

HIV/AIDS IN THE NATION'S CAPITAL

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

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

This *Seventh Report Card* looks for the first time at Housing and at HIV Treatment and Care, two critical issues in the District's response to the epidemic. The Report Card also draws attention to new data reported in HAHSTA's 2011 Annual Report that may be cause for concern.

REPORT CARD

NO. 7

MARCH 2011 to
JULY 2012



GRADES (A-F)

LEADERSHIP

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

B

PARTNERSHIPS & COLLABORATIONS

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

A-

HIV SURVEILLANCE

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

A-

GRANTS MANAGEMENT

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

B+

MONITORING AND EVALUATION

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

B-

HIV TESTING

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

A-

CONDOM DISTRIBUTION

Continue to expand condom distribution in the District.

A-

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 public education in the District.

OSSE: B-
DCPS: B+
CHARTER: C

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.

B+

SYRINGE ACCESS SERVICES

Continue to fund syringe 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.

B

SUBSTANCE ABUSE TREATMENT

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

B+

HIV/AIDS AMONG THE INCARCERATED

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

A

HIV TREATMENT AND CARE

N/A

HOUSING

N/A

EXECUTIVE SUMMARY

BECAUSE THE NEED IS STILL SO GREAT, MORE IS EXPECTED

Seven years ago, DC Appleseed published its report, *HIV/AIDS in the Nation's Capital; Improving the District of Columbia's Response to a Public Health Crisis*. Initiated at the request of the Washington AIDS Partnership and with the support of then-Mayor Anthony Williams, DC Appleseed and Hogan Lovells US LLP examined how the District government was managing the City's HIV/AIDS epidemic. DC Appleseed took on this role because of its independent reputation for investigating issues, publicly issuing its findings and recommendations, and advocating for and implementing necessary reform. As part of that on-going effort, DC Appleseed releases periodic report cards assessing the District's progress.

Purpose of DC Appleseed's Report Cards

This is the *Seventh Report Card* assessing progress made by the District since the initial report. The report cards have several goals: monitoring progress, highlighting areas for improvement, providing education regarding HIV/AIDS, and focusing attention on the epidemic. They also serve to recognize and encourage the progress and good work that the District government is doing as well as to bring attention to areas where more resources are needed.

With each set of grades, District officials often feel that some grades are too low and community stakeholders often feel some are too high. But everyone agrees that more needs to be done in the District to fight HIV and AIDS. As Dr. Gregory Pappas, Senior Deputy Director at the DC Department of Health ("DOH") HIV/AIDS, Hepatitis, STD, and TB Administration ("HAHSTA"), said on the Kojo Nnamdi show discussing the *Sixth Report Card*, "Even if the District got all A's, we still wouldn't be doing enough to address this epidemic."

He is absolutely right. As things improve, we need to raise the bar, because good isn't good enough. The purpose of the report cards and the grades is to spur necessary action to keep improving the District's response given the current state of the epidemic.

DC Appleseed's Approach to Grades

For each section of the report card, DC Appleseed collected information from government officials, HIV/AIDS service providers, and advocates in order to assess trends, progress, and concerns. The "grade" for a section attempts to encapsulate the District's effort to achieve results, address concerns, and implement best practices. An "A" does not mean the District should be satisfied that it has done all it can. An "A" reflects that significant progress has been made in an area since the 2005 report and that markedly better results have been achieved in that area. There is no formula for grade assignment. It's a balancing act between the glass half empty and the glass half full, with the "grade" recognizing progress achieved while highlighting the need for further improvement. Ultimately, the goal of the grades is to spur more and better action in effectively and appropriately addressing HIV/AIDS.

We are grateful to the District for the cooperation we received in producing this report card and for the commitment of District officials to implement recommendations. They recognize that the report card is a tool for change. Over the years the report cards have reported the significant improvements that have taken place. The District's response to HIV/AIDS has gone from disarray to being a national leader in many areas. But as Dr. Mohammad Akhter, Director of DOH, said at the June 20, 2012 release of the District's 2011 Annual Report, "We have a long way to go."

Current State of the Epidemic in the District

The Executive Summary of the District's 2011 Annual Report states that "[t]his report heralds a new era in reporting," and that "[t]his new era report provides the District's leadership and community the vital data necessary to drive a modern response to the city's multiple epidemics."

A longstanding priority of DC Appleseed's has been for the District to compile and release data on the HIV epidemic – data that would allow the District government and the public to measure the progress being made and to better target available resources. The 2011 Annual Report is a very useful tool for these purposes, and DC Appleseed commends HAHSTA for the significant progress that has been made in surveillance (detailed in the Surveillance section of this report card).

DC Appleseed also has encouraged the District to report on the incidence of new infections. Such data are the most precise means to assess whether the District's efforts are helping to control the epidemic's spread. We understand that the science may not be available yet to measure incidence accurately at a jurisdictional level and that surrogate markers should be considered to assess the impact of prevention measures being implemented.

Even though incidence data are not yet available, the data that are available in the 2011 Annual Report show that Dr. Akhter is right – we have a long way to go. For example, as Don Blanchon, Executive Director of Whitman-Walker Health noted in the June 28, 2012 Metro Weekly, there are troubling data in the 2011 Annual Report: “There are three numbers that show cause for concern, meaning our work is not done... One is the 835 people last year who were newly diagnosed with HIV. A second is 207 deaths from AIDS-related causes last year. The third is the statistics showing that, from 2005 to 2009, only 29 percent of HIV-positive people achieved full suppression of their viral loads, meaning there’s less risk of transmitting the virus.”

DC Appleseed found three additional numbers in the 2011 Annual Report further indicating that more must be done. Data reported on the HIV transmission rate, the number of new HIV (not AIDS) diagnoses, and the proportion of late testers are not yet showing the decreases we would want to see. While recognizing that these statistics have not been reported on long enough to show any conclusive trend, they are important markers to monitor going forward. And they indicate that the needed progress has not yet been achieved.

DC Appleseed recognizes that these data report only up to the end of 2010 and do not yet reflect the results of the work of the current administration. But these are troubling trends, and they highlight why DC Appleseed has continued – particularly in this report card – to call for more to be done.

Seventh Report Card Grades

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

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

- **Leadership (maintained grade of “B”):** Mayor Gray has brought renewed attention to the epidemic and established the Mayor’s Commission on HIV/AIDS to lead the District’s response to the epidemic. The District’s grade for Leadership is being kept at a “B” awaiting real impact and results from the Commission and DOH’s work. In this *Seventh Report Card* almost all sections maintained their grades from last year. The Leadership grade should increase when there is significant progress and grade increases throughout the sections of the report card, an indication that leadership is having an impact on the epidemic. A key test on whether leadership is having the needed impact will come next year when the District’s 2012 Epidemiology Report measures progress in reducing the number of new HIV cases.
- **Partnerships & Collaborations (maintained grade of “A-”):** The District has developed and sustained strong interagency collaborations and developed partnerships with other stakeholders in the community.
- **HIV Surveillance (maintained grade of “A-”):** HAHSTA’s academic partnership with George Washington University School of Public Health (“GW”) continues to be strong, and surveillance staff are recognized nationally for their leadership and for advancing the use of epidemiologic data to engage and retain people with HIV in the care and treatment continuum and to monitor improvements in their health. Ongoing staff vacancies cause concern that the progress may not be sustainable and may further delay reporting HIV incidence. The 2011 Annual Report was released June 20, 2012 and included for the first time reports on HIV (not AIDS) cases as the District’s name-based reporting system met Centers for Disease Control and Prevention (“CDC”) quality standards.

- **Grants Management (increased grade from “B” to “B+”):** HAHSTA continues to improve its timeliness in paying provider invoices and has reduced remediation and corrective action plans by improving communication with subgrantees. There is still room for improvement, as providers continue to report burdensome paperwork.
- **Monitoring & Evaluation (maintained grade of “B-”):** Since 2009 HAHSTA has been developing Maven, a comprehensive system that should simplify and improve data collection, analysis, and reporting. Ambitious plans and lingering staff vacancies have contributed to delays in the launch of the system. Maven will mark a turning point in targeting dollars and efforts to effective programs.
- **HIV Testing (decreased grade from “A” to “A-”):** The number of public-supported HIV tests continued to rise, totaling 122,356 in FY 2011 (an 11 percent increase over FY 2010). The District also has continued partnerships that offer testing in non-traditional locations. For the second year in a row, however, providers have reported unstable availability of testing kits, a difficult situation which was compounded by HAHSTA’s transition from oral to finger-stick testing. HAHSTA should improve timely communication with providers and ensure the availability of sufficient test kits.
- **Condom Distribution (maintained grade of “A-”):** HAHSTA reports that the District distributed 4.6 million condoms in FY 2011 (15 percent increase over FY 2010). And the successful DC Female Condom Project public-private partnership continued. For the second year vendor delays resulted in shortages in condoms, which we hope will be reduced in the future.
- **Public Education**
 - **Office of the State Superintendent of Education (“OSSE”) (increased grade from “C-” to a “B-”):** After years of delay, OSSE has made significant progress in assessing the efforts and effectiveness of schools in meeting the Health Learning Standards. OSSE reported to the DC Council on findings from the 2011 School Health Profiles and included a Health and Physical Education Assessment as part of this year’s standardized tests. No other jurisdiction conducts standardized tests for health and sexual education. OSSE also administered the Youth Risk Behavior Study successfully. More needs to be done in system-wide professional development and capacity building, and we will monitor progress in those areas in future years.
 - **DC Public Schools (“DCPS”) (maintained grade of “B+”):** DCPS continues to make progress in curriculum development, teacher training, and parent and community outreach programs.
 - **Charter Schools (increased grade from “Incomplete” to “C”):** There remains a dearth of information by which to assess the effectiveness, and even the existence of HIV/AIDS education in charter schools. The available information indicates that charter schools as a whole lag behind in many areas related to HIV/AIDS. Despite the Health Schools Act (“HSA”), the Public Charter School Board (“PCSB”) presently does not view health education as a core subject and does not require charter schools to adopt HIV/AIDS curricula or professional development. However, PCSB has identified opportunities to increase resources for public charter schools.
- **Youth Initiatives (maintained grade of “B+”):** HAHSTA continues to expand collaborations among city agencies and implement an ambitious Youth HIV Prevention Plan focused on expanding testing, utilizing social marketing to provide information, building capacity among youth organizations, and interrupting infections through large-scale initiatives. The new plan also includes strengthening data collection, which is important for improvements to planning efforts. Though HIV prevalence may be low among youth, high levels of sexually transmitted diseases (“STDs”), early sexual activity, and concurrent partnerships indicate the urgency of continuing to focus attention on District youth.

- **Syringe Access Services (“SAS”) (maintained grade of “B”):** After the closure of one of the major syringe access programs in 2011, HAHSTA quickly redirected that program’s grant to the two large programs remaining – Helping Individual Prostitutes Survive (“HIPS”) and Family and Medical Counseling Service (“FMCS”) – both of which were able to expand outreach and service delivery. This helped increase the total number of syringes provided by the programs funded by the District, but other figures indicate fewer client contacts and minimal increases in HIV testing and referrals. HAHSTA increased the funding available for DC Needle Exchange (“DCNEX”) and harm reduction services from \$580,000 to \$920,000 in the next grant cycle.
- **Substance Abuse Treatment (maintained grade of “B+”):** Since the *Sixth Report Card*, the DC Addiction Prevention and Recovery Administration (“APRA”) has experienced several changes in leadership. Throughout these changes, APRA has continued to secure federal funding to support its services. APRA also recently received approval for Medicaid funds to be used to pay for Adult Substance Abuse Rehabilitative Services. DC Appleseed looks forward to seeing continued growth and strengthening with stable leadership restored at APRA.
- **HIV/AIDS Among the Incarcerated (maintained grade of “A”):** Despite financial challenges, the Department of Corrections (“DOC”) has sustained its performance on HIV testing, treatment, and prevention among the incarcerated, and has implemented further improvements. To improve continuity of care, DC Appleseed recommends that the DOC and DOH work together to track linkages to care of inmates after discharge. In this report card, DC Appleseed includes an ungraded overview of federal correction facilities and the HIV treatment and services available to District inmates.

This *Seventh Report Card* includes new sections on Housing and on HIV Treatment and Care. These two sections are intended to give a brief overview of the importance and status of these two important issues in addressing the HIV/AIDS epidemic in the District. These sections are not graded but DC Appleseed intends to monitor progress in both these areas and assign grades in the next report card.

- **HIV Treatment and Care:** This section describes various sources of funding for HIV/AIDS medical care, gives a broad overview of services available in DC, describes recent research on the benefits of HIV treatment in preventing transmission, and provides background on how health care reform may impact HIV treatment and care. In future report cards, DC Appleseed will monitor the District’s progress in providing treatment options and improving health outcomes, as well as the District’s efforts to integrate HIV care and funding with its overall health care reform efforts.
- **Housing:** Stable housing is critical to HIV/AIDS prevention and care. It affects access to care, treatment adherence, maintenance in care, and the improved health of people living with HIV/AIDS. Homelessness and unstable housing also are associated with risky behavior and poor health outcomes. This section gives a general overview of housing resources for people with HIV/AIDS in the District. In future report cards we will monitor progress in meeting the housing needs of people living with HIV/AIDS and District initiatives to use limited resources more efficiently.

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

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

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

SEVENTH REPORT CARD

JULY 2012

LEADERSHIP: B

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

DC Appleaseed'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. In the *Sixth Report Card*, DC Appleaseed described the significant progress made under the administration of Mayor Adrian Fenty in strengthening the District's response and cited concerns that in the last year of his administration, grades had declined and there was a lack of progress in many important areas. We noted that Mayor Vincent C. Gray had assumed leadership at a critical juncture in the District's fight against HIV/AIDS, with the opportunity to build on the significant progress that had been made and jumpstart progress in areas that had been stagnant or already had begun to decline.

Though Mayor Gray has brought renewed attention to the epidemic and established a Commission on HIV/AIDS to guide his administration's response to HIV/AIDS, the District's grade for Leadership is being kept at a "B," awaiting real impact and results from the Commission's and DOH's work. In this *Seventh Report Card* almost all sections maintained their grades from last year. The Leadership grade should increase when there is significant progress and grade increases throughout the other sections of the report card, an indication that leadership is having an impact on the epidemic. A key test of whether leadership is having the needed impact will come next year when the District's 2012 Epidemiology Report measures progress in

reducing the number of newly reported HIV cases.

A review of local media coverage of HIV/AIDS shows that since taking office, the Mayor has spoken publicly and has participated in a number of events related to HIV/AIDS. He commented on the release of HAHSTA's 2010 and 2011 Annual Reports and publicly was tested at Bread for the City – a community-based medical clinic – on National HIV Testing Day in 2011, and spoke of the National HIV/AIDS Strategy ("NHAS") at his State of the District address. He announced a new District campaign using social networking to encourage HIV testing, and a public-private partnership which offers testing at Emergency Services Administration ("ESA") centers (described in the HIV Testing section). He attended several events throughout the community recognizing World AIDS Day, including volunteering at Food & Friends, attending a candlelight vigil in Dupont Circle hosted by Whitman-Walker Health, and issuing a proclamation declaring "World AIDS Day 2011." DC Appleaseed encourages the Mayor to continue raising awareness of the HIV epidemic at public events throughout the year.

The District will be hosting the XIX International AIDS Conference later this month. To help the District prepare for this important event, the Mayor has assembled a Host Committee to work with the International AIDS Society, and advise the Mayor, DOH, and HAHSTA on issues and matters relating to this event. Members include current and former representatives from District government, as well as leaders in the business community, healthcare field, and the hotel and restaurant industry. The Mayor's Office, the Council, and District agencies also have been working with the DC Community Coalition for AIDS 2012 ("DCCC"), the official Local Citizens' Host Committee for the Conference. The DCCC is using the conference as an opportunity to raise HIV/AIDS awareness in the community and work with District government to improve accountability of District leaders with responsibilities for HIV/AIDS.

Since the last report card, two pieces of legislation related to HIV/AIDS were passed by the DC Council, under the stewardship of Committee on Health Chair, David Catania.

One was the HIV/AIDS Continuing Medical Education Amendment Act of 2011, which establishes continuing education requirements for physicians, physician's assistants, and nurses on issue related to HIV and AIDS. The other is the Senior HIV/AIDS Education and Outreach Program Establishment Act of 2011, which will train seniors to serve as peer educators and to require DOH to administer the program. Both are scheduled to go into effect by late July. In addition, an HIV/AIDS treatment module was added in December 2011 to the academic detailing program created under the SafeRx Amendment Act of 2008. The new module offers evidence-based, unbiased education to Medicaid providers on HIV/AIDS treatment, pharmaceuticals, and post-exposure prophylaxis.

Two key leadership positions under DOH that are vital for the HIV/AIDS fight are the Senior Deputy Directors of HAHSTA and of APRA. Although the position at APRA was filled April 2011, the appointment lasted only until October. The agency then had interim leadership until the appointment of Dr. Saul Levin in March 2012. DC Appleseed hopes that Dr. Levin, an experienced and qualified psychiatrist, will build on the progress that has been made at APRA. At HAHSTA, Dr. Pappas and his staff continue to maintain the important progress that has been made over the last few years. DC Appleseed hopes to see leadership, vision and sustained progress at both of these critical agencies.

Mayor Gray established the Mayor's Commission on HIV/AIDS to advise the Mayor, the DOH, and HAHSTA on issues and matters related to HIV and AIDS. The Commission was charged with three core responsibilities: (1) Develop evidence-based HIV/AIDS policy recommendations and determine the best way to achieve treatment on demand in the District; (2) Develop recommendations regarding coordination of District-wide HIV/AIDS policy; and (3) Develop recommendations to control the epidemic while simultaneously creating training and employment opportunities in the District.

Commission members include the Mayor, the City Administrator, the Deputy Mayor for Health and Human Services, Council Members David Catania and Jim Graham, directors of several government agencies

central to HIV and AIDS, the US Parole Commission, academic and research institutions, churches, large community health clinics, health advocacy groups, and the DC Chamber of Commerce. DC Appleseed is encouraged to see the involvement of a broad sector of government and community. But the Commission would be stronger if membership included broader HIV expertise and a consumer perspective.

A great deal of focus is on the Commission as the forum for improving the District's response to HIV/AIDS. But after examination of the Commission's 16 months of work, it is not clear that there have been any solid results, in terms of defining a mission, issuing reports, or planning future actions. And some members of the community and the Commission are not clear on the plan, vision, timeline, or authority of the Commission. The Commission has met a total of five times, and each committee has met three times. There had not been a full committee meeting since January. A meeting on July 17 was announced just prior to the release of this report card. The Commission must be more active and aggressive in producing results if it is going to have a positive impact on the epidemic.

The District's grade for Leadership remains a "B." DC Appleseed hopes that over the next year there will be stronger and more informed engagement of members of the Commission resulting in clear results and positive outcomes.

PARTNERSHIPS & COLLABORATIONS: A-

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

Improved interagency coordination has been a priority for DC Appleseed since our original report, when we noted the near absence of collaboration among District agencies to support HAHSTA's response to the District's epidemic. Since then the District has made great progress in improving collaboration and communication among District agencies. Evidence of this can be seen throughout

most sections of this report card. In past report cards, the section on Interagency Collaborations has tended to be repetitive of initiatives detailed in other sections. In this report card, we have revised the section to incorporate a list highlighting interagency collaboration as well as other partnerships detailed in other sections.

Leadership

- As detailed in the Leadership section, the Mayor's Commission on HIV/AIDS includes representatives of key agencies that play a major role in the District's response to HIV/AIDS: DOH, HAHSTA, DCPS, the Department of Mental Health ("DMH"), and DOC.
- The Mayor has assembled a Host Committee (made up of representatives from DC Government, the business community, healthcare organizations and community business organizations ("CBOs"), and the hotel and restaurant industry) to help the District prepare for the upcoming International AIDS Conference.
- The District also has been working with the DC Community Coalition for AIDS 2012 – the Local Citizen's Host Committee for the International AIDS Conference – working to improve accountability in District government.

HIV Surveillance

- As detailed in Surveillance, HAHSTA has continued the academic partnership with GW that has played a central role in the strengthening of surveillance in the District and collaboration on the National HIV Behavior Study Series.
- HAHSTA is participating in HIV Prevention Trials Network research through the Partnership for HIV/AIDS Progress with the National Institutes of Health ("NIH").

Monitoring & Evaluation

- HAHSTA is working with DC Primary Care Association, service providers, and Chief Information Officer ("CIO") to reduce provider reporting burden when Maven is launched.
- HAHSTA is working with the CIO and CDC on data security issues.

- The National Minority AIDS Council ("NMAC") is providing HAHSTA with technical assistance to help them develop provider training tools in collaboration with CDC and the Health Resources and Services Administration ("HRSA").

HIV Testing

- HAHSTA continues to partner with Gilead Sciences, Inc. and FMCS to conduct HIV rapid testing at the Penn Branch office of the DMV and at a DC ESA service center.
- Walgreens Community Pharmacy (formerly BioScrip), in partnership with OraSure Technologies and HAHSTA is providing free rapid testing for HIV and hepatitis C in its District pharmacy.
- HAHSTA partnered with Radio One to promote HIV rapid testing among youth at a free concert.
- HAHSTA is working with the Department of Insurance, Securities and Banking ("DISB") to improve compliance with District law requiring insurance reimbursement for HIV screening.
- HAHSTA is working with DC Human Resources to promote HIV testing of DC government employees by their private physicians.

Condom Distribution

- HAHSTA partners with more than 475 condom distribution community partners, including CBOs and businesses across the District where the public can get free condoms.
- HAHSTA, the Washington AIDS Partnership, the MAC AIDS Fund, and several District CBOs participate in the DC Female Condom Project, a public-private partnership to increase education, awareness, and use of the new generation of female condom.

Public Education in the District

- OSSE collaborated with the State Board of Education to hold community meetings to educate parents about the Health Education Standards and the state of HIV/AIDS education in the District.

- DCPS collaboration with Metro TeenAIDS, Answer (at the Center for Applied Psychology at Rutgers), and Gilead Sciences, Inc. to create a curriculum and improve HIV/AIDS education efforts in the schools.

Youth Initiatives

- HAHSTA's new Youth and HIV Prevention Plan incorporates recommendations from the Youth Sexual Health Project convened by Council Member David Catania and the Committee on Health, and recommendations from HAHSTA's Youth and HIV/STD Work Group comprised of District agencies and CBOs serving young people.
- HAHSTA collaborated with Department of Employment Services ("DOES"), DCPS, OSSE, and CBOs to coordinate HIV education and testing at District Summer Youth Employment Program sites.
- HAHSTA continues to convene its Youth and HIV/STD Work Group comprised of District agencies and CBOs serving young people to guide planning and implementation of its youth initiatives. Over the past year the work group has not met as frequently as it had in previous years. HAHSTA has identified another opportunity to receive broader guidance by convening the numerous components within DOH that focus on youth.

Substance Abuse Treatment

- APRA manages the "12 Cities Project" - a component of National HIV/AIDS Strategy that aims to better coordinate HIV prevention, treatment, and care. APRA works in partnership with HAHSTA and DMH.
- APRA is working with DMH and Psychiatric Institute of Washington ("PIW") to conduct screenings at DC Superior Court.

HIV/AIDS Among the Incarcerated

- DOH, DOC, and Unity Health Care ("Unity") collaborate to provide medical care, conduct routine rapid HIV testing at the DC Jail, and provide medications and discharge planning upon inmate release.

HIV Treatment and Care

- DOH and the District Department of Healthcare Finance ("DHCF") have been

working together to expand Medicaid eligibility.

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

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.

Since DC Appleseed's original report, HIV surveillance in the District has improved significantly and has become a national model. The District received a grade of "A" in three consecutive report cards until last year when the *Sixth Report Card's* grade decreased to an "A-." Although HAHSTA had continued to produce annual surveillance reports, DC Appleseed was concerned about delays in continuing the academic partnership with GW, extended staff vacancies at HAHSTA, and the remaining staff's ability to handle an expanded scope of responsibility for additional infectious diseases. In this *Seventh Report Card*, the grade is maintained at an "A-."

DC Appleseed is pleased to report that the public health/academic partnership contract with GW was renewed for October 2011 to September 2012, and includes two option years for extension through 2014. When it was first established, the public health/academic partnership with GW provided technical assistance for surveillance. As the Strategic Information Bureau ("SIB") at HAHSTA has gotten stronger, the activities of the partnership now focus on strengthening data collection and analysis and expanding research.

SIB staff continue to be recognized nationally for the progress in HIV surveillance in the District over the last several years. Over the past year they have held leadership positions on the Incidence Project working on

national incidence level of HIV, on the CDC Community Viral Load Working Group, and have participated in expert consultations on HIV incidence, data integration, and data related to men-having-sex-with-men ("MSM"). HAHSTA and GW also have published papers and given presentations on DC's progress in surveillance at the Conference on Retroviruses and Opportunistic Infections, the International AIDS Society, the STD Prevention Conference, the HIV Case Definition Conference, and the CDC HIV Prevention Conference. Other jurisdictions are looking at SIB's developing Maven system as a model for data collection.

SIB and GW are working on several important research projects. One is the National HIV Behavior Study Series ("NHBS"). In 2011, NHBS work included publication of the 2011 report on the injection drug user ("IDU") cycle, analysis and reporting on the heterosexual cycle, completion of data collection for the MSM cycle, and initiation of the next IDU cycle. In June 2012, the second heterosexual cycle report was released. The findings indicate that the HIV rate among low-income heterosexual women in the sampled high-prevalence areas increased from 6.3 percent in 2008 to 12 percent in 2010. Data collection for the second IDU cycle will begin this summer.

HAHSTA and GW also are participating in NIH-funded research under the HIV Prevention Trials Network on ways to improve linkage to HIV treatment and care. The HAHSTA participation in the HIV Prevention Trials Network studies is through the Partnership for HIV/AIDS Progress between DC and NIH. HAHSTA participates in the TLC Plus (HPTN 065) testing, linkage to care study and the DC Cohort. HAHSTA provides surveillance data to these studies. They also are participating in research on hepatitis and HIV co-infection.

The District is one of six jurisdictions funded under the CDC's Program Collaboration and Service Integration ("PCSI") initiative to implement a streamlined health system for the prevention, care, and treatment of HIV/AIDS, viral hepatitis, STDs, and TB. This is referred to as a "syndemic" or integrated approach for diseases that share many behavioral, social, environmental, and biological factors. As PCSI implementation proceeds,

SIB is restructuring disease surveillance to a common model, staff, and timeline across diseases.

HAHSTA is at the forefront in identifying how to use epidemiological data to engage and retain people with HIV in the care and treatment continuum and to monitor improvements in their health. It also is interested in assessing how stability in care might prevent HIV transmission. This strategy emphasizes monitoring HIV surveillance in relation to patient care, treatment, and health outcomes. In this integrated public health approach, prevention and treatment data become part of surveillance data. The goal is better linkage coordination and improved management of HIV. This strategy would enable HAHSTA to track follow-up and care. DC Appleseed is encouraged by this effort and will monitor its implementation to assure that it remains consistent with the HAHSTA mission of monitoring surveillance data in the District.

DC Appleseed has long stressed the importance of HAHSTA's development of a system to measure and monitor HIV incidence. Such a system is needed both to assess whether the District's prevention efforts are succeeding and to better target those efforts. In the last report card, we reported that HAHSTA planned to calculate a three-year incidence estimate under the renewed partnership with GW. We also reported that the 2011 HAHSTA Annual Report would for the first time include information on new HIV cases, as DC's HIV data reached recommended CDC maturity levels after switching from code-based reporting to name-based reporting.

The 2011 Annual Report was released on June 20, 2012. It presented for the first time information on HIV cases separate from AIDS cases. This is an important step in understanding the local epidemic and will allow presentation of data by stage of disease; however, it will not provide information on HIV incidence. New HIV cases refer to cases that have not been identified before, and do not by themselves indicate recent infection. CDC's Serologic Testing Algorithm for Recent HIV Seroconversion ("STARHS") has been used at the national level and in other jurisdictions to estimate HIV incidence. However, this algorithm recently has been found to be inaccurate in small populations, and CDC is discouraging its use for estimating local

incidence. Heeding this caution, HAHSTA is working closely with CDC, GW, and other states to decide on the best method to calculate incidence at a jurisdiction level. HAHSTA plans to release HIV incidence estimates in 2013.

Community Viral Load (“CVL”) represents a mean HIV viral load among people with HIV/AIDS in a specified population. It is used to measure viral suppression and HIV transmission potential at a population level. Research is showing that it can be used as a predictor of HIV incidence. CVL also can provide valuable information on drivers of HIV transmission and quality of HIV care. HAHSTA recently published an article on the potential use of CVL for surveillance. It found that “CVL has the potential to serve as a tool for understanding transmission patterns, providing markers of access to care and treatment, and assessing trends in high HIV prevalence areas.” HAHSTA is considering CVL as one possible tool to assist in the measurement of HIV incidence.

SIB reports that the HIV surveillance and monitoring module of Maven is now complete and that HAHSTA hopes to have the system implemented this summer. Delays in the launch of Maven have been detailed in the Monitoring and Evaluation section of this report card. Without the full deployment of this system, the management and reporting of data will continue to be limited.

SIB has built a strong reputation and has significantly improved HIV surveillance in the District since the release of our original 2005 report. Staff’s leadership and participation in conferences, research, and expert consultations, and their innovative use of surveillance as a tool to fight the epidemic represent the progress that the District has made since 2005. DC Appleseed is concerned that continued staff vacancies pose a challenge to the District’s ability to maintain these high standards and are contributing to HAHSTA’s inability to fully launch Maven. SIB has lost two positions over the past year and reported seven vacancies. We look forward to the coming year, in which Maven should be up and running, and in which methods for estimating HIV incidence should have advanced to a stage where a first meaningful data point can be derived. The District grade for surveillance remains an “A-.”

GRANTS MANAGEMENT: B+

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

In FY 2011, HAHSTA awarded \$52,283,108 in grant funds to 70 HIV/AIDS service providers (“subgrantees” or “providers”). HAHSTA continued to utilize new policies and procedures described in the *Sixth Report Card* which are designed to ensure systematic grantee monitoring, such as the A-133 audit policy and remediation plan and corrective action plan policies. In addition to these formal procedures, they report an increased focus on informal day-to-day communication with subgrantees. Because of the continued progress in this area, the District’s grade for Grants Management is increased from a “B” to a “B+.”

Over the years, DC Appleseed has highlighted various concerns about the District’s management and monitoring of grants to subgrantees. These issues have included shortcomings in training grant monitors, overseeing compliance with licensing and certification requirements, conducting site visits, making timely payments to service providers, and competitively awarding grants. This year, HAHSTA has made significant strides in improving its grants management. HAHSTA has implemented training about contractor processes, tracking of provider licenses and certifications, and improvements in the structure and timing of site visits. Although some concerns remain, HAHSTA is responding to weaknesses in its grants management program, resulting in stronger grants management and monitoring practices.

PAYMENT PROCESS

In past report cards, DC Appleseed has expressed concern over the timeliness of HAHSTA’s invoice payments and the soundness of the agency’s invoice tracking procedures. In FY 2011, HAHSTA reported that it had paid 84 percent of its providers’ invoices within the requisite 30-day timeframe. This is up from the reported 72 percent on-time payment rate in fiscal year 2010, although

that figure may be imprecise given errors from manual invoice tracking reports we noted in last year's report card. The provider invoice approval process still requires that the grants management specialist manually enter invoice information into the District's Procurement Automated Support System ("PASS"). HAHSTA reports that at a future date the District Office of the Chief Financial Officer will move away from System of Accounting & Reporting ("SOAR"), a manual system, to an Oracle software suite that is more efficient for tracking activity associated with individual subgrantee purchase orders. Eventually, this may lead to the creation of a new procurement system, but PASS will likely remain the District's procurement system for at least another fiscal year.

The provider invoice approval process clearly delineates all the steps in the payment process and calls for timely processing of invoices. The focus on ensuring timely payment appears to have had a positive impact, as several providers confirmed that payments have been timely. Providers also recommended that HAHSTA eliminate burdensome paperwork and perform more payment functions electronically.

GRANT MONITORING AND OVERSIGHT

Grantee Performance Ratings

HAHSTA has implemented a new grantee performance rating system that measures performance on an individual award level, as opposed to measuring the performance of a provider as a whole, as is the case with HAHSTA's other evaluative instruments. This pilot program began in 2011 and evaluated 63 awards. Of those, two did not get a satisfactory rating and consequently were not awarded funding the subsequent fiscal year. In the future, the performance rating program will be expanded to assess all providers on a quarterly basis. With this evaluation, subgrantee performance is reviewed on three different metrics: financial management, service provision, and reporting & communication. These review criteria mirror requirements set forth in the District's City-Wide Grants Manual and Sourcebook ("Grants Manual"), which provides uniform guidelines

for the city's grant-making entities. HAHSTA assigns a cumulative grade to each provider based on all four quarterly evaluations so that the provider's annual rating takes into account the provider's development over time. The goal of the rating is to determine empirically which providers merit more grant funds, and in which areas of service provision.

A-133 Audit Policy

As described in the *Sixth Report Card*, the A-133 audit policy governs OMB Circular A-133 audits, which are mandated by the federal government for all entities expending \$500,000 or more in federal funds and are performed by an independent accounting firm. There were no grant management-related findings in fiscal year 2011, although this lack of findings could be affected by HAHSTA-reported difficulties in identifying the subgrantees required to complete an A-133 audit.

Remediation Plan and Corrective Action Plan Policies

Our *Sixth Report Card* discussed HAHSTA's remediation plan and corrective action plan policies. These policies seek to address subgrantees' deficiencies in meeting programmatic goals and/or administrative requirements objectively and promptly. A remediation plan is appropriate for routine programmatic deficiencies, whereas a corrective action plan is warranted for egregious violations and shortcomings. This year, HAHSTA mandated a total of 30 corrective action plans. Each plan was resolved and closed satisfactorily for HAHSTA. Although 30 corrective action plans appears to be a large number for one year, the plans appear to function properly to resolve serious deficiencies smoothly and quickly.

License and Certification Requirements

A recurring issue has been HAHSTA's efforts to ensure that all subgrantees are current with license and certification requirements. Last year we reported that HAHSTA had implemented a monthly review of upcoming expirations wherein HAHSTA notifies providers that their licenses or certifications are up for renewal. If a subgrantee does not comply with one or more of the licensing, insurance, or certification requirements, HAHSTA will first communicate the

deficiency informally. If necessary, HAHSTA will escalate to a remediation plan, but the goal is to achieve subgrantee compliance with all legal requirements without interrupting services. According to HAHSTA, all of the 70 subgrantees currently are compliant with applicable certification, insurance, and licensing requirements. This is an improvement over last year's reported full compliance by 69 of 71 subgrantees.

Agency Capacity Assessment Monitoring ("ACAM") Policies

The ACAM program has been in existence for over two years and aims to perform assessments and audits of grantees. In fiscal year 2011, HAHSTA conducted 37 initial assessments and 44 comprehensive site visits. The initial assessment takes place within 30 days of a grant award for first-time HAHSTA funding recipients. At the initial visit, grants management specialists and program officers meet with subgrantees and obtain information in order to categorize the subgrantee's capacity level. After HAHSTA assigns the subgrantee a capacity level, grants management and program monitors collaboratively develop the subgrantee site visit schedule. The comprehensive site visit consists of routine monitoring and a determination whether follow-up assistance and/or a revised site visit schedule are warranted. In addition to these initial assessments, HAHSTA also performed two follow-up visits. The follow-up visits are conducted for low capacity subgrantees between 7-8 months from the initial assessment for new subgrantees, and between 19-20 months from initial assessment for subgrantees in their second year. For moderate and high capacity subgrantees, follow-up visits are conducted on an as-needed basis. Of the providers HAHSTA was scheduled to visit, all received either an initial assessment or a comprehensive site visit. However, only one low capacity provider received a follow-up visit in fiscal year 2011. The second follow-up visit conducted in fiscal year 2011 was to a high capacity subgrantee.

GRANT AWARDS AND RENEWALS

In the *Sixth Report Card*, we reported on progress in HAHSTA's handling of grant renewals. HAHSTA reports additional steps taken in FY 2011 to improve the grant award and renewal process. HAHSTA has implemented contractor training to educate employees about proper contracting processes. The Office of Contracts and Procurement requires all contract administrators to undergo training on procurement and contract monitoring practices.

Another issue raised in the *Sixth Report Card* was preferential treatment and inadequate competition in awarding grants. In response to this issue, HAHSTA took steps to ensure more robust competition by enhancing the composition of its external review panels to evaluate grant applications and requiring approval by the Director of DOH for grant awards. Further, the District's Grants Manual requires a process for conducting competitive grant awards.

CONCLUSION

Weak grants management in the past has been the target of public and press criticism of the District's HIV/AIDS response. Improvements in grant management are very helpful to assuring the public and elected officials that funds are well spent, and toward keeping the focus on the vital public health efforts needed to attack the epidemic. We encourage HAHSTA to continue to improve its grants management and monitoring processes. We recommend that HAHSTA automate its payment process, create a system to identify subgrantees requiring A-133 audits, conduct site visits to low-capacity providers and follow the District's competitive grant processes. In recognition of HAHSTA's sustained progress, the District's grade is raised to a "B+."

MONITORING AND EVALUATION: B-

Implement a 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.

In the *Sixth Report Card*, DC Appleseed reported on the District's ongoing efforts to implement Maven, a monitoring and evaluation ("M&E") program for HIV and AIDS, as well as for hepatitis, STDs, and tuberculosis. DC has been developing Maven since 2009. The District's grade for M&E remains a "B-."

HAHSTA has reported that the average development time for a comprehensive monitoring and evaluation system like Maven is three years. The District's ambitious roll-out strategy in implementing the system combined with significant staff vacancies in the M&E team at HAHSTA caused some delay in the original deployment strategy. The District has formed new collaborations with other successful administrations nationally as well as the CIO for DOH to ensure a phased-in deployment of Maven in FY13. HAHSTA reports that it has developed the infrastructure necessary to monitor and evaluate provider effectiveness since the last report card and that the HIV/AIDS module of Maven is almost complete. However, before the M&E module can be finalized, appropriate infrastructure, a secure environment, and a provider training and roll out strategy must be implemented.

One ongoing project has been the development of a Maven interface from electronic medical record systems currently in production. HAHSTA is working with DC Primary Care Association, providers, and the CIO to build a bridge between eClinicalworks and Maven to reduce the provider reporting burden. Final implementation of the core medical service component of Maven used to monitor and evaluate HRSA services for the HIV/AIDS module awaits the completion of that process. Other components of Maven, however, will be deployed this calendar year including HIV counseling, testing, and prevention; AIDS Drug Assistance Program ("ADAP"); HRSA Support Services; Sexually Transmitted Diseases and Hepatitis surveillance modules.

Maven will collect client-specific data instead of the aggregate service data that HAHSTA currently receives through multiple systems and mechanisms. This should provide HAHTSA with improved monitoring linkages, service provision, client retention, program effectiveness, and health outcomes. It also should facilitate coordination among surveillance, prevention, and care staff members involved in monitoring the impact and outcomes of funded programs. Because Maven implementation requires development of the newly released CDC integrated security and confidentiality guidelines (April 2012), a security mechanism for submitting data through a web-based system while safeguarding client information must be reviewed, revised, and approved to ensure compliance with federal guidelines and the highest standards for client-level data security. HAHSTA is working with the CIO and CDC on data security issues.

HAHSTA's M&E program is intended to ensure that the District is spending money effectively, efficiently, and appropriately. Maven will link program dollars and services to clinical outcomes and is expected to speed the receipt and analysis of data significantly. The rapid processing of surveillance data would help providers and HAHSTA in their prevention and treatment efforts. Maven has been shown in other states to allow providers and policy-makers to see the impact of programs more quickly and to adjust to new information and circumstances. Providers will be required as a condition of their grant award to enter data into Maven monthly or quarterly, depending on the program. HAHSTA currently has in place a successful STD rapid treatment and outreach program and is in the process of extending it to treatment of HIV/AIDS. Because monitoring data will arrive more quickly through Maven, HAHSTA and providers should be able to improve and expedite service delivery and effectiveness.

Implementation of Maven could result in a significant shift in HAHSTA's M&E and funding efforts. Information collected through Maven could result in HAHSTA making changes to providers' funding based on client-specific data or outcomes. To this end, HAHSTA plans an education program for providers on the new M&E program and its potential impact on funding policies. NMAC is

providing HAHSTA with technical assistance to help HAHSTA develop provider training tools in collaboration with CDC and HRSA. The first training tools for testing and ADAP should be available in the summer of 2012. HAHSTA also plans to use NMAC to train providers on an ongoing basis.

There remain a number of vacancies within SIB at HAHSTA, and DC Appleseed remains concerned that HAHSTA will not be able to implement a comprehensive and timely M&E program. The implementation of Maven, which is in many ways the keystone of the M&E program, has taken much longer than anticipated. Its development could be bolstered by the addition of HAHSTA employees, and a Maven data manager is among those positions that were reported to be vacant. DC Appleseed encourages HAHSTA to fill this position as promptly as possible. Once Maven is fully operational, it will require adequate staffing. As DC Appleseed noted in the *Sixth Report Card*, the broadening of the scope of M&E for HIV must similarly see an expansion in the agency's staff.

HAHSTA has made progress in developing Maven and preparing for an appropriate provider interface, security mechanisms, and provider training for the new system. Staff vacancies in M&E continue, however, and Maven still has not been implemented. DC Appleseed expects the full launch of Maven to mark a turning point in targeting dollars and efforts to programs that work. This pivotal moment in the fight against HIV/AIDS should be advanced as quickly as possible. The District's grade remains a "B-." We look forward to the implementation of Maven in the next year.

HIV TESTING: A-

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

Individuals who know they are HIV positive are more likely to change their behavior to prevent transmission and, if necessary, to seek appropriate care and treatment. If HIV testing were offered routinely as a part of medical care, more people would elect to

undergo such testing and learn their HIV status.

In our *Sixth Report Card*, the District maintained an "A" for HIV testing based on increasing the number of tests conducted in DC, promoting HIV testing in non-traditional settings, supporting targeted HIV testing in the community, promoting routine testing in medical settings, and creating innovative partnerships to achieve testing goals. However, there was concern about inconsistent availability of test kits provided by HASHTA, and the *Sixth Report Card* recommended that HAHSTA better anticipate demand and ensure the availability of sufficient test kits. The *Sixth Report Card* also recommended that HAHSTA develop a citywide strategy for routine HIV testing in all medical settings and offer rapid tests at District-run facilities.

In the past year, the District has continued to expand its HIV testing program, with HAHSTA reporting 122,356 publicly-supported HIV tests for FY 2011, an impressive 11 percent increase over FY 2010. San Francisco – by comparison – provided 17,683 tests in 2010. The District's HIV testing program also tested more individuals than significantly larger metropolitan areas such as Brooklyn (106,272 in 2008-2009) and Chicago (93,451 in 2009). These jurisdictional comparisons highlight the success of HAHSTA's expanded HIV testing program.

HAHSTA reports that 84.3 percent of these tests were conducted in a clinical setting and 15.7 percent conducted in a non-clinical setting, with a total of 821 positive test results. Although the total test figure is shy of the agency's stated goal for FY 2011, it reflects a continued positive trend over the last five years. The District offers support in the form of direct funding, technical assistance and/or the provision of free rapid HIV testing supplies to 45 entities, including hospitals, medical providers and CBOs, and the DC Jail.

HAHSTA's collaboration with Gilead Sciences, Inc. continues to expand HIV testing in the District by offering testing services in non-traditional locations. Gilead, HAHSTA, and FMCS are collaborating to conduct rapid HIV testing at the Penn Branch office of the DMV located in Ward 7. In FY 2011, 5,355 HIV tests were administered, substantially exceeding its goal of 3,000 tests. To date in

FY 2012 (October 2011 to May 2012), the agency reported 3,002 HIV tests at the DMV site. Building on the success of this collaboration, a similar testing program has been initiated at the Anacostia ESA service center that serves individuals receiving public benefits. The program is funded by Gilead with FMCS performing the testing and providing linkage to care. HAHSTA reported 3,239 HIV tests (with approximately a one percent positive rate) administered between October 2011 and May 2012. The goal is to provide 6,500 tests during the year.

In the *Sixth Report Card*, DC Appleseed commended HAHSTA and Gilead for funding HIV testing by Whitman-Walker Health staff at the Crew Club, a gym catering to gay and bisexual men. In FY 2010 the positive results rate at the Crew Club was considerably higher than the rate at other facilities – four percent versus one percent. To initiate the program, Gilead collaborated with HAHSTA and provided the program’s first-year funding; HAHSTA agreed to fund future years. HAHSTA has taken over funding for FY 2012. The program now is being conducted at the Crew Club and Glorious Health and Fitness Club by Us Helping Us, People Into Living, Inc.

A promising new public-private partnership among OraSure Technologies, Walgreens Community Pharmacy (formerly BioScrip), and HAHSTA is making rapid HIV and hepatitis C testing available at no cost to the public through a local pharmacy. It was reported that this is the first pharmacy in the country to offer both rapid HIV and rapid HCV tests on demand. The CDC is also piloting HIV pharmacy testing in the District with Walgreens, Greater than AIDS, and Whitman-Walker Health.

HAHSTA has made efforts to increase HIV testing among the District’s youth. As part of the agency’s CARE Part A sub-grant for Early Intervention Services, Metro Teen AIDS offered HIV testing services to 257 youth in the District. Each youth received both a rapid HIV test and risk reduction counseling. The District’s FY 2012 – 2015 goals include expanding HIV/AIDS education among area youth and providing greater access to and awareness of HIV testing. These efforts will emphasize high-risk youths.

HAHSTA continues its social media and marketing efforts promoting HIV testing. As part of the “Ask for the Test” marketing campaign, HAHSTA partnered with Radio One to offer a free concert at the 9:30 Club for individuals who were tested during December 2011. This initiative reached its goal of encouraging 1,200 residents to get tested. Additionally, in an effort to target the senior population, the District has released new advertisements featuring “older” adults, including Ms. Senior DC. HAHSTA also recently filled a full-time social marketing staff position. DC Appleseed hopes that this new position will lead to an expanded awareness of HIV testing options through social media initiatives.

On HIV Testing Day 2012, the District announced a new initiative to promote HIV testing of DC government employees by their private physicians. HAHSTA expects the program to launch on July 23. HAHSTA is developing an educational video which will be available online through DC Human Resources’ training platform. It will provide information on HIV and address concerns including confidentiality, health insurance, and employment, and encourage employees to incorporate HIV testing into their routine health care. HAHSTA also is developing educational materials and marketing “Ask for the Test” materials featuring DC government employees. During the first three months of the campaign, DC government employees will be given two hours paid leave to watch the educational video and/or to obtain the test.

The District continues to face challenges in overcoming private physicians’ reluctance to conduct routine HIV testing. One of the obstacles is concern on the part of practitioners that they will not obtain third-party reimbursement for routine HIV testing services. To address this, in FY 2011 HAHSTA distributed a series of “Dear Colleague” letters to local medical providers. These letters were part of a continued effort to explain the benefits of routine HIV testing and to educate providers in proper billing procedures for the tests. The *Sixth Report Card* commended the District for its partnership with Pfizer and the Global Business Coalition to launch an “Offer the Test” campaign encouraging doctors in private practice to offer routine HIV testing. The campaign was suspended in FY 2011,

but HAHSTA reports that the new management of Pfizer has expressed interest in reviving the initiative. DC Appleseed applauds HAHSTA's ongoing efforts to educate and encourage routine HIV testing by private physicians and hopes to see the return of the "Offer the Test" campaign and similar initiatives in FY 2012.

DC Appleseed commends the District for the overall increase in HIV tests performed in the District and the expansion of routine screening. DC Appleseed remains concerned by reports from providers that rapid HIV testing kits were in short supply or unavailable during the summer of 2011. Some providers were forced to suspend HIV testing temporarily. HAHSTA worked with a handful of providers who receive testing money directly from CDC to use dollars from those grants for testing kits, and negotiated for providers to be able to purchase the test kits from OraSure at a discounted rate. HAHSTA also reprogrammed \$120,000, a portion of which was distributed to each testing provider to purchase test kits.

HIV testing also declined briefly at several hospital emergency departments. The decline may warrant consideration by hospitals and other clinical settings of more sustainable testing processes and the use of testing technologies that are also more sensitive and specific. These technologies increase the likelihood of diagnosing people earlier in the course of infection, and testing can be more easily integrated into the routine process.

In a June 24, 2011 letter, HAHSTA informed testing providers that as a cost-saving measure it would be transitioning some providers from OraQuick oral rapid tests, which cost the District \$11 each, to Clearview, which requires a finger stick to collect blood and costs \$7.50 each. HAHSTA later clarified that the success of testing initiatives meant that over 74,000 rapid oral test kits had been used which had exhausted the HAHSTA contract ceiling – as set by the Office of Contracts and Procurement – with OraSure Technologies, the maker of OraQuick. Subsequently, HAHSTA revised the plan to transition to Clearview. Hospitals and clinical settings were provided Clearview finger-stick tests; CBOs providing testing through community outreach were provided oral tests.

The hospitals and larger clinics reported to DC Appleseed that their testing programs have not been affected greatly by the shortage at HAHSTA or the transition to Clearview. During the period when HAHSTA was not providing oral test kits, the hospitals used other resources to acquire test kits. Most hospitals and clinics have accepted the transition to the fingerstick test and do not report an increase in the number of individuals declining HIV tests. The impact of the shortage was greater among smaller CBOs. With small budgets and fewer resources, some CBOs reported difficulties in continuing their testing programs and temporarily suspended their programs. Some borrowed test kits from larger programs until HAHSTA resumed supplying the kits.

Although the impact of the test kit shortage and the transition to different technology varied among providers, all complained of a lack of transparency in HAHSTA's actions. The agency's notifications and changes in policy regarding HIV test kits were not clear to providers and made implementation more complicated than necessary. DC Appleseed received numerous reports that HAHSTA was unresponsive to inquiries concerning the shortage of test kits. Similarly, providers noted that the agency made the abrupt switch to Clearview without providing adequate notice. For FY 2012, DC Appleseed encourages HAHSTA to enact policies that ensure consistent, timely communication between the agency and the providers it supports and to better anticipate demand and ensure the availability of sufficient test kits.

In a February 2012 hearing of the DC Committee on Health, Council Member David Catania criticized HAHSTA for failing to request an increase from the Council of the \$1 million contract limit with OraSure so as to avoid the shortage. In response, DOH officials stated that they would request an increased FY 2012 contract for HIV tests if necessary.

Several providers reported problems concerning the limited training offered by Clearview in FY 2011. HAHSTA reports that it is now offering monthly trainings on testing with Clearview and monthly trainings on testing with OraQuick and that it also is willing to schedule training at a facility if there is a sufficient number of trainees. DC Appleseed will

monitor the availability and schedule of testing trainings to ensure that they are meeting the needs in the community.

Under DC's Insurance Coverage for Emergency Department HIV Testing Act, insurance companies are required to reimburse providers for routine screening performed in hospital emergency departments. HAHSTA reported that it is working closely with the DISB on enforcement of the law. In October 2011, DISB notified the area's major third-party payors of the requirement to promptly reimburse insureds for voluntary HIV testing performed while the patient is receiving emergency medical services. Despite the fact that the law requires reimbursement for screening, representatives of several hospital emergency departments reported that institutions' multi-year contracts with insurance companies, which were negotiated prior to the legislation, did not include fees for the provision of HIV testing. For example, GW Hospital staff reported that during FY 2011 the emergency department was not reimbursed for HIV tests.

DC Appleseed commends HAHSTA for the increase in HIV tests conducted in the District in 2011. However, DC Appleseed is concerned that supply shortages and inadequate communication with community partners that were reported in the *Sixth Report Card* have continued. DC Appleseed did not reduce the District's grade in HIV Testing last year, but this year the grade is being reduced from an "A" to an "A-."

CONDOM DISTRIBUTION: A-

Continue to expand condom distribution in the District.

Condom use is universally regarded as a safe and effective HIV prevention measure. In DC Appleseed's *Sixth Report Card* the District's grade for Condom Distribution was raised from a "B+" to an "A-" in recognition that HAHSTA had reached the ambitious goal it had set in FY 2007 to triple its annual condom distribution numbers to three million condoms a year by FY 2009. While acknowledging these achievements, DC Appleseed also raised concerns regarding some supply

shortages and lack of communication with providers. In this report card, the grade is maintained at an "A-."

HAHSTA reports that the District distributed 4.6 million condoms in FY 2011 (a 15 percent increase over FY 2010) and 2.5 million packets of lubricant. This number is impressive when compared to other condom distribution programs. The distribution of 4.6 million condoms in the District results in 7.6 condoms per capita. Other jurisdictions' per capita distribution is as follows: 1) Philadelphia distributed 1.5 million condoms in 2010 – .98 condoms per capita; 2) Chicago distributed 10 million condoms in 2010 – 3.7 condoms per capita; 3) Baltimore distributed 2.6 million condoms in 2010 – 4.2 condoms per capita; and, New York City distributed 36 million condoms in 2011 – 4.4 condoms per capita. DC Appleseed commends the District for being the leader in the nation. Furthermore, HAHSTA's condom distribution network has expanded to include 475 community partners in the District – CBOs and businesses where the public can get free condoms. In FY 2012, the District's goal is to distribute 4.5 million condoms; 1.1 million condoms were distributed in the first quarter, indicating that this goal is within HAHSTA's reach if current rates continue.

For FY 2011, HAHSTA partnered with a new condom vendor, Ansell Healthcare LLC. A factor in the change of vendors was supply shortages with the previous vendor. Although HAHSTA reports that vendor-side supply problems have been less frequent with Ansell Healthcare, shipment delays continue to occur and result in supply shortages. These vendor-side supply issues have led to condom shortages among some of HAHSTA's community partners. While several CBOs experienced a reduction in the number of condoms and lubricant packets they received in monthly orders, other CBOs reported no shortages. Some organizations were able to purchase condoms to make up for any shortages. However, others were unable to satisfy the demand for condoms in their communities. HAHSTA also reported that there was a six-week period in early FY 2012 during which the vendor did not provide HAHSTA any lubricant packets. Fortunately, immediately prior to that time, HAHSTA had by chance provided double the amount that

CBOs had requested, so no providers were out of lubricant. HAHSTA reports that they have spoken to the director of the New York City condom program who expressed similar frustration regarding vendor supply shortages. Of concern to some providers, was that HAHSTA did not provide advance notice of anticipated shipment delays or shortages. DC Appleseed encourages the District to improve communication concerning shortages and delays to its community partners.

HAHSTA continues to provide support to the DC Female Condom (“FC2”) Project, a public-private partnership among HAHSTA, Washington AIDS Partnership, and MAC AIDS described in the *Sixth Report Card*. The overall aim of the three-year project is to increase FC2 education and awareness and make the FC2 a part of the District’s comprehensive HIV prevention tool kit, after which HAHSTA will take over procurement and distribution. In its first two years (March 2010 – January 2012) the Project distributed 485,000 FC2s, provided 19,000 extensive and 41,000 brief education sessions, conducted 946 group sessions, and trained 476 peer educators. The first two years were funded by the MAC AIDS Fund (\$545,000 for year one and \$330,000 for year two). HAHSTA provided the social marketing (\$80,000 in year one and \$85,000 in year two). MAC AIDS Fund has contributed an additional \$131,000 for year three, and HAHSTA is providing \$140,000 in the form of social marketing and FC2 procurement. As a result of this collaborative partnership, the DC Female Condom Project has become a national leader in terms of distribution and comprehensiveness of coverage. MAC AIDS Fund was originally committed to funding the first two years of the program, but extended its funding for a third year, which is focused on training 150-200 providers, developing a curriculum, and assisting other jurisdictions in promoting the female condom.

Two studies have assessed the effectiveness of the DC Female Condom Project – one led by the Johns Hopkins University School of Public Health (“Johns Hopkins”) and the other by Mosaica. Johns Hopkins’ research is a cost-effectiveness study that was published in the March 2012 issue of the journal *AIDS & Behavior*. It found that

promotion of FC2s in areas with high HIV prevalence is a very effective public health investment. The Mosaica study is a utilization study, supported by the original MAC AIDS funding, which is examining the frequency of use and experience with the FC2 among 50 women. HAHSTA expects that this study will be published sometime during FY 2012. In addition to these studies, FC2 use is included in population-based studies undertaken in the District, including the recently-released study from the NHBS heterosexual cycle.

The District continues “DC’s Doin’– It,” an extensive FC2 social marketing campaign. Other jurisdictions are developing FC2 marketing materials based on DC’s campaign. HAHSTA translated the materials into Spanish and is developing educational and marketing materials for transgender individuals and men who have sex with men. It is evident that the social marketing campaign has been successful since the recently-released NHBS study on heterosexual behavior reported that the rate of female condom use by participants increased from practically zero to nearly nine percent overall and 15 percent among women. DC Appleseed commends HAHSTA, Washington AIDS Partnership and MAC AIDS Fund for the success of this program.

HAHSTA also continues its “Rubber Revolution” social marketing campaign, which received a 2011 Bronze Anvil Award from the Public Relations Society of America and a 2012 Hermes Creative Platinum Award from the Association of Marketing Communication Professionals. DC Appleseed commends the District for the recognition its social marketing campaigns have received and expects that the recent hiring of a full-time social marketing staff person will ensure that ongoing efforts are effective and appropriate.

The District’s grade for condom distribution has been maintained at an “A-.” DC Appleseed commends the high numbers of condoms distributed and the success of the FC2 public-private partnership. DC Appleseed hopes that difficulties with the vendor are resolved and encourages the District to improve communication with the community concerning supply shortages and delays.

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 public education in the District.

In the *Sixth Report Card*, DC Appleseed reported on the DC public education systems' response to the Healthy Schools Act ("HSA"), which was passed by the DC Council in May 2010 and required that all DCPS and public charter schools meet the Health Education Standards established in 2007. OSSE, DCPS and DC public charter schools are primarily responsible for providing and assessing HIV/AIDS education in the District. OSSE functions as the State Education Agency ("SEA") for the District. DCPS and each public charter school function as separate school districts or Local Education Agencies ("LEAs"). DC currently has 54 LEAs. Under the HSA every LEA is required to meet the Health Education Standards, and OSSE is responsible for assessing and reporting on progress in meeting them.

To evaluate the important role of these three separate entities, DC Appleseed provided separate grades for each. Despite evidence of progress, OSSE received a grade of "C-" in the *Sixth Report Card* due to its extended delays in ensuring implementation of the Health Learning Standards across the District. DCPS received a "B+," reflecting its achievements in providing HIV/AIDS education, including adjusting curricula and supporting professional development. Public charter schools received a grade of "Incomplete," because of a lack of information and transparency with respect to HIV/AIDS education across the system.

Now, over two years since DC passed the HSA, and in an ever-changing public education landscape, we evaluate how – and to what extent – public education in the District, and specifically these three entities, have complied with the Health Education Standards of the HSA. We also assess the progress each of these entities has made in implementing more effective HIV/AIDS

education in the District. There has been some progress, but it varies widely among the three entities.

OSSE: B-

OSSE has made significant progress in assessing the efforts and effectiveness of schools in meeting the Health Education Standards. To comply with the HSA, OSSE has developed a Health and Physical Education Assessment ("Assessment") which will be part of DC's standardized testing effort, putting health on a par with subjects mandated by the federal government. The Assessment is comprised of 50 multiple-choice questions focused on skills and knowledge that include some HIV/AIDS questions. The Assessment was administered for the first time this past spring, and the results – which should be available after the summer – will serve as a baseline for future assessments. OSSE administered the Assessment in grades five and eight, and in one grade in high school, during the two-week period of DC Comprehensive Assessment System ("CAS") testing. Notably, no jurisdiction other than the District conducts standardized tests for health and sexual education.

DC Appleseed and others in the community were concerned that OSSE might encounter resistance from some public charter schools in implementing the Assessment. However, OSSE reports to DC Appleseed that all of the public charter schools conducted the Assessment in 2012.

The HSA also requires that an annual School Health Profile survey be completed by each elementary, middle, and high school by February 15th of each year. For 2011, OSSE received the required report from over 95 percent of schools and included these in its report to the DC Council.

In 2011, OSSE successfully administered the CDC's Youth Risk Behavior Survey ("YRBS"), which surveys health-risk behaviors – including sexual risk behaviors – among middle and high school students every two years. This was an improvement over 2009, when OSSE failed to obtain the minimum response level from DC schools to satisfy the survey requirement.

Most of OSSE's work appears to be moving in a positive direction, as evidenced by the following:

- In collaboration with the State Board of Education, OSSE held a series of meetings in 2011 (one in each ward) designed to educate parents about the Health Education Standards and the state of HIV/AIDS education in the District.
- OSSE successfully won a new federal award – the Personal Responsibility Education Program (“PREP”) – as part of the ACA, which it used to provide five small grants to CBOs to implement an evidence-based or promising program designed to educate adolescents on both abstinence and contraception to prevent pregnancy and sexually transmitted infections, including HIV/AIDS.
- OSSE contracted with the Sexuality Information and Education Council of the United States (“SIECUS”), a national organization, to build the capacity of schools to provide quality sexual health education.
- OSSE has created the Coordinated Health Education Team (“CHET”), an initiative to develop a multi-disciplinary approach to coordinating effective health and physical education strategies that support positive health and academic outcomes within public and charter schools.

DC Appleseed commends these efforts, and encourages OSSE to build on these efforts with longer-term initiatives that are enacted system-wide.

Finally, although OSSE has done some professional development and capacity building in schools, the agency has not yet developed a long term systematic plan to support these efforts. In this regard, DC Appleseed recommends that OSSE consider leveraging the DC Community College and its new teacher training program as a potential resource and location for serving all DCPS and public charter schools.

OSSE's grade is being raised to a “B-.” OSSE's progress in implementing the Health Education Standards and the HSA is commendable, and it is clear that OSSE is concerned about the professional development of teachers and quality curricula in schools.

Over the next year, DC Appleseed hopes OSSE will build on its efforts, and implement a plan to make long-term and system-wide improvements. DC Appleseed will monitor the implementation of the Health Education Assessment and will report on progress in our next report card.

DCPS: B+

As indicated in the *Sixth Report Card*, since the HSA delegated responsibility for student comprehension assessment to OSSE, DCPS has focused its efforts on curriculum development, teacher training, and parent and community outreach programs. DCPS has continued to make progress in each of these areas, and has demonstrated its commitment to HIV/AIDS awareness and prevention. The comprehensive, multi-faceted approach that has been embraced by DCPS to improve health education is very encouraging.

DCPS has woven evidence-based interventions into its curriculum and has continued its efforts to support teachers in improving health education across all schools and grade levels. Within the last year, DCPS has made minor revisions to the “pacing” guides, which are used to prioritize the Health Education Standards and identify resources for teachers. DCPS has utilized strategic partnerships and supplemental funding to further bolster the sexual health education curricula. An example is DCPS's collaboration with Answer (at the Center for Applied Psychology at Rutgers), Metro TeenAIDS, and Gilead. Answer created a curriculum, provided classroom education and worked with identified health teachers to improve the quality of HIV education. The goal of the program is to raise the standard of HIV education in the city over the next 3-5 years, to ensure that struggling and/or new DCPS teachers implementing the curriculum can provide high quality HIV education on their own.

With regard to teacher accountability and training, DCPS reports that it has made steady progress. DCPS uses an evaluation system referred to as IMPACT to measure progress across all subject areas, including health. DCPS believes that its teachers are improving in HIV education, though it was unable to obtain data for sexual health education from the evaluation system. In addition,

all teachers in DCPS receive professional development on a regular basis. DCPS also has designed an additional set of training programs on delivering HIV and sex education. And in March 2012, DCPS held its third annual health summit, which provided teachers with an entire day of sexual health education training.

DCPS continues to place a strong emphasis on parental outreach and involvement to improve HIV/AIDS awareness among students. DOH funds several local organizations to provide a free, five-week course to teach parents how to communicate with their children about sexual health issues. In addition, the DC Parent-Teacher Association works to keep parents informed. Recently, it invited a preeminent sexual health educator to speak with parents about teen sexual health issues.

DCPS also has expanded its pregnancy prevention programs. For example, DCPS expanded a secondary pregnancy prevention program – New Heights Teen Parent Program – which works with pregnant and parenting students. It was previously in two high schools, but is now in 13. DCPS also continues to support an effective auxiliary condom distribution program in DC high schools, known as Wrap M.C., which supplements the DOH’s condom-distribution program through school nurses.

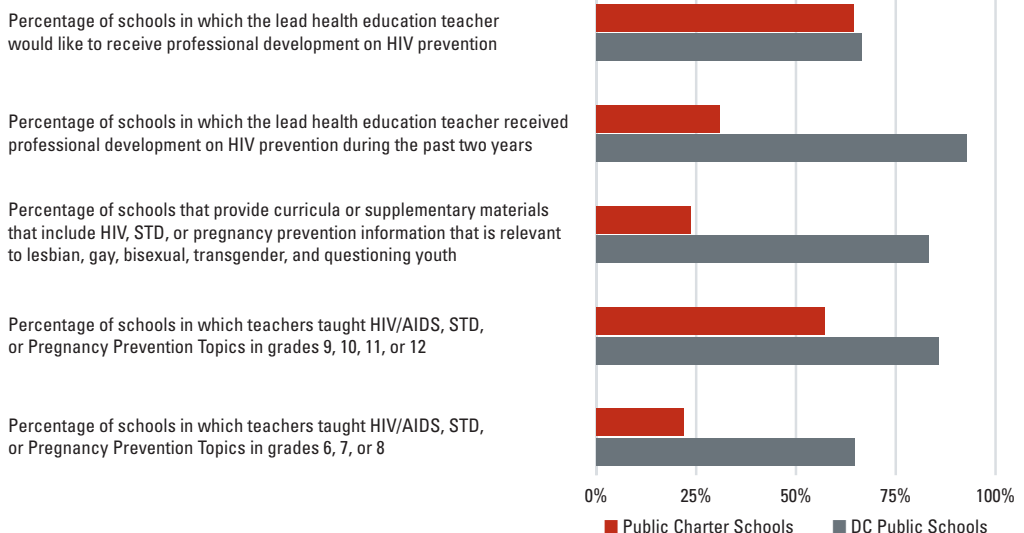
Overall, DCPS has continued to advance health education – and specifically HIV/AIDS awareness – through its holistic approach to dealing with the crisis. DCPS has supported

its teachers effectively, engaged parents, and cooperated with public interest organizations. DCPS should be commended for the help it has provided to DC students, and DC Appleseed hopes to see them continue to expand their efforts. DCPS’ grade remains a “B+.”

PUBLIC CHARTER SCHOOLS: C

In the *Sixth Report Card*, DC Appleseed had insufficient data to grade the public charter schools on HIV/AIDS curriculum and teacher training. There remains a dearth of information by which to assess the effectiveness, and even existence, of HIV/AIDS education in public charter schools. More data will be forthcoming as the results from the city’s Health Education Assessment become available.

Currently the only data on record are the School Health Profiles. According to the 2010 survey, funded by the CDC, while DCPS as well as the public charter schools have much room to improve, the public charter schools lag behind in many areas related to HIV/AIDS. Twenty-six public charter schools responded on the profile that their health curriculum did not comply with the DC Health Education Standards, and 54 responded that they did not have a certified health teacher on staff. The following chart compares DCPS to all public charter schools. It should be noted that results between each school (public or charter) vary.



Given that DC public charter schools now educate 41 percent of public school children in the District, this lack of transparency and accountability threatens the health of those children. DC Appleseed hopes that the Public Charter School Board (“PCSB”), which has primary oversight responsibility for DC public charter schools, will recognize the urgency and seriousness of this situation and integrate the results from the Health Education Assessment into its Performance Management Framework.

DC Appleseed applauds the public charter schools for participating in the Health Education Assessment component of the DC-CAS, which was administered by OSSE for the first time this spring. DC Appleseed believes it is important for the PCSB to use this opportunity to work closely with OSSE to ensure high quality health education for all DC youth.

Among PCSB’s various responsibilities is the charge to ensure that DC charter schools meet basic educational standards. In this role, PCSB’s Performance Management Framework includes students’ progress in meeting the standards set out by the State Board of Education. PCSB, however, does not currently incorporate health education into the Performance Management Framework, because it does not view health education as a core subject, despite the HSA. For this same reason, PCSB presently does not require charter schools to adopt HIV/AIDS curricula or participate in related professional development programs.

The organizations that concern themselves with the academic achievement of public charter schools – PCSB, the Student Support Center, and Friends of Choice in Urban Schools (“FOCUS”) – have the potential to play a vital role in fostering health education, and in particular HIV/AIDS education in public charter schools. DC Appleseed recognizes the need to protect each charter school’s autonomy, but believes such autonomy can be achieved while also facilitating communications among schools; leveraging resources in the community to the benefit of schools; and working cooperatively with schools to improve the efficacy of HIV/AIDS education.

DC Appleseed commends PCSB for having taken some important steps toward increasing the resources available for public charter schools. For example, PCSB is exploring a partnership with a California-based organization that recruits college students to teach health education to high school students. Likewise, PCSB is in discussions with Metro TeenAIDS to identify age-appropriate model curricula. In addition, PCSB will be creating a new position within the organization to focus on health education. And PCSB has expressed a willingness to develop a pilot program for a group of volunteer charter schools to serve as models for other schools.

Although intentions among the public charter schools and the organizations that support and represent them show considerable promise, their efforts to date do not reflect the sense of urgency and comprehensive planning needed to afford DC students the necessary HIV/AIDS education. In the last report card, we gave a grade of “Incomplete” in hopes of compliance with the Health Schools Act. Due to the minimal progress they have made with respect to HIV/AIDS education, the public charter schools receive a grade of “C.”

CONCLUSION

As a whole, the education system in the District continues to move in a positive direction as it implements a city-wide sexual health and HIV/AIDS prevention curriculum. Important progress has been made in implementing the HSA and student assessment; DCPS continues its commitment to a multi-faceted approach to improving HIV/AIDS education; and leaders in the public charter schools are starting to make strides for improving HIV education, although that does not yet hold for all students in the public charter school system. Further progress will depend on commitment within the various entities responsible for ensuring high quality education for youth in DC – individual schools or LEAs, OSSE, the State Board of Education and the Deputy Mayor for Education. DC Appleseed commends the District for the progress seen over the last year and looks forward to seeing the District continue to build on its efforts.

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.

In our third year reviewing the District's youth initiatives related to HIV prevention, DC Applesseed continues to see progress. HAHSTA implemented its initial Youth HIV Prevention Plan, and has developed a subsequent plan for 2012 through 2015. The District has stated a long-term goal of realizing an HIV-free generation of youth, but of course much work remains. The District's grade for Youth Initiatives was raised from a "B" to a "B+" in the *Sixth Report Card* for continuing progress in implementation of the Youth HIV Prevention Plan, though DC Applesseed also noted the importance of finalization of a subsequent plan. The District's grade remains a "B+."

According to the 2010 DC YRBS, the majority of high school-aged youth and a significant proportion of children in middle school are sexually active. Compared to national figures, youth in the District start sexual activity earlier (13.3 percent report having sexual intercourse before the age of 13 compared to 5.9 percent nationally) and have engaged in sexual activity with more partners (23.9 percent have had sex with more than four partners compared to 13.8 percent nationally), raising the risk for HIV and STD transmission. More than three-quarters of DC youth reported using a condom in their last sexual experience, but usage tends to drop as youth age, declining from 79 percent for 14 to 17 year olds to 45 percent for 18 to 24 year olds. Additionally, 11.8 percent of high school students in the District describe themselves as gay, lesbian or bisexual (an increase from 3.4 percent in 2007).

The number of new AIDS cases among youth 13-19 has remained relatively level at approximately five per year. Though the overall rate of HIV infections among youth in DC is less than one percent, STD rates indicate significant unsafe sexual behavior and opportunities for HIV transmission. Nearly seven percent of all 15-19 year olds who got tested

were diagnosed with chlamydia—more than three times the national average. In addition, more than two percent tested positive for gonorrhea, comprising half of all such cases reported in DC. In HAHSTA's school and community-based STD screening program, the average STD infection rate is 10 percent.

HAHSTA reports that the city's efforts continue to be guided by the 2007-2010 Youth and HIV Prevention Plan, which has been revised into the DC Youth 2012-2015 HIV/STD Prevention Plan. Though not yet final, drafts of the plan indicate that the new plan is more aggressive and expansive than the prior one. The plan attempts to address, in a systematic way, youths' primary and secondary HIV/AIDS prevention and intervention needs. The new plan also incorporates recommendations from the Youth Sexual Health Project convened by Council Member David Catania and the Committee on Health, and recommendations from HAHSTA's Youth and HIV/STD Work Group comprised of District agencies and CBOs serving young people. The core elements are: expanding testing, utilizing social marketing to provide information, building capacity among youth organizations, and interrupting infections through large-scale initiatives. The plan focuses on early intervention, STD and HIV testing, and on policy changes related to the availability of condoms. It also seeks to maintain and enhance engagement with DCPS and increase the focus on charter schools (which comprise 41 percent of the school population). Goals include a measurable reduction in infection rates, significant improvements in tools and resources within schools and communities, new data about youth and their behaviors and interactions, and improvements in knowledge and understanding regarding prevention.

One of the most significant additions to the plan is the inclusion of increased data collection. Data for use in planning youth programs have primarily come from one data source, the YRBS, funded by CDC. While containing important information, the survey is primarily done in DCPS, and experts have indicated that there may be limitations to how well it represents schools in general. A more robust and thoughtful pursuit of data should improve planning.

HAHSTA coordinated HIV education and screenings at District Summer Youth

Employment Program sites in 2011. The collaborative effort included DOES, DCPS, OSSE, and CBOs. Unfortunately, plans for the 2012 health expo were cancelled because of the demands of the International AIDS Conference and delays in finding a contractor to handle the logistical arrangements. HAHSTA expects to resume the event in 2013. In addition to collaborating with other DC agencies, HAHSTA also funds four organizations to provide HIV prevention education to youth throughout the District. The programs use established educational interventions targeting youth and risk factors, and include peer education.

HAHSTA continues to convene its Youth and HIV/STD Work Group comprised of District agencies and CBOs serving young people to guide planning and implementation of its youth initiatives. Over the past year the work group has not met as frequently as it had in previous years. HAHSTA has identified another opportunity to receive broader guidance by convening the numerous components within DOH that focus on youth. The first meeting was held on May 22, 2012.

DC Appleseed commends the District for continuing to expand collaborations among city agencies to strengthen and improve HIV/AIDS education, prevention, and awareness. The grade for Youth Initiatives remains at a “B+” because of HAHSTA’s continued commitment to find innovative ways to provide HIV prevention measures to youth. DC Appleseed is hopeful that the new Prevention Plan is finalized in the near future.

SYRINGE ACCESS SERVICES: B

Continue to fund syringe access and complementary services (e.g., HIV testing and counseling and drug treatment referrals) and adopt additional measures to address prevention with substance-using population.

Since our original report, DC Appleseed has urged the District to support and expand syringe access services (“SAS”) to help prevent HIV transmission and link IDUs with treatment, care, and services. The District has been funding SAS with local dollars since

2008 through its DC NEX. The last report card lowered the District’s grade from a “B+” to a “B” because the number of SAS providers had not increased from the original four [and in fact decreased to three with the closure of PreventionWorks (“PW”)], and because of delays in finalizing SAS grant agreements, declines in complementary services reported by programs, and the lack of progress on developing a comprehensive substance use and HIV plan.

HAHSTA’s 2011 Annual Report includes data showing that the number of newly diagnosed HIV/AIDS cases attributed to injection drug use has decreased by 70 percent since 2006. A similar trend is seen in newly diagnosed HIV (not AIDS) cases, with the proportion declining from 11.8 percent in 2006 to 5.2 percent in 2010. These declines have been attributed primarily to the effectiveness of SAS in preventing HIV transmission in the District. DC Appleseed urges that these declines not be interpreted as an indication that investment in SAS is sufficient. Rather, DC Appleseed believes that because SAS has been effective, continued investment in and expansion of SAS are warranted.

In FY 2011, HAHSTA awarded \$580,000 among four CBOs: FMCS (\$300,000), PW (\$130,000), HIPS (\$125,000), and Bread for the City (\$25,000). As we reported last year, PW – the oldest and one of the largest SAS programs in the District – closed after 12 years. At that time, DC Appleseed stressed the importance of HAHSTA redirecting PW’s SAS grant to other SAS providers to minimize the disruption in services and outreach. HAHSTA redirected \$79,190 to FMCS and \$50,810 to HIPS. With the reprogrammed funds, FMCS extended its hours from 24 to 32 per week, expanded to cover nine sites, and offered arranged deliveries twice a week; and HIPS extended its hours from 16 to 38 hours per week, added eight peer secondary exchangers, and added arranged deliveries twice a week. DC NEX award levels were maintained in FY 2012: \$379,190 to FMCS, \$175,810 to HIPS, and \$25,000 to Bread for the City. The programs report that with this level of funding they may not be able to sustain the progress made last year. Programs have identified locations they are unable to serve without additional funding. In its recently released Notice of Funding

Availability, HAHSTA increased the total funding to \$920,000. The funding will be comprised of \$720,000 for direct syringe access services and \$200,000 for complementary harm reduction services addressing injecting drug use. DC Appleseed applauds the District for this increase in local funds for SAS and complimentary services.

HAHSTA reports that in FY 2011, DC NEX programs exchanged 382,000 syringes, an increase of 65,000 over FY 2010 despite the loss of PW mid-year. During the quarter in which PW operated, it reported 31,000 syringes exchanged. FMCS reported 237,000 syringes exchanged (44 percent increase over FY 2010), HIPS reported 102,000 exchanged (163 percent increase), and Bread for the City 12,000 (135 percent increase). Although the increase in the raw number of syringes exchanged is encouraging, the number of exchange transactions fell from 6,428 to 5,922. In addition to syringe access services, the programs conducted 1,631 HIV tests and made 253 referrals to substance use treatment – of some concern, as these important figures showed only minimal increase.

DC Appleseed is pleased that HAHSTA promptly reprogrammed PW's award to other SAS providers and that the providers were able to expand their operation to absorb some of PW's outreach and minimize the impact of its closure on service delivery. DC Appleseed has urged HAHSTA in the past to invest more to support syringe access and complementary services. DC Appleseed is hopeful that the investment of additional funds described above will help stabilize, strengthen, and expand these services to better meet the need in the community. It is also important that the District conduct a needs assessment to better understand the appropriate level and type of services needed to address HIV among substance users. The District's grade remains a "B."

SUBSTANCE ABUSE TREATMENT: B+

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

Substance abuse treatment is an essential component of a successful response to the HIV/AIDS epidemic. Since our initial report, the District has improved its substance abuse services. In this *Seventh Report Card*, the District's grade remains a "B+."

Since the *Sixth Report Card*, APRA has experienced several changes in leadership. In April 2011, Senior Deputy Director Tori Fernandez Whitney was replaced by Dr. Kimberly Leonard, who remained in that position until October 2011, when she resigned. She was replaced by Shaun Snyder who acted as Interim Senior Deputy Director from October 2011 until March 2012, when Dr. Saul Levin became Senior Deputy Director.

Throughout these changes, APRA has continued to secure federal funding to support its services. In FY 2011, the District was awarded a federal Minority AIDS Initiative Targeted Capacity Expansion: Integrated Behavioral Health/Primary Care Network Cooperative Agreement for \$4 million over three years. This grant is part of HHS' "12 Cities Project," which is a component of the NHAS that supports and accelerates comprehensive HIV/AIDS planning and cross-agency response in the 12 jurisdictions with the highest AIDS burden in the country. The grant will be implemented by APRA, HAHSTA, and DMH, and will support a "no wrong door" approach to screening and treatment for mental health issues, substance abuse, and HIV at any point of entry into the District's treatment system. After screening, individuals will be referred for treatment services.

APRA continues to use funding from the \$10.6 million Strategic Prevention Framework State Incentive Grant ("SPF SIG") awarded for July 2009 through 2014 and the \$13.1 million Access to Recovery ("ATR") III grant awarded for October 2010 through September 2014. Under the SPF SIG, APRA developed a strategic plan with two priorities: 1) prevent the onset and progression of risk of marijuana use by children and adolescents; and 2) prevent the onset of alcohol

use and reduce underage drinking. APRA will work with an array of subgrantees, including four SPF SIG Coordinators linked to the DC Prevention Centers, to pursue these priorities. APRA continues to fund four prevention centers that serve two geographic wards each. Each center serves as a resource for prevention activities and data collection in its wards. In FY 2011, these centers served 8,454 youth and 4,338 adults.

In FY 2011, under the ATR III grant, 2,252 clients received an array of recovery support services, including recovery support evaluation, care coordination, spiritual support, recovery coaching and mentoring, educational support services, life skills services, transportation services, and housing. This exceeded the target of serving 1,759 clients. APRA plans to expand the population served under the ATR III grant to 3,994 clients in FY 2012, with increased focus on women, women with dependent children, ex-offenders, youth and young adults, and members of the National Guard.

APRA continues to operate the Adolescent Substance Abuse Treatment Expansion Program ("ASTEP"), which allows youth enrolled in Medicaid to participate in the treatment program of their choice. APRA reports that four providers are certified to provide adolescent substance abuse treatment under the program. During FY 2010, 282 adolescents received Medicaid-covered services through ASTEP. In FY 2011, 476 adolescents received services. APRA has worked to improve access to ASTEP services and increase Medicaid reimbursement by appointing a quality assurance specialist who is responsible for strengthening partnerships with agencies that serve children and for monitoring and overseeing ASTEP providers.

APRA recently received approval of a state plan amendment ("SPA") to the District's Medicaid program that will allow Medicaid funds to be used to pay for Adult Substance Abuse Rehabilitative Services ("ASARS"). Similar to the ASTEP program, the ASARS program allows the District to leverage its financial resources through Medicaid matching funds. The program will provide assessment and diagnostic services, clinical care coordination, crisis intervention, medically managed intensive inpatient detoxification, substance

abuse counseling, medication management, and medication assisted treatment.

Prior to the *Sixth Report Card*, APRA completed implementation of the District Automated Treatment Accounting ("DATA") System. This system includes a complete electronic medical record, with the client's assessment plan and notes from each encounter, and allows APRA to automate payment to providers. Providers must enter notes from each encounter within specified deadlines in order to receive payment from APRA. In addition to facilitating timely and correct payment for providers, the DATA system has helped APRA collect data needed for grant applications and quality measurement and improvement. APRA plans to begin using the data to set benchmarks for quality performance within the next year.

All APRA providers have adopted the DATA system, but some providers find it challenging to use, particularly for patients receiving both mental health and substance abuse treatment. Some providers report that they have to maintain two record systems because the DATA system is not interoperable with other payors' systems, and it does not accommodate mental health information. DC Appleseed recommends that APRA continue to work with providers to address these concerns. APRA representatives noted that they were working on reviewing the provider list to identify overlap between DMH and APRA providers and clients and would like to align consent procedures across the agencies. DC Appleseed supports this goal, and we encourage APRA to look for other ways to facilitate coordination for mental health and substance abuse treatment. APRA also is evaluating the possibility of opening the DATA system to the Residential Substance Abuse Treatment ("RSAT") unit at the DC Jail to allow inmates' records to be transferred smoothly to care after release from the Jail.

APRA has continued to increase the number of individuals assessed for treatment. During FY 2011, APRA's Assessment and Referral Center ("ARC") assessed 7,714 individuals, compared to 6,643 in FY 2010 and 5,552 in FY 2009.

APRA continues its collaboration to conduct screenings at the DC Superior Court by providing assessment services at the

courthouse. APRA works with DMH to use the Psychiatric Institute of Washington (“PIW”) to perform these evaluations.

Detoxification services continue to be provided under contracts with two private entities, Providence Hospital Seton House and PIW. At the time of the *Sixth Report Card*, APRA was developing a request for proposal (“RFP”) for assessment and referral services conducted at ARC. APRA has since decided not to pursue that RFP. In FY 2011, 7,714 individuals received assessments through the ARC and 1,708 patients were referred for detoxification services.

The substance abuse treatment units at the DC detention facility, which are funded through the Department of Justice RSAT grant and the DC Office of Justice Grants Administration, continue to serve a particularly vulnerable population. The RSAT program is certified by APRA. Furthermore, the DC Jail’s opioid treatment program, which provides methadone or buprenorphine to inmates, has been certified by APRA and the National Commission on Correctional Health Care.

The RSAT men’s unit serves approximately 50 to 80 inmates with four staff. The female unit currently serves 20 to 28 women with two staff and a joint program assistant shared with the men’s unit. DC Appleseed continues to be impressed by the inmates’ overwhelmingly positive comments on the program. During our visit to the RSAT men’s unit, inmates said they appreciated the opportunity to address their substance abuse and mental health needs and to receive effective treatment and education, including peer-to-peer counseling and GED courses. The inmates said the program could be improved by adding more clinicians and case workers.

The RSAT program’s certification would permit the program to expand if funding were available. Currently, funding limitations present challenges to the program, including restricting the ability to hire additional staff needed to treat more inmates. The RSAT staff indicated that they would like the program to be an APRA contractor, but APRA has concluded that the program does not qualify for funding because, contrary to APRA’s consumer choice policy, inmates

lack a choice of providers while they are in detention.

The successful treatment of inmates in the RSAT also is affected by outside agencies’ funding restrictions. As those agencies limit their programs or shut down, inmates have fewer options for continuing care after they leave the Jail. DC Appleseed recommends that the District provide sufficient resources to address these limitations and allow inmates to complete their recovery.

APRA has continued to work to improve access to substance abuse treatment services through efficient use of the District’s resources. DC Appleseed is hopeful that the agency will be able to maintain the progress it has made over the years, especially with increasingly limited financial resources. The District’s grade for Substance Abuse Treatment remains a “B+.” DC Appleseed looks forward to seeing renewed growth and strengthening with stable APRA leadership.

HIV/AIDS AMONG THE INCARCERATED: A

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

Since DC Appleseed’s 2005 report, the District has made significant progress on testing, treatment, and discharge planning for HIV and AIDS among the incarcerated. The District’s grade was an “A” in the *Sixth Report Card*, for its continued efforts despite funding cuts to both testing and discharge planning. In this report card, the grade continues to be an “A.” In addition to examining local services, DC Appleseed also explores the services provided by federal agencies to address the need for HIV and AIDS testing and treatment among the populations incarcerated in or recently released from federal prisons.

DOC continues to offer rapid HIV testing to inmates at intake if it is the inmate’s first DOC incarceration or if the inmate does not have a documented HIV test within the last six months. Testing also is provided

by request at any time during a sick call. Due to continued budget reductions in the contract, Unity reduced the frequency of testing from 90 days to six months. This policy exceeds the CDC's recommendations, which state that inmates who are at high risk for HIV should be offered opt-out HIV testing annually.

In 2011, there were 15,222 intakes to the medical unit at the DC Jail. Of those, 5,042 did not receive an HIV test because they had been incarcerated and tested at the Jail within the prior six months, they had been tested in the community during the prior six months, they previously had tested positive, or they declined because they were not sexually active. Thus, there were 10,180 intakes who were eligible for testing. Of those intakes, 312 inmates were inadvertently not tested, and 1,102 inmates declined to be tested because they did not want to know their status or failed to give a reason for their refusal. Thus, 11 percent of intakes were not tested. This is an increase from the seven percent refusal rate last year, but continues to show that DOC's automatic testing program, which is a national model, continues to reach a very large percentage of inmates. DC Appleseed commends DOC and Unity, the medical care provider at the Jail for its continued successful HIV testing program.

DOC also reported that no HIV testing took place for two days when OraQuick tests were temporarily unavailable. This test kit shortage and DOH policy change is detailed in the HIV Testing section of this report card. DOC reports that it has had access to OraQuick tests since August 2011, but supplies of the test remain tight. We encourage the District to ensure that DOC continues to have an adequate supply of these tests.

DC Appleseed is concerned about the continued decline in the total number of discharge planners at DOC. Since last year, under its contract, Unity has reduced the number of discharge planners from 5.5 to 4 full-time equivalents, a significant reduction from the 11 discharge planners in earlier years. DOC no longer has a discharge planner working at the courthouse to arrange appointments; these inmates receive a package of information and their medications upon release. Even though Unity has fewer discharge planners working at DOC facilities now than in the

past, all inmates who are HIV-positive or have other chronic conditions have a discharge plan prepared at intake and an initial meeting with a discharge planner within one to two weeks of intake, followed by meetings at subsequent chronic care visits. Discharge planners continue to assist inmates with their transition back to the community by addressing their health care and social service needs. Unity staff reported that the discharge planners are now more coordinated with primary care providers in the community, and 41 percent of inmates have a follow-up visit with a Unity provider in the community after release. Data are not available on follow-up visits with non-Unity providers because DOC does not have authorization to track inmates' visits to those providers after discharge. Because of the importance of retention and continuity of care, DC Appleseed recommends that DOC provide information to DOH to allow DOH to track inmate linkages to care after discharge.

In 2011, 100 percent of HIV-positive patients at the DC Jail had an undetectable viral load in the first, third, and fourth quarters of the year. Unity achieved or exceeded the benchmarks for other HIV care measures in almost all of the reporting periods, including measurement of CD4 and viral load within the past four months, PCP prophylaxis within two weeks of a CD4 count greater than 200, administration of Pneumovax, and first visit within 30 days after HIV diagnosis.

DOC continues to provide a 30-day supply of medications to HIV-positive inmates upon discharge, serving 338 patients in 2011. In past report cards, DOC reported the number of patients and the amount of ADAP money used to provide HIV/AIDS medications at discharge. However, DC Appleseed has learned that DOC did not request reimbursement from ADAP for all of these expenses. Due to this error, approximately \$200,000 in expected savings to the District was lost. Though the source of the error is unclear, none of the personnel responsible for seeking reimbursement remain at DOC. HAHSTA worked with DOC to ensure that ADAP reimbursement was received for nearly \$400,000 in HIV/AIDS medication provided at discharge in the current ADAP grant period.

Despite financial challenges, DOC has sustained its performance on HIV testing,

treatment, and prevention among the incarcerated, and has implemented further improvements. DC Appleseed commends Unity for its provision of high quality HIV testing, treatment, and discharge planning services to HIV-positive inmates. We are aware that the contract for medical services may be put out for bid soon and will monitor the grant process to assure that there are no reductions of these crucial services in any future contract. DC Appleseed applauds the DOC's continued commitment to ensuring the high standards related to HIV/AIDS prevention and care at the DOC detention facilities, resulting in the District's HIV testing program remaining a national model.

In this *Seventh Report Card*, the District again receives an "A." DC Appleseed hopes that the commitment to the care and discharge planning needs of those with HIV in the Jail will continue, that inmates are provided with a 30-day supply of medication upon discharge, and that DOC appropriately bills ADAP for the HIV/AIDS discharge medication.

Federal Correctional Facilities

For this report card, DC Appleseed expanded its review of HIV testing and treatment to include DC inmates who are housed in or released from federal correctional facilities. As of December 2011, 5,418 DC inmates were housed in Federal Bureau of Prisons ("BOP") facilities. Forty-six percent of these inmates were housed in three facilities: Rivers Correctional Facility in North Carolina (998 inmates), Federal Correctional Institution Schuylkill in Pennsylvania (855 inmates), and Federal Correctional Institution Morgantown in West Virginia (634 inmates).

The BOP is working toward universal HIV testing as recommended by CDC. Currently, 60 percent of facilities provide universal testing at intake or within four to six weeks of intake. Since 2004, BOP has used pharmacists to review the prescribed medications and viral load for each HIV-positive inmate and make recommendations to local healthcare providers to improve treatment. According to a BOP representative, under this program, the percent of HIV-positive inmates with an undetectable viral load has increased from 32 percent to approximately 82 percent. It also was reported that inmates in BOP facilities

receive a 30-day supply of medications at release.

The BOP's contract facilities, such as Rivers Correctional Institution, are not bound by BOP's guidelines, and BOP does not have access to inmate health records from those facilities to monitor testing or treatment. In future report cards, we hope to identify more information about testing and treatment provided at Rivers and other contract facilities.

According to both BOP and CSOSA, discharge planning for inmates in federal facilities can be a challenging task because the inmates often return to DC from facilities at considerable distance. Each prison's staff must work with agencies in numerous communities, and CSOSA has to reach out to many prisons. BOP has a national re-entry coordinator and regional coordinators, and in 2011, BOP began hiring re-entry coordinators for each of its major institutions. CSOSA sends information on resources in the District to those coordinators. It has been reported that CSOSA often has difficulty obtaining information on an inmate's health needs prior to release, complicating CSOSA's ability to conduct a required risk and needs assessment and coordinate care upon release. Both BOP and CSOSA indicated that they are working on improving coordination, and DC Appleseed encourages these efforts.

CSOSA works to facilitate DC inmates' return home by holding quarterly "resource day" video conferences with inmates at some BOP facilities and contract facilities. During these conferences, speakers from numerous governmental agencies and CBOs provide information on the resources available to help inmates receive healthcare, including HIV testing, treatment, and prevention services; education; job training and placement; housing; mentorship; and spiritual guidance when they return to the District. For example, at the video conference with the Rivers Correctional Institution on February 14, 2012, speakers on health care included HAHSTA, Unity, University Legal Services, Community Education Group, U.S. Department of Veterans Affairs, and DMH. Inmates receive a packet of information about these resources and may ask questions of the speakers. CSOSA records the video conferences, edits them to remove inmates' identifying information, and provides copies of the video and the

reference materials to each BOP institution that house ten or more DC inmates. CSOSA also provides literature on these services in its waiting rooms and at Unity's Re-entry Health Center at Our Lady of Perpetual Help. These appear to be helpful methods of sharing information with inmates and former inmates in DC and across state lines. DC Appleseed applauds these efforts and looks forward to learning more about CSOSA's progress in future report cards.

HIV TREATMENT AND CARE

Thirty years after HIV was identified, the epidemic has changed dramatically. Although there is no cure yet, the virus is no longer viewed as an immediate death sentence. Instead – with access to treatment and care – HIV can be managed as a chronic disease that individuals can live with for years. And, by improving an infected individual's health and reducing the amount of virus circulating in the body to a level that is undetectable, the chance of transmission also can be reduced greatly.

This section is a new addition to the report card. At this stage, DC Appleseed does not attempt to evaluate the District's progress in the area of treatment and care. Instead, this section describes the treatment and care landscape and lays the foundation for how DC Appleseed intends to monitor progress in future report cards.

This section will describe various sources of funding for HIV/AIDS medical care, give a broad overview of treatment services available in DC, describe recent research on the benefits of HIV treatment in preventing transmission, and provide background on how the Patient Protection and Affordable Care Act ("ACA") is impacting HIV treatment and care. We will also describe the framework for how we propose to monitor progress in the District's provision of HIV treatment and medical care.

FUNDING

In the latest report available from HRSA, in 2008, among DC HIV-positive individuals

served by Ryan White funds, approximately 10 percent were covered by private insurance, 47 percent were covered by Medicaid, 9 percent were covered by Medicare, 20 percent were covered by other public insurance, 1 percent had other insurance, and 12 percent lacked insurance coverage.

The Ryan White Comprehensive AIDS Resources Emergency ("CARE") Act

The Ryan White CARE Act was enacted in 1990, and has been the largest federal program for HIV/AIDS patients, providing treatment and care to people living with HIV/AIDS who are underinsured and uninsured. The Program is divided into several "Parts," with Parts A and B particularly important in the provision of treatment and care for individuals living with HIV/AIDS in DC. A number of non-profit entities in DC also receive Part C grant funds to support HIV/AIDS services.

Part A assistance is available to eligible metropolitan areas ("EMAs") that are most severely impacted by HIV/AIDS. The DC EMA, which receives Part A funding, includes DC, suburban Maryland, northern Virginia, and two counties in West Virginia. Part B of the Ryan White Program provides grants to states, DC, and U.S. territories, and eligibility is based on a formula related to reported living cases of HIV/AIDS. DC currently receives Part B grants as well. Both Part A and B funds can be used to fund core medical and support services to people living with HIV/AIDS. In Grant Year 20 (2011 – 2012), DC Care Act funds were approximately \$35 million. Finally, Part C grants are provided directly to service providers to fund early intervention and primary care HIV/AIDS service programs, as well as to support planning and capacity development programs for nonprofit and public entities to better develop their ability to provide HIV primary care services to vulnerable populations. More specifically, Part C funded programs in the District provide AIDS education and training center services to the community, as well as outpatient early intervention services ("EIS") to populations with or at risk for HIV/AIDS.

Twenty entities within DC have received Part A funding for grant year 22, and provide services ranging from core medical treatment such as ambulatory outpatient care and case management to support services such

as child care and linguistic services. These providers include community health centers, hospital clinics, AIDS service organizations, and non-AIDS specific grassroots nonprofits. In grant year 21, the amount each provider received in Part A funding ranged from as little as \$62,904 to \$2,297,379. In 2010, 12,215 people in DC received HIV/AIDS assistance through Ryan White funding, out of the 17,272 people in DC diagnosed and living with HIV. HAHSTA recently implemented several new HIV initiatives targeted at increasing access to treatment and care for those living with HIV/AIDS. In 2010, HAHSTA launched the "Red Carpet Entry," a program designed to facilitate immediate access to care for newly diagnosed and out-of-care individuals.

In addition, the DC EMA receives Part A funds for the Minority AIDS Initiative ("MAI"), which funds services targeted at minority populations. In FY 2011, eight programs were funded through this initiative. Each program used the funds to support a variety of services. Among the four programs that provided services to DC residents in FY 2011, 910 clients received primary care, 655 clients received medical case management, 58 clients received mental health services, 64 clients received substance abuse services, 942 clients received outreach, and 167 received psychosocial services.

DC's Part B funds include an earmark for ADAP, which provides HIV-related prescription drugs and other supports, such as insurance co-pays, to DC eligible persons living with HIV/AIDS. Eligibility requirements include DC residency and an income cap (500 percent of the Federal Poverty Guidelines, or \$4,513/month for a family of one). DC ADAP has open enrollment, and most importantly, no waiting list. Since FY 2010, the District also has supported the ADAP budget with additional local dollars.

Part C funding supports both early intervention and primary care for persons with HIV/AIDS, as well as capacity development programs. In FY 2011, 10 providers across the DC EMA received over \$3.88 million in Part C funding. Five of the 10 providers in the DC EMA who received Part C funding in FY 2011, operated their Part C programs in the District itself, receiving roughly \$1.57 million in Part C funding across three outpatient EIS program grants and two capacity

development grants. Further, in FY 2012 private, non-profit entities in the District received over \$2.25 million in Part C funding to support five Part C Outpatient EIS programs.

Medicare and Medicaid

In addition to the Ryan White Program, Medicare and Medicaid provide much needed coverage for individuals living with HIV/AIDS. While Medicaid and Medicare are not programs that specifically target HIV/AIDS patients, both are important sources of coverage for people living with HIV/AIDS. It is estimated that nationwide Medicaid is the single largest source of coverage for those living with HIV/AIDS.

Other Sources

Individuals living with HIV/AIDS may obtain health care coverage from other sources. For example, DC provides medical assistance to residents who are not eligible for Medicaid through the DC Alliance program. DC Alliance provides comprehensive health services such as primary and chronic care services, and inpatient and outpatient care. Moreover, individuals living with HIV/AIDS may be covered through private insurance plans.

Health Reform: Patient Protection and Affordable Care Act

Enacted in 2010, and upheld by the Supreme Court in June 2012, the ACA promises to reduce challenges that individuals living with HIV/AIDS face in obtaining coverage for treatment and care, as it significantly reshapes access to health care coverage in the United States. When fully implemented, the ACA will greatly expand access to insurance coverage for people living with HIV/AIDS, and will provide stronger consumer protections and new funds for HIV/AIDS care.

First, the law increases opportunities for low-income individuals with HIV/AIDS to receive coverage by (a) expanding eligibility for Medicaid and (b) providing new opportunities for low-income individuals to purchase subsidized private insurance. Second, the law contains consumer protections likely to benefit individuals with HIV/AIDS, whose high health care costs often prevent them from qualifying for coverage. ACA provisions implemented in 2012 prohibit discrimination based on health status and pre-existing

conditions and lifetime limits on the dollar value of coverage. In addition, states must establish high risk pools to provide coverage to uninsured people with chronic conditions, such as HIV/AIDS.

Health care reform is already positively impacting individuals with HIV/AIDS in the District. HAHSTA has been awarded multiple ACA-funded grants to support HIV/AIDS surveillance, tracking, and prevention projects. In addition, District residents living with HIV/AIDS – who might previously have been unable to obtain health insurance – can now enroll in the Pre-Existing Condition Insurance Plan. Also, in accordance with HHS guidelines, beginning on August 1, 2012, individual and group health plans in the District will be required to provide women with annual screenings for HIV and other sexually transmitted diseases, without imposing cost-sharing requirements on them.

With health care reform, more people will be eligible for Medicaid, more people will have access to private insurance, and the number of uninsured will decline. This expanded ability to bill payors enhances the fiscal stability of CARE Act funded agencies. Furthermore, reform presents opportunities for HAHSTA for access to better funded coverage for HIV/AIDS patients. For example, HAHSTA plans to explore whether using CARE Act Part B funds to purchase insurance policies through the Pre-existing Condition Insurance Policy pools is more cost-effective than directly purchasing and supplying drug benefits.

The District has been at the forefront of advancing the ACA, as one of a very few jurisdictions nationwide that has started ACA implementation. As a part of Medicaid expansion under the ACA, DOH has worked with the DC Department of Health Care Finance (“DHCF”) to transfer patients from ADAP to Medicaid who are at or below 133 percent of the Federal Poverty Level. As a result of this, HAHSTA transitioned 60 percent of individuals (nearly 1,200 beneficiaries) off ADAP. This resulted in cost saving to ADAP and frees up ADAP slots for those eligible for ADAP but not Medicaid.

DC Appleseed will monitor District efforts to integrate HIV care and funding with the overall health care reform efforts.

TREATMENT AS PREVENTION

In December 2011, *Science Magazine* hailed HIV Treatment as Prevention as the breakthrough of the year. This was based on a clinical trial of 1,763 couples conducted by the HIV Prevention Trials Network. The trial showed that early initiation of antiretroviral therapy (“ARTs”) reduced the risk of heterosexual transmission by 96 percent. This section provides a basic understanding of the concept of treatment as prevention and its possible implications.

An individual’s viral load is the single greatest risk factor for all modes of HIV transmission, and HIV/AIDS researchers have long debated whether providing ART earlier to decrease a patient’s viral load might cut transmission rates. A viral load test measures the level of HIV in an individual’s blood, with low or undetectable (suppressed) levels being best. The concept is simple – as an individual’s viral load drops due to ART therapy, there is not enough virus circulating in the individual’s fluids to transmit that virus to another person effectively. This concept was confirmed through the HIV Prevention Network trial.

Since its publication and widespread acceptance by the medical community, questions have shifted to the economic feasibility of delivering ART as a preventive tool, and the long-term sustainability of treatment. HAHSTA has embraced the potential for ART as prevention. ART can be used for HIV prevention in three main ways: 1) treating people living with HIV to lower their viral load and thus decrease their infectiousness; 2) providing post-exposure prophylaxis after HIV exposure (sexual or needle sharing); and 3) using ART to prevent mothers from transmitting the virus to their children.

After reviewing available data and in collaboration with many stakeholders, in November 2009, the World Health Organization revised its guidelines to recommend starting ART earlier for everyone with CD4 \leq 350 cells per cubic millimeter, compared to the pre-2009 guideline of 200 CD4 cells per cubic mm. HHS guidelines also recommend ART for patients with CD4 counts between 350 and 500 cells per cubic mm. These guidelines are consistent with ADAP eligibility; however, the extent to which District healthcare professionals are recommending ART at this early

stage is unknown. DOH fully supports the new approach and announced in June 2012 that it would be sending educational materials to all medical providers in the District updating them on the new treatment guideline for HIV treatment to start immediately upon diagnosis.

CARE AND TREATMENT INDICATORS

One of the three overarching goals of the White House's NHAS is to "increase access to care and improve health outcomes." With the NHAS calling upon states and local jurisdictions to report progress toward achieving the goals, the ability to measure HIV/AIDS indicators becomes more important.

HIV care is often presented as a continuum, with stages spanning from a person being unaware of his or her HIV status to achieving viral load suppression. The effectiveness of treatment scale-up and strategies depends on the ability of the health system to move patients along that continuum. HAHSTA collects regular reports from agencies it funds on indicators of HIV/AIDS treatment and care services and uses the indicators to gauge whether treatment resources are being deployed effectively, to assess quality of care, and to identify areas for improvement. The indicators also provide a means to measure progress and assess the District against similar jurisdictions. Finally, the indicators also are useful to providers for quality improvement purposes.

DC Appleseed has identified four core indicators it will use to assess and monitor HIV/AIDS treatment and care in the District. The four indicators representing the continuum are: (1) Linkage to Care; (2) Retention in Care; (3) Viral Load Suppression; and (4) Recapture/Re-Engagement. The first step of engagement in HIV care requires the identification of people living with HIV through testing, which is discussed in this report card in a separate chapter.

Linkage to Care: This indicator captures how soon after diagnosis individuals are connected with care. It is measured by the percentage of individuals connected to HIV/AIDS care within three months of diagnosis. According to HAHSTA's 2011 Annual Report,

76 percent of people diagnosed with HIV in 2010 were linked to care within three months. This is a 31 percent increase from 2006, when only 58 percent of cases were linked to care within three months. HAHSTA seeks to achieve an 85 percent linkage to care rate in 2015, which is consistent with the NHAS target.

Retention in Care: This indicator assesses whether individuals with HIV/AIDS receive continuous care, defined as at least two visits for routine HIV/AIDS medical care within 12 months of diagnosis at least three months apart. The NHAS has set a goal of increasing from 73 percent to 80 percent the percentage of Ryan White clients in continuous care. In DC in 2010, 35 percent of Ryan White HIV/AIDS Program clients were in continuous care, an improvement over the 23 percent in 2009.

Viral Load Suppression: Viral load suppression measures the degree to which HIV/AIDS is controlled in an individual. Among the 4,879 HIV cases diagnosed in the District between 2005 and 2009, 2,730 (60 percent) have achieved viral suppression, but only 1,391 (less than a third) have been able to maintain viral suppression. NHAS seeks to increase by 20 percent the percentage of diagnosed gay and bisexual men, diagnosed Blacks, and diagnosed Latinos with undetectable viral loads.

Recapture/Re-engagement: To improve its retention rate, DC has focused on identifying those who dropped out of care by matching data provided by CBOs to determine whether patients have sought care elsewhere. HAHSTA has undertaken special initiatives around the city to identify and locate missing patients and engage in follow-up activities to bring them back into care.

In future report cards, DC Appleseed also may identify and consider other indicators to assess treatment and care in the District. Patient satisfaction and other appropriate indicators will be explored. While recognizing the usefulness of collecting and monitoring indicator data, DC Appleseed recognizes that there are many challenges. The demands of reporting requirements can be quite burdensome, particularly for programs receiving funds from diverse sources with separate reporting requirements. Maven is expected

to help alleviate this burden. It also is difficult to interpret data, as HAHSTA reports that primary care providers are not sure what they should report and how, and the quality of the reporting varies. DC Appleseed expects that with implementation of Maven and appropriate training for providers, the District's comprehensive data gathering will be more accurate, less burdensome, and more useful.

HOUSING

Stable housing is critical to HIV/AIDS prevention and care. It affects access to care, treatment adherence, maintenance in care, and the improved health of people living with HIV/AIDS. Homelessness and unstable housing also are associated with increased risky behavior and poor health outcomes. The NHAS recognizes the role of housing stability in improving HIV/AIDS service delivery and improving health outcomes. Though housing was not an issue addressed in the original 2005 report, DC Appleseed recognizes the importance of housing in the District's comprehensive response to HIV/AIDS. This section is intended to give a brief overview of housing resources in the District.

The District also has recognized the need to provide low-income and homeless people living with HIV/AIDS ("PLWHA") with housing and services to support obtaining housing. The District provides funds – both federal and local – and services for homeless or low-income PLWHA to obtain permanent housing, housing subsidies, rental assistance, and counseling for obtaining housing. The following is a summary of the programs available in the District, and indicates which local or federal agency is in charge of the program, what services are available, and how successful the programs have been in delivering services.

Available housing programs include HIV-specific housing programs administered by HAHSTA and non-specific housing programs available to all based on income, disability, or elderly status; people with HIV may also qualify by disability or income status.

Housing Opportunities for People with AIDS ("HOPWA")

The U.S. Department of Housing and Urban Development ("HUD") manages the national HOPWA program, which provides assistance to families with at least one member with HIV who are experiencing housing distress. HAHSTA administers HOPWA in Washington, DC, as well as portions of Southern Maryland, Northern Virginia, and West Virginia.

According to HAHSTA's 2011 Annual Report, there are 14,465 PLWHA in the District. Of those, HAHSTA estimates that 6,800 – 8,300 qualify for housing assistance, yet fewer than 400 housing slots are available under the HOPWA program at any one time. Most of these slots are tenant-based vouchers and allow applicants to choose housing. The remaining slots are primarily facility-based, serving PLWHA temporarily in transitional and emergency facilities. HUD allocates 90 percent of HOPWA funds using a formula based on a jurisdiction's cumulative AIDS cases and area incidence. Since 2006, HAHSTA's budget for HOPWA has hovered around \$13 million and supports the following five programs:

- (1) Tenant-Based Rental Assistance ("TBRA") Program is a basic rental subsidy that is provided to help individual households afford housing costs such as rent, utility costs, security deposits, and/or utility deposits. Participants receive a housing voucher that they can use to lease housing. Participants pay approximately 30 percent of their household income toward rent. Historically, subsidies given under the TBRA program have accounted for the bulk of the HOPWA funds distributed in the District.
- (2) Short-Term Rent, Mortgage, and Utility Assistance ("STRMU") provides short-term, needs-based assistance to prevent homelessness and increase housing stability by helping homeowners and renters remain in their homes. Funds distributed for the STRMU program are the second largest expenditure by program under HOPWA.
- (3) The Facility-Based Housing Assistance program provides emergency or transitional housing assistance to PLWHA

and allows an opportunity to develop an individualized housing and service plan to guide the client in identifying permanent housing. Of the approximately 400 slots currently available each month on average under the HOPWA program, 60 are reserved for short-term transitional or emergency housing.

- (4) Permanent Housing Placement Services help establish a permanent residence when the participant seeks continued occupancy. Individuals seeking assistance can use the subsidies for housing referrals, tenant counseling, application and credit check fees, and first month's rent and security deposit. Costs associated with permanent housing are typically the lowest among other HOPWA programs.
- (5) HAHSTA funds Housing Counseling Services' Metropolitan Housing Access Program ("MHAP") as the single point of entry to housing services for PLHWA in the District. MHAP primarily provides help with financial assistance applications, central intake for HAHSTA-funded housing programs, and information on and access to the various housing programs administered by Housing Counseling Services.

Ryan White HIV/AIDS Program

In 2010, HAHSTA received \$31,452,528 under Ryan White Part A for HIV emergency relief for the DC EMA. This funding is primarily for core medical services, but up to 25 percent of it can be used for support services, including housing services. The housing services allowed under the CARE Act are a relatively narrow sub-set of housing services, and generally are limited to short-term assistance. Currently, DC does not offer housing assistance supported by CARE Act Part A or Part B funds.

DC uses some Part A supportive services funds for Emergency Financial Assistance ("EFA"), which can be used for emergency rental and utility assistance. To apply for EFA, a PLWHA must have a case manager and that case manager must apply through DC CARE Consortium, which is funded by HAHSTA under Ryan White Part A as the single point of entry and the single point of payment for EFA.

Audits by D.C. Office of the Inspector General ("OIG")

The OIG has audited HAHSTA four times since 2005 in connection with the administration of grants related to funding for HIV/AIDS – both HOPWA and Ryan White funds. In particular, the OIG has audited HAHSTA with regard to contracts it has with facility-based providers for transitional and emergency housing. The most recent audit was initiated at the request of HAHSTA and focused on a single subgrantee – Hill's Community Residential Support Services, Inc.

The audit found that HAHSTA needs to ensure that grant monitors require subgrantees to operate in compliance with grant agreement terms. With regard to reimbursement practices, the OIG indicated that: 1) HAHSTA needed to require grant monitors to validate that all costs submitted to HAHSTA for reimbursement were for actual receipt of goods and services in order to ensure that grant funds were being used for intended purposes, and 2) HAHSTA needed to ensure that grant monitors only accept valid documents as evidence that payments were made for goods and services. Finally, HAHSTA needed to implement an internal control structure to provide proper oversight and monitoring of all subgrantees.

Other Housing Assistance Available to Homeless and Unstably Housed PLWHA in the District

In addition to the HIV-specific housing programs administered by HAHSTA, the D.C. Housing Authority ("DCHA") administers other non-specific HUD housing programs based on income, disability, or elderly status.

Public Housing. DCHA receives aid from HUD to manage public housing units for low-income residents at affordable rents. Public Housing is limited to low-income families and individuals. DCHA determines eligibility based on income, disability, or elderly status. People with HIV may also qualify by disability or income status. DCHA considers HIV/AIDS a disability under the eligibility formula for public housing. Once DCHA determines an applicant's eligibility, his or her name is put on a waiting list, unless DCHA is able to assist immediately.

Housing Choice Voucher Program (“HCVP”) – formerly Section 8.

DCHA administers several programs funded by HUD, for low-to-moderate-income families, providing vouchers for affordable housing across the city. As of 2009, there were 10,500 families in the District participating in the federal HCVP, with more than 25,000 more on the waiting list.

Bridges Fund. The District funds a small program designed to fill gaps in federal programs and support transition to longer-term subsidies. MHAP administers the Bridges Fund, funded locally with \$200,000 from the DC Council.

There are thousands of people on the waiting list for D.C. housing programs. According to DCHA, in 2008, there were nearly 25,000 on the waiting list to receive housing assistance, and Defeat Poverty DC has reported 26,000 D.C. residents on the waiting list for affordable housing.

As the academic community has come to recognize housing as a structural intervention for HIV/AIDS, it is important that the District and the relevant governmental agencies and programs consider the effect of housing on PLWHA. While D.C. has a litany of housing programs that support unstably housed and homeless PLWHA, there are still hundreds of PLWHA waiting to be housed in the District. And, although DCHA and HAHSTA may give priority to HIV/AIDS applicants, the sheer number of people requiring housing overburdens current resources.

Moving forward, DC Appleseed will monitor the District’s progress in addressing the housing needs of people with HIV/AIDS. We hope to see increased efforts to identify, address, and resolve barriers to meeting the need in the community. We also will report on progress in reducing waiting lists and District initiatives to more efficiently use limited financial resources. We will also consult with consumers living with HIV/AIDS.