

District of Columbia
Department of Health
Administration for HIV Policy & Programs



Comprehensive Plan for HIV Health and Support Services
2006 – 2008

Submitted to:
US Department of Health and Human Services,
Health Resources and Services Administration, HIV/AIDS Bureau

TABLE OF CONTENTS

EXECUTIVE SUMMARY	1
INTRODUCTION	2
SECTION I: ASSESSMENT OF NEEDS	3
DESCRIPTION OF THE DISTRICT OF COLUMBIA.....	3
EPIDEMIOLOGICAL PROFILE OF THE DISTRICT	4
THE HIV DISEASE DEMOGRAPHIC AND GEOGRAPHIC LINK.....	10
NEEDS ASSESSMENT PROCESS	13
SUMMARY	24
SECTION II: CONTINUUM OF CARE.....	26
DESCRIPTION OF THE CURRENT SERVICE DELIVERY STRUCTURE.....	26
COORDINATION OF SERVICES	33
HIV DISEASE HEALTH CARE AND TREATMENT FUNDING	34
SYSTEM OF CARE	36
FACILITATING ACCESS TO SERVICES	38
SUMMARY.....	40
SECTION III: BUILDING ON QUALITY CARE: A SHARED VISION AND MISSION.....	41
EARLY INTERVENTION STRATEGIES	41
IMPROVING THE CONTINUUM OF CARE	42
SUMMARY	47
SECTION IV: GOALS, OBJECTIVES, MONITOR, AND EVALUATION	48
OUTREACH GOALS.....	49
SERVICE GOALS.....	52
COORDINATION GOALS.....	57
EVALUATION	58
CONCLUSION.....	59
REFERENCE	60

LIST OF FIGURES AND TABLES

FIGURES

Figure 1: Map of Quadrants in the District of Columbia.....	3
Figure 2: Map of Wards in the District of Columbia.....	3
Figure 3: District of Columbia Adult/Adolescent (age > 12) AIDS Cases, by Year of Initial Diagnosis and Proportion by Gender, Reported through December 31, 2004.....	7
Figure 4: District of Columbia Adult/Adolescent Female AIDS Cases by Year of Diagnosis and Mode of Exposure, Reported through December 31, 2004.....	7
Figure 5: District of Columbia Adult/Adolescent Male AIDS Cases by Year of Diagnosis and Mode of Exposure, Reported through December 31, 2004.....	8

TABLES

Table 1: HIV Incidence, HIV Prevalence and HIV (not AIDS) Prevalence by Demographic Group and Exposure Category.....	5
Table 2: HIV Disease Cases among Adult Females by Race/Ethnicity and Mode of Transmission, District of Columbia, 1995 – 2004.....	8
Table 3: HIV Disease Cases among Adult Males by Race/Ethnicity and Mode of Transmission, District of Columbia, 1995 – 2004.....	9
Table 4: Racial/Ethnic Distribution by Ward, District of Columbia.....	10
Table 5: Selected Socio-demographic Factors: Unemployment, Median Household Income, per Capita Income, and Poverty Level.....	11
Table 6: Distribution of Adults by Education.....	11
Table 7: Total Females in Population, Percent of Total Female Population, Cumulative HIV Disease Cases, Percent of Cumulative HIV Disease Cases, Living HIV Disease Cases, Percent of Living HIV Disease Cases and Prevalence Rate by Ward.....	12

EXECUTIVE SUMMARY

The District of Columbia Administration for HIV Policy and Programs develops a comprehensive plan every three years to improve programs for those in need of HIV-related care in the District. The Comprehensive Plan for 2006-2008 is organized into the following four sections: 1) Assessment of Needs; 2) Continuum of Care; 3) Building on Quality; and 4) Goals, Objectives, Monitor, and Evaluate.

In the first section of this Plan, the District of Columbia demographic and epidemiological profiles are described in detail to illustrate the impact of HIV disease on the city. As related to epidemiological profiles, the most current data available are presented as HIV disease incidence and prevalence among racial and ethnic groups, gender, age, and modes of HIV transmission categories. In addition, a summary of the District's geographical data as linked to HIV disease and social economic indicators are presented. Then, in this section, there is a review of needs assessments that document HIV-related concerns and issues, including those of specific populations as well as those of prevention, care, and support providers.

The second section of the Comprehensive Plan describes the continuum of care for clients living in the District of Columbia. That continuum of care, as encapsulated within a health care system, is depicted through a discussion of: a) the current service delivery structure; b) the coordination of HIV-related services; c) the HIV health care and treatment funding; d) the care system; and e) the facilitation in accessing services.

The vision and mission of the District of Columbia Department of Health Administration for HIV Policy and Programs, CARE Act services for 2006-2008 is discussed in the third section of this Plan. The journey is titled, "Building on Quality." Quality is the structural foundation by which the vision and the mission include providing early access into care and prevention services via counseling and testing, while improving on the continuum of care through new initiatives that focus on special populations in need of outreach, prevention, and care services.

Perhaps the most important component of this document is the fourth section. It provides a road map for "Building on Quality." Within this section, the actual goals, objectives, and the system of monitoring and evaluating are framed within the areas of outreach, service, and coordination as a method of devising a functional plan to identify and address the HIV-related prevention, care, and support needs of persons living in the District of Columbia.

INTRODUCTION

In the year 2003, the Centers for Disease Control and Prevention reported that an estimated 850,000—950,000 persons in the United States were living with the human immunodeficiency virus (HIV), including 180,000—280,000 who did not know their HIV status.¹ HIV disease continues to be a devastating and debilitating illness. Its impact has negatively altered the physical, psychological, cultural, and spiritual well-being of many communities. Moreover, some communities that are being negatively impacted by the effects of HIV disease have traditionally struggled with other health and socio-economic issues.

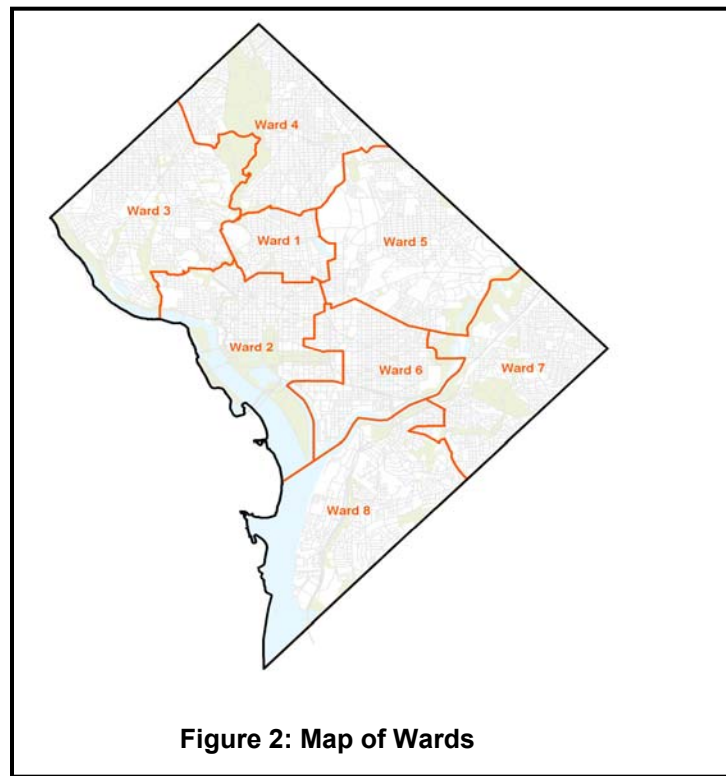
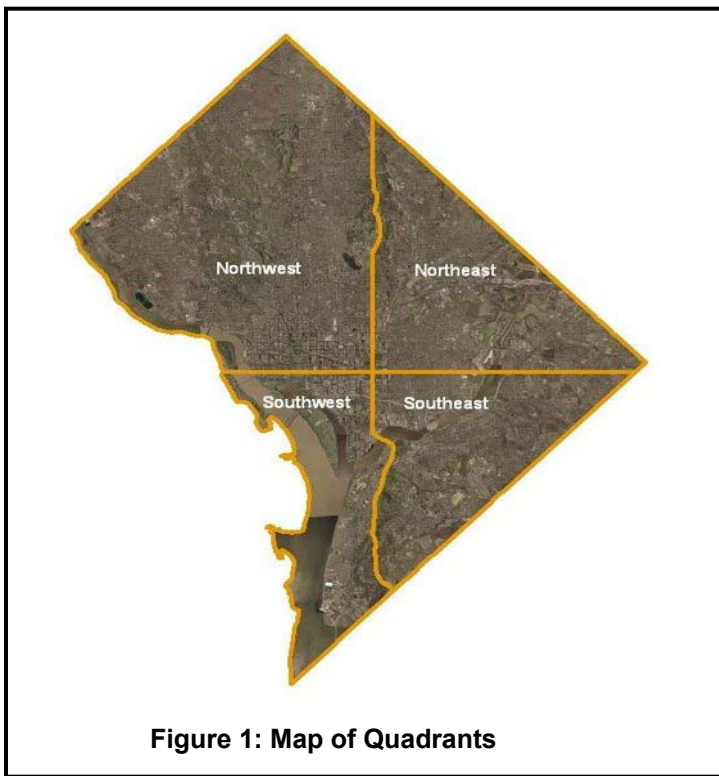
The District of Columbia and the Administration for HIV Policy and Programs have been able to support many of its residents in managing HIV disease through developing and implementing initiatives and making new and advanced treatments available to those in need. However, it has been a challenge to shift with the direction in which HIV disease is moving—a shift that is slowed down by the poverty and the stigma attached to HIV disease in some areas of the city. Populations that are primarily impacted by HIV disease include African Americans, women, persons living in Wards 7 and 8, individuals who are 50 and over, and African American men who have sex with men (MSM). Overall, the influence of HIV disease on persons living in the District of Columbia is embedded in and guided by the health, social, economic, political, and legislative systems in the District

SECTION I: ASSESSMENT OF NEEDS

DESCRIPTION OF THE DISTRICT OF COLUMBIA

The District of Columbia is unique in that it operates simultaneously as a city, a state, and the seat of the federal government. It is a densely populated urban area of about sixty-one square miles. It is divided into four quadrants (NW, SW, NE, and SE), and has eight (8) governing jurisdictions referred to as Wards.

Figures 1 and 2: Maps of Quadrants and Wards, respectively, in the District of Columbia



According to the US Census Bureau, the District's estimated population in 2005 was 550,521, a 3.8% decrease from the population in the 2000 Census.² The following profile of the general demographic characteristics for the District were: 269,366 (47.1%) male and 302,693 (52.9%) female; median age is 34.6 years; 248,388 families/households (114,166 family households with children under 18 and/or blood relatives; 56,631 married couple families; 47,032 female-headed households with no husband present); 134,172 non-family households; (108,744 households living alone, and 24,903 household 65 years and over).²

EPIDEMIOLOGICAL PROFILE OF THE DISTRICT

As reported in Table 1, HIV disease incidence (the number of cases reported January 1, 2003 through December 31, 2004) was 1,886 in the District of Columbia. Of the 1,886 cases, 86.8% were African American/Black, 7.7% White, 4% Hispanic/Latino, and less than 1% Asian/Pacific Islander and American Indian. Of the total HIV disease incidence, 69.6% was male and 30.4% was female. The largest proportion of HIV disease incidence has been reported among 20-44 year olds (64.5%); followed by 44+ (34.4%). Related to exposure category of the 1,018 cases that were reported, 37.0% were heterosexual, whereas 31% were men who have sex with men (MSM).

HIV disease prevalence (the number of people living with HIV disease) surveillance through December 31, 2004, indicated that of the 9,036 reported cases in the District: 81.8% was African American/Black; 13.2% was White; 4.2% was Hispanic/Latino; and less than 1% was Asian/Pacific Islander (A/PI) and American Indian. In addition, 73.7% was male and 26.3% was female. In the age category of 45+ years, 52.0% of the HIV disease prevalence was reported followed by 46.9% in the group of 20-44 years. Based on 8,943 of HIV disease prevalence cases reported, 40.0% was MSM, 28.3% was injection drug users, and 26.2% was heterosexual.

As of December 31, 2004, the reported prevalence of HIV (not AIDS) in the District of Columbia was 17,205 cases. Of that total, 81.7% was African American, 14.6% was White, 3.2% was Hispanic, and less than 1% was Asian/Pacific Islander and American Indian, whereas 70.1% was male, and 29.9% was female. The highest proportion of HIV cases reported was 71.2% within the age group of 20-44 years, followed by 26.8% of the cases within the age group of 45+ years. MSM was the exposure category for 29.0% of the 17,155 total cases reported, whereas heterosexual and injection drug users were 25.9% and 24.0%, respectively.

Table 1. HIV Incidence, HIV Prevalence and HIV (not AIDS) Prevalence By Demographic Group and Exposure Category

Demographic Group/ Exposure Category	HIV INCIDENCE: <u>01/01/03 to 12/31/04</u>		HIV PREVALENCE <u>as of 12/31/04</u>		HIV (not AIDS) Prevalence <u>as of 12/31/04</u>	
	<i>HIV Incidence is defined as the number of <u>new</u> AIDS cases diagnosed during the Period specified.¹</i>		<i>HIV Prevalence is defined as the number of people living with AIDS as of the date specified.²</i>		<i>HIV Prevalence is defined as the estimated number of diagnosed people living with HIV (not AIDS) as of the date specified.</i>	
Race/Ethnicity	Number	% of Total	Number	% of Total	Number	% of Total
White, not Hispanic	146	7.74	1,196	13.23	2,512	14.60
Black, not Hispanic	1,637	86.80	7,392	81.81	14,056	81.70
Hispanic	84	4.45	379	4.19	551	3.20
Asian/Pacific Islander	7	0.37	46	0.51	52	0.30
American Indian/Alaska Native	6	0.32	11	0.12	17	0.10
Multi-Race	6	0.32	11	0.12	0	0.00
Unknown	0	0.00	1	0.01	17	0.10
Total	1,886	100.0	9,036	100.00	17,205	100.00
Gender	#	% of Total	#	% of Total	#	% of Total
Male	1,313	69.62	6,659	73.69	12,061	70.10
Female	573	30.38	2,377	26.31	5,144	29.90
Total	1,886	100.00	9,036	100.00	17,205	100.00
Age at Diagnosis (Years)	#	% of Total	#	% of Total	#	% of Total
<13 years	5	0.27	43	0.48	50	0.29
13 – 19 years	17	0.90	63	0.70	294	1.71
20 – 44 years	1,216	64.48	4,236	46.88	12,250	71.20
45+ years	648	34.36	4,694	51.95	4,611	26.80
Total	1,886	100.00	9,036	100.00	17,205	100.00
Adult/Adolescent AIDS Exposure Category	#	% of Total	#	% of Total	#	% of Total
Men who have sex with men	600	31.90	3,581	40.04	4,966	28.95
Injection drug users	505	26.85	2,531	28.30	4,110	23.96
Men who have sex with men and inject drugs	70	3.72	408	4.56	736	4.29
Heterosexuals	695	36.95	2,347	26.24	4,435	25.85
Other/Hemophilia/blood transfusion	9	0.48	69	0.77	82	0.48
Risk not reported or identified	<5	N/A	7	0.08	2,826	16.47
Total	2,018	100.00	8,943	100.00	17,155	100.00
Pediatric AIDS Exposure Categories	#	% of Total	#	% of Total	#	% of Total
Mother with/at risk for HIV infection	5	100.00	92	98.92	46	92.00
Other/Hemophilia/blood transfusion	0	0.00	1	1.08	1	2.00
Risk not reported or identified	0	0.00	0	0.00	3	6.00
Total	5	100.00	93	100.00	50	100.00

¹ Age group represents age at HIV disease diagnosis.

² Age group reflects age as of December 31, 2004.

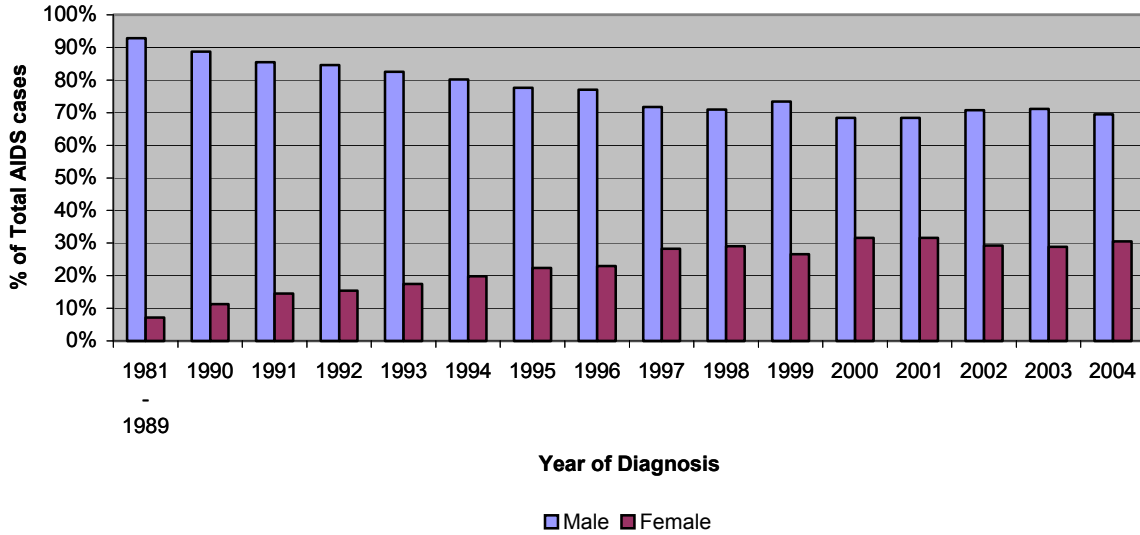
SOURCE: Centers for Disease Control and Prevention, *Letter to Doug Morgan dated August 29, 2005*: HIV disease surveillance data tables for grantees of Ryan White CARE Act planning process. Pages 4 – 6. Government of the District of Columbia, Department of Health Administration for HIV Policy and Programs, HIV Disease Surveillance and Epidemiology Division; 12/05.

As illustrated in Figure 3, there has been an increase in the proportion of HIV disease cases diagnosed among women and a decrease in the proportion diagnosed among men over the course of the epidemic in the District of Columbia. In 1995, HIV disease cases diagnosed in women and in men were 22% and 78%, respectively, of the total number of reported cases. Comparatively, in 2004, the proportion had risen to as high as 32% female HIV disease cases and decreased to as low as 68% male HIV disease cases. The rapid rise of HIV disease incidence among women is consistent with national trends. In the United States overall, the proportion of HIV disease incidence among women also increased threefold over the last decade, with significant variability by geographic region. HIV disease incidence in women is highest in regions where injection drug use (IDU) has historically been a predominant mode of HIV transmission. In the United States, the first evidence that HIV could be transmitted via heterosexual contact was the appearance of AIDS related opportunistic infections in non-IDU sexual partner(s) of male IDUs. Within the District of Columbia, recent HIV disease incidence among women is highest in Wards 7 and 8. Nearly 40% of HIV disease incidence in these areas is attributed to injection drug use, compared to 26% District-wide. Nearly half of all HIV disease cases among women have been attributed to injection drug users. The proportion of HIV disease cases attributed to heterosexual contact has also increased over time. From 2000 to 2004, heterosexual contact cases among both men and women have increased significantly. Figures 4 and 5 show the proportion by risk category of adult HIV disease cases diagnosed in years 2000 through 2004.

Also, Figure 4 shows in detail the change in number of HIV disease cases by mode of transmission among adult females in the District of Columbia. The graph shows a steady decline of HIV disease cases attributed directly to injection drug use and a rise in number of cases associated with heterosexual contact. These heterosexual contact cases among women are associated with injection drug use. The number of cases having No Identified Risk (NIR) has also been steadily increasing since 1995. Similarly, among adult males, Figure 5 shows a steady rise in the number of HIV disease cases with heterosexual contact as the risk factor. HIV disease cases among male injecting drug users seem to be on a decline since 1996, while cases with No Identified Risk (NIR) have been increasing since 1995.

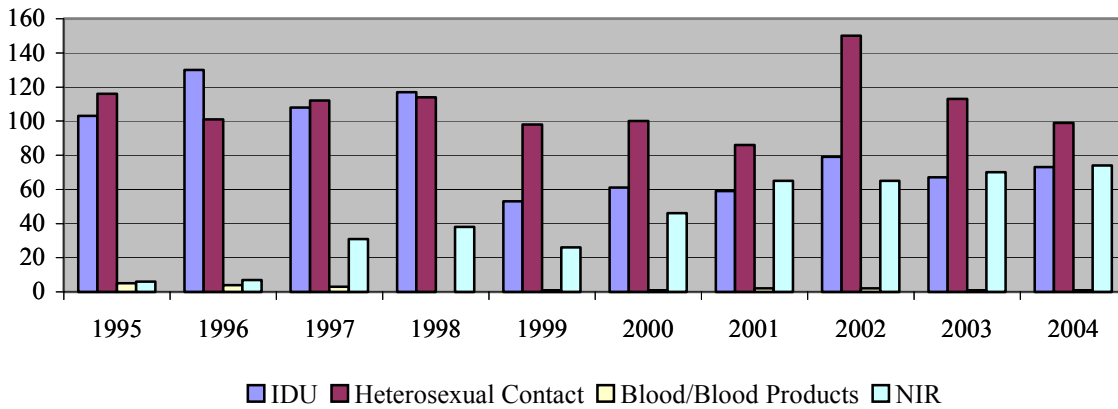
Of the 2,264 cumulative HIV disease cases reported between 1995 and 2004 among African American females, the modes of transmission were: 45.2% heterosexual; 36% IDU; and 33.8% heterosexual sex with persons living with HIV disease (PLWH) (Table 2). The modes of transmission of the 5,069 cumulative HIV disease cases reported during that same period among African American men were: 38.5% MSM; 27.5% IDU; and 11.3% heterosexual sex with PLWH (Table 3).

Figure 3. District of Columbia Adult/Adolescent (age > 12) AIDS Cases, by Year of Initial Diagnosis and Proportion by Gender, Reported through December 31, 2004



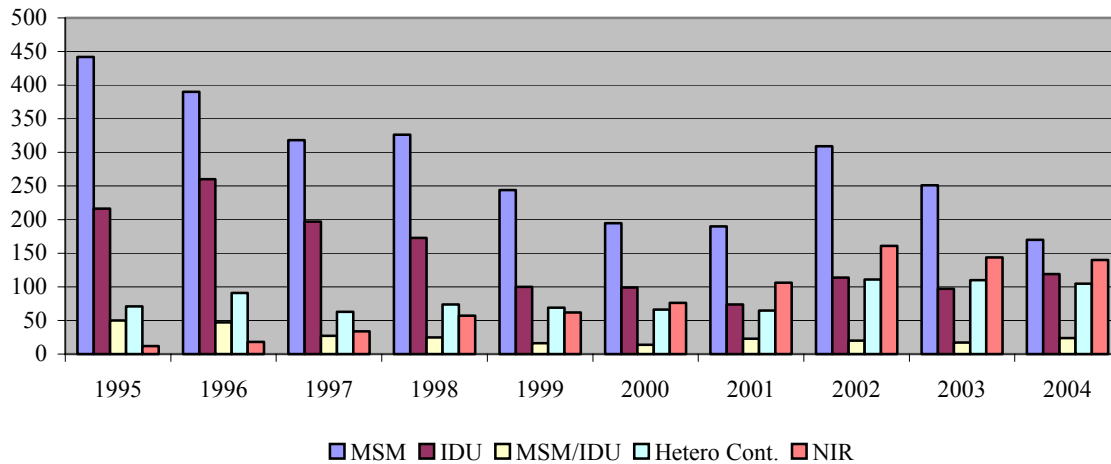
SOURCE: HIV/AIDS Surveillance and Epidemiology Division, Administration for HIV Policy and Programs, Department of Health, Government of the District of Columbia; December 2005.

Figure 4. District of Columbia Adult/Adolescent Female AIDS Cases by Year of Diagnosis and Mode of Exposure, Reported through December 31, 2004



SOURCE: HIV/AIDS Surveillance and Epidemiology Division, Administration for HIV Policy and Programs, Department of Health, Government of the District of Columbia; December 2005.

Figure 5. District of Columbia Adult/Adolescent Male AIDS Cases by Year of Diagnosis and Mode of Exposure, Reported through December 31, 2004



SOURCE: HIV/AIDS Surveillance and Epidemiology Division, Administration for HIV Policy and Programs, Department of Health, Government of the District of Columbia; December 2005.

Table 2. HIV Disease Cases among Adult Females by Race/Ethnicity and Mode of Transmission, District of Columbia, 1995 – 2004.

Females	African American/Black		White		Hispanic/Latina		Total ¹	
	No.	%	No.	%	No.	%	No.	%
IDU	816	36.0%	28	40.0%	9	18.4%	855	35.7%
Het. Sex w/IDU	244	10.8%	7	10.0%	4	8.2%	257	10.7%
Het. Sex w/Bi Male	11	0.5%	0	0.0%	3	6.1%	14	0.6%
Het. Sex w/Recipient Blood Prod.	<5	<1%	<5	<5%	0	0.0%	<5	<1%
Het. Sex w/PLWH	766	33.8%	24	34.3%	25	51.0%	819	34.2%
Heterosexual total	1,023	45.2%	32	45.7%	32	65.3%	1,093	45.7%
Blood/Blood Products	16	0.7%	0	0.0%	0	0.0%	16	0.7%
No Identified Risk	409	18.1%	10	14.3%	8	16.3%	428	17.9%
Total	2,264	100.0%	70	100.0%	49	100.0%	2,392	100.0%

SOURCE: HIV/AIDS Surveillance and Epidemiology Division, Administration for HIV Policy and Programs, Department of Health, Government of the District of Columbia, 2004.

¹ Total includes 9 cases of A/PI and American Indian/Alaskan Native race.

Table 3. HIV Disease Cases among Adult Males by Race/Ethnicity and Mode of Transmission, District of Columbia, 1995 – 2004

Males	African American/Black		White		Hispanic/Latina		Total ¹	
	No.	%	No.	%	No.	%	No.	%
MSM	1,953	38.5%	706	84.4%	166	58.5%	2,834	45.7%
IDU	1,394	27.5%	34	4.1%	21	7.4%	1,450	23.4%
MSM/IDU	233	4.6%	25	3.0%	6	2.1%	264	4.3%
Het. Sex w/ IDU	183	3.6%	<5	<1%	9	3.2%	193	3.1%
Het. Sex w/PLWH	572	11.3%	21	2.5%	36	12.7%	629	10.1%
Het. Sex w/Recipient Blood Prod.	<5	<1%	0	0.0%	0	0.0%	<5	<1%
Heterosexual total	759	15.0%	22	2.6%	45	15.8%	826	13.3%
Blood/Blood Products	11	0.2%	5	0.6%	<5	<1%	18	0.3%
No Identified Risk	719	14.2%	44	5.3%	44	15.5%	811	13.1%
Total	5,069	100.0%	836	100.0%	284	100.0%	6,203	100.0%

SOURCE: HIV Disease Surveillance and Epidemiology Division, Administration for HIV Policy and Programs, Department of Health, Government of the District of Columbia, 2004.

¹ Total includes 14 cases of A/PI and American Indian/Alaskan Native race.

Important to note, in 2002, the Centers for Disease Control reported that among persons age 10-19 years, the rate for Chlamydia was 1,558 per 100,000. In the District, the rate (1,915 per 100,000) for the same age group was slightly higher.³ In addition, among that group, the rate of gonorrhea in the District was 991 per 100,000 (almost twice the national average).³ This data indicates that youth are practicing behavior that can expose them to HIV infection. It is also important to note that the average time between new HIV infections and AIDS-defining illness is approximately 10 years. Persons who become infected with HIV as adolescents may not show up in statistics until they reach their early 20s.

THE HIV DISEASE DEMOGRAPHIC AND GEOGRAPHIC LINK

In the District, certain geographical areas are impacted disproportionately by HIV disease. These same areas are populated by individuals of a lower socio-economic status when compared to other locations in the District. As indicated in Table 4, Wards 7 and 8 are predominantly African American (96.2% and 89.6%, respectively), whereas Ward 3 is mostly White (89%). The overall unemployment rate in 2001 in the District was reported to be 6.4%, in comparison, the rate in Ward 8 was 12%. Of the 541, 617 persons for whom poverty was measured, 20.2% or 109,415 persons were below the poverty level in the District. Ward 3 had the highest median household income and per capita income, and it also had the lowest number persons living below poverty. By contrast, Wards 7 and 8 had the lowest median household income and the smallest per capita income, and it also had the highest percent of persons living below the poverty level (Table 5). Seventy percent (70%) of the persons residing in Ward 3 were college graduates while only 11% and 8% residing in Wards 7 and 8, respectively, were college graduates (Table 6).

Another indicator of disparity among Wards is the distribution of HIV disease cases among females. Of the 3,644 HIV disease cases reported to date, 14.1%, 14.3%, and 17.6%, respectively, were in Wards 7, 6, and 8, whereas 1.1% of the cases were in Ward 3. Related to the number of females living with HIV disease, of the 2, 503 reported cases, 14.2% and 17.4%, respectively, at the time of diagnoses resided in Wards 7 and 8, whereas 1.0% resided in Ward 3.

Table 4. Racial/Ethnic Distribution by Ward, District of Columbia

	Total Pop.	White	Black/African American	American Indian	Asian/Pacific Islander	Hispanic (all races)
DISTRICT OF COLUMBIA*	572,059	176,101	343,312	1,713	15,189	35,744
%	100%	30.8%	60.0%	0.3%	2.7%	6.2%
Ward 1**	76,656	43.3%	52.1%	0.5%	4.1%	23.3%
Ward 2**	76,084	61.0%	31.1%	0.4%	7.5%	9.8%
Ward 3**	75,512	89.2%	4.5%	0.2%	6.2%	8.1%
Ward 4**	72,079	18.6%	79.4%	0.4%	1.5%	7.0%
Ward 5**	69,219	11.0%	87.7%	0.3%	1.1%	2.2%
Ward 6**	66,931	30.3%	67.8%	0.3%	1.6%	2.2%
Ward 7**	68,647	3.2%	96.2%	0.3%	0.3%	0.9%
Ward 8**	66,359	8.8%	89.6%	0.3%	1.3%	1.6%

***SOURCE:** 2000 US Census Data, December 22, 2005 News Release.

**** SOURCE:** 1998 DC Office of Planning/State Data Center, Population by Race & Hispanic Origin by Ward.

Table 5. Selected Socio-demographic Factors: Unemployment, Median Household Income per Capita Income, and Poverty Level

Ward	Unemployment ¹ (%)	Median Household Income ²	Per Capita Income ²	Persons for whom poverty is measured ²	Percent below poverty level ²
1	6.3	\$36,902	\$23,760	68,531	22.0%
2	5.6	\$44,742	\$42,660	60,238	18.7%
3	2.3	\$71,875	\$58,584	68,528	7.4%
4	6.5	\$46,408	\$27,057	73,377	12.0%
5	8.8	\$34,433	\$19,173	67,587	20.0%
6	7.8	\$41,554	\$28,636	64,522	21.1%
7	7.9	\$30,533	\$16,959	69,869	24.9%
8	12.8	\$25,017	\$12,630	69,003	36.0%
D.C.	6.4	\$40,127	\$28,659	541,657	20.2%

SOURCE: ¹ Twelve-month average for 2001, U.S. Bureau of the Census, D.C. Office of Planning/State
² D.C. Office of Planning/State Data Center, 1999.

Table 6. Distribution of Adult Population by Education

Ward	Persons 25 years and over	High School Graduates	College Graduates %
1	54,614	67.6	35.6
2	52,940	81.4	52.3
3	57,808	94.1	70.1
4	56,539	73.5	24.8
5	50,657	65.6	19.4
6	50,952	71.0	31.8
7	46,839	64.3	11.6
8	38,782	61.3	8.0
District	409,131	73.1	33.3

SOURCE: Census 2000, U.S. Bureau of the Census, and D.C. Office of Planning/State Data Center.

**Table 7. Total Females in Population,
Percent of Total Female Population, Cumulative HIV Disease Cases, Percent of
Cumulative HIV Disease Cases, Living HIV Disease Cases, Percent of Living HIV Disease
Cases and Prevalence Rate by Ward**

	Total Female	% of Total Female	Cumulative Cases ^c	% of Cumulative Cases	Living Cases ^d	% of Living Cases	Prevalence Rate ^e
1	36,503	12.1	493	13.5	342	13.7	94
2	33,702	11.1	334	9.2	230	9.2	68
3	41,470	13.7	39	1.1	26	1.0	6
4	39,638	13.1	354	9.7	229	9.1	58
5	38,687	12.8	520	14.3	352	14.1	91
6	33,998	11.2	459	12.6	300	12.0	88
7	39,552	13.1	515	14.1	355	14.2	90
8	39,143	12.9	643	17.6	435	17.4	111
Mental	n/a	n/a	3	.08	2	0.8	-
Homeless	n/a	n/a	130	3.6	102	4.1	-
Prison	n/a	n/a	138	3.8	117	4.7	-
Unknown	n/a	n/a	16	.44	13	.52	-
Total	302,693	302,639	3,644	3,644	2,503		83

SOURCE: District of Columbia Department of Health, Administration for HIV Policy and Programs Surveillance and Epidemiology Division; 12/2005.

^a Ward: geo-political residence at time of initial HIV disease diagnosis.

^b Includes children less than 13 years old, adolescents and adults.

^c Includes persons with a diagnosis of HIV disease, from the beginning of the epidemic through 12/2004.

^d Number of persons living with HIV disease, diagnosed through 12/31/04.

^e Prevalence rate: the number of persons living with HIV disease per 10,000 people.

NEEDS ASSESSMENT PROCESS

As an essential part of the District’s Ryan White II comprehensive planning process, a variety of needs assessments were reviewed. In this process, existing needs were identified; unmet needs were determined; resources were examined; and trends in service utilization, priorities, gaps, and access were analyzed.

Specifically, the following qualitative and quantitative data was reviewed in order to assess HIV disease service needs in the District of Columbia:

- *DC EMA Quality Assurance Assessment Highlights of Findings, 2004*
- *Crystal Meth Data from Several Sources, 2005*
- *Client Survey Findings: “To assess client’s access to medical treatment, and support & prevention services,” 2005*
- *District of Columbia Statewide Coordinated Statement of Need, 2002*
- *Washington, DC Transgender Needs Assessment Survey, Final Report for Phase II, 2000*

1. Title: 2004 DC EMA Quality Assurance Assessment Highlights of Findings

Document Author(s):	Westcon International Ltd.
Method(s) of Data Collection:	Chart review of 741 charts across six service categories.
Data Collection Time Period:	Report is dated 2004
Description of Participants:	20 organizations Eligible Metropolitan Area (EMA)-wide: 9 in DC, 2 in Suburban Maryland, and 9 in Northern Virginia
Summary of Findings:	146 Primary Medical Care charts reviewed 360 Case Management charts reviewed 56 Dental Care charts reviewed 55 Mental Health Care charts reviewed 56 Substance Abuse Counseling/Treatment charts reviewed 68 Nutritional Counseling charts reviewed Strengths and weaknesses were noted in most service categories. Many weaknesses were related to a lack of

client demographic data, lack of data related to client's HIV-infection or disease status, and lack of client signature on specific forms.

Compliance with provision of HIV-specific patient education regarding medical treatment, safer sex, needle use practices, and self-monitoring of symptoms was problematic.

Most providers operated within the guidelines of the established protocols; however, some seemed unfamiliar with or failed to follow the protocols.

Recommendations:

AHPP should provide copies of the most recent versions of applicable protocols to all grantees.

AHPP should review these protocols with each prospective provider for consistency in service requirements and expectations.

The established protocols should be integral elements of future grant agreements.

Future grant agreements should, in reasonable specificity, define service providers' responsibilities with respect to quality assurance.

AHPP should consider developing standard client intake and initial assessment forms as well as standard forms for documenting routine laboratory tests and health indicators such as viral loads and CD4 counts.

Such standard forms, if well coordinated, should meet the needs of the service providers as well as the requirements of the protocols.

AHPP, in concert with providers, should devise, at appropriate levels, means of ensuring patient education on HIV disease issues including medical treatment, safer sex, needle use practices, and self-monitoring of symptoms.

Establish standard documentation of patient education that emphasizes secondary prevention and requires the signatures of both the provider and the patient.

AHPP, as a priority, should invest in technical assistance to address the quality assurance and quality improvement issues raised by this assessment.

Review this and previous QA assessments and develop curricula to meet the technical assistance needs of the respective providers.

At a minimum, the curricula should focus on highlighting best practices and accurate and complete recording of clinical information.

2. Title: *Crystal Meth Information from Title I Application and Other Sources*

Document Author(s):	HIV/AIDS Administration, District of Columbia Department of Health
Method(s) of Data Collection:	Compilation and analysis of available data
Data Collection Time Period:	2005
Description of Participants:	N/A
Summary of Findings:	<p>Abuse of methamphetamine has increased dramatically in recent years particularly among gay men but also among MTF (Male to Female) transgendered individuals and increasingly among some groups of lesbians.</p> <p>Currently, 75% of outpatient substance abuse treatment admissions to Whitman Walker Addiction Services (WWAS) report crystal methamphetamine use as compared to 50-60% in year 2001 and 35% in year 2000.</p> <p>In 2005, 16% of Lambda Center admissions for medical detox reported methamphetamine use.</p> <p>In 2001, WWAS reported alcohol as the number one primary-drug of choice. In 2005, methamphetamine was the primary drug with cocaine second and alcohol third.</p>
Recommendations:	The rise in crystal meth use suggests an increase in HIV infections and is a complicating condition for the treatment

of HIV disease, and this should be taken into account when planning for services. This suggests a need for increased substance abuse treatment services and increased outreach and prevention services for populations involved with crystal meth use.

3. Title: 2005 Client Survey Findings: “To assess client’s access to medical treatment, and support & prevention services.”

Document Author(s):	Elona Finkelstein, May 2005
Method(s) of Data Collection:	Written survey distributed by Title I-funded service providers to target groups in English and Spanish. A \$10 food voucher was provided as an incentive to complete the instrument.
Data Collection Time Period:	February – April 2005
Description of Participants:	1,103 Persons Living with HIV Disease and Caregivers. 610 (55%) live in DC; 275 (25%) live in Maryland; 168 (15%) live in Virginia; and 50 (5%) live in West Virginia.
Summary of Findings:	<p>(1) Reported Utilization of Medical Care 738 respondents needed medical care in the last 6 months <i>6% who needed the service did not receive it.</i> By jurisdiction: % who needed the service but did not receive it: DC – 4%; MD – 9%; VA – 7%; and WV – 4%</p> <p>(2) Reported Utilization of Dental Care / Oral Health 502 respondents needed dental services in the last 6 months <i>29% who needed the service did not receive it.</i> By jurisdiction: % who needed the service but did not receive it: DC – 34%; MD – 21%; VA – 27%; and WV – 16%</p> <p>(3) Reported Utilization of Case Management 638 respondents needed case management services in the last 6 months <i>7% who needed the service did not receive it.</i> By jurisdiction: % who needed the service but did not receive it: DC – 9%; MD – 6%; VA – 5%; and WV – 8%</p>

(4) Reported Utilization of Mental Health

297 respondents needed mental health counseling in the last 6 months:

12% who needed the service did not receive it.

By jurisdiction: % who needed the service but did not receive it:

DC – 15%; MD – 7%; VA – 9%; and WV – 8%

(5) Reported Utilization of Substance Abuse Treatment Services

164 respondents needed substance abuse treatment services in the last 6 months.

23% who needed the service did not receive it.

By jurisdiction: % who needed the service but did not receive it:

DC – 23%; MD – 22%; VA – 88%; and WV – 18%

(1) Barrier: Long Wait for Appointment

1,061 respondents responded to the statement, “a long wait for appointments”

73% “disagreed” with the statement, 24% “somewhat agreed,” and 12% “agreed”

By jurisdiction: % who either “somewhat agreed” or “agreed” with statement:

DC – 41%; MD – 27%; VA – 36%; and WV – 34%

(2) Barrier: Difficulties Communicating Needs to Case Manager

1,040 respondents responded the statement, “difficulties communicating needs to case managers”

82% “disagreed” with the statement, 11% “somewhat agreed,” and 8% “agreed”

By jurisdiction: % who either “somewhat agreed” or “agreed” with statement:

DC – 18%; MD – 20%; VA – 17%; and WV – 16%

(3) Barrier: Service Providers Don’t Understand People Like Me

1025 respondents responded to the statement, “service providers don’t understand people like me”

77% “disagreed” with the statement, 16% “somewhat agreed,” and 7% “agreed”

By jurisdiction: % who either “somewhat agreed” or “agreed” with statement:

DC – 25%; MD – 22%; VA – 21%; and WV – 19%

(4) Barrier to Medical Appointments: Can't get transportation

1,058 respondents responded to the statement, "can't get transportation"

74% *disagreed with the statement*, 17% "somewhat agreed," and 9% "agreed"

By jurisdiction: % who either "somewhat agreed" or "agreed" with statement:

DC – 27%; MD – 23%; VA – 29%; and WV – 20%

(5) Barrier to Medical Appointments? Can't Get Childcare

910 respondents responded to the statement, "can't get childcare"

90% *"disagreed" with the statement*, 5% "somewhat agreed," and 5% "agreed"

By jurisdiction: % who either "somewhat agreed" or "agreed" with statement:

DC – 9%; MD – 12%; VA – 10%; and WV – 5%

(6) Barrier to Medical Appointments? No evening or weekend hours

1,011 respondents responded to the statement, "no evening or weekend hours"

74% *"disagreed" with the statement*, 13% "somewhat agreed," and 13% "agreed"

By jurisdiction: % who either "somewhat agreed" or "agreed" with statement:

DC – 25%; MD – 27%; VA – 30%; and WV – 19%

What topics/issues did the case manager discuss with the client?

54% discussed their medical treatment and/or dental care/oral health

54% discussed adherence to HIV medications

42% discussed their practices of safer sex

36% discussed attending HIV risk reduction counseling

Services to which Clients were referred by the Case Manager

42% were referred to medical treatment and/or dental care/oral health

17% were referred to treatment adherence counseling

20% were referred to mental health counseling

12% were referred to substance abuse counseling

21% were referred to HIV risk reduction education

Recommendations:

This report does not include recommendations.

4. Title: *District of Columbia Statewide Coordinated Statement of Need, 2002*

Document Author(s):	HIV/AIDS Administration, District of Columbia Department of Health
Method(s) of Data Collection:	Review of various needs assessment documents, epi-data, client surveys, and focus groups. Feedback provided from attendees (more than 500 residents) who participated in an HIV disease conference as well as feedback from a meeting with service providers.
Data Collection Time Period:	2001
Description of Participants:	Residents of DC, service providers, and people living with HIV disease
Summary of Findings:	<p>Among emerging trends are adults over the age of 45 and youth as well as co-infection with Hepatitis.</p> <p>Treatment adherence and failure issues are noted. Increased mental health services, outreach to MSM, men on the “down low (DL),” and the incarcerated are identified. More women are getting infected. The critical service gaps identified are: Prevention, Ambulatory Outpatient Care, Mental Health, Substance Abuse, Housing, Childcare, and Case Management.</p> <p>Cross Cutting Issues:</p> <ul style="list-style-type: none">• Education needed for PLWH, service providers, intergovernmental agencies, and the community at large.• Specialty Health Care—few clients can access specialty health care before funds are expended. Recommended to separate this category from primary medical care and allocate funds accordingly.• Quality of Care—quality assurance and evaluation of service delivery should take into account

ethnicity, sexual orientation, and lifestyle of those utilizing the services.

- Housing—affordable, accessible and safe housing is difficult to obtain.
- Geographical Focus—East of the Anacostia River—needs incentives and capacity building efforts to concentrate on development of organizations in this hard reach area.
- Medicaid Certification—community based organizations should become Medicaid certified due to limitations of federal funds.

Recommendations:

The document identifies several broad goals:

- Substance Abuse and Mental Health:
To improve the service needs of multiple-diagnosed PLWH in the District of Columbia through cross-education among providers of substance abuse, mental health, and HIV-related care.
- Women:
To improve the health service delivery system for women in the District of Columbia.
- Secondary Prevention:
To provide resources for prevention of co-morbidities not related to HIV in PLWH.
- Linkages:
To avoid the duplication of services.
To better educate case managers on the services of providers and improve accessibility of case management services.
To initiate a collaborative effort among providers toward client tracking through the utilization of Xpres and data systems.
- MSM:
To develop intervention and prevention mechanisms targeting MSM.

5. Title: *Washington, DC Transgender Needs Assessment Survey, Final Report for Phase II*

Document Author(s):	Jessica M. Xavier
Method(s) of Data Collection:	Survey of 252 gender variant individuals
Data Collection Time Period:	September 1999 – January 2000
Description of Participants:	Age ranges 13 to 61, with nearly 80% 36 years and under. 75% born anatomically male, 24% female and 1% intersexed. 70% African American and 22% Latina/o. 84% are U.S. citizens, and 20% have immigrated to the U.S., mostly from Latin American countries. 65% self-report as gay with their gender identity as Transgender, and their relationship status as single (69%). 58% are employed in paid positions and 29% report no source of income at all.
Summary of Findings:	<p>The most commonly reported sources of information about HIV disease for all participants are HIV seminars, workshops, and focus groups (22%), doctor’s offices (12%) gay and lesbian bars or nightclubs (11%) and schools (11%). Of those who are not HIV positive or who do not know their HIV status, nearly forty percent report being tested within the last six months, and a third report a testing frequency of every six months. However, 18% report never being tested.</p> <p>Twenty-five percent of all participants report being HIV positive, with 53% report being HIV negative and 22% who do not know their HIV status. Thirty-two percent of the Males-to-Females (MTFs) report being HIV positive. Seventy percent of the seropositive participants were diagnosed more than two years ago, and two-thirds believe they became infected with HIV through unprotected sex with non-transgendered males. Only 8% of the seropositive participants report encountering barriers to receiving HIV/AIDS services. The most common inaccessible service is hospitalization (3 cases), and the most common barrier cited is provider insensitivity or hostility to transgendered people (3 cases). Quality and sensitivity ratings of accessed transgender care services are also good to excellent, with somewhat higher overall access levels than regular or transgender-related medical care.</p>

Conclusions drawn in the report include:

1. The transgendered population is radically different from MSM communities.
2. Many socioeconomic factors in the transgendered population negatively impact access to all forms of health care and housing.
3. The high overall HIV prevalence rate of 25% (32% in MTFs), along with the high numbers who report unsafe sexual behaviors, demonstrate a population at a significantly high, immediate risk for HIV disease and other STDs.
4. With regard to alcohol and drug abuse co-factors, 46% of the participants report having had sex while drunk or high, and 22% admit to drug use as a reason for having unsafe sex, along with 9% who had unsafe sex to obtain drugs.

Recommendations:

1. A paradigm shift is strongly recommended in order to provide effective prevention methods specifically targeted at transgender subpopulations. The establishment of a Gender Variant (GV) category separate from MSM must be carefully considered.
2. The development of HIV/STD education and prevention materials specifically targeted to transgendered people is an immediate and pressing need. As with other populations, effective prevention materials must be culturally-appropriate and sensitive to transgendered subpopulations.
3. Transgender outreach efforts must be continued and should be expanded to include additional transgendered subpopulations, especially Latina/o and FTM groups.
4. Creative solutions to housing difficulties of transgendered people should be explored, including the establishment of transgender-only housing units, floors in existing housing facilities, lockable rest-room or separate wash-room facilities if necessary, and additional training for staff of assisted housing agencies.
5. The development of a pilot program for transgendered people in the District's vocational rehabilitation system should be planned in conjunction with the appropriate DC

Government agency, along with sensitivity training for its personnel.

6. The implementation of educational programs for medical providers about transgender care, and transgender sensitivity and awareness in-service programs for the staffs of AIDS service organizations (ASOs), social service community organizations (CBOs), substance abuse treatment facilities, and housing agencies should be made a permanent part of regular in-service training.

7. The establishment of a local clinical program for hormonal sex reassignment and transgender-related care, with careful monitoring of blood levels during hormone administration, and provision of transgender-sensitive gynecological care for transsexual men and women.

8. The development of educational programs for transgendered people about transgender care. Health education plays a key role by empowering transgendered people to become informed consumers of transgender-related care. These programs would help transgendered people become more informed about their bodies and sexual anatomy, the risks involved in transgender-related care, the procedures and treatment options available to them, and their rights as consumers under the *Benjamin Standards of Care*. This would increase their likelihood to seek greater access to transgender care, which would impact positively on their overall health. Successful resolution of incongruent gender identity and somatic states should reduce the impact of negative body issues that lower self-esteem and create opportunities for high-risk sexual behaviors and substance abuse. Such programs also present excellent opportunities for additional efforts to raise awareness about HIV disease and its prevention.

SUMMARY

In conclusion, the District of Columbia is unique in that it is a city, a state, and the seat of the federal government with residents who are predominantly African American followed by White, Hispanic, Asian/Pacific Islander, and American Indian. The District has not been left unscathed by the HIV disease epidemic. In fact, the number of reported persons living with HIV disease is among the highest in the country.

The most current epidemiological data available for the District suggests that HIV disease is most prevalent among African Americans, males, MSM, persons aged 50+, and injecting drug users. In addition, geographic-focused data indicate there are links among geographical areas, race/ethnicity, socio-economic indicators, and HIV disease. For example, in Ward 8, African American females with a lower social economic status are in direct contrast to the White females in Ward 3 of a higher social economic status. The African American females in Ward 8 are more likely to be infected with HIV disease than the White females in Ward 3.

The review of the qualitative and the quantitative assessments for this section revealed the following:

- Need to broaden funding base for services
- Assure access for populations with specific needs (e.g., transgendered persons, women, pregnant women, MSM, and IDU) into targeted services if needed and provide education to them with the appropriate care
- Improve linkages among case management and other services including improved documentation of services referred and services received
- Improve linkages among prevention and patient care, and patient care and secondary prevention services
- Conduct cross training for substance abuse and mental health providers
- Coordinate with other agencies that serve people with chronic or severe illnesses (e.g., substance abuse, mental health, and diabetes)
- Improve surveillance data collection and dissemination process in the District of Columbia
- Enhance data systems to assure valid data is available, including data on services funded that are not contracted
- Improve efficiency in conducting needs assessments, developing plans, and monitoring and evaluating progress in meeting plan goals
- Reports on sub-grantee expenditures
- Standardize protocols and create “best practices” training for providers
- Provide education of protocols
- Standardize intake and assessment forms
- Increase documentation of client-level outcomes
- Assure that processes take into account client diversity

The needs assessment process is vital to creating the Comprehensive Plan for 2006-2008. Its utility is manifested in the development of the goals and objectives for the Plan. Moreover, those goals and objectives are based on the findings in the needs assessment process that pinpoint key issues such as gaps in services, quality of care, needs of special populations as well as strong intra- and inter-agency linkages that are required to adequately support persons living with HIV disease.

SECTION II: CONTINUUM OF CARE

DESCRIPTION OF THE CURRENT SERVICE DELIVERY STRUCTURE

History of the District's Response to the Epidemic

HIV disease found its place quickly and intensely among the population living in the District of Columbia. Early in the history of the disease in this country, the public health and medical communities responded to meet the needs of those infected and to find effective methodologies to prevent its spread. From the beginning, the District has benefited from a steady increase in CARE Act and other funding sources, allowing a continuum of care to be established in ways that were responsive to the needs of PLWH.

A series of Director's Organization Orders led to the establishment of what is now the District of Columbia Administration for HIV Policy and Programs (AHPP). The first Order established an AIDS Program Coordination Office in 1986 (#140 of July 31, 1986). The second established an Office of AIDS Activities (#152 of June 9, 1987). The third created was the Agency for HIV/AIDS (#219 of December 7, 1993), and the fourth expanded the agency into the Administration for HIV/AIDS (#8 of May 27, 1997). The responsibility for Ryan White Title II programs lies within the CARE Services Division of the Administration for HIV Policy and Programs.

Infrastructure of AHPP

The Administration for HIV Policy and Programs carries out its mission by monitoring the spread of HIV disease in the District and coordinating the provision of services through partnerships with provider organizations. The CARE Services Division of the Administration for HIV Policy and Programs ensures all District residents living with HIV receive equal access to quality health care regardless of race, ethnicity, or economic status. Within the Division, services fall into three broad service categories: medical services, social/support services, and housing services.

In the District of Columbia, Ryan White Title II programs are an integral part of the total system of care, which includes all Ryan White Titles as well as Medicaid, Addiction Prevention Recovery Administration (APRA), and other programs. This total system has a goal of providing a "continuum of care" as defined by HRSA: "a coordinated delivery system, encompassing a comprehensive range of services needed by individuals or families with HIV infection to meet their health care and psychological service needs throughout all stages of illness."

Funded Service Areas, FY 2005

During FY 2005, the Administration for HIV Policy and Programs funded the following service through Ryan White Title I and Title II CARE Act funds:

- Case Management;
- Family Centered Case Management;

- Complementary Therapies;
- Discharge Planning Services for Ex-offenders;
- Services for Ex-offenders;
- Substance Abuse Counseling;
- Treatment Adherence;
- Early Intervention Services;
- Ambulatory Outpatient/Primary Medical Care;
- Mental Health;
- Dental/Oral Health;
- Emergency Drug Assistance;
- Nutritional Counseling;
- Emergency Rental Assistance;
- Food Bank; and
- Transportation

Addressing Gaps in Services

Based on the results of the *Unmet Need Framework calculations* (number of persons aware that they have HIV but are not in care), recent epidemiological data and the overall goals and objectives of Department of Health related to the HIV disease epidemic in the District, there will be programmatic changes in services. Geographically, the placement of some services will be determined by quadrants and neighborhoods of the city with higher poverty and HIV disease unmet needs. By focusing on specific areas of the city, AHPP will provide services in nontraditional locations where there are unmet needs of HIV disease high-risk populations. Community kitchens, neighborhood employment services, and diverse support agencies such as Women, Infant, and Children (WIC), are examples of proposed nontraditional locations to access hard to reach populations in the District.

Also, more services for women and youth will be identified, and appropriate intervention for those populations will be designed and implemented. In addition, AHPP expects to bring a large number of “out of care” residents into care through counseling and testing and early intervention services.

AHPP’s Grant Administration and Accountability

Currently there is no Finance Department at AHPP. The Grants and Contracts Division is currently working in that capacity. They approve all supporting documentation for invoices and ultimately approve or deny payments. This division works in tandem with the Office of the Chief Financial Officer (OCFO), who provides an auditor to accompany both Grants and Program staff when site visits are conducted for sub-grantees.

Grant administration and accountability are essential components to providing adequate and timely services to persons living with HIV disease in the District. AHPP continues to excel in the distribution of Title II funds as legislatively mandated. Seventy-five percent to eighty-five percent of CARE Act funds are consistently obligated within 90 days of receiving the Federal Notice of Award. This is accomplished by engaging in pre-award activities 120 days before the

award is received. Once the Notice of Grant Award is received, provisional sub-grants are released and programs begin providing services. In most cases, continuity of care can be seamlessly ensured through this process.

Once sub-grants are distributed, sub-grantees are assigned a program monitor and a grants management specialist (fiscal monitor). Collectively, these monitors are responsible for monitoring and recording successes and challenges in executing sub-grants. Fiscal monitors ensure compliance with the terms and conditions of the grant agreement and program monitors support and guide agencies in the development and execution of services to persons living with HIV. Together the monitors conduct site-visits, provide technical assistance, and provide recommendations for remediation of any programmatic issues.

Request for Application (RFA) Process

Approximately every two years, AHPP releases a Request for Applications (RFA) which invites the submission of applications for funding under Ryan White Title II. The service areas that are available for funding are based on needs assessments, epidemiological and service utilization data, and coordination with Title I and other sources of funding. Once applications are submitted, they are reviewed by an external panel. Based on the scores and funding availability, awards are made.

Service Point of Entry

AHPP ensures that CARE Act funds are the payor of last resort by requiring clients who may be in need of CARE Act funded services to undergo an intake process that includes eligibility screening. For clients receiving case management services (approximately 95% of all CARE Act clients), documentation of eligibility screening appears in the client record. For those who do not receive case management services, their point of entry is typically through ADAP.

Program Monitoring

A program monitor conducts a monthly desk-audit of program deliverables and outcomes for each sub-grantee. When program monitors identify a programmatic concern, they contact the sub-grantee directly and offer assistance. In addition, the program monitor works with the sub-grantee to develop a corrective action plan that is time framed and measurable. Annual programmatic site visits are conducted to review program files, interview staff, and review documentation of program outcomes. As with fiscal concerns, the ultimate goal is to support the delivery of high quality health and support services to persons living with HIV disease. AHPP program monitors will work very closely with grant management specialists and quality assurance staff members to achieve this goal.

Quality Management

During fiscal year 2004, 4.1% of Title II funds or \$827,215 was allocated to Quality Management efforts. The Administration for HIV Policy and Programs has established and implemented systematic safeguards with periodical updates to ensure that quality HIV services

are provided to persons living with HIV. To implement these safeguards, the AHPP has developed a Quality Management Team (QMT) that includes a health care professional with experience in substance abuse and mental health and a social worker with expertise in case management and social services. They both have extensive health care experience and expertise in relation to total quality improvement management with service delivery, outcome measures, and developing standards and protocols.

The overall goals of the QMT are to measure the quality of HIV programs and make recommendations for improvement through programmatic site visits and extensive chart reviews. The U.S. Public Health Service guidelines and standards of care developed by the Title I Planning Council are used to guide the quality assurance process. When the Quality Management Team finds a sub-grantee in need of technical assistance, it makes a referral to DC TechNet, a program that offers extensive technical assistance in both fiscal and program operations. Through DC TechNet, sub-grantees can obtain on-site services to help them establish and maintain the protocols to provide services that meet quality management standards.

A part of the quality assurance process has been the development of the Case Management Operating Committee (CMOC), which is comprised of representatives of case management organizations in the District. The CMOC meets monthly to address issues such as coordination and duplication of case management efforts, assessment of changing needs within the HIV/AIDS community, and to discuss policy and practice issues. Specifically, the committee develops standards of care for case managers and has formed an association of case managers to review various models of case management and certification for case managers. Also, the committee provides quarterly training for case managers on topics, including the following: Medicaid, genotypic testing, quality management, ADAP, drug adherence, and the role of the case managers as key advocates and motivators for the client. Continuing Education Units (CEU) are given to participants.

Also, in an effort to improve case management service delivery throughout DC, a quality assurance subcommittee of CMOC was established to improve and amend the Case Management Protocol currently utilized by the majority of HIV disease case management agencies. This protocol is the result of best practice standards gathered from a variety of HIV disease services providers throughout the United States. The purpose of this protocol is to provide a guide to assure quality HIV disease case management throughout the District of Columbia EMA.

The goals of the District of Columbia EMA's Case Management Quality Assurance Protocol are as follows:

- Provide a guideline for HIV case managers to practice strength-based, client centered, culturally sensitive, and outcome-driven services to residents of the District of Columbia EMA who are infected with/affected by HIV.
- Highlight and emphasize the importance of standards of case management that are consistent throughout the varied HIV disease case management agencies.
- Provide support and advocacy for on-going HIV disease case management training, education, and professional supervision.
- Establish minimum standards for HIV case management practice EMA-wide.

Specific QA Activities

During fiscal year 2004, comprehensive site visits were conducted to assess the quality of existing programs. The site visits utilized a standardized instrument designed to obtain programmatic and operation information through staff and client interviews and a review of all pertinent documentation.

Also in 2004, the Quality Management Team conducted two studies in partnership with the Ryan White Title I program. The first was a cross sectional study of case management services and primary medical care. The purpose of the study was to determine actual caseload capacity, staff qualifications, and make recommendations for improvement.

The second study measured client-level outcomes based on service provision and access. The purpose of the study was to determine to what degree geographically-centralized services affect client level outcomes, including treatment adherence and compliance.

Specific QA Site Indicators

Quality service indicators have been developed for the six identified core service areas within Title I. These services areas are: Primary Medical Care, Case Management, Oral Health, HIV-related Medication, Substance Abuse and Mental Health. Listed below are the service indicators and the corresponding service categories (Case Management, HIV-related Medications, and Substance) that are specific to Title II programs:

Service Category

Indicators

Case Management

- 85% of all clients will remain in primary care.
- 75% of new clients not currently in care will be linked into primary care.
- 75% of all clients will show attainment of identified needed support services.
- Client assessments will be conducted on 75% of all new clients and updated every three (3) months on all clients as long as the client case remains open.
- 85% of uninsured clients will be screened and referred for health insurance (i.e., Medicaid/Medicare).
- 75% of clients will have a minimum of one face-to-face per quarter of each year.
- 75% of clients will have documented monthly telephone contacts.

HIV/AIDS Medications

- 100% of prescribed medication is HIV-related medication.
- 100% of clients are offered HAART treatment with CD4 <500 and Viral Load 5,000.
- 85% of clients offered HAART will receive treatment.
- 100% of clients on HAART treatment are receiving combination therapy.
- 100% of clients are offered Protease Inhibitors treatment with CD4 <200 or viral load between 5,000 and 10,000.
- 85% of clients offered Protease Inhibitors will receive treatment.
- 100% of clients who have ever had CD4 counts below 200 or a CD4 percentage ever below 12% are offered PCP Prophylaxis treatment.
- 85% of clients offered PCP Prophylaxis will receive treatment.

Substance Abuse Treatment and Counseling

- 100% of clients not in primary medical care will be linked into care.
- 85% of clients will receive appropriate treatment and counseling (i.e., individual, group, family, support, etc.)
- 85% of all counseling appointments will be kept.
- 100% of new clients will have a substance abuse assessment completed.
- 75% of clients deemed appropriate will participate in risk-reduction programs.
- 75% of clients will be seen in a program(s) at least weekly.

Recent Initiatives

Based on HIV disease epidemiological profiles, needs assessments, and gaps in services, Title II is targeting women, infants, youth, and communities of color through the following initiatives:

Women, Infants, Children, and Youth (WICY)

The Administration for HIV Policy and Programs has placed a major emphasis on services to women, children, and youth. This cross-program integration (i.e., prevention, housing, planning and evaluation, Title I, Title II) commitment to this population resulted from a review of the epidemiological data and community input in a World AIDS Day Town Hall meeting focusing on women and girls. Currently, 33% of CARE Act funds support services for this population.

Cases of HIV disease among women in the District of Columbia are increasing, especially in Wards 7 and 8. As a result, the District has prioritized sub-grantees who serve women and their children in those areas. This includes a capacity building initiative that identifies smaller community-based organizations that have access to specific target populations (such as post-partum mothers and female IV drug users). The District of Columbia has also paired larger, established HIV organizations that have experience working in the areas of prevention and care for women, children, and youth with small community based organizations that serve a specific population, but may not have experience in providing HIV services. In addition, the District has made a commitment to fund demonstration projects that specifically address the needs of women, children, and youth.

Minority AIDS Initiative (MAI)

MAI focuses on reducing disparities and improving access to care and services in disproportionately impacted communities of color. MAI funding through the ADAP program has been targeted towards Outreach and Referral services that are designed to enhance knowledge of ADAP-availability in communities of color. The program's goal is to increase awareness and provide culturally and linguistically appropriate education on the ADAP and its associated services (access to care, treatment adherence, and treatment updates) among subgroups within the target populations, specifically persons newly diagnosed with HIV, HIV positive persons not linked into care, and HIV positive persons who have not accessed ADAP within the past six months. In addition to direct client education, the programs will perform outreach activities to physicians and other service providers who offer services to the African American and Latino communities in an effort to increase client awareness and enrollment in ADAP. The primary activities for this program consist of: street level outreach and individual health education to clients; participation in community health education events; conducting presentations to physicians and service providers; and screening clients for eligibility and ensuring enrollment in ADAP.

Ward 7 Initiative

Based on surveillance and epidemiological data, there is strong indication that service capacity building is essential to lessening the devastating impact of HIV disease in Ward 7. An initiative to meet the HIV disease care and prevention needs of persons residing in that area has been funded through AHPP.

The Administration of HIV Policy and Programs has contracted with a consulting group to plan, coordinate, implement, and evaluate the following activities targeting community members and potential providers in Ward 7:

- Administer a needs assessment.
- Conduct focus groups.
- Compile, analyze, and interpret needs assessment and focus group data.

Findings from the needs assessment and focus groups will be used in the development of a scope of work that will be written into a Request for Application (RFA). The application will then be used to identify and select organizations that are qualified to initiate capacity building in that area. In addition, the data gathered in that community will assist in eventually establishing a resource center specific to HIV disease prevention and care.

COORDINATION OF SERVICES

The District of Columbia's All Titles Committee members (comprised of providers from varying funding streams) continue to meet quarterly to discuss and coordinate HIV disease services in the District. The primary focus of coordination is the co-location of services such as treatment adherence with primary medical services as well as substance abuse programs with mental health services.

Coordination also occurs between CDC funded and local prevention initiatives and CARE services. Given the new emphasis on making HIV antibody testing a routine part of medical care in the CDC's new *Advancing HIV Prevention Initiative*, the Administration for HIV Policy and Programs (through Title II) has placed emphasis on linking people who test HIV positive to early intervention services that include primary medical care and case management. As a result, many of the counseling and testing sites are co-located with primary medical care and/or case management services.

As the paradigm for HIV service delivery shifts, the need to integrate prevention and care becomes more apparent. In response to this, the Administration for HIV Policy and Programs is developing a plan that would consolidate the Ryan White Title I Planning Council and the District's HIV Prevention Community Planning Group to develop a comprehensive community planning process. This coordinated effort will be key in creating a road map for the development of services and programs that mirror the complex issues surrounding HIV disease in this region.

Additionally, key components of this comprehensive plan will be used to develop ways to maximize resources to ensure equity and parity in services.

HIV DISEASE HEALTH CARE AND TREATMENT FUNDING

Medicaid

The District of Columbia currently receives 70 cents from the federal government for every dollar spent on Medicaid.⁴ Thus, there is a strong incentive to maximize enrollment in Medicaid rather than use programs funded solely with local resources. Many of AHPP's primary care providers are Medicaid certified, and the District continues to reinforce the importance of billing Medicaid for enrolled clients.

During AHPP's Single Point of Entry eligibility system for ADAP, clients are referred to other programs such as Medicaid if they appear to be eligible. This system ensures that clients are referred to the most comprehensive and cost-effective health programs available. In addition, the District has recently begun an inter-agency prenatal initiative between the state Medicaid agency and the Administration for HIV Policy and Programs to encourage prenatal HIV testing and offer access to the range of HIV-related services.

Expanded Medicaid Programs

The federal government has issued grants to Medicaid for programs for patients who have HIV disease but who do not fully meet Medicaid eligibility requirements for health services. These grants have given rise to the following demonstration projects:

Ticket to Work—This HIV-specific demonstration program in the District expands Medicaid eligibility to include persons with HIV disease who: (1) work at least 40 hours per month; (2) have incomes under 300 percent of the federal poverty level (FPL); and (3) do not have job-related health insurance. The District program is capped at 420 persons.

Section 1115—This Project is intended to “provide more effective, early treatment of HIV disease by making available all Medicaid services, including antiretroviral services.” During the demonstration, up to 620 HIV-positive persons with incomes at or below 100 percent of federal poverty level and resources (value of assets, including cars and saving, that beneficiaries may possess and remain eligible for Medicaid) with the categorically-needed limits will be allowed to enroll in the demonstration.

DC Alliance

DC Healthcare Alliance is a public-private partnership funded by the District of Columbia Government for residents who lack health insurance and whose income is at or below 200% of

the federal poverty level. The program's focus is on providing care for patients with serious illnesses. All enrolled members of the services have been assigned a medical home with a primary care physician. To better coordinate care services, new programs and a patient-tracking system have been implemented. Overall, the purpose of the program is to shift medical care from an emergency room and acute care setting to community-based health clinics and primary physicians in support of the District's many low-income residents who are in need of care and who do not qualify for Medicaid.

The cornerstone of this health care reform initiative was the creation of the Healthcare Safety Net Administration (HCSNA), which began operations May 1, 2001.⁵ Currently, the HCSNA provides oversight and monitoring over the DC Healthcare Alliance and ensures compliance with contracts. The key objective of its efforts is to make certain that cost-effective, high quality care services are available and accessible to all individuals enrolled in the Alliance program.

Medicare Part D

After many years of discussion and debate and two years of intensive program planning and development, Medicare prescription drug coverage became effective January 1, 2006.⁶ The historic expansion of Medicare also brings enormous change to Medicaid programs. Nationwide, over 6.1 million low-income seniors and people with disabilities who are enrolled in both Medicaid and Medicare ("dual eligible") are transitioned from Medicaid drug coverage to Medicare "Part D" coverage offered through private plans.⁶

On Medicare Part D, persons living with HIV disease may be required to pay a \$250.00 per deductible, \$34.00 per month premiums, and co-pays per prescription. However, the deductibles and the monthly premiums may be eliminated based on eligibility for low-income subsidies. The greatest expense to clients appears to be out-of-pocket. Based on the high cost of medications for persons living with HIV, the initial months of the coverage period will result in the client reaching the "doughnut hole," at which point there is no coverage for prescription drugs. At that same point, clients may need to access ADAP services. The District of Columbia's goal is to assist clients, if needed, with all expenses that are out-of-pocket.

State Children's Health Insurance Program

The District funds the State Children's Health Insurance Program (SCHIP). The program offers health insurance to any child living at or below 300% of the federal poverty level. Outreach services through both Title I and II provide activities to link SCHIP participants to HIV disease health and support services.

Housing Opportunity for People Living with AIDS (HOPWA)

The changing housing market in the District limits access to safe and affordable housing for low-income persons living with HIV. Among HIV planning bodies, there is discussion about HOPWA's eligibility requirement criteria and gaps in their system. The Title II program works with HOPWA by providing training to case managers about HOPWA regulations. Based on those regulations, the case managers at their monthly meetings are able to realistically discuss

the housing vacancies, waiting lists, and supportive and tenant based rental assistance that impact people living with HIV.

Substance Abuse Prevention and Treatment Services

The District of Columbia has prioritized the co-location of substance abuse and mental health counseling services with primary medical care and case management services. In addition, by working with the District's Addiction Prevention and Recovery Administration (APRA), the District is able to provide individuals with dual and multiple diagnoses, with easy access to essential services. Of particular note, persons living with HIV are given priority for APRA services, and referrals are made by both case managers and physicians. All substance abuse programs are contractually required to conduct HIV risk assessments and provide basic HIV-education to all clients.

SYSTEM OF CARE

Case Management Services

Points of entry into the system are facilitated by outreach workers, referrals from other services, self-referrals, referrals from hospitals, and HIV-counseling and testing sites. Many of the HIV-counseling and testing sites in the District are co-located within primary medical care and Title II-funded case management services. This enables easy access to case management for clients who test HIV positive. Test sites that do not have case management services have post-test counselors who have a referral list of agencies in the area that offer these services. At this time, they may also discuss various options with the client (e.g., housing). The client is encouraged to select one case management provider, and then a counselor assists the client in arranging for an initial appointment with a case manager at the selected agency. Also, the counselor conducts follow-up to ensure that the client did attend the initial appointment with the case manager.

Assuring that all clients have a primary care physician and are attending medical care appointments is a major priority for all case management services. The current case management system in the District of Columbia is based on a HIV Case Management Quality Assurance Protocol that has been developed by the Case Management Operating Committee (CMOC) to meet the unique needs of persons living with HIV. The protocol identifies the following key steps that are components of case management: a) determining client eligibility; b) conducting client intake; c) conducting comprehensive bio-psychosocial assessment; d) facilitating the development and implementation of the client service plan (including updating and/or re-assessing service plans as needed); e) providing ongoing monitoring; f) implementing exit planning and case closure; and g) identifying referral needs and assisting the client in accessing services. A primary focus of the client intake and assessment process is the identification of the current primary care needs, emergency concerns, and the identification of psychosocial concerns that may interfere with the treatment process. For individuals who are not currently connected to primary care, every effort is made to schedule a primary care appointment soon after intake.

The client is then expected to actively participate in the intake, assessment, and case planning processes. One of the most significant activities is the signing of the medical release of information form that allows the case manager to speak directly with other service providers to assure that the client is receiving essential primary care and support services. The client's continuation in primary medical care and adherence to treatment regimens is assessed each time that the care plan is reviewed and revised. If at any time, the client falls out of primary medical care, or if changes in circumstances (such as loss of private insurance) necessitate a change in primary medical care provider, the case manager works with the client towards the goal of continuing in the care system.

ADAP

The Administration for HIV Policy and Programs manages the District of Columbia AIDS Drug Assistance Program (ADAP) as a drug prescription provider of last resort. ADAP operates as an independent division reporting directly to the Senior Deputy Director for AHPP. It currently functions through a public/private partnership, and its responsibilities include certification of client eligibility and fiscal monitoring.

Medications are purchased through the U.S. Department of Defense (DOD) Drug Pricing System, at a savings of 41% over average wholesale prices. To dispense medications to ADAP clients, the District of Columbia Department of Health (DOH) has issued a contract to the Care Drug Corporation as well as a contract to Repete Service to transport medications to the pharmacies. Under the Repete Service agreement, all geographical regions in which the network pharmacy are located will be supplied with medications, thus facilitating access to ADAP clients. A free home delivery service is available in order to accommodate those with physical mobility issues.

Title II monitors ADAP utilizations on a monthly basis using the Web MD Data Collection System, a web-based pharmacy benefits manager. In addition, DOH meets monthly with pharmacy contractors to monitor and ensure the effective and appropriate management of ADAP funds.

There has been a consistent decline in utilization of ADAP clients assessing ADAP services. The trend is attributable to the transfer of ADAP clients to D C Medicaid under the Ticket-to-Work initiative, therefore providing considerable savings to the program. Other cost-strategies implemented by ADAP are as follows:

- Single point of entry application process, which enables clients to apply for both ADAP and Medicaid benefits simultaneously, thus, expediting the process for eligible clients to access Medicaid. Staff members assist clients in accessing COBRA, DC Alliance, and privately funded patient assistance programs
- ADAP may pay for clients' medications during periods not covered by their insurance because some medical policies place limits on the amount of medications that can be accessed each year
- Refer individuals that fail to meet Medicaid eligibility requirements to Title IV clinical trial initiatives

- Assist client in using pharmaceutical patient assistance programs and clinical trials, and in engaging private hospitals as well as community clinics and physicians that may be able to provide temporary treatment

FACILITATING ACCESS TO SERVICES

Each funded CARE Act service location operates as an access point to the entire continuum of HIV disease care services. When a person discovers that he or she is infected with HIV, the most likely entry point into the HIV disease care system is through their HIV post-test counselor and/or their medical provider. HIV testing counselors are provided with referral lists of services that can be handed directly to clients who test HIV positive. This effort is helped by the Centers for Disease Control and Prevention's counseling and testing initiative that emphasizes connecting HIV positive individuals with primary medical care and social services. In many instances, HIV-testing and counseling is offered at the same location as case management and primary medical care, which simplifies the referral process.

Additionally, toll-free telephone resource lines help to broaden access to care in the District. The toll-free phone lines, accessible from anywhere within the District, are maintained five days a week, from 10:00 am to 7:00 pm, along with a TTY line for deaf and hearing impaired individuals. All phone line operators are people living with HIV and who are familiar with the services available in the District of Columbia and surrounding jurisdictions of the EMA. In addition to helping clients' access services, the toll-free line operators assist clients in resolving issues with service providers. Individuals seeking information about clinical trials funded by Ryan White Title II can use the Internet to access this information.

Also, when clients seek entrance into the AIDS Drug Assistance Program (ADAP), as stated earlier, they complete a single application process for ADAP and Medicaid services. This coordinated process ensures that those who are Medicaid eligible will have access to other HIV disease care and support services.

Resource Inventory

The resource inventory, for the purpose of this document, is simply an accounting of all the resources currently available in the District of Columbia. The table, which follows, contains information about the service providers and services funded under the Ryan White CARE Act Title II in the District of Columbia in the 2005 Grant Year.

Resource Inventory

Subgrantee	Ward	Service Category												
		Case Mgmt.	Family Centered Case Mgmt.	Comp. Therapies	Early Intervention Services	Clinical Trials	Treatment Adherence	Drug Formulary Mgmt.	Transitional Case Mgmt.	Comprehensive Prevention	PWA S/G	Discharge Planning	Health Communication/ Public Info.	XPres
Andromeda	4	√					√							√
Building Futures	2		√											√
Carl Vogel	2	√		√	√		√							√
Ctr. For Minority Studies	5						√							√
Children's Nat'l Med. Ctr.	5	√	√											√
Clinical Pharmacy Assoc.	n/a							√						
DC Care Consortium	2					√								√
Damien Ministries	5	√												√
Family & Medical Counseling	8	√	√				√		√	√	√			√
Georgetown Univ. Med. Ctr.	2	√												√
Howard Univ. Hospital	1	√												√
Institute for Behavioral Change	6	√												√
La Clinica del Pueblo	1	√												√
Miracle Hands	5													√
Our Place	6												√	√
Terrific	1		√											√
Ummah Endowment Fund	2												√	√
Union Temple Baptist Church	8	√												√
Unity Health Care, Inc.	1	√												√
Us Helping Us	1													√
Washington Free Clinic	1	√					√							√
Whitman Walker Clinic	2	√	√											√
Women's Collective	2	√												√

SUMMARY

It is clear that the process of providing a seamless continuum of care within a health care system for persons living with HIV disease is intricate and influenced by many facets such as legislative policy, social and cultural norms, and poverty among the underserved and the underrepresented communities in the District of Columbia. Even in face of those challenges, the Administration for HIV Policy and Programs has been able to establish a continuum of care based on its delivery structure, coordination of services, HIV health care and funding for treatments, care system, and support of clients in accessing services. Therefore, a goal of the Comprehensive Plan 2006-2008 is to identify and address the elements of existing services that impede a seamless continuum of care for persons living with HIV disease.

SECTION III: BUILDING ON QUALITY CARE: A SHARED VISION AND MISSION

To sustain and build on a quality continuum of care, the overarching goals (based on the shared vision and mission of the Title II program) that are being proposed over the course of the next three years are as follows: 1) facilitate, support, and encourage early access into care for the newly diagnosed HIV positive person, 2) provide quality services to those in care, and 3) support retention in and adherence to care for persons living with HIV disease in the District of Columbia. Specific activities and programs such as Early Intervention Strategies (EIS), new initiatives, and identifying special populations who may also have problems with co-infections and multiple-diagnoses will assist us in accomplishing our overarching goals.

EARLY INTERVENTION STRATEGIES

In June of 2005, the Centers for Disease Control and Prevention (CDC) announced that an estimated 1.039 million to 1.185 million people in the United States are living HIV disease, of whom an estimated 24 % to 27% are unaware of their serostatus.⁷ Moreover, when those who are unaware of their serostatus are combined with the number who know their serostatus (but who receive care intermittently), it is clear that hundreds of thousands of PLWH in the United States are not receiving care in keeping with the current treatment guidelines.⁷ Poverty, stigma associated with HIV infection, fear, and distrust of the public health system, and multiple health problems are all barriers.⁸

To examine the Early Intervention Strategies' (EIS) impact on getting people into testing, a study sponsored by Health Resources and Services Administration (HRSA) HIV/AIDS Bureau (HAB) explored EIS's success of counseling and testing. Findings indicated that HRSA has been successful through EIS in reaching people at highest risk for undiagnosed HIV infection and in getting those who are tested to return for their results.⁸

The District of Columbia Ryan White Title I and Title II programs will increase funding for EIS services and identify special populations as well as geographic areas with the greatest need for those services in the District of Columbia. An intra-agency collaborative will be developed and implemented with Prevention and Counseling, Testing and Referral (CTR) services to increase the success of EIS. The focus(es) of EIS will be to: a) test to determine HIV status; b) counsel the newly diagnosed individuals on living with HIV disease; c) provide the newly diagnosed individuals with practical information on living with HIV disease; d) provide referrals to appropriate prevention and risk reduction programs to individuals who are HIV negative; and e) establish a mechanism among the agency providing counseling and testing and the agency providing the medical care, and support services will be established and used to follow up on referrals and to ensure that individuals will be able to obtain needed services.⁹

IMPROVING THE CONTINUUM OF CARE

The major goal of the District of Columbia is to build on a quality continuum of care that is seamless to the HIV positive persons seeking HIV disease services. Thus, the purpose of continuum of care in a system is to provide PLWH with the necessary tools and services that facilitate and promote the indicators of well-being such as health, self-efficiency, and shelter.

The system of care must be responsive to emerging trends in populations, gaps in and barriers to services, new and improved drug treatments, and government and legislative policies. It must also include ongoing quality assurance, program and fiscal monitoring, and evaluation to ensure that the needs of people living with HIV disease continue to be met. As already a part of the system of care provided by Title II, the following activities and services will be continued and improved upon:

- Intra- and Inter-HIV disease Agency outreach and referral system(s)
- Information and education for providers, clients, and general public on issues related to HIV disease posted in and accessed through a web-based format
- Coordination with other District and federal agencies, including Medicaid, Department of Mental Health, Alcohol Prevention and Recovery Administration, Maternal and Child Health, to provide a system of care for persons living with HIV disease
- Services linked to and guided by current surveillance and epidemiological data
- Provide the education and skills to the responsible persons that may be needed to respond to a paradigm shift in the care, support, and prevention services
- Address the needs of those who know their status and who are not in care
- As influenced by HAART, continue to address the changing paradigm in HIV disease as a shift from supporting PLWH in preparations for death to one of disease management for improving health and quality of life.

In addition to expanding the continuum of care above, there are specific initiatives that are proposed. First, the expansion of the ADAP program will provide us with a greater ability to serve those in need of care, and second, geographic-focused initiatives will allow us to access and to offer services to the underserved and the underrepresented.

ADAP and TAP

The capacity of our AIDS Drug Assistance Program will be increased through re-establishing the Treatment Adherence Program (TAP). The main goals of this effort are to standardize and offer guidance to providers who are attempting to implement, monitor, and evaluate their individual treatment adherence programs while taking into consideration the diverse populations being served and the necessity for provider flexibility. In addition, the program will support the development of protocols and

outcome measures that will include definition of terms, eligibility requirements, data gathering and reporting, documentation, confidentiality issues, and other program needs.

Also, TAP will assist in developing policies to address an information exchange mechanism among providers in the District as well as ADAP's providers around the country, which would foster a meaningful beneficial dialogue in an effort to manage adherence, treatment modalities, gender disparities, and enrollment issues. Additionally, concerns to be considered in that exchange are the criteria being utilized for placing new medications on the formulary and the procedures for client access to prescriptions.

As part of TAP, the following activities are proposed: a) Treatment Adherence Conference and Symposium; b) a case manager training with follow-up sessions; and c) an ongoing effort to develop and distribute ADAP educational and adherence materials to traditionally underserved, underrepresented populations as well as other at-risk groups.

ADAP and Computerized System

The ADAP program requires the collection of pertinent data (relative to failures in medication) from Titles I, II & IV of the Ryan White Emergency Care Act. This may be accomplished by developing a combined computer reporting system (capturing Web MD and Xpres Care data), which could retrieve and code data from the participating CBOs and network pharmacies. The program will need qualified personnel to monitor, collect, analyze, and interpret this data that will be then used to coordinate corrective strategies for failures in medications. In addition, a computerized record keeping system for providers as well as an electronic application process for clients will be designed and implemented.

ADAP Health Insurance Initiatives

ADAP is a portal to Medicaid benefits and other health insurance initiatives. As a part of building on the quality of care, AHPP will continue to expand Medicaid eligibility through both the Ticket to Work and the HIV Medicaid 1115 waiver initiatives for persons living with HIV disease in the District of Columbia.

Another proposed health insurance initiative through ADAP is the implementation of a private medical insurance co-payment pilot. This initiative will focus on providing the underemployed and those who are unable to meet their private insurance co-payment requirements. The program anticipates enrolling approximately 50 clients in the pilot initiative with co-payment benefits of up to two hundred dollars per client, per month, bringing the total cost to \$100,000 for the year of 2005-2006. In addition, we calculate the cost of implementing, monitoring, and evaluating the pilot at approximately \$74,000 for the year.

Geographical-Focus Initiatives

There are geographic areas in the District of Columbia that are in dire need of service capacity building. These areas are largely composed of African Americans who are of a lower social economic status and typically underserved. As stated in Section II of this plan, there is currently a Ward 7 initiative focusing on capacity building in that area. The plan will be to continue and build onto the Ward 7 initiative while designing and implementing an initiative for Ward 8.

Special Populations

Based on the assessments of needs in Section I of this comprehensive plan, some populations are at an increased risk for HIV infection in the District of Columbia. Thus, focused HIV prevention and care efforts must be given to the following populations that were identified in the needs assessment process: women of color, persons 50 or over, aging/long-term survivors, perinatally infected pre-teens/teens, adolescents, homeless, men who have sex with men (MSM) on the “down-low (DL),” returning ex-offenders, and IDUs.

- Women of color—the rate of AIDS diagnoses for African American women (50.2/10,000 women) was 25 times the rate for white women (2.0/100,000) and 4 times the rate for Hispanic women (12.4/100,000). African American and Hispanic women together represented about 25% of all US women, yet they account for 83% of AIDS diagnoses reported in 2003.¹⁰
- Persons 50 and older—older people are at increasing risk for HIV disease and other STDs. About 10% of all people diagnosed with HIV disease in the United States—approximately 75,000 Americans—are age 50 and older. As a result of older people not getting tested for HIV/AIDS on a regular basis, there even may be more cases than are known.¹¹
- Aging/Long-term survivors—those PLWH who have been diagnosed and living with the disease for ten or more years. Both groups (persons 50 and older and PLWH) have continued to increase due in large part to the expanded use of HIV disease antiretroviral therapies (HAART).¹² In effect, people with HIV are living longer, aging, and requiring health support services for longer periods of time. In addition, there are co-morbidities (e.g., high blood pressure, diabetes, coronary diseases), which may not be related to HIV or the results of side effects from medications.
- Perinatally infected pre-teens/teens—an emerging population includes those born with HIV and those who are acquiring it at an early age and are now reaching their teenage years and becoming sexually active; hence, the need for prevention programs and early access into care services.¹³
- Adolescents—with rapidly increasing rates of HIV infection among adolescents, there is a need for additional intensive intervention programs that target adolescents, reach those with HIV disease who are not in the health care system, and improve access to youth-sensitive case management and support services.¹⁴ Adolescents also need public awareness campaigns targeted toward them, as they did not grow up with the high visibility of the HIV disease emergency.

- Homeless—the lack of affordable housing and a weakening economy are among the factors which have attributed to homelessness among PLWH in the District of Columbia. Homeless PLWH continue to present a challenge to the healthcare system, due to their inability to access or qualify for residential services based on residency requirements.¹⁵ Many clients are transient and live in temporary or short-term housing (leading to frequent changes in addresses), making it difficult to track clients and provide continual high quality services, treatment, and case management.
- “Down low” (DL) MSM’s present a unique challenge to risk reduction strategies. Men on the DL disassociate their behavior and its consequences.¹⁶ They are less likely to know their HIV status and to access services.
- Returning ex-offenders—the DC Department of Corrections estimates that thousands of ex-offenders will return to the District of Columbia over the next few years. Improved linkage across primary care and case management will assist the incarcerated returning to the community in maintaining treatment and accessing services after release from prison.
- Injection Drug Users (IDU)—injection drug use is important in the transmission of blood borne infections (particularly HIV and Hepatitis B and C). It is the second leading route of HIV transmission for both African American men and women.¹⁷

Proliferation of Street/Recreational Drugs

The proliferation of street or recreational drug use, such as Ecstasy and Crystal Methamphetamine (Meth), is linked to increased HIV risk behaviors (i.e., practicing unprotected intercourse) primarily among gay and bisexual men. For example, a service provider for gay and bisexual men in the District reported in 2005 that three-quarters of their HIV disease admissions were associated with Crystal Meth abuse, compared to 35% in the year 2000. Additionally, among their clients, Crystal Meth was reported as the most common drug of choice, followed by cocaine and alcohol.

Co-infections and Multiple-Diagnoses

Co-infections

Injection drug use is one of the main ways people become infected with HIV. It is also the main route of becoming infected with the Hepatitis C virus (HCV). In fact, 50%-90% of HIV infected injection drug users are also infected with Hepatitis C.¹⁸ Many people with Hepatitis C do not know they have the disease. Moreover, infection with HCV is more serious in HIV infected persons because it leads to liver damage more quickly, and liver disease is the number-one cause of non-AIDS related death in patients with HIV disease.¹⁸

In addition, co-infection with HCV may also affect treatment of HIV infection. Knowledge of treatment adherence and failure is an emerging trend as some clients are finding their combination therapies are no longer effective in managing HIV disease.¹⁸ To prevent failure, more resources directed towards treatment adherence education, treatment specialists, and genotypic testing (now available to every client) will be needed to help clients prolong the usefulness of their HAART regimens, especially among the IDU population.¹⁸ As such, it is important for HIV infected persons to know whether they are also infected with HCV, and if not, they need to know the necessary steps to prevent infection.

As a result of the physical changes caused by sexually transmitted diseases (STDs), including genital lesions that can serve as an entry point for HIV, the presence STDs can increase the chances of contracting HIV by three-to five-fold.¹⁹ In addition, because co-infection with HIV and another STD can cause increased HIV shedding, there may be an increased chance of a co-infected person spreading HIV to others.¹⁹

Multiply-Diagnosed

Psychological distress (i.e., depression, anxiety, anger) and substance abuse are associated with increased risk behaviors and poor treatment adherence among persons living with HIV disease. As related to psychological distress, it may be a precursor to engaging in unprotected sex as well as promoting dropping out of care and inconsistent medication adherence. Similarly, drug use decreases one's resolve to practice safer sex with one's partner(s). In addition, it not only impacts the ability to consistently remain in care (i.e., keeping scheduled appointments), but it may decrease the efficacy of prescribed medications. Hence, clients require a continuum of care and treatment that includes psychotherapy, day treatment, substance abuse treatment, inpatient hospitalization, and treatment adherence counseling as linked to living with HIV disease.

SUMMARY

In concluding, even though there have been advancements in treatment (especially HAART), and people are living with improved quality of life, “Building on Quality” of care is still a major undertaking. Persons living with HIV disease in the District are challenged with the stigma associated with being positive, poverty, mental illnesses, co-infections, homelessness, and substance abuse, which all act on some level as barriers to early access to care, retention in services, and adherence to treatments. Therefore, the goals of “Building on Quality” in this Comprehensive Plan are to address all the barriers to early access to and retention in care and adherence to treatment among persons living with HIV disease in the District of Columbia.

SECTION IV: GOALS, OBJECTIVES, MONITOR, and EVALUATION

In order to develop effective goals and objectives with an appropriate system for monitoring and evaluating the Comprehensive Plan, the AHPP assessed needs, evaluated the current system of care, and proposed building on a quality system of care while taking into account the unique role of Title II services and the critical issues identified by HRSA. Within this context, the District of Columbia's Ryan White Title II program will focus its strategies over the course of the next 3 years on increasing outreach, services, and coordination of efforts that include:

Outreach

- Reach those who are out of care
- Outreach to special populations
- Outreach to new and non-traditional community based organizations
- Address the changing needs of individuals who are in care

Services

- Focus services on specific geographical areas in the District
- Assure quality of programs
- Re-establish the Treatment Adherence Program (TAP)
- Expand Early Intervention Strategies
- Support health insurance initiatives
- Enhance computerized ADAP data reporting
- Expand the scope of discharge planning

Coordination

- Combine planning processes for services
- Coordinate services with health disciplines or organizations within the District of Columbia

OUTREACH GOALS

Goal A: Reach those who are out of care.

By March 2008, to facilitate, support, and encourage greater utilization of Ryan White Title II services in an effort to increase the number of people receiving early and ongoing care.

- **Objective A.1:** By end of Years 1, 2, and 3, identify persons who are out of care.
 - **Activities:** Within the first quarter, review epidemiological, surveillance, and utilization data to create a base line to identify persons out of care.
 - **Activities:** Develop a monitoring tool to guide the scope of work.
 - **Monitor:** Quarterly monitoring of epi, surveillance, and utilization data using various tools of assessment to determine persons out of care.
 - **Monitor:** Compile, analyze, and interpret data collected, and create outcome reports.

- **Objective A.2:** By the end of the Year 1, develop and implement outreach activities with Prevention and Counseling, Testing and Referral (CTR) services.
 - **Activities:** Convene bi-weekly meetings with designated staff members of Prevention and CTR services to discuss current trends in HIV testing and accessing care as well as plan and coordinate HIV testing and referral activities.
 - **Activities:** Identify existing coordinated strategies for outreach using Prevention and CTR services.
 - **Monitor:** A monthly review and documentation of the progress of the established objectives.

- **Objective A.3:** By the end of the first six months, implement specific strategies to get persons tested and, if needed, into care.
 - **Activities:** Involve community members of HIV high risk groups and hard-to-reach populations in implementing strategies for testing.
 - **Activities:** Fund entities such as emergency rooms, substance abuse treatment programs, detoxification programs, adult and juvenile detention facilities, and sexually transmitted disease (STD) clinics to deliver early intervention services.
 - **Activities:** Contractually establish referral relationships between CARE Act services and point of entry entities funded for Early Intervention Strategies.
 - **Activities:** Create a base line with epi, surveillance, and utilization data within the first quarter.
 - **Activities:** Identify existing coordinated strategies for outreach (i.e., Prevention and CTR services)

- **Monitor:** Quarterly monitoring of epi, surveillance, and utilization data using various tools of assessment.
- **Monitor:** Develop a monitoring tool as an activity to guide the scope of work.
- **Objective A.4 (Ongoing):** Coordinate efforts between case management and prevention case management in providing services to HIV positive persons and high risk HIV negative persons.
 - **Activities:** At quarterly CMOC meetings develop and implement service coordination plan(s) between case managers and prevention case managers.
 - **Activities:** Conduct quarterly cross trainings through CMOC for CARE Act, case managers, and prevention case managers, and conduct monthly related meetings.
 - **Activities:** Survey and/or conduct focus groups with prevention case managers.
 - **Activities:** Assess the knowledge and training needs of prevention case managers.
 - **Monitor:** Look at increased attendance of prevention case managers.
- **Objective A.5 (Ongoing):** Case Management Operating Committee (CMOC) protocol will be used to assess adherence to and retention in treatment among HIV positive persons who drop in and out of care.
 - **Monitor:** Use protocol to determine whether or not a client is adhering to treatment.
 - **Monitor:** A monthly review and documentation of the progress of the established objectives.

Goal B: Outreach to special populations.

By March 2008, increase the number of individuals in Wards 7 and 8 who enter early care and who remain in and adhere to treatment.

- **Objective B.1:** By the end of the first six months, determine where persons in Wards 7 and 8 are receiving care.
 - **Activities:** Review utilization data for Wards 7 and 8 as it pertains to early care.
 - **Monitor:** Monitor Xpres data for utilization in Wards 7 and 8.
 - **Monitor:** Review and document Xpres data for utilization in Wards 7 and 8.
- **Objective B.2:** By the end of Year 1, identify new partners to provide services in Wards 7 and 8. (See services)

- **Activities:** Find space in the community as an incentive for current providers to conduct outreach in Wards 7 and 8.
- **Activities:** Develop a collaborative relationship between existing providers and newly identified providers in Wards 7 and 8 (e.g., peer providers).
- **Monitor:** Review and document progress of identifying new service providers in Wards 7 and 8.

Goal C: An immediate and ongoing outreach to new and non-traditional community based organizations who service people living with HIV.

By March 2008, outreach to new and non-traditional community based organizations as points of entry into care for people living with HIV.

- **Objective C.1:** Establish prevention and care outreach with new and non-traditional community based organizations by providing HIV information in such places as the waiting rooms of WIC programs and mental health programs.
 - **Activities:** Present HIV messages on television and radio and/or provide literature for waiting rooms within non-traditional organizations so they become a point of information.
 - **Monitor:** Monitor number of referrals from non-traditional organizations and number of brochures and pamphlets given to clients.
 - **Monitor:** Monitor number of calls to the hotline; add a code on brochures that must be entered on the hotline to see where people received information. This monitoring process can be used with CTR services as well.

Goal D: Address the changing needs of individuals who are in care.

By March 2008, while being responsive to the changing needs of persons already in care, conduct outreach that encourages greater utilization of CARE Act services.

- **Objective D.1:** By the end of the first quarter of Years 1, 2, and 3 identify the needs of those already in care.
 - **Activities:** Within the first quarter, review epidemiological, surveillance, and utilization data to create a base line to identify needs of persons already in care.
 - **Activities:** At the end of each year, compile, analyze, and interpret survey or focus group data gathered on populations already in care to identify barriers to accessing services.
 - **Activities:** Develop a monitoring tool to guide the scopes of health and support services.
 - **Activities:** Once a year during the planning process, identify the things that stand out and enhance the scopes of work.

- **Activities:** Based on the change in needs, modify applicants' responsibilities yearly.
- **Activities:** Using Focus Interview Groups' (FIGs) results to determine if applicants' responsibilities need to be modified.
- **Monitor:** Quarterly monitoring of epi, surveillance, and utilization data using various tools of assessment to determine the needs of persons already in care.
- **Monitor:** Compile, analyze, and interpret data collected, and create outcome reports.
- **Objective D. 2:** By the end of the second quarter of Year 1, research best practices across the country to identify strategies to assist in addressing the needs of those already in care.
 - **Activities:** Conduct cross jurisdictional assessment of best practices.
 - **Monitor:** If best practices are suitable, implement them, if not, discard them.
- **Objective D.3:** By the end of the first quarter of Year 1, develop needs assessments based on epidemiological, surveillance, and utilization data and emerging trends in populations to be used by providers to evaluate the service needs of their existing clients.
 - **Activities:** Modify existing needs assessment tools to be used for Title II service areas.
 - **Activities:** If needed, create assessment tools or measures.
 - **Monitor:** Monthly review and document the progress of established objectives and activities.

SERVICE GOALS

GOAL E: Focus services on specific geographical areas in the District of Columbia.

By March 2008, to increase funding to develop a system of care and to address the early intervention needs for the underserved communities of Wards 7 and 8.

- **Objective E.1:** By the end of the fourth quarter of Year 1, implement the Ward 7 Initiative, which will be used to build service capacity within the Ward 7 geographical area. (i.e., outreach to providers)
 - **Activities:** Compile, analyze, and interpret data from needs assessments and focus groups in that area.
 - **Activities:** Based on focus groups and needs assessment findings, a scope of work will be determined for capacity building and then written into a Request for Application (RFA).

- **Activities:** Develop a resource center in that area.
 - **Activities:** Identify organizations that will be willing to be a part of HIV service providers.
 - **Activities:** Conduct informational meetings with all HIV service providers (non-traditional) that do not receive government funding but who may be interested in providing services and receiving support from CARE Act programs.
 - **Monitor:** Assess the number of responders or potential providers to the initiative.
 - **Monitor:** Assess the number of those who are awarded funds to provide capacity building.
- **Objective E.2:** By the end of the first quarter of Year I, develop a Ward 8 initiative.
 - **Activities:** Within the first quarter, review epidemiological, surveillance, and utilization data to determine those who are out of care in Ward 8.
 - **Activities:** Contract with a consultant to conduct focus groups and needs assessments of potential HIV providers in that area.
 - **Activities:** Compile, analyze, and interpret data from needs assessments and focus groups in that area.
 - **Activities:** Based on focus groups and needs assessment findings, a scope of work will be determined for capacity building and then written into a Request for Application (RFA).
 - **Activities:** The application will be used in funding organizations seeking to initiate capacity building in Ward 8.
 - **Monitor:** Assess the number of responders or potential providers to the initiative.
 - **Monitor:** Assess the number of those who are awarded funds to provide capacity building.
 - **Objective E.3:** By the first quarter of Year 1, review current epidemiological and surveillance data and trends in special populations to ensure that resources are appropriately focused on these communities.
 - **Activities:** Develop corrective action plans for misappropriated funds.
 - **Monitor:** Once every three years, identify and review needs for special populations.

GOAL F: Assure quality of programs.

By March 2008, develop and implement a quality assurance program to assure the effectiveness and cost efficiency of existing and new services that are funded through CARE Act programs for persons living with HIV disease.

- **Objective F.1:** By the end of the second quarter of Year 1, establish program measures and protocols to assess the quality of service within CARE Act programs.
 - **Activities:** Review and modify existing protocols and measures.
 - **Activities:** As needed, create and establish protocols and measures.
 - **Monitor:** Monthly review and document the progress of the established objectives.

- **Objective F.2:** By the end of Year 2, establish and update clear standards of care and establish six quality management indicators in core areas that will be used in assessing the quality of programs.
 - **Activities:** Review and update standards of care.
 - **Activities:** Based on program objectives, identify and establish quality management indicators.
 - **Monitor:** Monthly review and document the progress of the established objectives.

- **Objective F.3:** By the end of Year 3, establish and update clear standards of care and establish six additional quality management indicators in core areas that will be used in assessing the quality of programs.
 - **Activities:** Review and update standards of care.
 - **Activities:** Based on program objectives, identify and establish quality management indicators.
 - **Monitor:** Monthly review and document the progress of the established objectives.

- **Objective F.4 (Ongoing):** By the end of the first quarter of Year 2, provide quality assurance training and technical assistance for grantees with a need to establish and/or refine QA activities.
 - **Activities:** Identify best practices for protocol implementation.
 - **Activities:** Establish a peer provider network.
 - **Activities:** Develop training protocol and curriculum.
 - **Activities:** At the beginning of every grant year, as an orientation activity, provide standardized informational and practicum training to grantees.
 - **Monitor:** Assess the needs for training through Title II site-visits and providers' request for training.

GOAL G: Re-establish the Treatment Adherence Program (TAP).

By March 2008, re-establish the Treatment Adherence Program to include developing and standardizing protocols and measures and offering guidance to providers who are attempting to implement, monitor, and evaluate their individual treatment programs.

- **Objective G.1:** Re-establish the Treatment Adherence Program protocol.
 - **Activities:** Review and update existing TAP protocol.
 - **Activities:** Establish a community wide treatment committee.
 - **Activities:** Review reports and research on treatment adherence.
 - **Activities:** Use chart reviews with QA site-visits to enhance the TAP protocol.
 - **Monitor:** Review utilization at the pharmacy level to monitor whether or not patients are picking up their medications.
- **Objective G.2:** Develop a reporting mechanism for to monitor increased viral loads and CD-4 counts below 200.
 - **Monitor:** A monthly review and document the progress of the established objectives.

GOAL H: Expand Early Intervention Strategies.

By March 2008, increase the number of entry point entities associated with the Early Intervention Strategies that provide HIV counseling and testing with linkages into care for those who test positive and linkages into prevention services for those who test negative and are high risk.

- **Objective H.1:** Identify and fund entry point entities for Early Intervention Strategies such as mental health programs, community health and family planning centers, and substance abuse treatment programs.
 - **Monitor:** Assess the number of people who responded to the application process and the number of people who were awarded.
- **Objective H.2:** Entry point entities will use EIS to provide linkages into care for prevention services.
 - **Activities:** Provide pre-test counseling and testing and post-test counseling.
 - **Activities:** Provide practical information including the availability and use of treatment information for the newly diagnosed persons living with HIV disease.
 - **Activities:** Refer HIV negative clients to appropriate prevention and risk reduction programs.
 - **Activities:** Refer HIV positive clients to primary care and case management services.
 - **Activities:** Implement a system for assessing whether follow-up services were provided after referral.
 - **Monitor:** Monthly report the progress of established objectives.
 - **Monitor:** Monitor the number of referrals from the entry point entities.

GOAL I: Increase access to DC ADAP for clients with Medicare or private health insurance.

By March 2008, increase the number of clients with private insurance that can access, if they need, their prescription drug cap. In addition, ensure that Medicare clients are enrolled in Part- D prescription programs to ensure their ADAP eligibility.

- **Objective I:** By the end of Year 2, implement ADAP health insurance initiatives to make assistance available to ADAP-eligible clients with Medicare and private health insurance.
 - **Activities:** Contract with a vendor to administer insurance premiums for ADAP clients.
Activities: Implement a co-payment project that will enable ADAP clients to access any drugs on the DC ADAP formulary by assisting with co-payments or deductibles.
 - **Activities:** DC ADAP will work closely with contractors on all the health insurance initiatives to ensure that the programs meet the needs of ADAP clients.
 - **Activities:** Case managers will work with clients and the Administration for HIV Policy and Programs to ensure that client needs are met and that the process for accessing services are streamlined.
 - **Monitor:** Monitor whether or not clients are maintaining their health insurance.

GOAL J: Enhance computerized ADAP data reporting.

By 2008, a computerized system will be developed and implemented to retrieve and to code pertinent data relative to clients' failures in medications from participating CBOs.

Objective J.1: By the end of Year I, ADAP and Instructional Technology (IT) will be responsible for the implementation of the electronic reporting systems, medical records, and client application process.

- **Activities:** Combine ADAP reporting systems using Xpress and Web MD.
- **Activities:** Implement electronic ADAP medical records.
- **Activities:** Use an electronic form for clients' applications.
- **Monitor:** Use monthly reports to show the progress of the established objectives.

GOAL K: Expand the scope of discharge planning.

By March 2008, provide more monitoring of discharge planning in certain locations, and expand the scope of discharge planning to include hospitals, jails, prisons, and substance abuse treatment facilities to promote access to care for those in need of services.

- **Objective K.1:** Identify emergency rooms, hospital admissions, etc. in medical facilities to explore including HIV specialists in hospitals and other non-traditional Ryan White providers.
 - **Activities:** Through case management, the case manager will follow clients through their continuum of care.
 - **Activities:** Establish a 30-day plan as a link between hospitals and HIV care providers in the HIV community.
 - **Monitor:** Chart reviews to monitor the number of referrals.

COORDINATION GOALS

GOAL L: Develop a planning process that combines shared goals and objectives among care (across all Ryan White Titles), prevention, housing, and Early Intervention Services to increase the quality of and the accessibility to care.

- **Objective L.1:** Maximize funds across funding streams.
 - **Activities:** Combine community planning process.
 - **Activities:** Combine needs assessment activities.
 - **Activities:** Combine epi profiles.
 - **Monitor:** Monthly community wide meetings.
 - **Monitor:** Training of the planning body.
 - **Monitor:** Yearly evaluate the planning process.
- **Objective L.2:** Prevent duplication of efforts by closely scrutinizing program expenditures in providing services.

Grants and Contract Management will be responsible for the following:

 - **Activities:** Create enhanced mechanism of data reporting.
 - **Activities:** Develop a remediation plan for corrective actions.
 - **Activities:** Review sub-grantees requirements and contracting language.
 - **Monitor:** Quarterly site-visits to CBOs.

GOAL M: Coordinate services with disciplines/organizations in the District of Columbia.

By March 2008, to increase co-location of services to be shared by disciplines/organizations (i.e., APRA and health clinic sites) and Ryan White Title II programs.

- **Objective M.1:** To identify non-health disciplines.
- **Objective M.2:** Develop a written agreement with non-health disciplines/organizations.
 - **Monitor:** Track referred clients by non-health disciplines/organizations

EVALUATION

The evaluation is essential to the success, the continuation, and the replication of HIV services. By the end first quarter of the first year, a comprehensive evaluation plan will developed and implemented in order to guide the goals and objectives and the system of monitoring as presented in this document. The evaluation plan will focus on process and outcome evaluation methodologies, including modifying existing and/or developing new protocols, tools, or measures.

HIV Health and Support teams assigned the responsibility of accomplishing specific goal (s) will be directly involved in developing the evaluation plan. For team members, this will ensure that the comprehensive and the evaluation plans become working documents in facilitating successful outcomes.

CONCLUSION

HIV has the power to be a physically, psychologically, and spiritually-debilitating disease. However, the Title II programs have been able to provide a continuum of care for those individuals who are living with HIV disease even in presences of what appears, at times, to be a daunting and an insurmountable charge. This planning process was initiated to review the needs of special populations, the gaps in services, the process of accessing as well as remaining in the care system, and to visualize, identify, discuss and document the integral elements that could improve care for persons living with HIV disease.

REFERENCE

- (1) CDC (2003). Advancing HIV prevention: New strategies for a changing epidemic-United States, 2003. *Morbidity and Mortality Weekly Report*, 52, 329-332.
- (2) US Census (2005). Population Estimates for December 22, 2005. Retrieved December 30, 2005, from <http://www.census.gov/popest/estimates.php>.
- (3) Government of the District of Columbia, Department of Health (2003). The HIV/AIDS Epidemiologic Profile for the District of Columbia. *Department of Health, HIV/AIDS Administration, Division of Epidemiology*. Retrieved January 15, 2006, from http://www.dchealth.dc.gov/doh/frames.asp?doc=/doh/lib/doh/services/administration_offices/hiv_aids/pdf/epi_profile_2004.pdf
- (4) DC Appleseed Center (August 2005). *HIV/AIDS in the Nation's Capital: Improving the District of Columbia's response to a public health crisis*. Retrieved November 1, 2005, from <http://www.dcapleseed.org/projects/publications/HIV.pdf>.
- (5) District of Columbia Health Care Safety Net Administration, *2002 Annual Report Annual/Report v-2*. Retrieved December 25, 2005, from [http://doh.dc.gov/doh/frame.asp?doc=/doh/lib/doh/about/pdf/executive_summary.pdf&group=1802&open\[3320\]](http://doh.dc.gov/doh/frame.asp?doc=/doh/lib/doh/about/pdf/executive_summary.pdf&group=1802&open[3320]).
- (6) Kaiser Family Foundation (2005). *A Medicaid perspective on Part D implementation: The Medicare Prescription Drug Program*. Retrieved January 15, 2006, from <http://www.kff.org/medicaid/7447.cfm>.
- (7) CDC. *Fact sheet: A glance at the HIV/AIDS epidemic*. Retrieved January 15, 2006, from www.cdc.gov/hiv/pubs/Facts/At-A-Glance.htm.
- (8) HRSA, HIV/AIDS Bureau (2005). *Improved access to early intervention services: Expanding access to care*. Retrieved January 12, 2006, from www.hab.hrsa.gov.
- (9) HRSA, HAB (2003). *Tools for grantees: CARE Act II manual*. Retrieved January 12, 2006, from <http://hab.hrsa.gov/tools/title2/t2SecVIIIChap4.htm>.
- (10) CDC. *HIV/AIDS among women*. Retrieved January 15, 2006, from <http://www.cdc.gov/hiv/pubs/facts/women.htm>.
- (11) CDC. National Prevention Information Network. *The elderly*. Retrieved January 26, 2006, from <http://www.cdcnipn.org/scripts/population/elderly.asp>.
- (12) Gulick, R. M. (1997). Current antiretroviral therapy: An overview. *Quality of Life Research*, 6, 471-474.

(13) CDC (2002). Pregnancy in perinatally HIV-infected adolescents and young adults—Puerto Rico. *Mortality and Morbidity Weekly Report*, 52, 149-151.

(14) DiClemente, R. J., Durbin, M., Siegel, D., Kranovsky, F., Lazarus, N., & Comacho, T. (1992). Determinants of condom use among junior high school students in a minority inner-city school district. *Pediatrics*, 89, 197-202.

(15) National Coalition for the Homeless. *HIV/AIDS and homelessness*. Retrieved January 23, 2006, from <http://nch.ari.net/hivaids.html>

(16) Mays, V. M., Cochran, S. D., & Zamudio, A. (2004). HIV Prevention Research: Are we meeting the needs of African American men who have sex with men? *Journal of Black Psychology*, 6 (1), 78-105.

(17) CDC. *Outreach to injection drug users*. Retrieved January 13, 2006, from <http://www.cdc.gov/outreach/default.htm>.

(18) CDC. *Co-infection with HIV and Hepatitis C virus*. Retrieved January 20, 2006. <http://www.cdc.gov/hiv/pubs/brochure/coinfection.htm>.

(19) CDC. *HIV/AIDS among African Americans*. Retrieved January 14, 2006, from <http://www.cdc.gov/hiv/pubs/facts/afam/htm>.