide up to \$840,000 annually to support four prevention centers for children and youth in the District.

In addition to the new prevention grants, APRA continues to finance treatment services in the city. As of July 13, 2009, APRA served 4,068 residents through the Access to Recovery (ATR) program, which now also provides recovery housing to 100 individuals. ATR, which provides supportive housing for six months, intensive case management services, and education or job readiness support, prioritizes individuals with a history of incarceration in allocating the available housing. Of the four housing providers participating in the ATR program, one focuses on housing for women and children.

APRA also continues to provide treatment services through the New Communities Initiative, which helps residents living in physically and economically distressed areas access substance abuse treatment through remote intake services and four different community sites. The initiative screened 27,879 residents for substance use problems, completed substance abuse assessments for 689 people and referred 677 for detoxification or treatment in FY2008. To date in FY2009, 6,530 individuals have been screened for substance use disorders, 121 have undergone substance use disorder assessments, and 121 have been referred for detoxification or treatment. APRA has enrolled 1,700 people in a program that provides vouchers for individuals to seek treatment and recovery support services, and

hopes to serve 3,238 individuals by the fall. The agency also plans to expand the clinical services covered and provide recovery housing by the fall. In addition, APRA continues its collaboration to conduct screenings at the DC Superior Court.

APRA also made significant progress since our *Fourth Report Card* in expanding access to treatment services for adolescents. The District’s Medicaid program covers Early Periodic Screening, Diagnosis and Treatment services for children, but until recently the benefit was not being used to provide adolescent substance abuse treatment services. In the past year, APRA developed the Adolescent Substance Treatment Expansion Program (“ASTEP”), which allows youth enrolled in Medicaid to participate in the treatment program of their choice. APRA staff noted that four providers are currently participating in the program, but they expect all nine adolescent service providers will be participating in the near future. Because the federal government covers 70 percent of the costs for participating Medicaid beneficiaries, the District will be able to leverage local funding to support treatment for more youth or, possibly, to provide case management services that are not supported by Medicaid.

The substance use treatment units, which are funded through the DOJ Residential Substance Abuse Treatment (“RSAT”) grant at the DC Jail and the CTF, continue to expand. The therapeutic community units are full, and the male program has increased its capacity from 60 to 72, including eight men as mentors. The female unit at CTF has a proposal to increase the capacity to 40, which would include ten inmate mentors. The RSAT program is also in the process of expanding its staff from five to ten, and hiring clinicians with masters-level credentials. In addition, the RSAT program received a two-year full certification in April 2009 from APRA and currently is preparing to apply for American Correctional Association accreditation under the performance-based standards for therapeutic communities. Furthermore, the DC Jail’s Opioid treatment program, which provides Methadone or suboxone, to inmates, has been certified by APRA and SAMSHA.

DOC has facilitated a partnership with the United States Parole Commission (“USPC”) and the Public Defender Service (“PDS”)

with an MOU pending signature. This MOU would place the revocation of parole in abeyance to permit certain USPC inmates to complete 90 days of residential treatment in RSAT, followed by six months RSAT-approved residential and transitional aftercare programs, rather than revocation with transfer to a Bureau of Prison facility.

We commend the RSAT program for its ongoing efforts to help inmates re-enter the community after successful completion of the program. Currently, the RSAT program is conducting a pilot program for inmates diagnosed mental health conditions. The pilot project uses the case conference model to assist in discharge planning and provide referrals to recovery support services providers in the community, along with a 30-day voucher from APRA to pay for those services. External agencies such as DMH, DOH, University Legal Services and other community providers participate in the case conference.

As we reported in our *Fourth Report Card*, we are especially impressed that again during our visits to the program, inmates have overwhelmingly positive comments. The inmates described learning important life skills from outside speakers, such as patience, anger management, and parenting skills, as well as HIV and Hepatitis B prevention. Female inmates described the program as a self-help effort that uses films, reading and writing materials to assist women to help themselves. At least one inmate reported that previously she had not been able to get into a detoxification center without a referral, and so was grateful to have access to the treatment she needed while in the jail as well as a referral at the end of the program.

Not only has APRA continued to expand access to care through its programs, but it also has been increasingly dedicated to evaluating its programs to ensure that they are providing effective services to those who need them most. By October, APRA expects to finish implementing a client information system called the Web Infrastructure for Treatment Services ("WITS") to facilitate the use of evidence-based medicine to develop treatment plans for patients in the Detox center and to track and report clinical outcomes. APRA will determine if its current staffing levels are adequate or if additional licensed

and credentialed staff need to be hired to support expanded evaluation activities. The Director of Performance Management is also developing ways to incentivize the providers that have agreements with APRA to improve clinical outcomes to improve the transition between different levels of care.

Despite these accomplishments, one major weakness in APRA's continuum of substance abuse treatment services remains: the Detoxification Center. In fall 2008, APRA commissioned a formal evaluation of the Detox Center to identify areas for business and clinical improvement and to address deficiencies in care. This study, conducted by Dr. Peter Luongo between October and December 2008, found that the Center is inefficient, costly, and clinically outmoded.

The Detox Center currently operates 80 beds and spends \$5.6 million per year. The average length of stay for patients is more than eight days per admission, nearly double the average four-to-five day length of stay in most similar programs. This means that the Detox Center is spending more money per patient than in the typical program and is not able to serve as many patients as expected. Annual admissions to the Detox Center fluctuate from 1,800 to 3,200, but if the average length of stay were reduced to four or five days, the Detox Center could serve 3,900 patients. Dr. Luongo compared the APRA facility to a similar 60-bed program that includes an intermediate care program and spends 27 percent less per bed and concluded that APRA is overpaying for detoxification services by approximately \$2 million per year. Moreover, Dr. Luongo found that in his one week sample of admitted patients, 52 percent had been seen multiple times at the Assessment and Referral Center ("ARC") and 40 percent had an average of almost two prior admissions to the Detox Center. This finding suggests shortcomings in clinical programming, discharge planning and retention of patients in the community continuum of care. Dr. Luongo also reported serious problems in the standard of care provided. Many of the staff do not meet the minimal professional competencies required for work at a detoxification center.

In order to address these shortcomings, APRA Senior Director Tori Fernandez-Whitney described to DC Appleseed several important

reforms that APRA already has undertaken. First, APRA has issued an RFA for a private organization to take over the operation of both the Detox center and the ARC. The RFA includes incentive payments that will provide a 2 percent penalty or up to a 3 percent incentive payment for the vendor, depending on compliance with the RFA performance standards. Performance standards will be tracked through the newly developed WITS system, which is expected to be operational later this year. Applications are due on August 10, 2009, and APRA expects to award the contract by mid-October. APRA anticipates there will be significant cost savings achieved through the privatization of these services, approximately \$2 million annually, and the number of clients served in both facilities will be increased. The savings will be reinvested into the service delivery infrastructure and used to provide appropriate oversight by APRA.

Ms. Whitney also reminded DC Appleseed of the very real problem of relapse in all substance abuse treatment services. She indicated that APRA was trying to extend patients' time in contact with the system through more widespread use of the case management model to improve discharge planning from the Detox Center and reduce the rate of relapse. APRA plans to conduct an evaluation of the New Communities Initiative and to assess concerns that patients are being referred to the District's Detoxification Center unnecessarily, when other lower levels of care are more appropriate. Ms. Whitney reported to DC Appleseed that the community host sites are paid for each referral to the DetoxCenter, and the Detox Center has been found to admit people who do not actually need detoxification services. These evaluation efforts are especially important in today's limited funding environment.

DC Appleseed is encouraged by reports that many of the APRA programs that target vulnerable, underserved populations such as prisoners, adolescents, and residents of economically and physically distressed communities, continue to increase their enrollment. In addition, APRA has demonstrated its commitment to providing cost-effective services by enhancing evaluations of its programs and obtaining additional federal grants. Furthermore, DC Appleseed is encouraged by

the implementation of the recommendation to privatize the ARC and Detox Center. We anticipate a further increase in the District's grade if the positive outcomes of these measures can be achieved.

## HIV/AIDS AMONG THE INCARCERATED: A

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

In DC Appleseed's 2005 report, we recommended that the District implement routine HIV testing at the DC Jail, improve collection of HIV and AIDS data among the incarcerated, ensure that HIV-positive inmates receive medications upon discharge, and work to improve discharge planning services.

At the time of the *Fourth Report Card*, DOC had made commendable progress in implementing the recommendations from DC Appleseed's 2005 report, which was reflected by the "A" grade. The *Fourth Report Card* noted that DOC had continued its "automatic" HIV testing program for over two years, and had contracted with Unity Health Care ("Unity") to provide comprehensive health services, including discharge planning, at the District's detention facilities under a community correctional care model. DOC also had made significant progress toward ensuring that HIV-positive inmates receive their medications upon discharge and had started to use AIDS Drug Assistance Program ("ADAP") funding to provide medications to inmates at discharge. This *Fifth Report Card* finds that DOC has continued its progress on all of these measures, providing critical health services to DC's inmates and to the DC community at large.

DOC's "HIV Automatic Testing and Counseling Program" continues to operate successfully and is considered a national model, replicated by other correctional systems. In addition, the CDC 2009 guidelines for testing in correctional facilities recommend a program similar to the DC Jail program. Under DOC's HIV testing program, all inmates are offered voluntary, rapid HIV testing upon intake. Inmates who refuse test-



ing at intake are offered the test the following day and may request to be tested at any time during sick call. Once staff learns the results of the preliminary HIV rapid test, inmates who test positive receive an immediate referral to a staff doctor for additional care, as well as the opportunity for counseling.

Since Unity assumed responsibility for the testing program on October 1, 2008, it has provided testing to 87 percent of inmates. Of the remaining 13 percent, Unity reports that 10 percent decline testing, but this figure includes inmates who have been tested in the prior 30 days who would not be appropriate to retest. It also includes a number of inmates who tell the medical staff that they are HIV positive. The remaining 3 percent are those inmates not tested because DOC records show they are HIV positive, and a very small group of inmates who are inadvertently not tested at intake. This testing program continues to provide critical data on the rates of HIV infection among the incarcerated and helps DOC to provide opportunities for treatment and prevention to this historically underserved population. In addition to improving the health of individual inmates, these steps are helping to reduce the spread of HIV in the community.

In the *Fourth Report Card*, DC Appleseed recommended that DOC revise its 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. Additionally, inmates transferred to a DOC facility from the Federal Bureau of Prisons would already have been tested through the federal system and would not need to be tested again. DC Appleseed continues to recommend that DOC modify its electronic systems so that the reasons an inmate is not tested can be properly recorded. Such a system will likely explain why a certain percentage of inmates are not tested, eliminating any suggestion that DOC's automated testing program does not reach the full inmate population. We understand that DOC plans to implement this change in the near future.

DOC and Unity have developed effective case management and discharge planning services which identify inmate needs and

ensure continuity of care. Within 24 hours of intake, all inmates meet with one of 12 discharge planners available at the jail to assist inmates with their transition back to the community by addressing their health care and social service needs. Two specific discharge planners are designated for HIV positive inmates and work to assess these inmates' needs post-release, including medical insurance, medications, food stamps, appointments with primary care, HIV care and mental health providers, housing assistance, employment and vocational training, and substance abuse counseling services.

Six case managers assist in the discharge planning process by working to connect HIV-positive inmates with care and support in the community. Before an inmate is discharged, discharge planning staff will set up any appointments the inmate needs with health care providers and will arrange for a limited supply of medications. The case managers attempt to verify that former inmates attend their scheduled appointments for follow-up care in the community. Overall, DC Appleseed is pleased with case management and discharge planning services provided by DOC. By addressing the unique needs of DC's HIV-positive inmates upon their release, this program helps to improve the health of the whole community.

In addition, DOC continues to use ADAP funding to provide a 30-day supply of medications to HIV-positive inmates upon discharge. For October 2008 to March 2009, DOC received reimbursement from ADAP for drugs provided to 97 inmates totaling \$102,400. DOC reports that medications are consistently being provided to all inmates in need of it. If an inmate is released without obtaining medication, DOC and Unity staff makes every effort to find that individual and deliver medication to him or her. DC Appleseed commends DOC's success in providing inmates with HIV/AIDS access to medications upon release.

Through additional collaboration with HAA, DOC makes condoms available to inmates throughout their stay at the Jail as well as upon release. Inmates can obtain condoms at any time via a sick call. DC Appleseed commends DOC's policy of making condoms available to inmates at the Jail. However, as noted above, condoms are not available

at the CTF according to CCA policy. DC Appleseed strongly recommends that DOC leaders have discussions with CCA leaders regarding this policy. It is essential that these inmates have access to protection against the transmission of HIV/AIDS and other STDs while incarcerated

In recognition of the District's continued progress in the provision of HIV/AIDS services to the incarcerated, the District has earned an "A."