Government of the District of Columbia, Department of Health

HIV/AIDS, Hepatitis, STD, and TB Administration

Comprehensive Plan
and
Statewide Coordinated Statement of Need

Vincent C. Gray
Mayor,
District of Columbia

GOVERNMENT OF THE DISTRICT OF COLUMBIA
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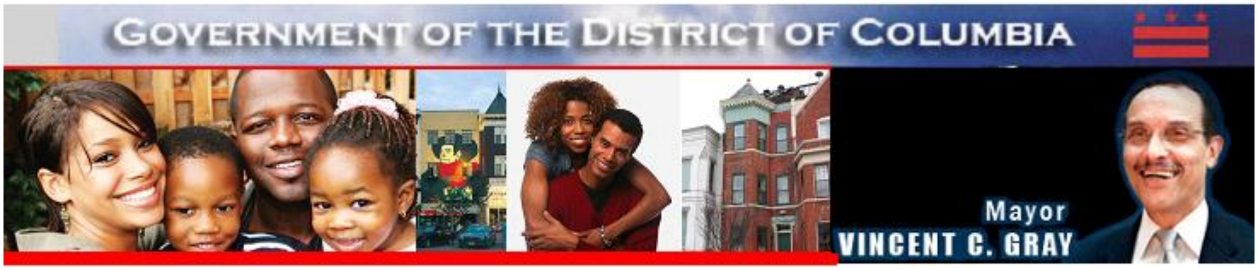
GOVERNMENT OF THE DISTRICT OF COLUMBIA
Mayor
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Executive Summary

Overview: The 2012-2014 combined Part B Comprehensive Plan & Statewide Coordinated Statement of Need is a 3-year blueprint for the development and enhancement of a comprehensive and responsive system of HIV/AIDS related services that addresses the needs of individuals with HIV disease and the challenges faced over time. This document describes the collaborative process by which the District of Columbia foresees will lead to an “ideal” system of care. It also describes the roles and activities assumed by HIV/AIDS stakeholders in the District to work towards this “ideal” system of care. The comprehensive plan also discusses the challenges faced in the context of an environment of declining federal funding and the changing face of the disease.

The District of Columbia: Washington, DC is home to approximately 601,723[1] people spread across just over a sixty-one square mile radius. It is divided into four (4) quadrants (NE, SE, SW, and NW) and 8 local jurisdictions or Wards. The District is racially and ethnically diverse, with the Black non-Hispanic population making up about half the population. Residents of Hispanic origin account for approximately 9% of the population. The District also has a large foreign born population with 13.4% of its residents reporting birth in another country during the period of 2006-2010.[2] While the District has a relatively high median household income ($115,016), approximately 18% of the total city population is reported as living below the federal poverty threshold. The District is characterized by an uninsured rate of 11-12% for residents under 65 years of age with income levels between 138%-400% federal poverty level[3]. According to the Kaiser Family Foundation, Fifty-two percent of those identified as below the poverty threshold receive coverage through the District’s Medicaid program, which was expanded in 2011 to move towards healthcare reform.

HIV/AIDS in the District: The Washington region was among the first metropolitan areas to be affected by the epidemic, with the District of Columbia and its inner suburbs becoming engaged first. The District government began to provide reporting, regulations, and resources for addressing the disease in 1983. According to the most recent data, the total number of District residents living with HIV disease was 14,465. This accounts for approximately 2.7% of the population 13 years of age and older; indicative of a continued generalized epidemic in the District. Although blacks accounted for just under half (46.0%) of District residents over the age of 12, 76% of people living with HIV/AIDS in the District as a whole are Black non-Hispanics.[4] For all PLWH in the District, the most frequent exposure category is men who have sex with men (MSM) (40%). There has been a steady reduction in new AIDS cases over the past five years, with fewer new AIDS diagnoses in the District each year. Trend data on HIV diagnoses, which with the maturing of the District of Columbia name-based HIV reporting systems are needed to better understand to what extent these changes reflect earlier testing versus a possible reduction in new infections.

The Continuum of Care: The system of care reflects the District's diligence and commitment to the delivery and quality of care for PLWH. It demonstrates the commitment to early entry into care following diagnosis; making care accessible throughout the District to as many residents as possible; providing high quality care to diverse populations; meeting critical needs for core medical services – particularly ambulatory medical care, medications, and medical case management – and providing support services necessary to help PLWH enter and remain closely connected to care. In the past several years, a number of initiatives were implemented to ensure the effectiveness of the continuum of care including: recapture initiatives, targeted efforts to ensure rapid access and entry into care, collaborations to improve service quality, especially in the area of medical case management, and increased efforts to ensure access to HIV medications and pharmaceutical assistance.

Service Needs and Gaps: Important service needs described by PLWH are for mental health and substance abuse services, oral health services, HIV-related medical care and medications, and medical case management. The most needed support services include housing and support groups (psychosocial services).

An "Ideal" Continuum of Care: An "ideal" system of care as described by PLWH/A, providers, and other concerned community members is one that seamlessly provides and coordinates HIV-related medical care; other preventive, primary, and specialty care; various medical-related core services; and support services. It would have an integration of prevention, testing, and care into a seamless system that begins with prevention education and continues through testing, health and HIV literacy, referral and linkage to care, navigation within and among the systems of care, treatment adherence, retention in care, and achievement of positive clinical outcomes including viral suppression. Such integration will help maximize both routine and community testing and as well as early entry into care, retention in care, and positive clinical outcomes. Additionally, it must, given the environment of healthcare reform, be responsive and adaptive to payment and funding from multiple sources.

Plan Goals: The District has a 3-year workplan with 5 goals that aim at strengthening the continuum of care and pursing the "ideal" HIV/AIDS prevention and care system. These 5 goals guide the work of the District.

1. Ensure HIV-positive persons learn their HIV status, enter care early through the promotion of effective strategies that enable individuals to access care and remain connected.
2. Ensure improved health outcome and access to medical and support services.
3. Maximize resources throughout the EMA through increased linkages and coordination among Ryan White programs and non-Ryan White programs (including Medicaid, Medicare, prevention, housing, District programs including APRA, Maternal Health and Child Health, Mental Health).
4. Improve coordination of prevention and care services within the District of Columbia to addresses the needs of communities affected by the disease and fulfill the legislative requirements.
5. Ensure the availability of emerging and state of the art pharmaceuticals and treatments in Washington, D.C.

Monitoring Progress and Measuring Outcomes: Progress reports will be made quarterly, outcome measures presented biannually, and overall progress assessed annually. Community & provider input and response sessions will continue to provide for feedback on ways to improve program services. Measures to be collected and evaluated will be those whose change affects clinical outcomes for clients.

Organization of the Comprehensive Plan and State Coordinated Statement of Need

In preparation for developed of the 2012-2014 Comprehensive Plan and Statewide Coordinated Statement of Need (SCSN) HAHSTA conducted a variety of activities. The results are described in the following pages. The document is outline in has four sections as described below.

Section 1: Where are we now? Describes the current state of the HIV/AIDS epidemic in the District of Columbia and the current system of care.

Chapter 1 – Describes the District of Columbia in terms of geography, population, income and poverty, and insurance coverage.

Chapter 2 – Is an epidemiological profile of the District which describes the burden of the epidemic by ward, age, gender, ethnicity, and mode of transmission. This chapter also addresses the unmet need – those who are aware of their HIV positive status but are not currently receiving services; and the unaware population –population estimates of those who are unaware of their HIV positive status.

Chapter 3 – Describes the current continuum of care in the District of Columbia.

Chapter 4 –Provides a discussion of the current service needs, gaps, and barriers to testing and care. Stakeholder input was gathered from local planning bodies, provider meetings, healthcare workforce trainings, surveys, focus groups, and community meetings.

Chapter 5 – Presents the District's Statewide Coordinated Statement of Need (SCSN) parts of which are interwoven within the comprehensive plan.

Chapter 6 – Reviews the goals and objectives from the 2009-2011 comprehensive plan and discusses the progress, challenges and lessons learned. This chapter highlights the achievements over the last 3-years including standardization of the medical case management guidance and launching of effective recapture of lost-to-care program.

Section 2: Where do we need to go? Describes an "ideal" system of care for the District of Columbia.

Chapter 7 – Envisions a system of care that meets the HIV service needs of a diverse population of PLWA by the establishment of medical homes that increase the continuity and quality of care provided to the individual. The ideal system of care fully integrates prevention, testing, and care. It also facilitates data sharing between providers to ensure positive clinical outcomes.

Chapter 8 – Illustrates the kinds of coordination and collaboration the District has in place and the proposed efforts to be implemented as part of the three-year plan.

Section 3: How will we get there?

Chapter 9 – Presents the workplan for how to achieve the District's "ideal" HIV care system. The workplan details the goals, objectives, desired outcomes, and timelines.

Section 4: How will we monitor progress?

Chapter 10 – Describes the monitoring and evaluating plan; a plan to measure the progress and success of the goals and objectives established in chapter 9.

Section 1. Where Are We Now? What Is Our Current System Of Care?

Chapter 1: Introduction

Overview

The Comprehensive Plan for Ryan White HIV/AIDS Program, Part B Grants is a blueprint for the development of a comprehensive and responsive system of HIV/AIDS related services that addresses needs and challenges as they change over time. The plan development process and the resulting documentation will aid the District of Columbia in establishing standards for best practices in the delivery of HIV/AIDS services within the context of declining federal funding and the changing face of the disease. The plan also explores the intersections of HIV/AIDS service delivery with the National HIV/AIDS Strategy (NHAS), Healthy People 2020, the Affordable Care Act (ACA), and the Statewide Coordinated Statement of Need (SCSN), envisioning an “ideal” system of care and makes the best use of concurrent health related strategies to design a 3-year plan for achieving the vision for the years of 2012-2014.

The Washington region was among the first metropolitan areas to be affected by the epidemic, with District of Columbia and its inner suburbs becoming engaged first. The District of Columbia government began to provide reporting, regulations, and resources for addressing the disease in 1983, along with Whitman-Walker Health. Other community-based providers and informal groups became involved in the suburbs very soon after. Washington was among the first metropolitan jurisdictions funded after passage of the Ryan White CARE Act in 1990, and is now in its 22nd year of managing a regional response to the epidemic. The HIV/AIDS, Hepatitis, STD and Tuberculosis Administration (HAHSTA), as the Grantee of the Part A regional component, with regional government sub-grantees, make up the “Washington, DC Eligible Metropolitan Area (EMA),” and together have made considerable progress over the last 22 years toward understanding the epidemic, reducing the spread of the disease and providing care and treatment for HIV positive individuals.

A Profile of the Metropolitan Region *(hereby referred to as EMA for the purpose of Ryan White)***:** There are many factors that impact the system of care in the District of Columbia. These factors greatly influence programs and services for people living with HIV (PLWH) disease. This section provides insight into the complex interconnectivity of the current system of care for PLWH in the District. In addition, it demonstrates the transient nature of clients, the similarities in services, shared provider networks, and the potential impact on resources in the District of Columbia. It is important to examine the relationships and the data across the District and the region to gain a full understanding of the impact of HIV disease and the impact on HAHSTA's efforts to effectively provide services to PLWH clients in the District of Columbia. Because of the close proximity of each jurisdiction, the broader array of HIV services available in the District, including a few like needle exchange only available in the District, PLWH clients seeking services outside the community they live because of stigma and other barriers often seek services in the District. In addition, some case managers in other jurisdictions indicated they sometimes refer PLWH clients to other jurisdictions for needed services unavailable or limited in their jurisdiction.

The Metropolitan EMA is the most geopolitically complex in the country. It includes the District and 24 independent municipalities in Virginia, Maryland, and West Virginia. The jurisdictions vary greatly not only in the size and face of the HIV epidemic, and the underlying public health care systems, but also in such characteristics as race and ethnicity, income levels, poverty, cost of living, unemployment, and expenditures on health. The EMA includes urban, suburban, and rural communities, spans 6,900 square miles, and was home to about 5.7 million people as of the 2010 Census. Its population grew by one-sixth from 2000 to 2010, with the greatest growth in the outer and distant suburbs. About half the residents of the EMA (49%) were White non-Hispanics, one-fourth (25%) Black, one-seventh (14%) Hispanic, one-eleventh (9%) Asian, and the rest (3%) mixed race and other. The District of Columbia metro area ranked 14th nationally in percent of foreign-born residents. As of 2010, according to census data, more than 1.2 million residents – nearly 22% of the population – were immigrants, an increase of nearly 48% from 2000. A large majority – 86% – lived in the suburbs surrounding the District of Columbia.

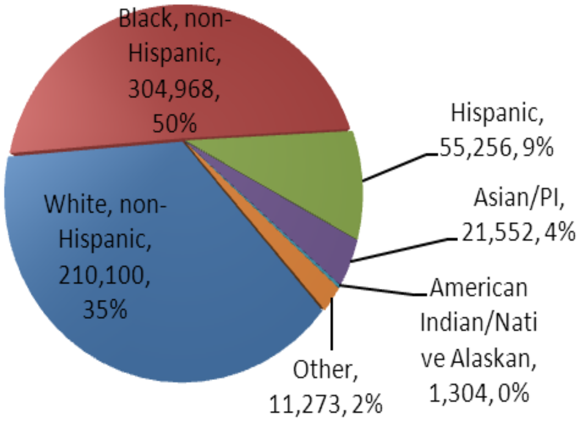
A. Socio-Economic Description of the District of Columbia

Population and Growth: Washington, DC is home to approximately 601,723[5] people spread across just over a sixty-one square mile radius. The District is divided into four (4) quadrants (NE, SE, SW, and NW) and 8 local jurisdictions or Wards. Each ward has a similar number of residents as the city reorganizes its wards every ten years as a result of census data. Currently, each ward has between 58,626 and 78,785 residents.

The District's 2010 population characteristics indicated that 13% of the population was foreign born. The Racial/Ethnic composition of the District's populations indicated that White, non-Hispanics totaled 210,100; Black, non-Hispanic totaled 304,968; Hispanics totaled 55,256; Asian/Pacific Islanders totaled 21,552; American Indian/Native Alaskan totaled 1,304 and the populations classified as other totaled 11,273. The age distribution among District residents showed that those ages 20-29 represented the largest segment of the population at 21.9% or 132,375, with the next largest segment at ages 60 years or older ,16.7% or 100,944; another large segment of the population were those ages 30-39 representing 16.3% or 98,526.

Race and Ethnicity:[6] The District of Columbia is racially and ethnically diverse, with the Black non-Hispanic population making up about half the population as indicated in Figure 2.

Figure 2: Racial/Ethnic Composition of Washington,D.C., 2010
Source: 2010 US Census [N=601,723]



According to 2012 census data, the White non-Hispanic population grew by nearly one-third in the District of Columbia between 2000 and 2010, and currently represents 35% of the total population. The Hispanic/Latino population grew by 1% in the District to a current rate of 9%.

The District also has a large foreign born population with 13.4% of its residents reporting birth in another country during the period of 2006-2010. The impact of the foreign born population on service providers is an increased need to provide culturally, linguistically and clinically appropriate services. Service providers in the District are reporting an increasing number of immigrants from Latin America, the Caribbean and Africa.

Income, Poverty, and Cost of Living: Income and poverty levels vary greatly by ward. The District of Columbia has both a relatively high median income level and a high rate of poverty as demonstrated by the fact that the median household income of the District is $115,016 yet 18% of the total population is reported as living below the federal poverty threshold. Ward 8 has an estimated poverty rate of 35%, nearly double the city-wide average. The average household income for residents of this ward is $44,076, a 4.4% decrease from the prior 5 year period as compared to the city-wide average which represents a 12% gain in household income.[7] Many of the variances observed among the wards with respect to income, poverty, and unemployment are also a result of the changing face of the District. In spite of the national economic recession, many historically impoverished areas have experienced revitalization, and are being rebuilt with an influx of highly educated, middle income, twenties and thirty year olds that are highly employable in the Washington job market. The District's relatively high cost of living, largely due to its housing costs, also supports an exodus of long-time (including relatively low income) residents of the District to near-by suburbs. This high cost of living is supported by the influx of highly educated and employable population and continued business development in the city. Another result of the high cost of housing is the severe challenge it creates to meet the housing needs of low income residents, including PLWH.

Figure 3: Income and Poverty Comparison by Ward, District of Columbia[8]

Ward	Median Household Income, 2008-2010	%Change	Percent of Residents Living in Poverty, 2010	Unemployment Rate
Ward 1	$98,485	27%	16%	7.2%
Ward 2	$190,692	11%	15%	4.0
Ward 3	$257,386	4.8%	6.9%	3.4%
Ward 4	$116,668	9.4%	14%	7.6%
Ward 5	$78,559	10%	19%	13%
Ward 6	$120,526	37%	18%	8.4%
Ward 7	$54,677	(7.2%)	26%	19%
Ward 8	$44,076	(4.4%)	35%	17%
District of Columbia	$115,016	12%	18%	9.2%
United States	$50,599	--	15.1%	--

Unemployment: While the economic environment has had significant impact in the District of Columbia, in March 2012, the Washington, DC metro area as a whole had the second lowest unemployment rate among the 49 metro areas with populations of at least one million – 5.5%.[9] For example, there was a 17% unemployment rate in Ward 8, in contrast; Ward 3 had an unemployment rate of only 3.4%, according to data from Neighborhood Info DC, a non-profit that compiles data on neighborhood demographics for use by community organizations.

Health Systems and Resources: The public health care systems in Washington, DC and the level of investment in public health affects the non-Ryan White resources available to support HIV/AIDS care as well as non-HIV specific services for people living with HIV disease. The following examples help to highlight these differences: per capita federal expenditures and grants, the per capita Medicaid expenditures, and the expenditures for public health and rankings.

As shown in Figure 4, the District benefits from very high per capita federal expenditures. The per capita figures include “grants, procurement, salaries and wages, retirement and disability payments, and other direct payments (such as Medicare benefits, the Supplemental Nutrition Assistance Program, and student financial assistance).”[10]

Figure 4: Per Capita Federal Expenditures and Federal Grant Funding for the District of Columbia, FY 2009[11]

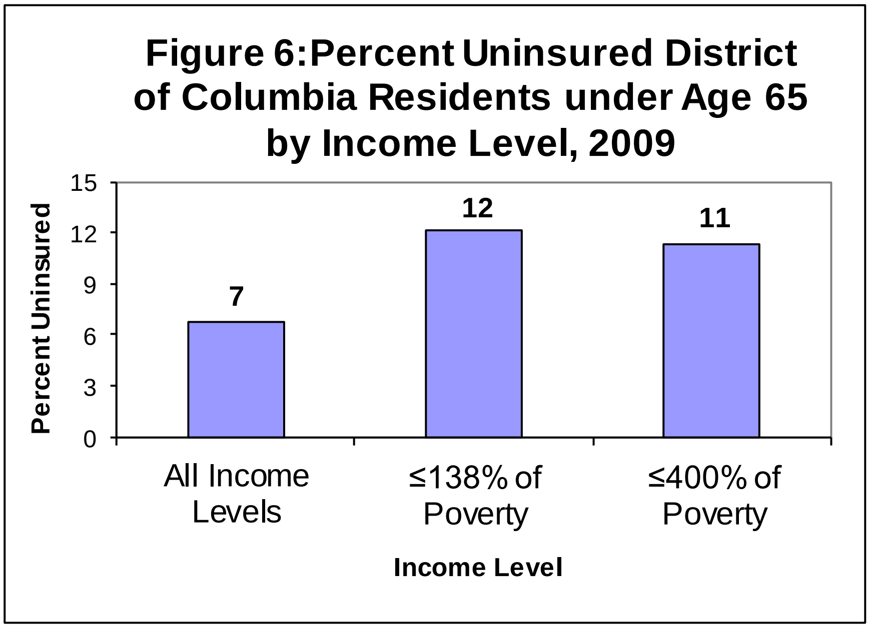
	Per Capita Federal Expenditures, FY 2009		Per Capita Federal Grants, FY, 2009	
	Federal Expenditures	Ranking (1 = Highest Funding)	Grant Funding	Ranking (1 = Highest Funding)
District of Columbia	$83,196[12]	Not Ranked	$16,107	Not Ranked
50-state Average	$10,929	--	$2,550	--

Figure 5 below shows both Medicaid expenditures and overall District expenditures for health. The Medicaid data (for FY 2007 and 2008) include both overall per capita expenditures and per capita expenditures for Medicaid clients who are disabled, since many people with HIV disease are eligible for Medicaid because they are disabled (Categorical requirements has been removed under early Medicaid expansion). As indicated, as of 2009, the District of Columbia had the highest per capita expenditures on health care in the country and was third in the nation in per capita overall Medicaid expenditures.

Figure 5: Per Capita Medicaid and Health Expenditures

	Per Capita Medicaid Expenditures[13]			Total and Per Capita Expenditures on Health, 2009		
	Disabled (FY 2008)	**HIV** (FY 2007)	**Total** (FY 2008)	**Overall Ranking** (1 = Highest Total Expenditures)	**Expenditures**	**Ranking** (1 = Highest Per Capita Expenditures)
District of Columbia	$19,901	$27,100	$8,309	3	$10,349	1
United States	$14,840	$24,867	$5,337	--	$6,815	--

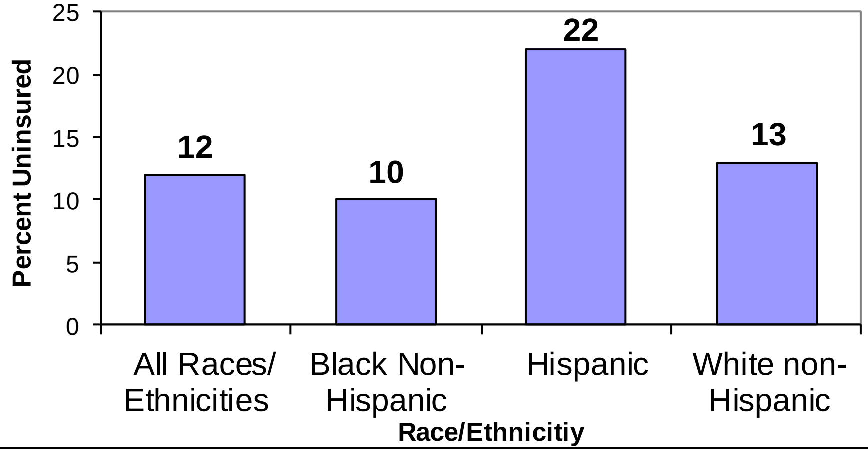
The following information is a profile on uninsured in the District and the surrounding jurisdictions.



Uninsured: A key determinant of the demand for Ryan White services, particularly primary care and medications, is the uninsured rates. Because of health care reform, knowing the number and percent of uninsured residents is necessary for planning. The District is well underway with implementation of health care reform. In 2011, The District started by implementing Medicaid expansion by changing the Medicaid eligibility guidelines. Figure 6, calculated by using Census Bureau Small Area Health Insurance Estimates (SAHIE) for the District, shows the percent uninsured for residents with varying levels of income. It provides a sense of the differences in uninsured rates among residents under 65 across income levels. The figures exclude people 65 and over because, except for undocumented or recent immigrants, they are typically covered by Medicare.

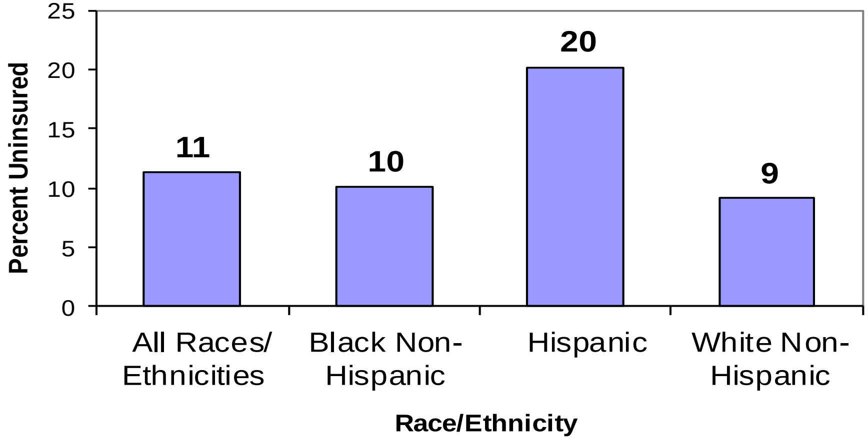
According to the federal poverty guidelines, in 2012, the poverty level is $11,170 for a single-person household and $23,050 for a four-person household.[14] As stated earlier, as of 2009, the District of Columbia had the lowest rate of the uninsured at all income levels – as well as the highest per capita expenditures for health. At 400% of poverty – the cut-off for federal subsidies of insurance premium under the proposed health insurance exchanges – the uninsured rate is lower than for the lower-income group (400% of poverty is $44,680 for a single person household and $92,200 for a family of four). Uninsured rates vary by race and ethnicity. Figures 7 and 8 below show the percent of uninsured District residents by race and income level. Figure 7 shows residents under 65 in the city by race with income levels less than or equal to 138% of Federal Poverty Level. Figure 8 shows the same breakdown for residents with incomes under

Figure 7: Percent Uninsured District Residents with Incomes ≤ 138% of Poverty by Race/Ethnicity, 2009



400% of poverty[15]. As expected, for residents under 400% of poverty, uninsured rates are slightly lower than for those at or below 138% FPL. In terms of race and ethnicity, uninsured rates are somewhat lower for African Americans and White non-Hispanics. The rates at both 138% FPL and 400% FPL are considerably higher for Hispanics than other ethnicities. This may reflect the fact that many Hispanics are both low income and recent immigrants or undocumented; they are unlikely to have employer-based insurance and ineligible for public insurance. It may also indicate low participation in public insurance despite eligibility.

Figure 8: Percent Uninsured District of Columbia Residents with Incomes ≤ 400% of Poverty by Race/Ethnicity, 2009



Chapter 2: Description of the Local HIV/AIDS Epidemic

Overview

This chapter describes the HIV/AIDS epidemic in the District of Columbia. It provides demographics of those living with HIV disease, such as gender, race/ethnicity, age, and mode of transmission. It presents the HIV prevalence data estimates for the District and discusses trends in new AIDS diagnoses, late testing, and a variant of the Gardner Treatment Cascade that describes the proportion of PLWH who attain viral suppression. In addition, this chapter provides an estimate for unmet need – PLWH/A who aware of their status but documented as not receiving HIV related medical care. Finally, it estimates the number of individuals who have HIV but are unaware of their status.

A. HIV/AIDS Epidemiological Profile for the District of Columbia, 2010

Understanding HIV Surveillance Data: The following terms and definitions may be helpful in understanding terminology used in this section.

- HIV diagnosis or case refers to a person with HIV infection who has not progressed to AIDS.
- An AIDS case refers to a person with a CD4 counts less than 200 cells/µL or an AIDS defining opportunistic infection.
- Name based HIV and AIDS cases only are reported, and anonymous tests are not reported. Reports are received from a variety of sources including hospitals, private physicians' offices, community-based organizations, clinics, and laboratories.
- Data on HIV and AIDS cases are currently entered into the federally enhanced HIV/AIDS Reporting System (eHARS) and de-identified case information is shared with the Centers for Disease Control and Prevention (CDC) monthly. CDC then uses these data to prepare national surveillance reports.
- Yearly the National Death Index is reviewed and reconciled against HAHSTA's database to determine living HIV cases in the District.

- This epidemiological profile uses some new terminology. All HIV and AIDS cases are referred to as "HIV cases." HIV-only or HIV, not AIDS, cases are referred to as "HIV/not AIDS." This change is consistent with CDC HIV Surveillance Reports.

Transition to Name Based Reporting: HIV/AIDS surveillance "as other disease surveillance is governed by state laws, and results in inconsistencies" has evolved over the past two decades. AIDS surveillance began as confidential name-based reporting; cases were reported by name in in most jurisdictions, HIV (not AIDS) surveillance began as code-based reporting. A unique identifier was generated for each HIV report that was typically a combination of the person's last name, date of birth, gender, and social security number. Code-based reporting systems had a number of limitations. For example, the code created to report HIV cases could not be evaluated for the uniqueness of the code elements or redundancy. Moreover, the reported HIV data were frequently not complete. As a result, there was a potential for duplicate reports both within the Name-based HIV and AIDS reporting system within the same state. For example, individuals may have been tested more than once, perhaps under a different name; they may have moved or died; or they may have been reported as an AIDS case.

The transition from code-based to name-based HIV reporting has lead to a decrease in reported HIV prevalence estimates.

The District began implementing HIV reporting by name in November 2006. In addition, the District of Columbia laboratories are now required to report all viral load tests, CD4 counts, and other tests indicative of HIV infection or an AIDS diagnosis.

The CDC estimates that it takes approximately five years for the name-based HIV reporting system to "mature." Therefore, the District of Columbia name-based reporting system was fully mature as of November 2011. The District now only reports name-based cases. This is the first time the District has been able to include reported rather than estimated HIV-non AIDS data in the Comprehensive Planning process. The use of these data is beneficial in the planning process as it permits a more accurate analysis of the trending of HIV disease.

As with all official surveillance data, this summary describes both people living with HIV (HIV/not AIDS and AIDS) who were diagnosed and reported to the CDC. They were residents of the District of Columbia when tested. Surveillance data do not take into account individuals who move *into* or *out of* the District of Columbia after diagnosis.

Figure 9: People Living with HIV (HIV/not AIDS and AIDS) in DC by Ward as of December 31, 2010

Status	Ward 1	Ward 2	Ward 3	Ward 4	Ward 5	Ward 6	Ward 7	Ward 8	Jail	Homeless	Total
HIV/not AIDS	753	644	137	494	697	668	632	754	355	96	5,230
AIDS	1,160	1,004	185	797	1,127	1,135	992	1,073	576	275	8,324
Total Cases	1,913	1,648	322	1,291	1,824	1,803	1,624	1,827	931	371	13,554
Percent of DC Cases	14.1%	12.2%	2.4%	9.5%	13.5%	13.3%	12.0%	13.5%	6.9%	2.7%	100%

* Variance in total infections due to 911 cases with missing address information; these cases are not included in Figure 9 nor this analysis.

The Epidemic in the District of Columbia: The epidemic in the District of Columbia is described in terms of the characteristics of people living with HIV/non-AIDS and AIDS and new AIDS cases. The summary reviews trends in AIDS incidence and key indicators such as late testing and entry into care. In addition, it reviews co-morbidities such as Hepatitis C and sexually transmitted infections (STIs).

People Living with HIV Disease: According to the most recent data, the total number of District of Columbia residents living with HIV disease was 14,465. This accounts for approximately 2.7% of the population 13 years of age and older; indicative of a continued generalized epidemic in the District of Columbia. Ward 1 has the greatest number of individuals living with HIV/AIDS with 14.1% of the District of Columbia HIV/AIDS population. It is followed closely by both Ward 5 and Ward 8 representing 13.5%.

Nationally, there are more people living with HIV/non-AIDS than with AIDS. In the 40 states and five other jurisdictions with mature HIV testing, there were almost 683,000 people reported as living with HIV/non-AIDS as of December 31, 2009; in the U.S. as a whole, nearly 491,000 people were living with AIDS.[16] Why are there fewer HIV/non-AIDS than AIDS cases in the District of Columbia?

The estimated HIV/AIDS prevalence rates (number of cases per 100,000 people) for the District of Columbia is shown in Figure 10. Prevalence is higher in the District of Columbia than in any of the 50 states – nearly 3% of District of Columbia residents have been diagnosed with HIV or AIDS.

Figure 10: District of Columbia HIV Prevalence Rates by Ward 2010

** Variance in total infections due to cases with missing address information not included in this analysis*

Ward	People living with HIV/not AIDS and AIDS		2010 Population	Prevalence Rate
	#	%	#	
Ward 1	1913	2.7	70,446	2,715.6
Ward 2	1648	2.1	76,785	2,146.3
Ward 3	322	0.5	70,721	455.3
Ward 4	1291	1.9	66,912	1,929.4
Ward 5	1824	2.7	67,399	2,706.3
Ward 6	1803	2.6	70,248	2,566.6
Ward 7	1624	2.6	61,826	2,626.7
Ward 8	1827	3.1	58,626	3,116.4
Homeless	371	-	-	-
Jail	931	-	-	-
Total DC	13,554	2.5	542,963	2,496.3
United States	960,000		308,745,539	310.9

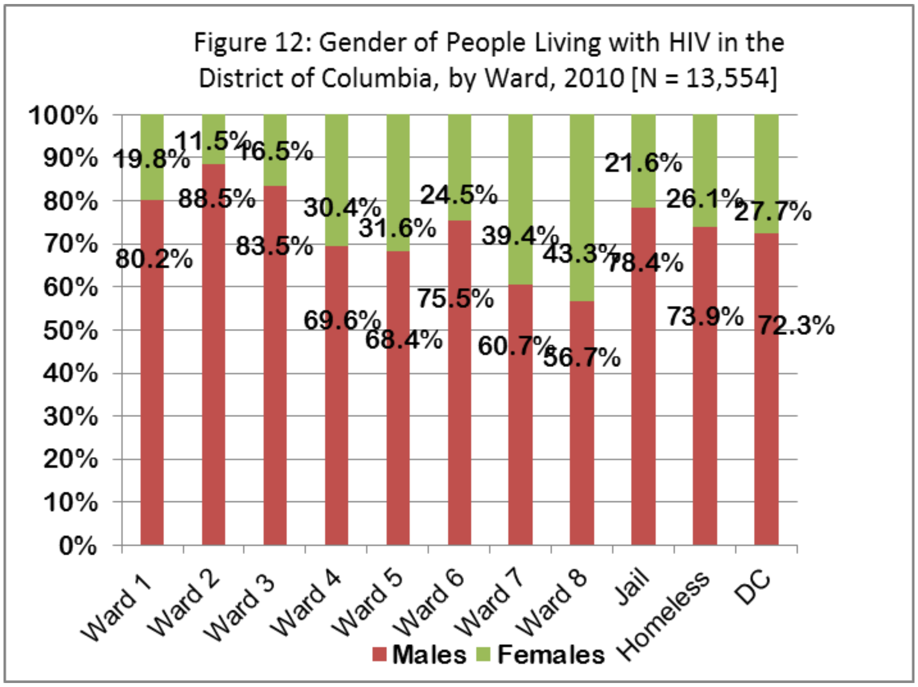
The known infection rate is 2.5% for all adults and adolescents, 4.7% for African Americans, and 7.4% for residents aged 40-49. As shown in Figure 10, the HIV prevalence rate in the District of Columbia is highest in the Ward 8 area of the City. Washington, DC have HIV/AIDS prevalence rates higher than the U.S. as a whole. These prevalence rates do not include people with HIV disease who do not know their status. The unaware burden of the disease is estimated in Section C of this chapter.

Gender: Just over seventy-two percent or 10,465 of PLWH in the District of Columbia are men. Women represent 27.7%, or 4,000 PLWH. The total number of living HIV/AIDS cased reported in Figure 11 represents an additional 911 cases previously excluded from ward specific data due to missing addresses information for Living HIV/AIDS cases as of 12/31/10.

Figure 11: PLWH/A in the District of Columbia by Gender, 2010*

Sex	Living HIV/AIDS Cases as of 12/31/10		District of Columbia Population, 2010		Rate per 100,000
	N	%	N	%	N
Male	10,465	72.3	246,885	46.7	4,238.8
Female	4,000	27.7	281,224	53.3	1,422.4
Total	14,465	100.0	528,109	100.0	2,739.0

Ward differences vary by as much as 31.8% as shown in the Figure 12. Ward 8 has the highest proportion of women at 43.3% and Ward 2 the lowest, at 11.5%. Men accounted for fewer than half (46.7%) of District of Columbia residents but almost three-quarters (72.3%) of living HIV cases. Among District of Columbia women, black women accounted for the majority of living HIV cases (92.4%). (Source: HAHSTA) For the U.S. as a whole, about 24% of people living with HIV disease are women, and were 23% of new diagnoses in 2009. Approximately 4.2% of male residents and 1.4% of female residents are diagnosed and living with HIV in the District of Columbia. According to the CDC, one in 139 U.S. women will be diagnosed with HIV disease; the likelihood ranges from 1 in 32 African American women to 1 in 106 Latinas and 1 in 526 White and Asian women.[17]



Race/Ethnicity: As indicated in Figure 13, excluding Wards 2 and 3, Blacks represent a majority of those living with HIV/AIDS. Blacks represented the greatest burden of the disease at 95% in both Wards 7 and 8 respectively. Although blacks accounted for just under half (46.0%) of District of Columbia residents over the age of 12, 4.3% of the total Black population in the District of Columbia was living with HIV in 2010 according to HAHSTA's most recent data for the 2012 Annual Report.

Figure 13: Race/Ethnicity of Living HIV/AIDS Cases by Ward as of 12/31/10

Race/ Ethnicity	Ward 1	Ward 2	Ward 3	Ward 4	Ward 5	Ward 6	Ward 7	Ward 8	Jail	Homeless
White	26%	47%	47%	11%	8%	19%	2%	2%	3%	7%
Black	57%	42%	37%	79%	87%	76%	95%	95%	93%	85%
Hispanic	15%	8%	9%	8%	3%	3%	2%	2%	2%	7%
Other*	2%	3%	7%	2%	2%	2%	1%	1%	2%	1%
Total	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%

**Source: HAHSTA May 2012*

As Figure14 indicates, 76% of PLWH in the District of Columbia as a whole are Black non-Hispanics, 16% are White non-Hispanic, and 6% are Hispanic/Latino. Another 2% are listed as other race/ethnicity. Other race/ethnicity includes mixed race individuals, Asians, Alaska Natives, American Indians, Native Hawaiians, Pacific Islanders, and individuals of unknown ethnicity.

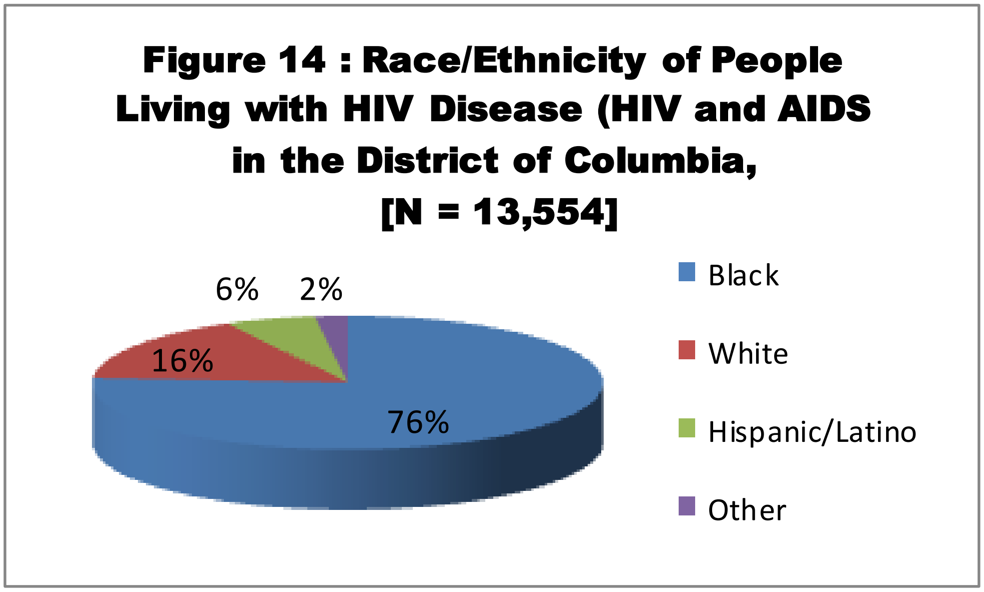


Figure 14 : Race/Ethnicity of People Living with HIV Disease (HIV and AIDS in the District of Columbia, [N = 13,554]

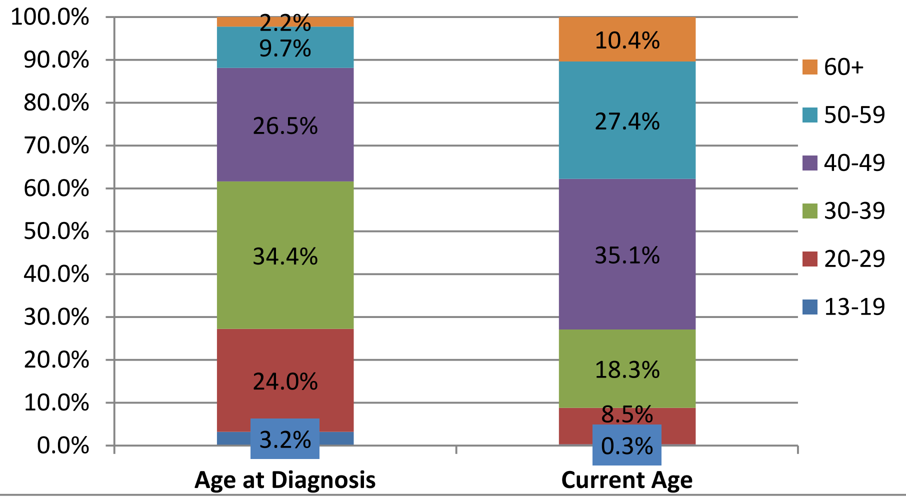
The current age of living HIV/AIDS cases in the District of Columbia as of December 31, 2010, as represented in Figure 15, shows the age group with the greatest number of individuals living with HIV/AIDS are those between ages 40-49, at 5,033 (rate per 100,000).

Figure 15: Current Age of Living HIV/AIDS Cases in the District of Columbia as of 12/31/10					
Current Age	Living HIV/AIDS Cases as of 12/31/10		DC Population, 2010		Rate per 100,000
13-19	53	0.4	50,106	9.5	105.8
20-29	1,271	8.8	133,759	25.3	950.2
30-39	2,656	18.4	98,021	18.6	2,709.6
40-49	5,033	34.8	76,273	14.4	6,598.7
50-59	3,951	27.3	71,438	13.5	5,530.7
>=60	1,501	10.4	98,512	18.7	1,523.7
Total	14,465	100.0	528,109	100.0	2,739.0

Age: Figure 16 shows age at diagnosis and current age of PLWH in the District of Columbia. As the charts indicate, more than one-third (34.4%) of PLWH were diagnosed when they were between 30-39, and just under one-third each between the ages of 20-29 and 40-49. Only 3.2% were diagnosed before their 20th birthday, and 11.9% were diagnosed at age 50 or older.

Given increasing survival rates, it is not surprising that the current PLWH population in the District of Columbia is older. As the figure 16 indicates, when totaled over two-thirds (71%) of PLWH are currently 40 or older, and more than one-third (36%) are 50 or older according to HAHSTA, May 2012 data.

Figure 16: Age at Diagnosis and Current Age of People Living with HIV/AIDS in the District of Columbia, 2010 [N=13,554]



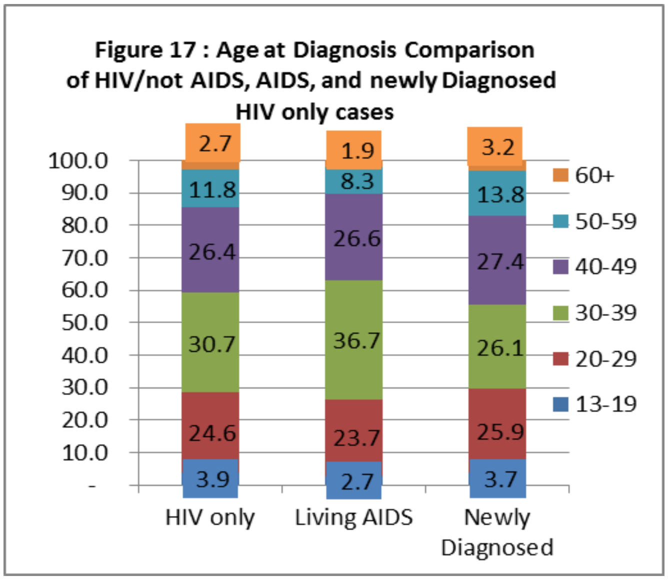


Figure 17 : Age at Diagnosis Comparison of HIV/not AIDS, AIDS, and newly Diagnosed HIV only cases

Also indicated in Figure 16, less than 1% of PLWH in D.C. are currently under 20 years of age, and 8.5% are ages 20-29. PLWH between the ages of 30-39 years in all Wards tend to be the most represented age group at diagnosis. As shown in Figure 17, people between the ages of 40 and 49 are most likely to be living with HIV/AIDS with the highest rate of HIV infection at 6,598.7 cases per 100,000 people. The PLWA population is also increasing primarily for two reasons. First, due to advances in treatment, PLWA are living longer with HIV disease.

An increased number of newly reported infections in the older adults may be due to late HIV testing. The majority of cases are not acute infection, but rather chronic, long standing HIV infection. Factors associated with late diagnosis of HIV infection in older people include: routine HIV screening being uncommon in this age group; poor awareness of HIV risk factors (including safe sex practices); failure of health care providers to consider HIV infection in this patient population; and confusion about HIV-specific or opportunistic infection (OI) with symptoms of other diseases frequently associated with older age (eg, Alzheimer's, dementia) (CDC 1998; Mack and Ory 2003; Grabar et al 2006). The continuing growth of the older (50+) PLWH population has important implications for HIV care.

Mode of Transmission: Figure 18 shows exposure categories for PLWH. For all PLWH in the District of Columbia, the most frequent exposure category is men who have sex with men (MSM) (40%), followed by heterosexual exposure (29%) and Injection Drug Users (IDU) (16%).

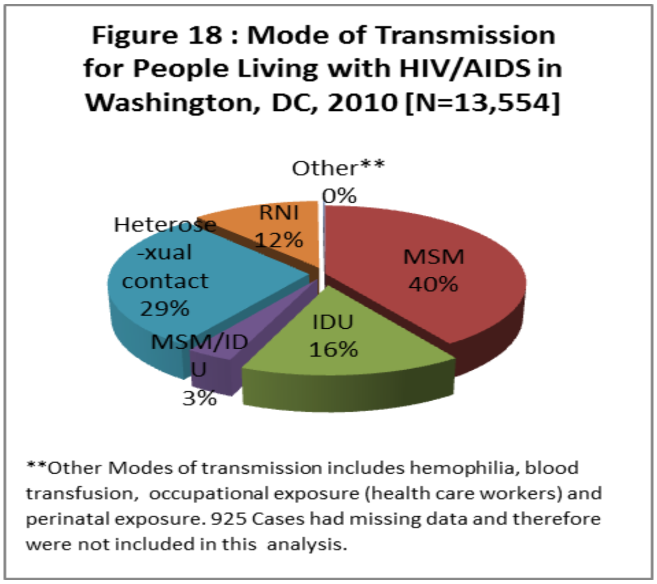


Figure 18 : Mode of Transmission for People Living with HIV/AIDS in Washington, DC, 2010 [N=13,554]

**Other Modes of transmission includes hemophilia, blood transfusion, occupational exposure (health care workers) and perinatal exposure. 925 Cases had missing data and therefore were not included in this analysis.

Trends: One of the most important, and encouraging, trends in the epidemic is the reduction in new AIDS cases. Figure 19 shows the number of new HIV diagnoses by Ward reported in the District of Columbia from 2006 through 2010. There has been a steady reduction in new AIDS cases over the past five years, with fewer new AIDS diagnoses in the District of Columbia each year. Trend data on HIV diagnoses, which are becoming available with the maturing of the District of Columbia name-based HIV reporting systems are needed to better understand to what extent these changes reflect earlier testing versus a possible reduction in new infections. Admittedly, treatment advances have substantially reduced AIDS-related morbidity and mortality and extended the lives of many. Still, not all who need treatment have access to it and treatment is not a cure.[18]

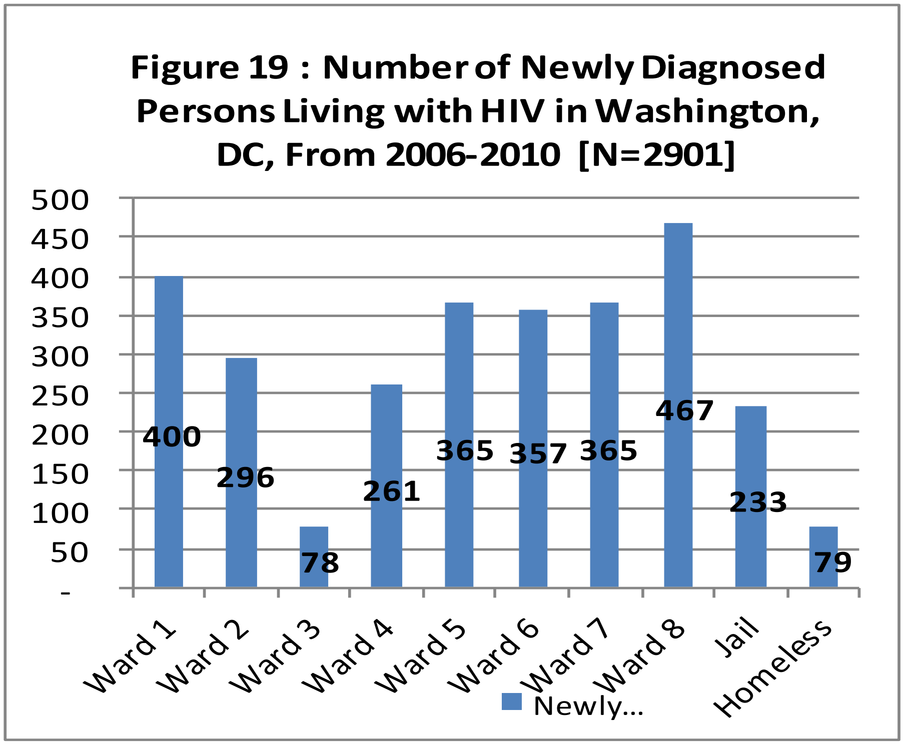
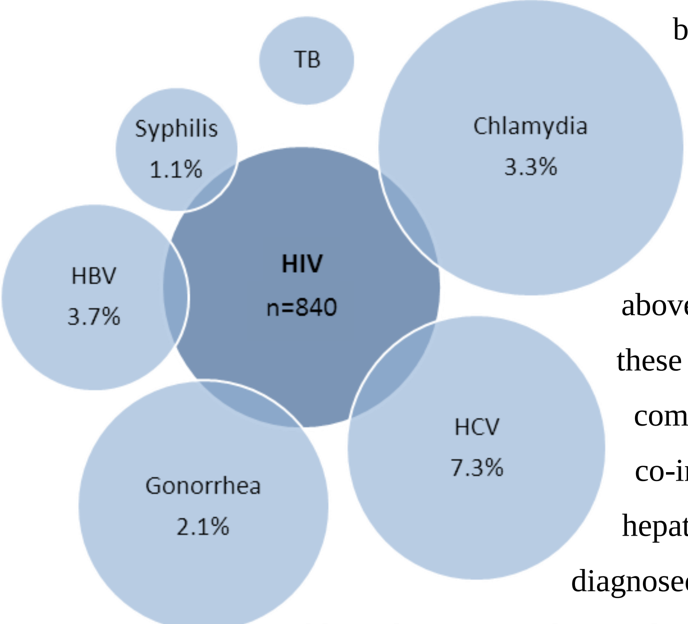


Figure 19 : Number of Newly Diagnosed Persons Living with HIV in Washington, DC, From 2006-2010 [N=2901]

Summary: The data indicate that, compared with the total population living with HIV and the total populations living with AIDS in 2010, newly diagnosed people were demographically consistent with exiting HIV positive people in the District of Columbia Similar to existing people living with HIV/AIDS, a newly diagnosed person was likely to be African American, male, 40 to 49 years of age, and have MSM as their primary exposure category. Overall, the number of newly diagnosed AIDS cases decreased by 33% between 2006 and 2010.

Co-Morbidities: People living with HIV often have co-morbidities that complicate care. Weakened immune systems make PLWH more susceptible to some diseases, and the risky behaviors that led to HIV infection may also place them at risk for other diseases. Of the newly diagnosed cases of HIV in 2010, 17.5% were identified as having a co-infection. As the diagram above shows, the most frequently occurring of these co-morbidities within the PLWH community has been hepatitis C. Hepatitis C co-infection was at 7.3% percent, followed by hepatitis B at 3.7%. Over 2% of those newly diagnosed with HIV were co-infected with chlamydia or gonorrhea, and 1.1% was co-infected with syphilis.



Late Testing: An important measure of success in HIV prevention, education, testing, and risk reduction is the extent of early testing. The sooner after infection people learn their HIV status, the sooner they can enter care, begin antiretroviral therapy as appropriate, and attain viral suppression. Late testing is measured by the percent of people who have an AIDS diagnosis within 12 months following diagnosis of HIV infection. Nationally, the rate of late testing was 37% in 2004 but decreased to 32% in 2007.[19] Recent years have experienced a decline in the late testing rate in Washington, DC. The rate has decreased from 55% in 2005 to 40% in 2009.

Entry into Care: Entry into care is an important measure of program success. An individual who tests positive for HIV should be linked to care as quickly as possible and begin treatment, including antiretrovirals, to minimize damage to the immune system, achieve viral suppression and optimize health outcomes. With "treatment as prevention" now a practice, early entry into care contributes to reduced transmission of the virus. The District of Columbia is working hard to help newly diagnosed individuals access care within 30 days, and to reemphasize support and access for individuals who know their status and want to enter or re-enter care. HAHSTA currently measures time between first detection of HIV with an individual and reporting of a viral load or CD4 test to the surveillance program.

Available data indicate that in the District of Columbia, 71% of people newly diagnosed with HIV in 2009 entered care (as measured by a reported CD4 or viral load test) within three months of diagnosis, and an additional 6% within 6 months, and 6% more within 12 months; the other 17% are not verified in care within a year after diagnosis. The data suggest that newly diagnosed PLWH who do not enter care within the first 3 months after diagnosis are in danger of remaining out of care for a year or more. Of the 29% of the District of Columbia newly diagnosed PLWH who did not enter care within the first three months, fewer than half (12% of the total group of newly diagnosed) entered care in the following nine months. More information is needed to better understand this situation.

Treatment Cascade: Treatment cascade provides a means of tracking PLWH from diagnosis through viral suppression over a period of one or more years. Use of such a treatment cascade measures treatment success but also identifies points within the "cascade" when individuals are documentation and/or lost to care -points in the continuum of care that need to be strengthened in order to increase the proportion of all PLWH who achieve viral suppression and other positive clinical outcomes. Table 19, below, shows the results of using Gardner's Treatment Cascade[20] to track newly diagnosed PLWH in District of Columbia from diagnosis to linkage to care, retention in care, and viral suppression. 6,318 individuals were diagnosed with HIV in all of the Washington, DC metropolitan area (includes neighboring jurisdictions) between 2005 and 2010. Of this group, 83% were linked to care, but only 25% were retained in care as of 2010, as measured by having had two laboratory tests reported during 2010, at least three months apart. Of those who remained in care, 84% had achieved viral suppression. Viral suppression rates were highest for MSM (90%) and lowest for adolescents (64%).

Table 19: Treatment Cascade, 2005-2010, for District of Columbia Metropolitan Area

Populations	HIV Diagnoses 2005-2010		Linked to Care*		Retained in Care**		Virally Suppressed‡	
	No.	%	No.	%	No.	%	No.	%
Overall (All Diagnoses)	6,318	100%	5,238	83%	1,296	25%	1,088	84%
MSM	2,594	100%	2,186	84%	517	24%	463	90%
IDU	572	100%	495	87%	131	27%	96	73%
Heterosexuals	1,731	100%	1,475	85%	388	26%	312	80%
Adolescents	694	100%	572	82%	134	23%	86	64%

* Evidence of at least 1 CD4 or viral load test reported to the surveillance program by 12/31/2010 and conducted on or after the date of HIV diagnosis,

** Defined (based upon HRSA definition) as having had 2 laboratory tests (CD4 or viral load) between 1/1/2010 and 12/31/2010 and at least 3 months apart.

‡ Based on use of the last viral load test reported in 2010; viral suppression is defined as ≤400 copies/ml

Since 2009, HAHSTA has been collecting data on modified HAB performance measures emphasizing those that measure outcomes of clinical performance. The participating providers are using 16 HRSA/HAB Performance Measures, including the proportion of all clients with defined medical visits, viral load monitoring, viral suppression, PCP prophylaxis, syphilis screening, oral exams, and ADAP application and recertification and are also applying some of the measures to pediatric clients and MSM. Regularly tracking late testers, linkage to care, retention in care, and clinical outcomes including viral suppression is a key priority for the District of Columbia in order to provide objective outcome measures for assessing the success of changes in the system of testing and care.

B. Estimate of Unmet Need

HRSA's framework for estimating unmet need calls for estimating the number of individuals in and out of care based the following operational definitions:[21]

- Unmet need is the need for HIV-related health care by individuals with HIV/AIDS who are aware of their HIV status but are not receiving HIV-related primary health care.
- An individual diagnosed with HIV or AIDS is considered to have an unmet need for care (or to be out of care) when there is no evidence that s/he received *any* of the following three components of HIV primary medical care during a defined 12-month time frame:
  1. Viral load (VL) testing,
  2. CD4 count, or

3. Provision of antiretroviral therapy (ART).

- A person is considered to have met need (or to be in care) when there is evidence of *any one or more* of these three measures during the specified 12-month time period.

The estimation approach is straightforward: specify the number of people diagnosed and living with HIV/non-AIDS (PLWH/non-AIDS) and the number of people living with AIDS (PLWA) as of a particular date in time, using surveillance data. A total of 17,272 [22] of HIV/AIDS cases were used in this estimation. Subtract the number of PLWH/non-AIDS and PLWA who received a viral load test or CD4 count or a prescription for ART during the specified 12 months. The result is the number of PLWH/non-AIDS and PLWA who have an unmet need for HIV-related medical care. Among the practical challenges are how to ensure that people in both public and private care are included, to link data so that double-counting of individuals is minimized, and to avoid counting people as out of care when they have moved to another jurisdiction or died. It should be noted that the District of Columbia did not have mature HIV name reporting when these estimates were made. The District of Columbia's HIV data matured as of November 2011. The estimation of unmet need calculated here is from a combination of data sources. Future estimates will use data subsequent to November 2011 which will provide a more accurate picture of the unmet need. Data used in these estimates is as of December 2010.

In 2010, approximately 7,203 (42%) of HIV/AIDS cases in the District of Columbia have an unmet need for primary medical care while 10,069 (58%) of PLWH/A have been found to have evidence that received primary care. Of the 9,108 AIDS cases, about 36% (3,230) have an unmet need, while for those with HIV (non-AIDS) aware of their status; about 49% (3,973) have an unmet need for primary medical care.

Table 20: Met and unmet need among HIV/AIDS cases in Washington DC, 2010

Need assessment	**HIV cases**		**AIDS cases**		**Total**	
	N	%	N	%	N	%
Met	4,191	51.3	5,878	64.5	10,069	58.3
Unmet	3,973	48.7	3,230	35.5	7,203	41.7
Total	8,164	100	9,108	100	17,272	100

C. Early Identification of Individuals with HIV/AIDS (EIIHA)/Unaware Estimate

Nationally, the CDC estimates that about 21% of individuals living with HIV/AIDS are unaware of their status. Using the CDC estimate, there were approximately 21,863 individuals with HIV/AIDS in the District of Columbia as of December 31, 2010, of whom 17,272 were aware and 4,591 were unaware of their status. However, HAHSTA believes that the percent of undiagnosed individuals in the District of Columbia is much higher than the national estimate. The first three cycles of the CDC's National Behavioral Surveillance System (NHBS) study in Washington, DC analyzed three subpopulations –heterosexuals, men who have sex with men (MSM), and injection drug users (IDU) – and found that 30-47% of people with HIV in these categories were unaware of their infection before participation in the study. Figure 21 includes those calculations based on the December 2008 diagnosed HIV and AIDS cases. The estimated number of undiagnosed individuals among these three categories alone is 25,233, more than triple the estimate derived from national proportions of undiagnosed.

Figure 21: Estimated HIV+/Unaware by Risk Factor, NMHBS Analysis as of December 31, 2008

Risk Category	Proportion of HIV+/Unaware/ (Local - NHBS)	Number Diagnosed and Living with HIV/AIDS	Estimated Number of HIV+/ Unaware	Estimated Total, HIV+, Aware and Unaware
Heterosexual	47.4%	12,099	10,903	23,002
MSM	41.2%	16,977	11,895	28,872
IDU	30.3%	5,601	2,435	8,036
Subtotal	42.1%	34,677	25,233	59,910

Several factors contribute to HIV positive individuals remaining unidentified, undiagnosed, and not receiving routine care. One primary issue is raising the awareness of providers to promote HIV testing as a routine part of care. Routine testing is less common among "mainstream" providers, and is not always encouraged by public or private payer sources. In the District of Columbia, many of the HIV affected population and potential clients have Medicaid coverage. One challenge has been ensuring that providers of Medicaid reimbursable services screen clients for HIV. Often this screening does not occur and opportunities to identify HIV infected individuals are lost.

Consistent with national trends, Washington, DC is challenged by declining tax revenues, uncertain economic systems and increased competition for limited resources. Increased reliance on rapid testing technology has contributed to eradicating challenges to providing test results, but budget pressures are prompting a re-consideration of relatively expensive rapid testing.

In the District of Columbia, some 44% of AIDS diagnosis present as late testers to the medical care system. People who don't know their HIV status are more likely than those in care to infect others, and late entry into care negatively affects health status.

Chapter 3: Description of the Current Continuum of Care

Overview

This chapter describes the current continuum of care in Washington DC. The term *Continuum of Care* is used to describe the range of services available to meet the needs of individuals at any point of time for a particular condition. In the case of care for persons with HIV/AIDS, HRSA defines a comprehensive continuum of care as a "coordinated delivery system, encompassing a comprehensive range of services needed by individuals or families with HIV disease to meet their health care and psychological services needs throughout all stages of illness." This includes primary medical care, HIV-related medications, mental health treatment substance abuse treatment, oral health care and case management services that assist PLWH in accessing treatment of HIV disease consistent with Public Health Services Treatment Guidelines. In addition, the continuum of care may include supportive services that enable individuals to access and remain in primary medical care.

In the Washington metropolitan region there are four separate but linked jurisdictions that overlap in the provision of services for PLWH disease creating a complex continuum that is also advantageous in terms of the number of providers and access to those service providers. Washington, DC leads those jurisdictions in both PLWH and funding for services for PLWH, so the District of Columbia is central to efforts to ensure a continuum of care both within and across these geographic and funding lines. The delivery of care is different in each jurisdiction because of differing PLWH demographics and considerable variations in public health and nonprofit health and human service infrastructure, policies, and resources. The District of Columbia is transitioning to a medical homes model for care to improve coordination of services provided for PLWH.

The continuum of care in the District of Columbia is rich under all CARE Act programs, and currently provides Ryan White Part B funded services through 19 sub-grantees across the city in the following service categories; AIDS Drug Assistance Program, AIDS Pharmaceutical Assistance, Medical Case Management, Family Centered Medical Case Management, Medical Case Management for Peri-Incarcerated, Treatment Adherence Counseling, Health Insurance Premium and Cost Sharing, and Early Intervention Services.

FIGURE 22: NUMBER OF RYAN WHITE PART B SERVICE PROVIDERS BY SERVICE CATEGORY

	ADAP	Medical Case Management	Family Centered Case Management	Case Management for Peri-Incarcerated	Treatment Adherence Counseling	Health Insurance Premium and Cost Sharing	Early Intervention Services
Number Of Providers	1	14	2	2	7	1	3

AIDS Drug Assistance Program (ADAP) is a District of Columbia administered program authorized under Part B of the Ryan White Program that provides FDA-approved medications to low income individuals with HIV disease who have limited or no coverage from private insurance, Medicaid, or Medicare.[23] Additionally, ADAP provides assistance with copayments and deductibles for individuals with private insurance. ADAP also provides financial assistance for eligible individuals living with HIV to maintain a continuity of health insurance or to receive medical benefits under a health insurance program. This includes premium payments, risk pools, co-payments, and deductible.

Medical Case Management services (including treatment adherence) are a range of client centered services that link clients with health care, psychosocial, and other services. The coordination and follow-up of medical treatments is a component of medical case management. These services ensure timely and coordinated access to medically appropriate levels of health and support services and continuity of care, through ongoing assessment of the client's and other key family members' needs and personal support systems. Medical case management includes the provision of treatment adherence counseling to ensure readiness for, and adherence to complex HIV/AIDS treatments.

Key activities include:

1. Initial assessment of service needs
2. Development of a comprehensive, individualized service plan including active client participation

3. A multi-disciplinary team approach to coordination of services required to implement the plan
4. Client monitoring to assess the efficacy of the plan
5. Periodic re-evaluation and adaptation of the plan as necessary over the life of the client. It includes client-specific advocacy and/or review of utilization of services. This includes all types of case management contact including face-to-face, phone, and other forms of communication
6. Treatment adherence targeting special populations such as substance abuse and transgenders.

Early intervention services include counseling individuals with respect to HIV/AIDS; testing including tests to confirm the presence of the disease, tests to diagnose the extent of immune deficiency, tests to provide information on appropriate therapeutic measures; referrals; other clinical and diagnostic services regarding HIV/AIDS; periodic medical evaluations for individuals with HIV/AIDS; and providing therapeutic measures.

Key activities include:

1. HIV screening and confirmatory tests
2. Tests to diagnose the extent of immune deficiency
3. Counseling to prepare the client for managing their HIV/AIDS diagnosis
4. Counseling clients on their risk behaviors and how to reduce transmission of HIV/AIDS
5. Tracking and monitoring of clients' linkage to primary medical care.
6. Recapture of PLWH lost to care.

A. The Current Continuum of Care

HRSA Expectations: HRSA/HAB expects each Part A program to establish and maintain "a comprehensive continuum of high quality, community-based care for low-income individuals and families with HIV." That continuum is expected to include (but not necessarily use Ryan White funds to support) "the core medical services specified in law, and appropriate support services that assist PLWH in accessing treatment for HIV/AIDS infection that is consistent with the Department of Health and Human Service (DHHS) Treatment Guidelines. Comprehensive HIV/AIDS care beyond these core services may include supportive services that meet the criteria of enabling individuals and families living with HIV/AIDS to access and remain in primary medical care and improve their medical outcomes."[24]

System of Care in the District of Columbia: Establishing, maintaining, and planning for a continuum of care is especially complex in the District of Columbia. The District of Columbia is in close proximity to three different state jurisdictions, is part of a metropolitan regional network of medical care and is the Grantee (HAHSTA) on behalf of the District of Columbia Mayor for the Ryan White Part A services funded throughout the EMA. Unlike most other metropolitan areas, the Washington region has significant numbers of people living with HIV disease in three of the four jurisdictions. This means four Medicaid systems, four Part B and ADAP programs, four different systems for providing health and human services.

HAHSTA is the agency that administers the entire portfolio of Part B services and in addition to serving as the Grantee for Part A, also directly manages administration of program services in the District of Columbia and two West Virginia counties within the EMA under Part A.

The District of Columbia offers a somewhat different set of services based on its own needs and priorities. In collaboration with its stakeholders and taking into consideration other federal and local funding streams, HAHSTA determines resource allocations. In GY 22, the District of Columbia funded 19 entities to provide Part B services, (See Figure 26, the Ryan White Service Provider Inventory, later in this chapter).

Principle Focus: The system of care reflects the District of Columbia's diligence and commitment to the delivery and quality of care for PLWH, its commitment to early entry into care following diagnosis, making care accessible throughout the District of Columbia to as many residents as possible, providing high quality care to diverse populations, meeting critical needs for core medical services – particularly ambulatory medical care, medications, and medical case management – and providing support services necessary to help PLWH enter and remain closely connected to care.

Fulfilling these Principles: In the past several years, HAHSTA made a number of changes in the continuum of care to fulfill these principles, with special emphasis given to rapid linkage to and retention in care for both newly diagnosed individuals and PLWH that have been out of care. This has involved such efforts as the following:

- *Recapture initiative* – In 2009, HAHSTA gave provider a mission to "recapture" clients loss to care using MAI funding. This initiative was labeled "Recapture Blitz." The participating providers included two-thirds of the District of Columbia's major public section providers and the "Cross-Part" Collaborative. All providers were recipient of at least one Ryan White funding source, Part A, B, C and D. The "recapture blitz" was a tremendous success and has been instituted permanently.

- *Designing efforts to ensure rapid access and entry into care* - implemented a "Red Carpet Entry" initiative designed to enable both newly diagnosed and out-of-care Ryan White eligible PLWH to obtain quick and easy access to HIV medical care. With "Red Carpet Entry," PLWH get "concierge" access to a first appointment with an HIV care provider within two business days. There are currently 34 counseling and testing sites referring to eleven medical care providers participating in the program.

- *Collaborating to improve service quality* – Over the past three years, HAHSTA has been an active participant, providing considerable leadership and support in the DC Cross-Part Collaborative. HAHSTA and the Collaborative's key focus are on changes that improve and demonstrate measurable clinical outcomes. The data collected are used to identify and prioritize quality improvement activities, develop and disseminate best practices and standards, and improve key activities to minimize/eliminate barriers in communication between providers and consumers. With new service agreements and as of March 2012 (Part A), and April 2012 (Part B), HAHSTA refined collection of both primary medical care and case management HAB performance outcome measures to identify and prioritize quality improvement projects, to routinely monitor the quality of care, and evaluate the impact of changes made to improve the quality & system of HIV care.

- *Ensuring access to HIV medications and pharmaceutical assistance* - ADAP and pharmaceutical assistance is a very high priority for the District of Columbia. These funds, especially ADAP has generally been supported out of Part B funds. The District of Columbia spent $14,631,303 in AIDS pharmaceutical Assistance by the end of 2010, representing

100% of total priority allocation for the fiscal year[25]. This represents 75% of the Part B expenditure for the District of Columbia.

- *Address gaps* - The remaining 25% of the Part B funds are used to address gaps in other core and support services. Reductions in federal and local funding leave many gaps towards which Part B funds are used to maintain continuity and quality of services.

Other examples of initiatives and activities HAHSTA has undertaken to improve access to care for PLWH and collaboration within the District of Columbia and the surrounding areas include:

Program Collaboration and Service Integration (PCSI): The goal of PCSI is to organize interrelated health issues, activities and prevention strategies to facilitate comprehensive delivery of services. Initial phases involved the establishment of four pillar teams. Each of the pillars teams is aligned with one of the pillars of the National HIV/AIDS Strategy. The pillar teams are composed of staff from each of the Bureaus within HAHSTA. The primary goal of each pillar is to find programmatic areas where collaboration can be optimized both internally and with our external partners.

***The 12 Cities Project*:** As a designated participant (due to AIDS burden, the District of Columbia ranks 3rd in the nation) in the 12 Cities Project initiative, birthed out of the National HIV/AIDS Strategy, the District of Columbia is serving as a proving ground for understanding how the various Federal agencies and their respective funding streams can be maximized towards reducing disparities by increasing access to continuous quality care for PLWH. By challenging HHS agencies and offices to coordinate their planning better, implementation, delivery and evaluation of HIV/AIDS services in each of these 12 jurisdictions, HHS seeks to reduce new HIV infections, promptly diagnose those who are infected with HIV and ensure that persons with HIV/AIDS have access to continuous, quality care, so as to reduce current disparities.[26] One local collaborative effort being scaled up is an interagency project with the Addiction, Prevention and Recovery Administration (APRA) and the Department of Mental Health (DMH) funded through SAMSHA with Minority AIDS Initiative fund. Although this collaborative effort is in the planning phases it has one primary goal that aims to ensure that clients accessing services with any of the three participating agencies receive wrap around services that are not duplicative.

Housing Assistance: Housing services to PLWH are provided primarily through HOPWA (Housing Opportunities for Persons with AIDS). PLWH are also served in regular Section 8 and other housing assistance programs, and some are eligible for other special housing programs for the mentally ill, elderly and disabled, or substance users. The District of Columbia serves as the grantee for HOPWA funds for the Washington, DC metropolitan area.

HOPWA was redesigned to provide housing for periods of up to two years. That limitation no longer exists, and HIV/AIDS has become a chronic illness. HOPWA resources have not been adjusted to reflect this reality; there have been cuts in recent years. There is very little transition out of HOPWA-supported housing, and waiting lists remain long and show minimal movement. Figure 23, below, shows clients served under each of the five HOPWA service categories during the 2011 program year; In addition to this direct housing assistance, HOPWA supports Housing Information and Referral Services, including Intake, Assessment, and Linkage Services, and Support Services.

Figure 23: Types of Services Provided under HOPWA, October 1, 2010 – September 20, 2011

Service Category	**Number of Clients Served Where Available**
Tenant-based Rental Assistance	331
Facility-based Housing Assistance	166
Short-term Rental, Mortgage, & Utility Assistance	282
Housing Information and Referral Services	Yes
Support Services: Direct HOPWA Funds and Organizational Linkages	Both

Eligibility for Services: Figure 24, below, shows the eligibility requirements for Part A, Part B, Medicaid, and other special state-specific health care programs in The District of Columbia. As the table indicates:

Figure 24: Health Care System Eligibility for Ryan White and as of 03/02/2012

Part/Source	District of Columbia
Part A	• Fills gaps • Generates Program Income • 500% of FPL • Eligibility for services based on whether client qualifies for other coverage
Medicaid	• 200% of FPL without regard to disabling condition
ADAP	• 500% of FPL • Rapid enrollment • Pays for insurance premiums, co-payments and deductibles • Direct drug procurement
Part B	• Fills gaps • Generates program income • 500% of FPL • Eligibility for services based on whether client qualifies for other coverage
Other	• **DC Healthcare Alliance** -200% of FPL for individuals not eligible for Medicaid - Locally funded primary care insurance - Not HIV specific - Does not pay for HIV medications

Service providers: The District of Columbia currently has 19 Ryan White Part B-funded service providers. They reflect a mix of types of organizations. Washington, DC has a wide range of ambulatory medical care providers and nonprofit organizations providing other core medical and support services. There are no public hospitals or clinics in the District of Columbia, but the District of Columbia offers a great deal of choice in ambulatory medical care providers, which include three of the District of Columbia's four community health centers (CHCs), an FQHC look-alike, other community-based clinics, and hospital-based clinics.

Providers of other core medical and support services include both AIDS service organizations (ASOs) and non-AIDS-specific grassroots nonprofits that serve the general population and in some cases target particular populations – among them the lesbian, gay, bisexual, and transgender (LGBT) community, Latinos and other immigrants, adolescents, women, sex workers, injection drug users, and the homeless. Given its extremely high rate of HIV/AIDS, the District of Columbia does extensive testing and works hard to link testing and care. It uses its Red Carpet Entry model to link PLWH to care through many medical providers.

Many PLWH need wraparound services from Ryan White but receive their medical care and medications through the already expanded Medicaid program or through the DC Alliance, a public insurance system that provides care to individuals with incomes up to 200% of poverty who are not eligible for Medicaid.

Table 25: PLWH served through Medicaid: Number of Clients and Estimated Expenditures for DC

Jurisdiction and Services	**Unduplicated Clients**			**Notes**	**Expenditures – Fee for Service Only**
	Fee for Service	**Managed Care**	**DC Alliance**		
District of Columbia (FY 2011)	Total HIV/AIDS Medicaid and Alliance Clients: 7,107 [Some have no HIV/AIDS claims during FY 2011 so are not included below]			Some clients moved between programs during the year and may be counted twice	
All Primary and Specialty Medical, inpatient and outpatient, including emergency, except for clinical services	2,848	3,160	600	• Medicaid Managed Care and DC Alliance operate on a capitated (cost per month) basis; cost estimates not available • No current Medicaid benefit for substance abuse services	$44,581,364
Medical Services, excluding inpatient	2,797	3,111	596		$5,280,521
Pharmacy	3,032	N/A	N/A		$13,838,647
Dental	1,011	1,002	209	Use of dental services by managed care clients considered very high	$1,736,523
Home Health	759	58	0		$12,798,775
Mental Health	1,010	N/A	N/A		$4,549,515
Hospice	45	4	0	Hospice	$459,620

Other Funding Streams: The District of Columbia also receives funding for HIV/AIDS care from other Ryan White “Parts,” Medicaid, Medicare, and other public and private sources. The most important are Medicare, and Medicaid. It is challenging to determine the exact level of such funding, particularly for Medicaid, since a number of clients are served through managed care organizations (MCOs) rather than fee for service (FFS) structures, and MCO costs are difficult to calculate. One output of the 12 Cities Project intends to produce is to better quantify Medicaid expenditures with respect to care for PLWA. This need is even more at the forefront as a result of the Healthcare Reform Act. Figure 25 above PLWH served through Medicaid: Number of Clients and Estimated Expenditures for the District of Columbia.

The District of Columbia also has special funding for particular populations and services that complement Ryan White services. For example:

- A three-year, $1.3 million a year federal grant to identify and provide a mix of services to homeless PLWH multiply diagnosed mental illness or substance abuse.
- Positive Pathways, a District of Columbia-based project funded through the Washington AIDS Partnership with federal support from AIDS United and the federal Social Innovations Fund, has trained

HIV-positive African Americans living in Wards 5-8 enter and remain in HIV-related care; its special focus is on women and their partners.

Changes in Funding Streams: Perhaps the largest change that has occurred in other funding streams involves the expansion of Medicaid in the District of Columbia, accomplished largely during the second half of 2011. Approximately 1,100 PLWH served under the DC Alliance and ADAP were shifted to Medicaid and weekly medication costs were reduced from $325,000 to $150,000 per week.[27]

B. Funded HIV Care and Services Inventory in the District

Figure 26 represents and inventory of Funded District of Columbia Providers by Funding Source and Services. The chart indicates the medical-related and support services for which they have funding, as well as other services they provide that are in addition to Part B-funds.

Figure 26: Inventory of Funded District of Columbia Providers by Funding Source and Services

	Provider Name	Location(s)	Funding from RW Part(s) and Other Sources	Core Medical-Related Services Provided	Support Services Provided	Does HIV Testing
1	AIDS Healthcare Foundation: Blair Underwood	2141 K St., NW, Suite 606 (Also mobile testing unit)	A, B	Outpatient/Ambulatory Medical Care, Early Intervention Services, Medical Case Management		Yes
2	Andromeda Transcultural Health	1400 Decatur St, NW (Also medical mobile outreach clinic)	A, B, Prevention	Outpatient/Ambulatory Medical Care, Early Intervention Services, Mental Health Services, Medical Case Management, Outpatient Substance Abuse Services	Medical Transportation, Psychosocial Support, Treatment Adherence Counseling	Yes
3	Building Futures	1440 Meridian Place, NW	A, HOPWA			
4	Carl Vogel Foundation	1012 14th St, NW, Suite 700	A, B, Local funding	Outpatient/Ambulatory Medical Care, Early Intervention Services, Mental Health Services, Medical Nutrition Therapy, Medical Case Management, Outpatient Substance Abuse Services	Food Bank/Home Delivered Meals, Outreach, Psychosocial Support	Yes
5	Children's National Medical	111 Michigan Ave., NW	A, B, D	Outpatient/Ambulatory Medical Care, Early Intervention Services, Mental Health Services, Medical	Child Care, Medical Transportation, Psychosocial Support,	

Figure 26: Inventory of Funded District of Columbia Providers by Funding Source and Services

	Provider Name	**Location(s)**	**Funding from RW Part(s) and Other Sources**	**Core Medical-Related Services Provided**	**Support Services Provided**	**Does HIV Testing**
	Center			Nutrition Therapy, Medical Case Management (*including Family-centered Medical Case Management),* Outpatient Substance Abuse Services	Treatment Adherence Counseling	
6	Christ House	1717 Columbia Rd. NW	A	Outpatient/Ambulatory Medical Care, Medical Case Management	Medical Transportation, *Residential Care*	
7	Community Education Group	3233 Pennsylvania Ave., SE	B	Early Intervention Services		
8	Community Family Life	305 E St., NW	A, HOPWA	Medical Case Management		
9	Damien Ministries	2200 Rhode Island Ave., NE	A, B, HOPWA	Medical Nutrition Therapy, *Medical Case Management*	Food Bank/Home Delivered Meals	
10	District of Columbia Care Consortium	1112 16th St., NW, Suite 400	A,B, HOPWA, Local funding	*Health Insurance Premium and Cost-Sharing Assistance*	Emergency Financial Assistance, Medical Transportation	
11	Family & Medical Counseling Services	2041 Martin Luther King., Jr. Ave., SE, Suite 105	A, B, HOPWA, Prevention	Outpatient/Ambulatory Medical Care, Medical Case Management, Medical Nutrition Therapy, Mental Health Services, Outpatient Substance Abuse Services, *Medical Case Management – Peri-Incarcerated*	Food Bank/Home Delivered Meals, *Treatment Adherence*	Yes
12	Food and Friends	219 Riggs Rd., NE	A	Medical Nutrition Therapy	Food Bank/Home-Delivered Meals	

Figure 26: Inventory of Funded District of Columbia Providers by Funding Source and Services						
	Provider Name	**Location(s)**	**Funding from RW Part(s) and Other Sources**	**Core Medical-Related Services Provided**	**Support Services Provided**	**Does HIV Testing**
13	Homes for Hope	30003 G Street, SE	B	Medical Case Management		
14	Howard University Hospital Healthcare	2225 Georgia Ave., NW, 3rd Floor	A, B, Prevention	Outpatient/Ambulatory Medical Care, Oral Health Care, Medical Case Management *(including Family-centered)*, Mental Health Services, Outpatient Substance Abuse Services; *Inpatient and specialty care*		Yes
15	Joseph's House	1730 Lanier Place, NW	A, B, HOPWA	Home & Community-based Health Services, *Medical Case Management*	Transitional Housing, *Hospice*	
16	La Clinica del Pueblo	2831 15th St., NW, Washington, DC	A B, C, DC, Prevention	Outpatient/Ambulatory Medical Care, Early Intervention Services, Medical Case Management, Mental Health Services, Outpatient Substance Abuse Services	Linguistic Services	Yes
17	Mary's Center for Maternal and Child Care	2333 Ontario Rd. NW, 3531 Georgia Ave., NW *[Also 9709 Flower Ave., Silver Spring, MD, and a mobile van]*	A, Department of Mental Health, federal Bureau of Primary Health Care	Oral Health Care, *Medical Care, Mental Health Services*		
18	Metro TeenAIDS	651 Pennsylvania, Ave., SE	A, DC, Prevention	Early Intervention Services	*HIV Counseling and Testing, Care Advocacy, Drop-in Center, Peer Education*	Yes
19	Regional Addiction	The Calvin Rolark Center,	A, B, HOPWA, Private	Outpatient/Ambulatory Medical Care, Medical Case Management,	*Residential Substance Abuse Services*	

Figure 26: Inventory of Funded District of Columbia Providers by Funding Source and Services						
	Provider Name	**Location(s)**	**Funding from RW Part(s) and Other Sources**	**Core Medical-Related Services Provided**	**Support Services Provided**	**Does HIV Testing**
	Prevention (RAP), Inc.	1949 4th St, NE		Medical Nutrition Therapy, Outpatient Substance Abuse Services	*(Therapeutic Community), Emergency Housing, Transitional Housing, Substance Abuse Prevention and Outreach Services*	
20	Terrific, Inc.	1222 T St., NW	B, HOPWA	Medical Case Management	*Transitional Housing*	
21	The Women's Collective	1331 Rhode Island Ave., NE	A, DC, Prevention	Medical Case Management	*HIV Prevention, Prevention with Positives, Female Condom Outreach and Education, Social services including peer-based support*	Yes
22	Transgender Health Empowerment	1414 North Capitol Street, NW	Part B, HOPWA Local funds		*Treatment Adherence*	
22	Unity Health Care, Inc.	*Anacostia HC*, 1220 12th St., SE; *Brentwood HC*, 1201 Brentwood Rd., NE; *Columbia Road HC*, 1660 Columbia Rd., NW; *Congress Heights HC*,	A, B, Prevention, Federal Bureau of Primary Health Care	Outpatient/Ambulatory Medical Care, Oral Health Care, Medical Case Management *(including Medical Case Management for Peri-Incarcerated)*	Treatment Adherence Counseling	Yes

Figure 26: Inventory of Funded District of Columbia Providers by Funding Source and Services

	Provider Name	Location(s)	Funding from RW Part(s) and Other Sources	Core Medical-Related Services Provided	Support Services Provided	Does HIV Testing
		3720 MLK Jr. Ave., SE; *East of the River HC*, 123 45th St., NE; *Good Hope HC*, 1638 Good Hope Rd., SE; *Hunt Place HC*, 4130 Hunt Pl., NE; *Minnesota Avenue HC*, 3924 Minnesota Ave, NE; *Southwest HC*, 850 Delaware Ave., SW; *Stanton Road Center*, 3240 Stanton Rd., SW; *Upper Cardoza HC*, 3020 14th St., NW; *Walker-Jones HC*, 40 Patterson St., NE;				

Figure 26: Inventory of Funded District of Columbia Providers by Funding Source and Services						
	Provider Name	**Location(s)**	**Funding from RW Part(s) and Other Sources**	**Core Medical-Related Services Provided**	**Support Services Provided**	**Does HIV Testing**
		Ballou Student HC, 3401 4th St., SE; *Eastern Student HC*, 1700 E. Capitol St. NE; *Unity at DC General*, 1900 Massachusetts Ave., SE; (plus services provided at 9 homeless sites)				
23	Us Helping Us	3636 Georgia Avenue., NW	A, B, DC, Prevention	Medical Case Management, Mental Health Services	Treatment Adherence Counseling, *Individual and group counseling, Support groups*	Yes
24	Whitman Walker Health	*Elizabeth Taylor* Medical Center 1701 14th St., NW *Max Robinson Medical Center* 2301 M L King Jr Ave, SE (Also mobile testing unit)	A, B, DC, Prevention, HOPWA, STD	Outpatient/Ambulatory Medical Care, Home & Community-Based Health Services, Medical Case Management, Mental Health Services, Medical Nutrition Therapy, Outpatient Substance Abuse Services, *Early Intervention Services*	Legal Services, Psychosocial Support, Treatment Adherence Counseling	Yes

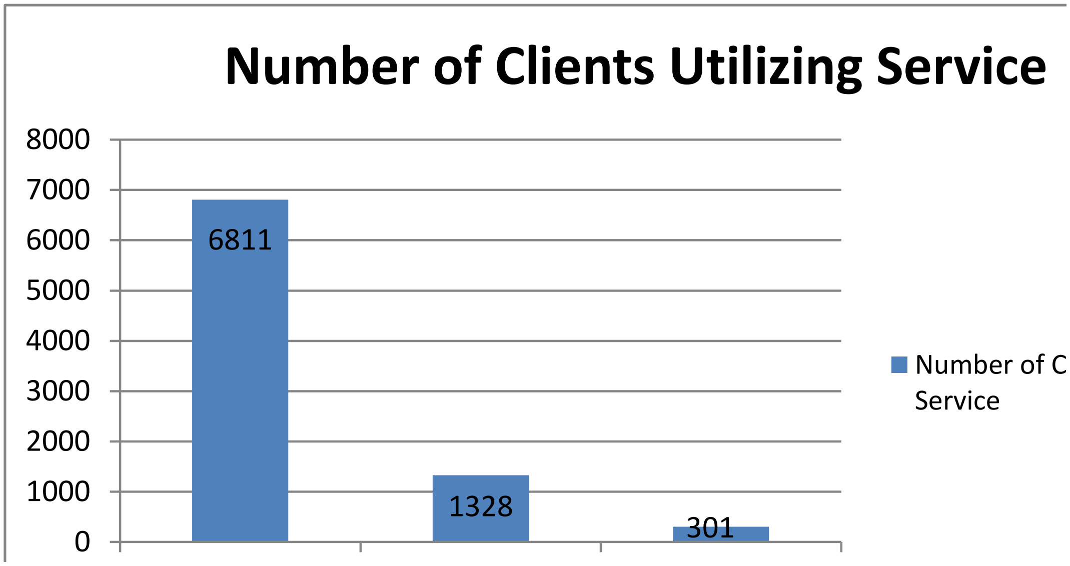
C. Service Utilization

Service utilization data for the District of Columbia are available but with limitations. The District of Columbia is currently in the process of implementing a new client-based monitoring and evaluation system, MAVEN.

MAVEN will enable HAHSTA to:

- Track clients across the continuum of care and across time periods,
- Complete more in-depth analysis of health outcomes,
- Evaluate cost and cost-effectiveness of programs and services,
- Improve the quality of the data,
- Adapt more quickly to future requests and/or changes in federal requirements.

In 2010, the single most used service category was medical case management; 6,811 CARE Act clients (56% of total) received this service, compared to 11% of the total number of Ryan White clients utilizing treatment adherence targeted to special populations, and 2% of clients using psychosocial support. The chart below represents the client utilization for these three services.[28]



Waiting Lists and Waiting Times: Utilization data give a sense of the demand for certain services, but do not provide direct information about the number of PLWH who needed a service but were unable to obtain it. HAHSTA jointly with the Planning Council, distributed an online provider survey to CARE Act and other major service providers, and it included questions about waiting lists and waiting times. Information from responding providers indicated that the vast majority have neither waiting lists nor waiting times of more than a week. The two nonprofit housing providers, however, indicated significant waiting lists – one, which provides the HOPWA-funded Tenant-Based Rental Assistance Program, reported a waiting list of 1,001 in the District of Columbia. The other operates housing for PLWH and other special-needs clients and has Part B as well as HOPWA funding; it has a waiting list of 96 for housing and 22 for medical case management. This provider estimated the waiting time at six years for housing; it refers clients to other providers where possible.

D. Ensuring Continuity of Care: Interaction of Ryan White and Non-Ryan White Funded Care/Services

The District of Columbia recognizes the critical importance of including both Ryan White and non-Ryan White funded services and providing for planned interaction among these two groups of providers in the continuum of care.

Ryan White Funded and Non-Funded Services: One direct and often overlooked level of interaction involves organizations that have Ryan White funding for some of their services, but provide additional services to Ryan White clients with other funding. Once a PLWH becomes a client, s/he is likely to be offered other services. For example, a multi-service organization might have Ryan White funding only for oral health services or support services such as food bank, while offering many other services needed by PLWH. An individual who receives that service may be offered primary medical care, food, legal services, and a variety of social services. Similarly, community-based organizations funded to provide support services such as outreach or non-medical case management may also provide support groups, counseling, food, or other assistance. In addition, a number of CBOs with funding for specific HIV education, prevention, and/or testing services often become a source of formal and informal support and services for PLWH.

CHCs/FQHCs: One of the most complex aspects of funder and service interactions is how to maximize the engagement of community health centers/federally qualified health centers (CHCs/FQHCs) in providing or coordinating medical care for PLWH. In the District of Columbia, three of the four CHCs/FQHCs and the one FQHC "look alike" are Part A providers. Even when a CHC/FQHC is funded for only one or two services, not including medical care, the link with Ryan White creates a valuable interaction with other providers and increases its engagement with PLWH. This provides an important additional resource.

Other Services: In the District of Columbia, a considerable amount of mental health and substance abuse treatment is provided by non-Ryan White providers; Ryan White case managers frequently make referrals to them. However, they vary in their knowledge of the special needs of PLWH. It is important that they receive opportunities for interaction with HIV-focused organizations and be offered training by area AIDS Education and Training Centers (AETCs). Mental health services have been identified as an area that needs additional targeted funding for PLWH.

Role of Medical Case Managers: Medical Case managers currently serve a key role in determining the level of referrals to and service interactions with both Ryan White and non-Ryan White providers. A very large portion (apart from the ADAP program) of the District of Columbia's Part B funding is used to support medical case management. While the focus on linking case management to medical care has been beneficial, both providers and PLWH believe that the expertise of the two types of case managers is often very different. Medical case managers often have much more clinical knowledge but much less capacity to help clients access support services, especially services not funded through Ryan White and offered by CBOs and non-medical providers. This can create challenges for PLWH who need help in identifying and accessing such services. Rather than look to their case managers for such referrals, PLWH must seek information from peers and other sources.

E. Current Prevention and Testing Programs

A System in Transition: The current system of prevention and testing in the District of Columbia is undergoing major change in response to the following:

- The Ryan White Treatment Extension Act of 2009, which established testing and linkage to care as shared responsibilities of CDC- and HRSA/HAB-funded programs and has led to the implementation of a variety of activities related to the Early Identification of Individuals with HIV and AIDS (EIIHA).
- The National HIV/AIDS Strategy, with its focus on preventing new infections through early diagnosis and treatment

- Recent research on “treatment as prevention,” which has demonstrated the value of anti-retroviral therapy (ART) as a means of reducing HIV transmission[29]
- The new CDC High Impact HIV Prevention Strategy, which calls for “combinations of scientifically proven, cost-effective, and scalable interventions targeted to the right populations in the right geographic areas” and emphasizes testing, linkage to care, early implementation of ART, access to condoms and sterile syringes, and prevention for positives
- The CDC funding guidance for 2012-2016, designed to implement the new CDC prevention strategy, which reallocates funds to focus on areas with the highest disease burden and requires that 75% of CDC core prevention funds be spent on prevention for positives; this has the effect of reducing resources and emphasis on Diffusion of Effective Behavioral Interventions (DEBIs) and other primary prevention initiatives with more limited reach
- National Enhanced Comprehensive HIV Prevention Planning (ECHPP) and implementation, targeting the 12 metro areas most affected by epidemic; these sites include the District of Columbia and Baltimore, and Maryland plans to apply the principles and interventions statewide
- The newly revised PHS treatment guidelines for HIV-related medical care, which recommend early initiation of antiretroviral therapy (ART) for all HIV-positive individuals – highlighting the need for early diagnosis and prompt entry into care

Current Prevention and Testing: Community input sessions, review of prevention materials, and discussions with staff provided a sense of the current and emerging prevention and testing efforts. Figure 27 summarizes the populations who are currently identified as high priority for prevention and testing efforts, and also identifies the populations identified by CDC.

Figure 27: Key Target Populations for HIV Prevention and Testing

CDC*	District of Columbia
PLWH	PLWH Priority on the following (no specific order): • Black heterosexuals of all ages • Black MSM of all ages • Latino MSM 20-39 • White MSM 20-49 • Black IDU 20-59 • Latino IDU 40-49 • White IDU 30-49
Gay and bisexual	High-risk HIV-negative individuals from the same populations as identified for PLWH

Figure 27: Key Target Populations for HIV Prevention and Testing

CDC*	District of Columbia
men of all races and ethnicities	above.
African Americans	Special Populations (no specific order) • High-Risk Youth • Transgender Individuals • Individuals involved in the sex trade • The deaf and hard of hearing • Individuals 50 or older • Latino heterosexuals 20-49 • Recent immigrants • Incarcerated and recently released individuals • Individuals with physical, mental or developmental disabilities • Homeless individuals
Hispanics/Latinos	
Injection Drug Users	
Transgender Individuals	
* CDC does not specify priorities among target populations but lists these five populations and places key emphasis on prevention for positives with regard to use of funds.	

Below is a summary description of current prevention and testing programs and priorities in the District of Columbia. As the core funding comes from CDC, programs reflect CDC's strategies and program requirements.

The District of Columbia uses both federal and local funds to support HIV prevention and testing. Because an estimated 3% of residents are infected, prevention and testing are very high priorities for the city. Key emphasis has been placed on ensuring access to condoms, maximizing testing in both clinical and non-clinical settings, and reaching and educating the entire District of Columbia population as well as specific target groups about HIV/AIDS. Prevalence rates for the following populations are above 3%: Residents aged 40-49 (7.4%), Black males (7.1%), residents aged 50-59 (6.1%), Hispanic males (3.5%), residents aged 30-39 (3.3%), residents of Ward 8 (3.1%), and residents of Wards 5 and 6 (3.0%).

The District of Columbia funds numerous prevention and testing sites, and provides direct funding, technical assistance, and/or free rapid HIV testing supplies to more than 45 hospitals, primary medical and community based organizations, and the District of Columbia Jail. Over the past several years, the District of Columbia has also focused on the following:

- **Routine testing for early diagnosis** – the District of Columbia has been a national leader in changing policies and providing incentives to encourage HIV testing as a part of routine medical care. Six District of Columbia hospital emergency departments do routine testing, and outreach has been done to private physicians as well as nonprofit clinics. The District of Columbia requires insurance providers to cover the costs of HIV testing, including in emergency departments. It provides for automatic screening for every inmate entering the District of Columbia correctional system.
- **Linkage to and retention in care and treatment to improve PLWH health outcomes and reduce new transmissions** – The District of Columbia continues to work to link prevention and care and to ensure that newly diagnosed PWLH are immediately linked to care. The Red Carpet Entry program involves close coordination with testing sites to provide rapid linkage to care for both the newly diagnosed and other HIV-positive individuals who have been out of care. The District of Columbia is now using treatment cascade measures to evaluate the success of test and linkage to care. Surveillance data indicate that the District of Columbia reduced the percent of late testers from 58% of those diagnosed in 2004 to 44% of those diagnosed in 2008 (The measure is made one year after testing, since the definition of late testing is an AIDS diagnosis when tested or within one year after testing). The District of Columbia also increased the proportion of newly diagnosed PLWH who were linked to care within 90 days from 48% in 2005 to 71% in 2009. Data for 2010 were not available.
- **Large and structural interventions to prevent new transmissions** – The District of Columbia provides access to free or low-cost medical care to all its low-income residents through the DC Alliance; about 93% of adults and 96% of children living in the District of Columbia have public or private health care coverage.[30] In 2011, the District of Columbia implemented Medicaid expansion using a waiver to include individuals up to 200% of poverty without a disabling condition. The District of Columbia makes both male and female condoms widely available in all eight wards; its female condom project was initiated as a public-private partnership with funding provided to the Washington AIDS Partnership by the MAC AIDS Fund. In 2011, more than 500,000 male and female condoms were distributed. The District of Columbia supports syringe exchange with non-federal funding. In 2011, more than 300,000 needles were exchanged and disposed.

- **Reduced Funding for Behavioral Interventions:** The District will submit a new prevention plan to CDC in June 2012 that reflects the new guidelines. The District's prevention and ECHPP plans and proposals state that much of the current funding for prevention efforts based on behavioral interventions will be redirected to implement the new CDC strategy:
- The District of Columbia is shifting core prevention funding from "limited impact behavioral interventions to larger scale approaches and targeted population activities." It is also "examining the existing service delivery network of over 90 prevention, care and treatment providers in order to maximize health outcomes and results."
- **Testing Sites:** Many prevention and testing providers also offer HIV-related care, and are listed in the provider inventory above. Testing sites are separately identified in Figure 28.

Figure 28: District of Columbia Supported Testing Sites (by Quadrant and Ward)

Organization	**Scope/Location**	**Description**
Northwest		
AIDS Healthcare Foundation Blair Underwood Healthcare Center	Ward 2	Free testing 3 days a week
Andromeda Transcultural	Ward 4	Free walk-in testing five days a week; languages include English, Spanish, French and Portuguese
Carl Vogel Center	Ward 2	Free walk-in testing 1 day a week; by appointment testing three afternoons a week
La Clinica del Pueblo	Ward 1	Free walk-in testing six days a week; all languages spoken [Clinic operates a health interpretation service]; targets all in need, particularly immigrants and Latinos
Planned Parenthood – Schumacher Clinic	Ward 2	Free testing by appointment 4 days a week; languages include English, Spanish; American Sign Language by appointment
University of the District of Columbia Health Services	Ward 3	Free walk-in testing five days a week; UDC faculty and students only
Us Helping Us, People into Living,	Ward 1	Free walk-in testing five days a

Figure 28: District of Columbia Supported Testing Sites (by Quadrant and Ward)		
Organization	**Scope/Location**	**Description**
Inc.		week; testing by appointment on first and fourth Saturdays; targets African Americans
Whitman Walker Health – Elizabeth Taylor Medical Center	Ward 1	Free HIV testing by appointment five days a week; languages include English, Spanish, American Sign Language
Northeast		
New Samaritan Baptist Church – HIV/AIDS Ministry	Ward 5	Free testing by appointment five days a week
Planned Parenthood – Ophelia Egypt Health Center	Ward 7	Free testing five days a week; American Sign Language by appointment
Sasha Bruce	Ward 6	Free walk-in testing two days a week; by appointment three days a week
The Women's Collective	Ward 5	Free testing five days a week; languages include English and Spanish; targets women and families
Unity Health Care – Brentwood Square	Ward 5	Free testing five days a week
Southeast		
Anacostia Neighborhood Health Clinic	Ward 8	Free testing four days a week
Department of Health Southeast Clinic	Ward 6	Free testing five days a week
Family and Medical Counseling Center	Ward 8	Free testing five days a week
The HOYA Clinic	Ward 6	Free testing two evenings a week
Sexual Minority Youth Assistance League	Ward 6	Free walk-in testing three late afternoons/evenings a week; other testing by appointment; targets GLBT adolescents and young adults

Figure 28: District of Columbia Supported Testing Sites (by Quadrant and Ward)

Organization	Scope/Location	Description
Whitman Walker Health – Max Robinson Clinic	Ward 8	Free walk-in testing five days a week (including Saturday); languages include English, Spanish, American Sign Language
Metro TeenAIDS	Ward 6	Free walk-in testing five days a week; languages include Spanish by appointment; targets youth and young adults aged 13-24
Unity Health Care – Anacostia Neighborhood Health Center	Ward 8	Free testing available four days a week
Southwest		
START at Westminster	Ward 6	Free testing by appointment
Unity Health Care – Southwest Clinic	Ward 8	Free testing four days a week by appointment only; walk-in testing ½ day
Hospital Emergency Departments		
Children’s National Medical Center		Routine testing in hospital emergency departments – extent of testing varies
George Washington University Hospital		
Howard University Hospital		
Providence Hospital		
Washington Hospital Center		
United Medical Center		

F. State and Local Budget Cuts and Insufficiencies

Over the past three years, the District received approximately level Part B funding. However, it faces challenges associated with increases in the number of clients, associated with improved testing, referral and retention activities, all in the context of the economic recession. PLWH who were previously employed and insured have lost their jobs become eligible for Ryan White services. State and local governments have been less able to provide funding to maintain or expand services due to reduced tax revenues since 2008. Even when HIV/AIDS funds are not reduced (or where the states or localities were not providing funding for HIV/AIDS services), related budget cuts or insufficiencies affect the availability of health and human services. From 2009 to 2011, public appropriations for mental health services were reduced by 19% in the District of Columbia.[31]

In the spring of 2012, the District of Columbia’s fiscal year 2013 budget was still being developed as the comprehensive plan was being completed.

Chapter 4: Description of Service Needs, Gaps, and Barriers

Overview

This chapter describes the service needs, gaps, and barriers for people living with HIV/AIDS in the District of Columbia and surrounding jurisdictions. Due to the transient nature of clients in the Washington, DC region, it is important to examine these characteristics & the data across the EMA. The descriptions summarize needs assessment data from people living with HIV disease, providers, HAHSTA and other interested community members, as well as service utilization data. It also describes prevention needs based primarily on data gathered by the prevention units and community planning groups supplemented by community town halls and provider roundtable discussions.

Findings indicate that the most important service needs as described by PLWH are for mental health and substance abuse services, oral health services, HIV-related medical care and medications, and medical case management. The most needed support services include housing, emergency financial assistance; food bank/home delivered meals, and support groups (psychosocial services). In some parts of the city medical transportation is identified as necessary to provide access to care. (Some PLWH do not want to access services in their own community for fear of being stigmatized).

In terms of service gaps, core medical-related services are for the most part available to PLWH in the city. The most frequently mentioned service gap across the city is housing, given high housing costs, low turnover in HOPWA slots, and limited other housing assistance. PLWH also report a need for consistent access to “wraparound” services, both medical-related and supportive, that help people enter and stay in care, remain adherent to medications, and live healthy and productive lives. These service gaps are seen as partly related to limited knowledge by case managers about available services. In addition, another issue seen as limiting, is that some medical case managers are reportedly not fully aware of available wraparound services, and Part A provider referral relationships with non-Ryan White funded providers is seen as limiting as well. However, specific service needs and gaps vary somewhat across the city, and more significantly by population group.

A. Care and Treatment Needs

Needs Assessment: PLWH needs assessment activities in the District of Columbia for Part B services are led by HAHSTA in conjunction with local planning bodies. Because PLWH clients often cross jurisdictional lines to access services, to obtain a true sense of client needs, assessment activities are often done as collaborations and findings shared. In addition, HAHSTA solicits input from provider groups serving PLWH clients through forum, discussion groups, as well as from client utilization data; data collected through quality management activities, like chart reviews and special initiatives like the Cross-Part Collaborative.

PLWH Survey: The last PLWH survey conducted by the Planning Council, completed in 2009, obtained data from 1,054 PLWH, the vast majority of them in care. As outlined in the following tables, it asked what services PLWH need and included the most commonly used Ryan White service categories as well as some services not supported through Part A funds. The data are several years old, but they provide useful supplemental information on service gaps.

Among support services, a majority of responding PLWH (53%) said they had needed help in finding or paying for housing during the past six months; this is the only support service needed by a majority of the PLWH. At least 40% indicated that they had needed each of the following: food bank or home-delivered meals (46%), transportation assistance (42%), legal services (40%), and safer sex/risk reduction counseling (40%). A slightly smaller proportion (37%) indicated a need for Emergency Financial Assistance – help with food, rent, or utilities. About one-fifth (19%), mostly women in a care-giving role, needed child care services. In addition, one-fourth of PLWH (26%) said they wanted to go back to work and needed employment training and placement assistance – a service not supported through Ryan White funds.

Special Studies: Special Studies carried out in 2011 by the Planning Council in conjunction with HAHSTA identified service needs for three specific populations, as shown in Figure 29 of the following page.

Figure 29: Identified Service Needs for Specific Populations

<table>
<tr><th>Population</th><th>Source</th><th>Core Medical-related Services</th><th>Support Services</th></tr>
<tr><td rowspan="2">African Immigrants</td><td rowspan="2">2009 PLWH Survey, 2011 Special Study</td><td colspan="2">Prefer to receive services where they are unlikely to see others from their nationality/community, due to concerns about confidentiality and stigma, some prefer services outside their jurisdiction of residence</td></tr>
<tr><td>• Medical care – free or low-cost
• Early Intervention Services – with peer support but with peers from a different country/community
• Mental health services</td><td>• Emergency Financial Assistance
• Food bank/groceries
• Linguistic services, particularly for those who do not speak French or Amharic
• Housing assistance
• Health and HIV information and education – information about living with HIV/AIDS and available services
• Support groups – not near their home due to confidentiality concerns</td></tr>
<tr><td rowspan="2">Latinas</td><td rowspan="2">2009 PLWH Survey, 2011 Special Study</td><td colspan="2">Prefer to receive services from a Latino-focused organization, where staff are bilingual so interpreters are not needed</td></tr>
<tr><td>• Medical care
• Access to medications
• Oral health services
• Mental health services
• Case management – both medical and general; includes care coordination and support, particularly for immigrants with few family supports</td><td>• Child care, so they can keep appointments
• Food bank/groceries
• Health education and information about available services and resources
• Outreach that is women-focused
• Support groups in Spanish</td></tr>
<tr><td rowspan="2">Older PLWH (55+)</td><td rowspan="2">2009 PLWH Survey, 2011 Special Study, 2012 Town Halls</td><td colspan="2">Prefer to receive services from clinicians and case managers with geriatric training and from peers who are themselves older PLWH</td></tr>
<tr><td>• A medical home to coordinate care
• Medical care for non-HIV conditions
• Co-pays for those 50-64 with public or private insurance
• Oral health services
• Early Intervention Services with peer support
• Mental health services, especially counseling from a therapist or licensed clinical social worker
• Medical nutrition therapy
• Case management – medical plus referrals to needed support or wraparound services</td><td>• Food bank/groceries – often needed every month due to limited incomes
• Housing assistance
• Support groups – senior-focused
• Health education – for newly diagnosed</td></tr>
</table>

At the District of Columbia PLWH town hall meetings sponsored by the Planning Council in the District in early 2012, participants were asked what service categories they consider the most important – the services that most need to be continued or expanded if funds are tight. The top seven service priorities are shown in Figure 30. As the table indicates, PLWH rank medical care and ADAP as their top priorities. Medical case management and housing services are ranked numbers three and four, followed by emergency financial assistance. The top seven is rounded out by oral health services and medical transportation.

Figure 30: Most needed services as identified at Spring 2012 DC PLWH Town Hall Meeting

1	Outpatient/Ambulatory Medical Care
2	AIDS Drug Assistance Program (ADAP)
3	Medical Case Management
4	Housing Services
5	Emergency Financial Assistance (EFA)
6	Oral Health Services
7	Medical Transportation

Key: *Italics = Support Services;* regular type – Core medical-related services

It should be noted, that PLWH priorities are similar from year-to-year, with little change over the years. Housing continues to be among the top priorities.

B. Service Gaps

Data from all sources indicate that with one notable exception, the most critically needed medical-related services are generally available to low-income, uninsured PLWH in the District who are eligible for Ryan White services. There are some reports that some providers have in the past reported wait times of 1-3 months for a first medical visit if it is not urgent, but generally newly diagnosed or formerly out of care PLWH can get enrolled, obtain laboratory tests, see a clinician, and receive a treatment plan within 30-60 days – and the District is working to reduce that to 30 days after first contact with a medical provider.

Other Waiting Lists or Wait Times: As noted earlier, there is a waiting list for HOPWA and for some other housing-related services according to providers attending HAHSTA's May 2, 2012 provider summit. Anecdotally, there have been reports at a local hospital based provider of increased wait times for initial appointments to see a medical provider. The hospital reports that it increased the number of medical providers available to see patients, thereby reducing the wait time to less than 30 days. While patients no longer have extended wait times to see a medical provider, this modification greatly increased the case load for medical case managers. In order to continue to meet the medical case management standards of care, the medical case management role will need to be supported during programmatic changes.

Inability to Obtain Needed Services: The 2009 Planning Council PLWH survey asked PLWH to identify not only the services they *needed* in the prior six months, but also the services they *needed but were unable to obtain*, and the services they *neither needed nor received.* From this information, it is easy to calculate two measures of service gaps:

- The percent of *all* 1,054 PLWH responding who were unable to obtain a particular service
- The percent of PLWH *who indicated a need for that specific service* who were unable to obtain it.

The findings indicated that 9% of *all* PLWH indicated in 2009 that they needed but were unable to obtain medical transportation over the prior six months, but 25% of those who *needed* medical transportation said they were unable to obtain it. The core medical-related services with the greatest service gaps in 2009 were oral health, unavailable to 36% of PLWH who needed it, and outpatient substance abuse treatment, unavailable to 25% of those who needed it. Support service gaps were highest for legal services (44%), child care (39%), Housing (39%), and emergency financial assistance (38%) – all well over one-third of individuals needing those services were unable to obtain them. More information is needed to understand the extent to which services were not available or whether the problem primarily involved a need for additional coordination of care and referrals.

Other Reported Service Gaps: There are some service gaps with regard to services other than ambulatory/outpatient medical care, medications, and medical case management – “wraparound” services, both medical-related and supportive, that are needed to help people enter and stay in care, remain adherent to medications, and live healthy and productive lives. According to PLWH, oral health services continue to be a challenge especially in the District. Additional resources have been allocated to the service category and remaining challenges appear to be associated with factors other than funding level. Other service needs and gaps vary somewhat by population group.

It is believed that for some health behaviors, PLWH seek services unavailable in areas other than where they live. In 2011 and 2012, led by the Planning Council, the District obtained structured input on service needs and gaps from District consumers, providers, and interested community members through a series of special studies and consultations. These included consumer and provider town hall meetings, input meetings with PLWH groups in the District with PLWH from specific populations and with peer community health workers, and key informant sessions.

The 2012 consultations for the Part A & Part B comprehensive plans and the town hall meetings as well as needs assessment activities, identified a number of service gaps. The most frequently identified gaps are summarized in Figure 31. Some are in specific Ryan White-defined service categories, while others involve a broader system of prevention, testing, and care. Some gaps were identified as EMA-wide, while others are jurisdiction-specific. Most frequently gaps include a lack of easily accessible, centralized information about testing and care; insufficient Hepatitis C testing and care, particularly for PLWH who are dually diagnosed; lack of sufficient age-appropriate care for both young PLWH (18-24) and for older PLWH (age 50-plus); housing assistance, both long-term and transitional; medical transportation overall and transportation that enables women with children to get to appointments; and accessible support groups for a range of PLWH populations.

Figure 31: District of Columbia-Specific Service Gaps

Service Gap	Description
Information	Information about how to obtain HIV testing and services, including availability of services for those who cannot pay – mentioned by consumers and providers in every jurisdiction. • Information on care is harder to find than information about testing sites. • Lack of centralized information on available treatment services. • Also need information to counter both the mistaken belief that HIV diagnosis is a death sentence and the equally unrealistic view that it is a chronic disease that can be controlled with a few pills and therefore is not a serious threat.
Hepatitis C Testing and Care	Testing, medications, and co-treatment. • Need more Hepatitis C testing. • Not enough coordination of treatment for PLWH co-infected with Hepatitis C. • Services related to Hepatitis C seen as far less accessible than HIV testing and medications.
Age-appropriate Services for Young Adults	Not enough providers with services that engage and meet the needs of young people aging out of pediatric programs, or other young PLWH, including

Figure 31: District of Columbia-Specific Service Gaps	
Service Gap	**Description**
	African American MSM.
Age-appropriate Services for Older PLWH	More services needed to meet the needs of both newly diagnosed and long-time survivors; there are few geriatric social workers or clinicians trained to address the intersection of health care issues related to HIV and aging.
Support to help PLWH enter and become fully connected to care	• Not enough peer community health workers to assist newly diagnosed PLWH as well as individuals who have been out of care. • Both inadequate numbers of peers and use of peers in too few service categories. • Peer-led support groups seen as a largely missing mechanism to help address this need.
Housing	Lack of decent, affordable housing. • Housing costs; especially rentals. • Long waiting lists for HOPWA and other subsidized housing. • Without stable housing, it is extremely difficult to get care – no way to store food bank groceries, refrigerate medications; difficulties in getting to appointments and maintaining contact with providers.
Medical Transportation	• Without access to transportation, clients cannot get to appointments and remain closely connected to care • Transportation a major issue in rural and outer suburban areas with limited or no public transportation • Bus tokens seen as insufficient for a woman with small children, especially where getting to care requires several transfers • Unreliable transportation (e.g., late pick-up by MetroAcess) can make clients late for appointments, which are then sometimes cancelled • Costs for medical transportation often high and seen as taking funds away from direct services • If gap cannot be closed, other means needed to make service more accessible – such as use of mobile medical vans or telemedicine
Support Groups (Psychosocial Support Services)	• Too few support groups, either broadly targeted or population-specific • Groups often run by medical providers and access is often limited to their medical clients – individual providers typically offer only a few groups, which do not meet all needs • Need for peer-led focus groups with appropriate supervision as well as professionally-led groups
Non-HIV-related Medical Specialty Care	Care not covered by Ryan White funds is very difficult to obtain, particularly for specialists not available at safety net clinics such as CHCs/FQHCs
Mental Health/ Psychiatric Services	Shortage of resources for mental health services, particularly for psychiatrists – often too expensive to hire and limited referrals available
Training for PLWH in Self-advocacy	Individual or group sessions needed so that consumers not only know what services are available but know how to work with providers to obtain the assistance they need and to take responsibility for managing their disease
Long-term Substance	Combination of residential and out-patient services to address the needs of

Figure 31: District of Columbia-Specific Service Gaps	
Service Gap	**Description**
Abuse Treatment	some long-time addicts, for whom most programs are too limited or short-term – intensive programs funded by other public and private sources are hard to access
Oral Health Care	• Still reported as hard to obtain for some PLWH • Concern that there are not enough providers available throughout the year • Some providers said to charge high up-front co-pays
Prevention education and outreach	• Testing available, but more outreach needed • Need outreach targeting specific populations, especially women

C. Barriers to Testing and Care

Special studies and community consultations identified a number of barriers to testing and to entry to and retention in care. Some of the barriers are specific to particular populations, as summarized in Figure 32, below. As the list indicates, some barriers are primarily client-based, others provider-based. Some can be minimized with increased awareness and training; others require system refinements.

Figure 32: Identified Barriers to Testing and Care	
Barrier	**Description**
Barriers to Testing	
Insufficient Routine Testing	• Hospitals test only when prevention funds are made available. • Clinicians in hospitals concerned about the time frame and the ability to give test results. • Some concern that patients will be billed for tests and be less likely to come for health care as a result. • Private physicians often concerned about costs and about providing results. • In some relatively low prevalence areas, low positivity rates may not justify the expense.
Who Pays for Testing	• Different insurer definitions of who is “high risk” and when a test is “necessary.” • Requirement that client pay for test or confirmatory test can delay or prevent routine testing or entry into care (confirmatory test is now done as part of first medical visit).
Coordination with Medicaid Certified Providers	• HIV affected population and potential clients have Medicaid coverage. One challenge has been ensuring that providers of Medicaid reimbursable services screen clients for HIV. Often this screening does not occur and opportunities to identify HIV infected individuals are lost.
Language and Cultural Issues	• While interpretation can be used to serve clients, outreach for testing requires bilingual personnel; for example, in WV, lack of bilingual staff makes outreach to farmworker population and other Latinos very difficult.

Figure 32: Identified Barriers to Testing and Care

Barrier	Description
Access	• Some locations have limited testing days and hours. • Requiring appointments can discourage testing.
Stigma and Confidentiality	• Among certain populations, people do not want anyone to know they are being tested, and may be unwilling to come to an office know for HIV testing services. • A community health center or other clinic may create less concern about confidentiality, unless front desk personnel or other staffs do not follow HIPAA and other confidentiality rules.
Barriers to Care	
Lack of PLWH Knowledge about Available Services or How to Access Them	• Many people still unaware of the existence of Ryan White services. • No single central source of information about available services. • Many people are unaware of the availability of free or low-cost services or unclear about eligibility requirements. • Private physicians often do not know where to refer people who test positive.
Weak Linkage to Care after Testing	• Some testing sites such as hospital emergency departments or private physicians' offices may lack personnel responsible for linkage to care. • Insufficient use of peer CHWs. • Some PLWH still get only a telephone number or a brochure rather than hands-on assistance in making and keeping an appointment.
Stigma	Still a major barrier, especially for certain populations such as African immigrants.
Intake Barriers	• Documents required can be challenging to provide, especially for homeless, individuals in shared or unstable housing, and immigrants. • Some documents, such as those on residency, must be notarized. • Intake done at each provider, so PLWH must carry documentation with him/her.
Delays in Getting First Appointment	Medical providers may be over capacity. Sometimes newly diagnosed or out of care may have to wait weeks or even months for a first medical appointment.
Language and Cultural Barriers	• Not enough culturally competent providers and staff to serve communities of color, immigrants, transgenders, other special populations. • Ryan White funds interpretation services, but some providers don't seem aware of them and rarely use them; this includes sign language interpretation. • Private physicians (including those with Medicaid MCO linkages) sometimes do not use interpreters because of cost.
Limited Engagement of Community-Based Organizations (CBOs)	• Some PLWH would be more likely to seek and remain in care if they could get services from a community provider they know and trust.
Housing Instability	It is almost impossible for PLWH to stay on medications, eat properly, and get to service appointments on time if they are homeless.

Figure 32: Identified Barriers to Testing and Care

Barrier	Description
Bad Initial Provider Experience	PLWH who have a bad experience with a provider soon after diagnosis may delay entry into care. Examples include: • Front desk personnel who do not maintain confidentiality or are not helpful or culturally competent. • Clinician or provider that is a "bad fit" • Provider that requires significant pre-payment for initial visit or lab tests at first visit.
Problems Navigating the System of Care	• A particular problem for newly diagnosed, PLWH who have had limited access to the health care system prior to diagnosis, and immigrants. • PLWH may access medical care and case management but no other needed services. • Common problem in the absence of a peer CHW. • Case managers sometimes so busy that they provide limited information or support and do not ensure that a referral is successful.
Lack of Experience with Insurance	• Challenges for PLWH who become eligible for Medicaid, Medicare, or local/state insurance-type programs in obtaining services other than medical care; • Most insurance does not pay for Ryan White-level medical case management, which may mean no service coordination unless the individual receives such services through Ryan White.
Insufficient Follow Up after Initial Link to Care	Insufficient follow up and assistance after intake or first appointment, for many reasons: • Particular problem for those diagnosed through routine testing or at sites without peer community health workers or other specifically assigned personnel – no one responsible for follow up. • Where "linkage to care" means a referral or one visit, PLWH may not get needed additional support. • Many providers with very limited capacity to provide follow up on clients who miss appointments. • Follow up that is not culturally competent. • Insufficient use of peer CHWs with cultural competence and time to do community follow up.
Difficulties related to Appointments	Few providers allow clients to get care unless they have an appointment, and some are very inflexible if the client is late – even though this may be due to a MetroAccess or other public transportation delay.
Multiple Sites and Appointments	Clients who must make multiple trips to varied locations to get services sometimes begin to miss appointments, not receive all needed services, and not remain fully linked to care.
Facility Access Issues	Access to provider may be difficult due to such factors as: • No evening or weekend hours. • Facility that is hard to reach via public transportation.

Figure 32: Identified Barriers to Testing and Care

Barrier	Description
	• Location that is not considered "safe" by some PLWH groups. • Physically inaccessible facilities (e.g., no elevator).
Distance and Transportation	• Transportation assistance may be insufficient – e.g., a woman with several children may not keep appointments if given bus tokens and expected to make several transfers.
Limited Referrals	Medical case managers vary in their awareness of non-medical and non-Ryan White providers and services.

An "ideal" system of care needs to recognize and remove or minimize these barriers. Among the most important barriers are challenges related to ensuring that PLWH who enter care obtain coordinated care, including referrals for needed medical-related and support services as well as system navigation support. There is a need for some form of medical home that ensures knowledgeable care coordination and includes community-based providers with special expertise related to particular populations and communities.

D. Population Specific Service Needs, Gaps, and Barriers

The District of Columbia includes diverse PLWH populations who face both shared and differing challenges and have both common and unique service needs. This section describes 13 populations – some of them overlapping – identified by HAHSTA, the Planning Council, providers, and consumers as having special service needs and barriers that need to be appropriately addressed within the District and jurisdictional systems of care. All the epidemiological data are as of December 31, 2010.

Adolescents: Youth 13-19 make up 3% of PLWH in the District. While their numbers are relatively small adolescents represent important challenges in prevention, testing, and care.

Providers and consumers, including relatives of HIV-positive adolescents, express concern that prevention messages including realistic warnings about HIV are not sufficiently targeting or reaching this population. A recent national Kaiser Health Foundation survey found that while in 1987, two-thirds of Americans viewed HIV/AIDS as the nation's most urgent health problem, only 7% nationally held that view in 2011 – compared to one-third of the District of Columbia residents. In addition, only four in ten people reported seeing, hearing, or reading about the epidemic in the past year, compared to seven in ten in 1987.[32] Young people were not around when HIV/AIDS was a top news item, and suburban youth are less likely to hear such messages now.

Several adolescent-focused prevention and testing providers target African American and Latino youth. The District regularly hosts a Youth HIV Work Group. However, with reductions in resources for targeted prevention programs and the new CDC prevention strategy, some of these targeted programs may be lost. This may make it harder to reach adolescents. There are differing opinions regarding HIV education in the schools, and many school settings do not permit discussion of condoms.

Provider personnel report that many adolescents do not understand the difficulties of living with HIV/AIDS. Because it is now a chronic disease, they imagine that becoming infected merely means taking a few pills. As a result, many are not sufficiently concerned to avoid unprotected sex and other risky behaviors.

Young people diagnosed with HIV as adolescents are difficult to engage and retain in care. For example, “treatment cascade” data from the District of Columbia indicate that of 654 adolescents diagnosed with HIV from 2005-2009, one in six (17%) had not been demonstrated as linked to care by the end of 2010 – there was no evidence of a single CD4 count or viral load test. Fewer than one in four (24%) were in care during 2010 – using a measure of two lab tests at least three months apart. Of those in care, about three in five (61%) had viral suppression, a lower rate than other populations including heterosexuals, MSM, or IDUs; between 74% and 78% of these groups were virally suppressed in 2010.

Providers and family members believe that adolescent PLWH are in particular need of age-appropriate care including prevention for positives services, so they learn the importance of changing behaviors and remaining connected to care, even if they do not have symptoms.

There is one children’s hospital with an HIV/AIDS adolescent specialization (and multiple Ryan White funding streams) is located in the city, some adolescents receive services at facilities outside the region. Regional programs all contract with the hospital. Some adult-focused organizations face challenges in providing age-appropriate care for this population. There are only a few adolescent-focused community-based providers in the region, most of them primarily engaged in prevention and testing.

Adolescents and Young Adults Transitioning out of Adolescent Care: While very few new perinatally infected cases are occurring today (only one perinatal case was reported in 2011), epidemiological data indicate that there are a growing number of young people aged 20-29 have been HIV-positive since adolescence. With improvements in medications, "AIDS babies" are growing to adulthood – and aging out of pediatric and adolescent services. At least one provider sometimes extends care until these young adults are in their early 20s, but both providers and caregivers report difficulties in transitioning such young people to adult care. These young adults need to learn disease self-management and how to navigate the adult system of care. There is concern about a lack of preparation and transitional support as they move to adult services and about a dearth of providers with special expertise in serving older adolescents and young adults. Areas of particular importance include retention in care, treatment adherence, and advice and support around issues such as forming families of their own and perhaps having children. To address these issues, HAHSTA initiated a navigator program for young adult clients who are transitioning from pediatric to adult care. The medical case managers work closely with clients for the first six to nine months as they transition into a different care system. The program takes advantage of the fact that one medical professional also works in the HIV clinic at a neighboring hospital. As a result, this provider is now a familiar face at both hospitals. This has helped ease the fear of some individuals as they are guided through their transition to adult medicine. Other providers also utilized youth advocates and youth outreach workers to help target youth making the transition to adult medicine when focusing on efforts to keep individuals in care.

Young MSM of Color: Another group of young adults of particular concern is MSM of color in their late teens and 20s, particularly African Americans. According to PLWH and provider personnel, young MSM who live in the suburbs of the Washington DC area tend to go into the District to socialize. Sometimes they are tested in the District of Columbia, where the level and variety of testing sites is greater than in most of the suburbs.

Nationally, the CDC reports that African American MSM represented about 73% of new infections among African American men and 37% of infections among MSM in 2009. The age and racial group with the largest number of new HIV infections was young African American MSM aged 13-29, and the number of new HIV infections among this population increased by 48% from 2006-2009.[33]

Once diagnosed, these young men tend not to immediately enter, or if they enter, not to remain in care – though rapid entry and committed follow up can be effective. A recent SPNS study of outreach, linkage, and retention in care for young MSM of color found that early entry into care was facilitated when the person providing the HIV test result made an immediate referral to care and called the provider for an appointment. The study also found that while 87% of young MSM of color in the study were linked to care within 90 days, retention in care was lower for African Americans (80%) than for Latinos (96%). The study concluded that: "While unique challenges exist in the care of adolescents infected with HIV from identification to engagement and retention in clinical care, programs that are responsive and dedicated to the needs of these youth can be successful in retaining them in care."[34]

As with the other groups of adolescents and young adults, ensuring culturally appropriate care is challenging. Often, these young men have limited experience with the health care system, and need help in learning to navigate the system and obtain needed services. In other locations, peers have proven effective with this population.[35]

Homeless: Homelessness makes it difficult for PLWH to enter or remain in treatment. It is almost impossible for PLWH to get to service appointments on time, store and stay on medications, or maintain good nutrition if they are homeless. Lack of housing subsidies for low income has contributed to the homeless problem.

A summit on HIV/AIDS and housing convened by the National AIDS Housing Alliance in 2005 found that anywhere from 17% to 60% of PLWH had experienced homeless or unstable housing at some point; the proportion of currently homeless PLWH ranged from 1% to 16%, with the highest rates in large cities.[36] In addition, while individuals tend to be homeless for periods of about six months, the *rate* of homelessness tends to remain constant over time.[37] The situation does not appear to have improved, with Housing Opportunities for Persons with AIDS (HOPWA) funds being reduced and budget-strapped state and local governments cutting housing assistance budgets. Some homeless shelters have been closed.

In the District, as of December 2010, an estimated 371[38] people living with HIV/AIDS were homeless when diagnosed. More often, PLWH become homeless after diagnosis, according to HAHSTA.

The District primarily depends on HOPWA and other assisted housing to provide housing assistance. Consumers consistently rate housing as a high-priority-service-need that is very difficult to meet. At a provider meeting recently, providers identified lack of stable housing as a barrier to treatment adherence. One recommendation offered was to expand the drop-in center model to link PLWH with their medications and medical providers. In these drop-in centers, PLWA could access a wide range of services from feeding and being administered daily medication dosages, to being reminded to keep medical appointments.

Immigrants: In the District of Columbia, an estimated 13.4% of the population is foreign born. The foreign-born population is extremely varied, as is the population of immigrants with HIV disease. Linguistic services providing interpretation and translation are funded in the District as well as the surrounding jurisdictions. There is great concern about reaching and serving immigrants, but a recognition of considerable barriers.

The two largest immigrant groups in the District and surrounding jurisdictions are Africans and Latinos. HAHSTA in conjunction with the Planning Council conducted special studies in 2011 on African immigrants and Latinas (many of whom are immigrants). It re-analyzed data for these populations from the 2009 Planning Council sponsored PLWH survey, held key informant sessions, and did a combination of focus groups and individual interviews with PLWH from these populations, as well as reviewing data on service utilization. It found a variety of expected barriers to care, from stigma to a lack of knowledge about the availability of free or low-cost care.

African immigrants: There are about 3.5 million African immigrants in the U.S. (based on 2009 data). Almost half have arrived since 2000, and about 860,000 received legal resident status from 2001-2009, many as refugees or asylum seekers fleeing persecution in their home countries. They come from many different countries and speak many languages. More than 70% are native English speakers or speak English "very well," according to Census data. Other common languages include Amharic and French. Africans are a large and important component of the PLWH population in the District and surrounding jurisdictions, though it is difficult to obtain accurate information about the size of the African immigrant PLWH population because this group is not considered a separate population for surveillance purposes or in client utilization data, except for a small number of providers that keep track of immigrant status and country of origin. Epidemiological data for the District identifies 303 African immigrants living with HIV and AIDS; two-thirds have a risk factor of heterosexual contact.

Many African immigrants come from countries with high rates of HIV and AIDS, and there is still a very high level of stigma in many communities. The study found that – unlike most other population groups – many Africans do not respond well to outreach by people from their own nationality group, due to stigma and confidentiality concerns. They do indicate an affinity with other immigrants because of the common experiences. Several clinics reported that African clients often call them from the parking lot or bus stop to be sure no one else from their nationality group is in the waiting room before they will enter the facility. They are often unwilling to participate in support groups near their homes and sometimes prefer to receive care in another area outside of their community. Some Africans expressed concern that when providers use interpreters, there may be a different individual at each visit. They feel this increases the number of people from their community who know their status and fear this may lead to its becoming publicly known.

Many Africans reportedly delay testing because they believe they cannot afford care; when made aware of Ryan White services at low to no cost, they are more likely to take action to learn their status.

Hispanics/Latinos: The Hispanic population totaled 54,749 or 9% in the District of Columbia from 2000 to 2010 according to the 2010 U.S. Census. Within that total, there is a large percentage (6.9%) classified as other Hispanic or Latino[39] according to 2010 Census data.

Culturally appropriate services are not always easy to find, according to Latinas interviewed. They stated a strong preference for Latino-focused providers and a willingness to travel some distance to access them. The District has two Latino-focused federally qualified health centers.

Injection Drug Users (IDUs): The number of PLWH whose risk factor is injection drug use (alone or along with MSM) is decreasing in the District of Columbia. In 2009 and again in 2010, new IDU-related AIDS cases diagnosed, represent about 9% of new AIDS cases in the District of Columbia.

Providers and consumers indicated that availability of clean syringes is an important means of preventing HIV infection among IDUs. This view is supported by national research, including a study in 2007 in Wisconsin (where the percentage of AIDS cases among IDUs was comparable to case numbers in the region). It found that between 1994 (when Wisconsin's needle exchange program began) and 2007, the state saw a 66% decrease in HIV infection among IDUs.[40]

Access to clean needles is important for other populations as well. Transgenders may share needles used for hormone injections. Individuals may share needles used to inject vitamins, insulin, or other prescription drugs.

The District has the only syringe exchange programs in the region. The District of Columbia Department of Health funds three syringe-exchange programs through non-federal funds.

Treatment cascade data for the District of Columbia over the past five years indicate that 536 IDUs were diagnosed with HIV/AIDS, 86% of them were linked to care at some point in the past five years, a little less than 27% were in care as of December 31, 2010, and 74% of those in care were virally suppressed. Retention in care is clearly a key concern. A total of 1,660 PLWH in the District of Columbia died over the past five years; 526 or almost 32% were IDUs, at a time when IDUs made up about 15% of the total HIV/AIDS population. Thus their death rate is double their proportion of the infected population.

Several service providers focus on serving PLWH with a history of substance use, including IDU, and individuals reportedly can locate service providers who have expertise serving this population. However, providers report challenges in serving active IDUs, particularly with regard to retention in care and treatment adherence. Some clinicians and other providers without specific expertise in assisting this population find them difficult to serve.

Multiply Diagnosed PLWH: Many PLWH have co-occurring conditions, from other STDs to mental illness, substance use, and homelessness. Multiply diagnosed PLWH generally require more intensive assistance and special clinical expertise. Challenges associated with IDU and homelessness have been separately discussed.

It is difficult to determine the proportion of clients of various service categories who are dually diagnosed. Under the current data system, most providers do not report the risk factors of their clients, and there is no consistent source of data on the impact of co-morbidities.

In examining the District and its surrounding jurisdictions, data for 2010 indicate that PLWH overall have about the same level of chlamydia as the general population, but are much more likely to be diagnosed with Hepatitis B and C and with syphilis and gonorrhea. They also have three times the rate of tuberculosis, though the percentages are very low for both populations.

The differences are particularly striking for Hepatitis C. In the District of Columbia, between 2005 and 2010, a total of 1,669 PLWH were diagnosed with Hepatitis C. Of this group, 88% were African American, and 69% were male. Two-thirds were 40 or older when diagnosed; more than one-fifth were 50+.

Testing and treatment for Hepatitis C were identified through provider and consumer consultations as a particular concern in the District. According to new data released by the CDC in February 2012, more people in the U.S. now die each year from Hepatitis C than from AIDS.

Between 1999 and 2007, recorded deaths from Hepatitis C increased to 15,106, while deaths from HIV/AIDS decreased to on average 12,734. The study identified HIV co-infection and minority status as among the factors associated with which deaths, along with chronic liver disease, Hepatitis B co-infection, and alcohol-related conditions.[41] The District plans to explore the number of PLWH in the jurisdiction who are dually diagnosed with HIV and Hepatitis C, and how testing and care might be made more available and better coordinated with HIV/AIDS services.

Getting tested for Hepatitis C is more difficult than obtaining an HIV test, and obtaining treatment can be challenging. While Ryan White pays for Hepatitis C testing for clients with HIV, there does not appear to be much joint HIV and Hepatitis C testing in the community. Some of the newest (and very expensive) Hepatitis C drugs are not considered safe and effective for PLWH on anti-retroviral therapy.

Older PLWH (Age 50+): The number of older PLWH is increasing rapidly, and there is not yet a full understanding of need or capability to meet the need. The American Academy of HIV Medicine issued a joint statement about older PLWH in September 2011 predicting that "within the next four or five years, more than half of all people living with HIV in the U.S. will be over the age of 50, as well as one in every six who are newly diagnosed."[42]

Older PLWH include two very different groups: long-term survivors, aging with the disease, and recently diagnosed older people.

Recently diagnosed: There are indications in some parts of the District and surrounding jurisdictions that older people with HIV are being diagnosed late – they are more likely than younger PLWH to have AIDS when they are diagnosed or within a year after diagnosis. One Duke University study found that older PLWH are "twice as likely as younger patients to have already developed AIDS by the time they are diagnosed with HIV infection," which means they may not benefit as much from anti-retroviral therapy.[43] This highlights the need for increased education and testing targeting older residents and their physicians. Many older people are poorly informed about HIV/AIDS. Often they had a single sex partner for many years and are not accustomed to condom use. Many do not see themselves as at risk, even though they may engage in unprotected sex. Physicians serving older Americans are often uncomfortable talking to them about sex and do not see their patients as being at risk. They may fail to identify symptoms of HIV disease. In addition, few public campaigns on testing target older Americans. The District has expanded the CDC routine opt-out testing age range from 18-64 to 18-82, due to the high rate of HIV/AIDS among older residents in the District. This may not be practical in lower-prevalence areas, but sexually active older people need to be educated and to have easy access to HIV testing.

Long-time survivors: A growing number PLWH who were diagnosed earlier in life and have lived with HIV/AIDS for years or decades are now in their 50s or 60s. Research indicates that HIV/AIDS and the medications used to treat it can contribute to premature aging and to a variety of health problems. The HIV and Aging Consensus Report described "increasing evidence that HIV infected individuals on HAART experience an array of 'non AIDS' conditions associated with HIV infection, HIV treatment, and/or behaviors, conditions, and demographics that typify those with HIV."[44]

All older PLWH: Once diagnosed, all older PLWH need access to medical care from clinicians and social workers trained to address the intersection of health care issues related to HIV and aging. Infectious disease physicians typically have limited training in geriatric medicine, and there are few geriatric social workers working in the HIV/AIDS field. In the early days of the epidemic, few PLWH lived long enough to grow old with the disease – but in the future, half of all patients may be over 50. To serve aging clients, clinicians may need ongoing access to geriatric specialists.

The new PHS Guidelines for medical care address the special considerations for caring for older PLWH. They call warning that ART-associated adverse events may be more frequent in older patients so close monitoring is required. They warn of the increased risk of drug interactions between ART and other medications, urge that HIV and primary care providers work together to optimize medical care, and recommend counseling to prevent secondary transmission.[45]

A Task Force on Older Americans convened by HAHSTA has been exploring ways to design and support HIV/AIDS education, testing, and services for older people. The Area Agency on Aging has been well represented, and may offer important opportunities for collaboration.

In 2011, a Special Study on Older PLWH, found that recently diagnosed older people find it particularly helpful to be linked to peers – PLWH of similar age – who can help them learn how to live with the disease and navigate the care system. Many want to stay with their primary care physician, who may have little expertise in HIV/AIDS. They are likely to be treatment-adherent; many are accustomed to taking medications. While those over 65 (except for recent immigrants and the undocumented) usually are on Medicare, they often have very limited resources, and find it difficult to afford co-pays or obtain wraparound services. A particular identified need was mental health counseling, of the type provided by licensed therapists or clinical social workers. Transportation is a challenge, especially given the varied rates and reliability challenges of MetroAccess. Unless they are able to obtain senior or other subsidized housing, older PLWH often struggle to make housing payments and have enough money left for other necessities. Some described going to multiple food banks every month. Many would like to participate in support groups, but find appropriate groups unavailable; groups are often operated by medical providers and open only to their medical clients. Older PLWH would like to see coordination between senior citizen and HIV/AIDS service providers. They find “medical home models” particularly helpful, because they minimize the number of separate visits requiring transportation arrangements.

Disabled PLWH: Relatively little attention has been given to disabled PLWH other than to ensure sign language interpreters for the deaf and wheelchair accessible facilities. Three Ryan White providers responding to the provider survey said their facilities were not wheelchair accessible. State and local government facilities are expected to provide "program access" regardless of when a facility was built. However private owners of older buildings must remove access barriers only when this is "readily achievable."[46] In practical terms, this often means they are not required to unless they do renovations. As PLWH live longer and survive debilitating illnesses such as strokes, an increasing number are likely to have limited mobility, poor eyesight or blindness, and other physical and mental disabilities. The role of HAHSTA in helping to ensure appropriate and accessible services for this group of PLWH needs to be determined.

Recently Incarcerated PLWH Returning to the Community: Recently incarcerated PLWH or individuals who will soon be returning to the community are often challenging to identify, reach, and serve. States and municipalities vary in their testing practices within prisons and jails, the extent of pre-release testing, and planning for re-entry and access provided to outside groups to do such testing and to develop pre-release treatment plans for HIV-positive inmates. The District of Columbia has no prisons, so its residents are incarcerated in penal facilities in other states, often far from the District, which complicates pre-release planning and re-entry. In the District along, about 5,000 individuals each year return to the community following incarceration, an unknown number of them HIV-positive – aware or unaware.

The District of Columbia has a testing program in its jail, which is to provide testing within 72 hours after entry, but many people opt out or are not tested. HAHSTA surveillance data indicate that in 2010 there were 538 PLWH in District of Columbia were diagnosed while incarcerated. Ryan White Part B funds are used to support pre-release planning by District case managers.

Some individuals are linked to care immediately upon release, and a number of agencies work to accomplish this. The District has a community-based organization which exists to serve formerly incarcerated women and has an HIV program. Those who have been incarcerated for a long period may be largely unaware of available services. Sometimes parole officers help provide and encourage follow up on service referrals. Consumers at a town hall that provided input for the comprehensive plan indicated that formerly incarcerated with special need for outreach include those who served their entire sentence and therefore have no parole officer and no one responsible for assisting with their transition or linking them to care.

Transgenders: The metropolitan area has a significant transgender population, but they are not differentiated in the Census and are not consistently counted by HIV testing sites or service providers. The National Center for Transgender Equality estimates that “transsexual” individuals are between ¼ and 1% of the U.S. population.[47] That would mean between 1,500 and 6,000 transgenders living in Washington, DC. Populations of transgenders tend to be higher in larger cities and in places were appropriate medical care is available and there is somewhat less stigma and discrimination.

A 2000 survey of transgenders in the District found that 25% of 562 transgenders surveyed were HIV-positive;[48] is consistent with national studies estimating a 28% positive rate.[49] Transgenders continue to face discrimination in employment, housing, and services. There have been recent hate crimes against transgenders in the District. The District along with thirteen states have anti-discrimination laws that include protection based on gender identity.

Discrimination and stigma can be major concerns for HIV-positive transgenders, and obtaining culturally appropriate and expert medical care is challenging. Many physicians are not expert at serving this population, and transgenders often want a medical home where they can obtain needed hormones as well as AIDS medications.[50]

Several Ryan White and non-Ryan White providers have projects that target and serve transgenders. The District has one transgender-focused community-based organization, and several others have projects that target and assist transgenders. There is continuing concern about how best to ensure that this population has full access to culturally appropriate services.

Insured or Formerly Insured PLWH: In the past several years, particularly since the economic downturn, an increasing number of PLWH who previously had employer-based insurance are losing their jobs and insurance for economic or health reasons. Providers and consumers note that these individuals are familiar with health insurance and their responsibilities for coordinating their own care, but they have almost no knowledge of the health care or HIV safety net. They need peer or other support to learn about Ryan White services and to be able to navigate the system of care. Enrollment of this population in HAHSTA’s Health Insurance Premium and Cost-sharing Assistance Program experienced significant growth in 2011.

The recently enacted federal Patient Protection and Affordable Care Act (PPACA) also offered relief for the expanding cost associated with providing treatment. It has expanded HAHSTA’s ability to enroll new clients into the most appropriate program to meet their needs for AIDS care. PPACA includes a provision that allows state Medicaid programs to submit state plan amendments (SPAs) to the federal government to expand eligibility to childless adults. The District's Department of Health Care Finance (DHCF) submitted a SPA that was approved on June 22, 2010 an effective December 1, 2010, childless adults with incomes up to 200% of the FPL are eligible to enroll in the Medicaid program without an otherwise disabling condition. This has eliminated the impending need to enact an ADAP waiting list.

E. Prevention Needs, Gaps, and Barriers

Prevention needs and gaps identified by PLWH and providers are summarized in Figure 33, below. They include a number of specific prevention and testing components and strategies, as well as planning and coordination needs. Funding reductions for prevention, along with changing strategies and priorities, mean that it is difficult to project the extent to which the identified needs and gaps will become greater or smaller over the next several years. In FY 2010, HAHSTA supported the delivery of over 110,358 tests of which 82% were done in clinical settings, however barriers remain. The following figure represents prevention needs and gaps.

Figure 33: Prevention Needs and Gaps

Need/Gap	Description/Explanation
Intensive prevention interventions	• Less and less availability of intensive prevention interventions that target specific populations • Plans for defunding of many DEBIs by end of 2012, including those that have proven effective in the District and surrounding jurisdictions with particular populations • Becoming less available following years of funding cuts and recent changes in CDC strategies that emphasize scalable, high-reach, lower-cost interventions • Some individuals need personal, intensive contacts
Outreach	• Not enough personal outreach to high prevalence populations and communities by culturally and linguistically appropriate people • Not enough media campaigns to address need for testing and stigma and inform people about available services • Too little use of social media to encourage people to get tested
Peer support	• Needed during or immediately after testing, to help newly diagnosed PLWH deal with their diagnosis and get linked to care • Also needed over time, to provide navigation, support, and advice • Peers need to matched to the PLWH they work with; this usually but not always means matching based on age, race/ethnicity, sexual orientation, and gender

Figure 33: Prevention Needs and Gaps

Need/Gap	Description/Explanation
Support for linkage to care	• Is improving • Still many testing sites in which "linkage to care" means receiving a brochure or a phone number, even when the newly diagnosed individual clearly needs more
Information about testing	• Need easy to find, user-friendly, updated information about testing site locations and access • Should include location, accessibility by public transportation, language spoken, days of the week and hours when testing is available, and whether appointments are required • Testing data available on HAHSTA website • Some populations such as African immigrants also need information about free or low-cost treatment prior to testing, because without it they see little benefit in learning their status
School-based education and prevention services	• Concern that less HIV education is being provided in schools now, perhaps due to CDC budget cuts • May reflect public belief that the epidemic is no longer such a serious threat • Youth lack accurate information about HIV, including its severity (not something for which you just take a bill every day) • Condoms not readily available to sexually active youth, but most schools do not allow distribution in schools – or even demonstrations as part of the prevention curriculum
Testing choices	• People have different needs and concerns around testing, so testing choices need to be available • Some people not comfortable getting tested at a health department – often because of fears about confidentiality or immigration status • Some people need counseling and support that may not be available in venues such as emergency departments or health fairs • Some people need to come to a CBO with deep ties to their community • Belief that the less choice available, the harder it will be to get people tested
Targeting of specific populations	• Concern that focus on prevention for positives (PFP) will leave little funding to focus on high-prevalence populations • Challenges in developing scalable, high-impact interventions that lead to testing and linkage to care
Community-based organization involvement	• Reduced role of CBOs feared • CBOs seen as having special capacity to reach particular populations, to get them tested and get/keep them engaged in care • Concern that some will lose prevention funding and stop providing HIV/AIDS services – and PLWH would lose a source of community support • May make it harder to reach and serve some target populations

Figure 33: Prevention Needs and Gaps

Need/Gap	Description/Explanation
PLWH involvement in planning	• Concern about a probable decreased role for prevention planning groups – new guidance due from CDC on what are now Prevention Planning Groups (PPGs) rather than Community Planning Groups (CPGs) • PPGs will not be responsible for prioritizing target population • New guidelines could further reduce PLWH and community input • Concern that this will lead to models and strategies that are less appropriate and effective • May also close off a leadership development opportunity and reduce informal community outreach, peer support, and peer advocacy
Linked prevention and care planning	• Linked planning most feasible in a single jurisdiction • Collaboration across counties or health regions also important and not automatic; most often happens at the state rather than sub-state level • Collaborative planning much more difficult in multi-jurisdictional environments • Need to provide for coordinated prevention and care planning that involves the jurisdictions – but this will require resources
Coordination of services provided by both prevention and care	• Testing, linkage to care, risk reduction for HIV-positive individuals, and retention in care all now shared responsibilities of prevention and care • Do need to coordinate to optimize results • Will require common definition of terms and outcome measures • New linkages needed across funding streams

Each of the jurisdictions has identified some prevention-related needs. They are summarized in Figure 34, below.

Figure 34: Prevention Needs and Gaps

Need/Gaps	Description/Explanation
Scalability and financing	• Lack of resources to fund prevention programs for several prioritized populations (HIV-negative Black heterosexual men, HIV-positive Latino MSM, transgender women, high- risk youth) • Need to leverage the health care system, under which about 93% of the District of Columbia adults have health insurance coverage, to help deliver prevention services • Need to increase share of testing funds that come through third party reimbursements such as insurance company payments
Coordination of services	• Need systematic screening for multiple morbidities (e.g., HIV and syphilis, Hepatitis B, Hepatitis C, TB) • Should coordinate HIV with mental health and substance abuse services • Need third party reimbursements to cover coordinated services

Figure 34: Prevention Needs and Gaps	
Need/Gaps	**Description/Explanation**
	• Must arrange for evaluation of effectiveness of coordinated service strategies, using outcome measures that consider both HIV and the co-morbidities
Shifting priorities	• Shift of prevention strategies requires focus on scope and scale • Must evaluate existing prevention service network and determine whether services need to continue, modified, or replaced, based on program results • Need to ensure that transition leads to more impactful prevention and testing and that outcomes are improved for key populations and communities
Prevention with Positives	• Need to increase coordination of prevention for positives services funded under Prevention with Early Intervention Services and other services funded under Ryan White • Must determine how to include risk reduction strategies within other service categories such as Mental Health and Outpatient Substance Abuse Services

F. Capacity Development Needs

A number of capacity development needs were identified, but limited resources to meet them. About half of the Ryan White providers responded to the provider capacity and capability survey conducted jointly by HAHSTA and the Planning Council in early 2012 to provide input for the comprehensive plan. Eleven of them identified capacity development needs, as did the approximately 20 providers represented at the 2012 provider town hall. Identified needs include the following:

- **Assistance in preparing for health care reform:** Specific needs identified include information, training, and/or technical assistance related to the following:
    - Navigating health care reform – an overview and specific requirements and expectations for HIV service providers
    - Forecasting of changing operational environments for nonprofits, their practical implications, and how to address them as individual providers and as a care network
    - Available resources including funding opportunities and in-kind assistance
    - Selection, implementation, and "meaningful use" of electronic medical records systems

  - Third party billing, particularly for Medicaid including Medicaid Managed Care Organizations
- **Training and support in installing and fully using the new Maven system**
- **Clinician training,** including the following focus areas:
  - Regular adherence training sessions for nurses and other staff
  - Training in providing HIV care for primary care physicians,
  - Training and technical assistance in working with older PLWH, with a special focus on social workers and clinicians
- **Cultural competence:** includes:
  - Training in working with diverse and changing populations, including all communities of color, the GLBTQ community, and the disability community; particular focus on groups such as African immigrants, Latinos, transgenders, deaf, and disabled, recognizing that different providers and jurisdictions have different needs based on their level of HIV/AIDS experience, community environment, and client populations
  - More knowledge of both the federal Limited English Proficiency (LEP) Guidelines that apply to all federally funded providers and the resources available to providers to meet these guidelines
  - Introduction to the CLAS (Culturally and Linguistically Appropriate Services) Standards and their use
- **Capacity to provide services in more than one location:** includes ways to co-locate services and where necessary and house staff in central service locations
- **Capacity for collaboration between clinical and non-clinical providers:** includes HAHSTA assistance clarifying expectations for such linkages and building an infrastructure for collaboration
- **Expectations and methods for linking prevention and care:** what is expected of Ryan White providers and how these expectations can be met in operational ways that improve entry into and retention in care
- **Models and best practices in care coordination between medical and support service providers:** training that asks providers to share effective approaches and serve as peer consultants where appropriate

Providers noted that some of these capacity development needs can be met through the AIDS Education and Training Centers. HAHSTA currently coordinates with the AETC in a number of capacity building & training initiatives, including prevention of perinatal transmission. The expertise of the AETC can be leverages to address a variety of HIV-related training needs.

Chapter 5: Statewide Coordinated Statement of Need

A. Participation and Process for the Development of the SCSN

In an effort to efficiently organize the development of the 2012-2014 Part B Comprehensive Plan and the Statewide Coordinated Statement of Need (SCSN), the District of Columbia has combined both requirements in a single document. HAHSTA has in prior years obtained approval from the Health Resources Services Administration (HRSA), HIV/AIDS Bureau (HAB) to combine the SCSN and Comprehensive Plan and thus, the findings of the SCSN are included in this document.

The combined Part B Comprehensive Plan and SCSN is a 3-year blue print of the District of Columbia's effort to provide a comprehensive and responsive system of HIV/AIDS related services that address the needs and challenges of PLWH as they change over time. The development and completion of the plan assists HAHSTA with implementing effective HIV/AIDS service delivery in the challenging environment of federal funding cuts and the changing face of the disease.

This chapter reviews the last SCSN and summarizes the findings from a meeting conducted in April 2012, when participants from all CARE Act programs identified emerging trends, critical gaps in services and contributed to the development of broad goals to achieve over the next three years as efforts to provide effective HIV care in the District of Columbia.

In an ongoing effort to solicit PLWH input, HAHSTA held four meetings of the District of Columbia Delegation and participated in eight PLWH meetings in conjunction with the Ryan White Planning Council. Additional planning for the 2012 SCSN included an invitation from HAHSTA to all major providers of Ryan White services in the Washington, DC area. There were 18 participants that attended the SCSN meeting representing nine different organizations. The meeting was a facilitated discussion session covering a wide range of issues that impact the delivery of services to PLWH.

2009 SCSN	2012 SCSN
Emerging Trends – "Evolving circumstances, policies, procedures or resources that affect service delivery"	**Emerging Trends – "Evolving circumstances, policies, procedures or resources that affect service delivery"**
Need for District of Columbia Department of Health to advocate for HIV education in the schools. (This would be a helpful linkage with prevention efforts).	Challenges for PLWH who become eligible for Medicaid, Medicare, or local/state insurance-type programs in obtaining services other than medical care;
The nurse shortage is hampering the ability of primary care programs to hire nursing staff.	Most insurance does not pay for Ryan White-level medical case management, which may mean no service coordination unless the individual receives such services through Ryan White
There is increasing numbers of clients who are co-infected with Hepatitis C. The D.C. Healthcare Alliance program does not cover this treatment and this drives up the average cost of primary treatment and care.	Hepatitis C Testing, and care including; medications, and co-treatment • Need more Hepatitis C testing • Not enough coordination of treatment for PLWH co-infected with Hepatitis C Services related to Hepatitis C seen as far less accessible than HIV testing and medications
Providers reported significant numbers of persons are falling out of care and it is difficult to re-connect with them.	HAHSTA initiated a "Recapture Blitz" to identify clients loss to care and link them back into care. The participating providers included two-thirds of the District's major public section providers. All providers were recipient of at least one Ryan White funding source, Part A, B, C and D. The "recapture blitz" was a tremendous success and has been instituted permanently.
Across CARE Act funding, there needs to be a standard definition for medical case management, especially since not every agency has on-site primary medical care.	In 2010, HAHSTA developed and began implementing guidance for a comprehensive Medical Case Management Training Program. Broader implementation of this efforts include ongoing training to more than 300 nurses, social workers, and case workers in the District and surrounding jurisdictions.
Critical Gaps and Barriers to Service	**Critical Gaps and Barriers to Service**
The old allocation model is not useful. Medical care is not the top need in the District and	Lack of decent, affordable housing • Housing costs; especially rentals

2009 SCSN	2012 SCSN
Emerging Trends – "Evolving circumstances, policies, procedures or resources that affect service delivery"	**Emerging Trends – "Evolving circumstances, policies, procedures or resources that affect service delivery"**
there needs to be more funding for mental health and substance abuse services.	• Long waiting lists for HOPWA and other subsidized housing • Ryan White funding only for EFA rent and utility emergency assistance
Key service gaps include treatment adherence, services for transgender population and growing need for food vouchers and a food bank.	Intake Barriers • Documents required can be challenging to provide, especially for homeless, individuals in shared or unstable housing, and immigrants • Some documents, such as those on residency, must be notarized • Intake done at each provider, so PLWH must carry documentation with him/her
There is a need for food, especially with the recent hard economic times. Other gaps include transgender housing, effective strategies to serve increasing numbers of MSM adolescents, and funds to pay for transportation to work and job training.	• Without stable housing, it is extremely difficult to get care – no way to store food bank groceries, refrigerate medications; difficulties in getting to appointments and maintaining contact with providers
A significant number of adolescent females are being treated for sexually transmitted infections (STI) and most report they are not referred for HIV testing. It is important to get clinic settings to encourage HIV testing. This strategy would help with the unmet need in the District.	Study common opportunistic infections experienced by children to determine clinical consequences of HIV's presence in the body through childhood and adolescence, effort should be made to determine the clinical consequences of exposing individuals to antiretroviral medications through childhood and adolescence.
There needs to be improvement in the release of information processes between the D.C. Public Schools and mental health providers around Individual Education Plan (IEP), which have valuable school-based information necessary for effective treatment strategies with adolescents and children.	The medical literature points to antiretroviral therapy and HIV potentially being linked with increased likelihood for individuals being diagnosed with diabetes. Funded agencies could be approached to provide datasets relating to dually diagnosed patients (HIV and DM). MAVEN will to be a good source of data when examining biological interaction or relationships between diseases.
The process for food stamps eligibility is long	Strengthen partnerships with other District of

2009 SCSN	2012 SCSN
Emerging Trends – "Evolving circumstances, policies, procedures or resources that affect service delivery"	**Emerging Trends – "Evolving circumstances, policies, procedures or resources that affect service delivery"**
and cumbersome and is a barrier to care for families. The re-certification process can take from 45-60 days and drains Ryan White resources.	Columbia agencies to reduce barriers to care and improve access to services.
Stigma is a significant barrier among substance abuse users. Most know their status but they will not test due to stigma as many fear this knowledge will disrupt their using habits. They also fear becoming an outcast in their peer networks.	Develop effective strategies to reduce stigma.
The service system needs an effective treatment adherence model.	Ryan White Providers should be encouraged to follow AAHIVM standards for Elder HIV care and they should be incorporates all Ryan White Provider standards of care.
Transportation for homeless clients is a barrier.	The need to share more incidence data with PLWH
Cross Cutting Issues – "Concerns shared by a number of CARE partners"	**Cross Cutting Issues – "Concerns shared by a number of CARE partners"**
With increasing numbers of transitioning adolescents into adult primary care settings, providers need effective strategies to link and retain in care this population. If not, they may potentially be lost to care as adults.	Not enough providers with services that engage and meet the needs of young people aging out of pediatric programs, or other young PLWH, including African American MSM
Community connections are very important and there needs to be ongoing forums and dialogue among agencies about patient needs.	Older PLWH - More services needed to meet the needs of both newly diagnosed and long-time survivors; there are few geriatric social workers or clinicians trained to address the intersection of health care issues related to HIV and aging
Better discharge planning needs to be done in order to transition persons out of jails and into community-based HIV (services). Continuity of care is difficult, especially for those on HAART.	• Need systematic screening for multiple morbidities (e.g., HIV and syphilis, Hepatitis B, Hepatitis C, TB) • Need third party reimbursements to cover coordinated services
There is a need to get providers to discuss customer satisfaction and quality improvement	• Must arrange for evaluation of effectiveness of coordinated service

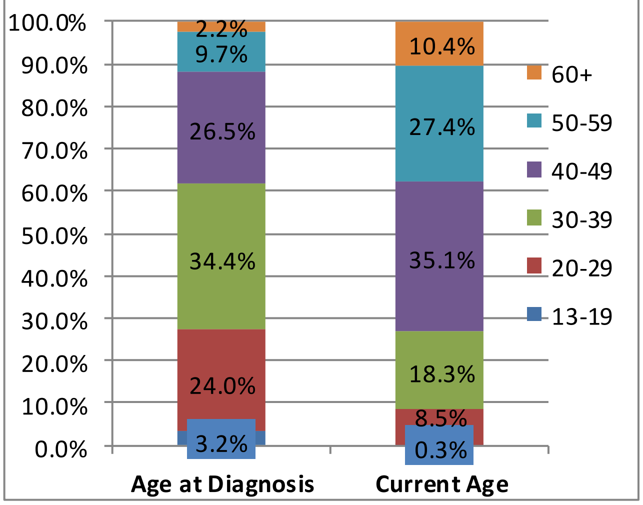
2009 SCSN	2012 SCSN
Emerging Trends – "Evolving circumstances, policies, procedures or resources that affect service delivery"	**Emerging Trends – "Evolving circumstances, policies, procedures or resources that affect service delivery"**
as a community.	strategies, using outcome measures that consider both HIV and the co-morbidities
Need for information coordination across mental health, substance abuse, and housing services regarding client health status and outcomes.	• Should coordinate HIV with mental health and substance abuse services
Broad Goals	**Broad Goals**
Develop and build collaborations with CARE Act program providers and non-CARE providers such as housing, substance abuse, mental health, social services in order to fully address the multiple needs of PLWH/A.	Use the Monthly Case Management Trainings to promote greater collaboration among CARE Act providers.
Increase the capacity of providers to work with special populations including adolescents, transgender and persons newly released from incarceration.	Examine data from the provider capacity and capability survey to determine provider capacity to serve special populations.
Continue efforts to increase accountability through improved data collection systems.	Implement an automated monitoring and evaluation system
Continue efforts to find persons not in care and implement strategies that retain persons in care.	Expansion of Red Carpet program to increase linkage to care rates and recapture rates.
Strengthen collaborations in order to provide a seamless, integrated system of care that is culturally competent.	Establish and implement an operating model that provides for coordination of care through the use of medical homes.
Collaborate with correctional systems to establish coordinated planned release.	Improve linkage to care for recently release from incarceration

B. HRSA Expectations

This section describes HRSA expectation

People Living with HIV Disease: According to data as of December 30, 2010, there were 14,465 adults and adolescents living with HIV disease in the District of Columbia, accounting for 2.7% of District residents. Approximately 4.2% of males residents and 1.4% of female residents are diagnosed and living with HIV. Men accounted for less than half (46.7%) of District residents but almost three-quarters (72.3%) of living HIV cases, while women represented 53.3% of District residents and 27.7% of living HIC/AIDS cases. Although blacks accounted for just under half (48.4%) of District residents, three-quarters (75.4%) living with HIV were black. Among District women, black women accounted for the majority of living HIV cases (92.4%). District residents between 40-49 years of age and black males have the highest rates of HIV at 6,598.7 and 6,344.1 cases per 100,000 population respectively.

Figure 16: Age at Diagnosis and Current Age of People Living with HIV/AIDS in



Age: Figure 16 shows age at diagnosis and current age of PLWH in the District. As the charts indicate, more than one-third (34.4%) of PLWH were diagnosed when they were between 30-39, and just under one-third between the ages of each 20-29 and 40-49. Only 3.2% were diagnosed before their 20th birthday, and 11.9% were diagnosed at age 50 or older. Given increasing survival rates, it is not surprising that the current PLWH population in the District is older. As the figure indicates, Well over two-thirds (71%) of PLWH are currently 40 or older, and more than one-third (36%) are 50 or older. Less than 1% is under 20 years of age, and 8.5% are ages 20-29. As indicated, people between the ages of 40 and 49 are most likely to be living with HIV/AIDS with the highest rate of HIV infection at 6,598.7 cases per 100,000 people. Additional information describing the HIV epidemic in the District of Columbia is available in Chapter 2.

Table 36: Living HIV Cases and Rates among Adults and Adolescents by Sex, Race/Ethnicity, and Current Age, District of Columbia, 2010

	Living HIV/AIDS Cases as of 12/31/10		DC Population, 2010		Rate per 100,000
Sex	N	%	N	%	
Male	10,465	72.3	246,885	46.7	4,238.8
Female	4,000	27.7	281,224	53.3	1,422.4
Total	14,465	100.0	528,109	100.0	2,739.0
Race/Ethnicity					
White	2,390	16.5	194,895	36.9	1,226.3
Black	10,907	75.4	255,758	48.4	4,264.6
Hispanic	833	5.8	45,361	8.6	1,836.4
Other*	335	2.3	32,095	6.1	1,043.8
Total	14,465	100.0	528,109	100.0	2,739.0
Male					
White	2,285	21.8	96,247	39.0	2,374.1
Black	7,210	68.9	113,649	46.0	6,344.1
Hispanic	703	6.7	23,459	9.5	2,996.7
Other*	267	2.6	13,530	5.5	1,973.4
Total	10,465	100.0	246,885	100.0	4,238.8
Female					
White	105	2.6	98,648	35.1	106.4
Black	3,697	92.4	142,109	50.5	2,601.5
Hispanic	130	3.3	21,902	7.8	593.6
Other*	68	1.7	18,565	6.6	366.3
Total	4,000	100.0	281,224	100.0	1,422.4
Current Age					
13-19	53	0.4	50,106	9.5	105.8
20-29	1,271	8.8	133,759	25.3	950.2
30-39	2,656	18.4	98,021	18.6	2,709.6
40-49	5,033	34.8	76,273	14.4	6,598.7
50-59	3,951	27.3	71,438	13.5	5,530.7
>=60	1,501	10.4	98,512	18.7	1,523.7
Total	14,465	100.0	528,109	100.0	2,739.0

*Other race includes mixed race individuals, Asians, Alaska Natives, American Indians, Native Hawaiian, Pacific Islanders, and Unknowns

C. Description of Needs, Barriers, Gaps, and Underserved

Chapter 4 of the comprehensive plan describes the service needs, barriers, gaps and the underserved populations. Due to the transient nature of the populations, many HIV positive individuals reportedly seek to avoid accessing services near where they live for fear of stigma. The identification of needs, barriers, gaps and underserved populations in this chapter takes into consideration the needs across the EMA in order to provide a more comprehensive picture of this challenge. It summarizes needs assessment data from people living with HIV disease, providers, HAHSTA bureaus and jurisdictional sub-grantees. It also describes prevention needs based primarily on data gathered by prevention units and community planning groups through the EMA, supplemented by community town halls. The findings that reflect needs, barriers, gaps and underserved are described in detail in Chapter 4.

Unmet Need

The estimate for unmet need is the variance between the number of people diagnosed and living with HIV and AIDS (PLWH/A) as of a particular date in time, less the number of PLWH/A who received a viral load test or CD4 count or a prescription for ART during the specified 12 months. The result is the number of PLWH/A who have an unmet need for HIV-related medical care. A total of 17,272 of HIV/AIDS cases were used in this estimation. A comprehensive explanation of unmet need in 2010 is described in Chapter 2.

Unaware Population Needs

Nationally, the CDC estimates that about 21% of individuals living with HIV/AIDS are unaware of their status. Using that estimate, there were approximately 21,863 individuals with HIV/AIDS in the District as of December 31, 2010, of whom 17,272 were aware and 4,591 were unaware of their status. In addition to the characteristics of the unaware population in the District, Chapter 2, includes a detailed description of the needs of the unaware population.

Special Populations

The District of Columbia includes diverse PLWH populations who face both shared and differing challenges and have both common and unique service needs. Several populations are briefly discussed in this section – identified by HAHSTA, the Planning Council, providers, and consumers as having special service needs and barriers that need to be appropriately addressed within the District and jurisdictional systems of care. A number of special populations are briefly described on the following pages, however, population specific service needs, gaps and barriers are identified in detail in chapter 4. All the epidemiological data are as of December 31, 2010.

Adolescents and Young Adults Transitioning out of Adolescent Care: Young people who were perinatally infected represent a growing and particularly challenging subgroup of adolescents and young adults. While very few new cases are occurring today (no perinatal cases were reported in 2011), epidemiological data indicate that there are a growing number of young people aged 20-29 have been HIV-positive all their lives or since adolescence. With improvements in medications, “AIDS babies” are growing to adulthood – and aging out of pediatric and adolescent services. At least one provider sometimes extends care until these young adults are in their early 20s, but both providers and caregivers report difficulties in transitioning such young people to adult care. These young adults need to learn disease self-management and how to navigate the adult system of care. There is concern about a lack of preparation and transitional support as they move to adult services and about a dearth of providers with special expertise in serving older adolescents and young adults. See chapter for additional details

Young MSM of Color: Another group of young adults of particular concern is MSM of color in their late teens and 20s, particularly African Americans. Nationally, the CDC reports that African American MSM represented about 73% of new infections among African American men and 37% of infections among MSM in 2009. The age and racial group with the largest number of new HIV infections was young African American MSM aged 13-29, and the number of new HIV infections among this population increased by 48% from 2006-2009.[51] Chapter 4 includes a detail description on young MSM of color in the District as well as the EMA and their need among special populations.

Homeless: Homelessness makes it difficult for PLWH to enter or remain in treatment. It is almost impossible for PLWH to get to service appointments on time, store and stay on medications, or maintain good nutrition if they are homeless. Lack of decent, affordable housing for PLWH is a serious problem. Particularly in the District and the inner suburbs, housing is expensive, and there are few affordable rental units. In the District, an estimated 371 people living with HIV/AIDS were homeless when diagnosed. More often, PLWH become homeless after diagnosis. Specific needs of homeless PLWH are discuss in detail in chapter 4.

Older PLWH (Age 50+): The number of older PLWH is increasing rapidly, and there is not yet sufficient provider capacity to ensure age-appropriate services. The American Academy of HIV Medicine issued a joint statement about older PLWH in September 2011 predicting that

"within the next four or five years, more than half of all people living with HIV in the U.S. will be over the age of 50, as well as one in every six who are newly diagnosed."[52] There are recent efforts underway in the District as well as the surrounding jurisdictions that focus increased efforts on the older PLWH. For the past two-years, HAHSTA has been working with an Older Adults in HIV work group to identify program strategies the address programs of PLWH and aging, in addition, chapter 4 elaborates in greater detail efforts across the EMA to address this challenge.

Recently Incarcerated PLWH Returning to the Community: Recently incarcerated PLWH or individuals who will soon be returning to the community are often challenging to identify, reach, and serve. In the District along, about 5,000 individuals each year return to the community following incarceration, an unknown number of them HIV-positive – aware or unaware. Additional details about efforts to address the needs of recently released PLWH returning to the community are described in Chapter 4.

D. Shortfalls in Healthcare Workforce

The healthcare shortfall in the District of Columbia as it relates to the delivery of HIV care and treatment is primarily positions, like dentists (highly skilled) with the expertise and interest in servicing PLWH. In addition, there is a shortfall in medical case manager positions due to the high turnover rate, and low wage rate.

E. Description of How Various Stakeholder Inputs Were Incorporated into the SCSN

HAHSTA sought stakeholder input for the SCSN though a variety of activities. During the year, representatives from the various HAHSTA bureaus participated in town halls, provider forums and monthly meetings. Additionally, they assisted in facilitating consumer and provider participation in focus groups, surveys and key informant sessions. HAHSTA served as a member of the Cross-parts collaborative and monthly Medical Case Management Training/feedback sessions. There were ongoing collaborations with the local AETC to facilitate provider trainings or for participation in special initiatives. As the grantee to the Part A program, HAHSTA played a key leadership role in partnering with the Planning Council and continuously solicited stakeholder input from both consumers and providers. Throughout the 3-year period, HAHSTA engaged in a wide range of activities to solicit stakeholder input and to maintain an ongoing process to identify need and improve services to PLWH.

Chapter 6: Evaluation of the 2009-2011 Comprehensive Plan

Overview

This chapter summarizes progress and challenges in implementing the 2009-2011 comprehensive plan, as well as lessons learned over the past three years. Overall, the District completed or made significant progress on most of their objectives. External factors – from new requirements in the 2009 Ryan White Treatment Extension Act to passage of healthcare legislation to funding delays in 2011 due to late Congressional action on the budget, as well as local changes in HAHSTA structure and staffing – complicated work on some objectives.

A. Progress, Challenges, and Lessons Learned

Figure 37, below, provides the goals and objectives from the previous comprehensive plan, along with planned deliverables, timeline, progress made, challenges encountered, and lessons learned. As the chart indicates, the District has made progress in many aspects of its operations, including the development and implementation of guidelines for medical case management in not only the District of Columbia but implemented EMA-wide. Further establishment of these efforts include ongoing training to more than 300 nurses, social workers, and case workers in the District and surrounding jurisdictions. The District has also provided technical assistance to providers to strengthen quality improvement infrastructures at the primary medical care provider level to assure improved health outcomes. Preparation for the release of MAVEN, the District's comprehensive HIV/AIDS monitoring and evaluation system is shown in the foundational development of interactive monitoring tools that will operate inside the system. Ultimately, the tools will provide increased access to disease monitoring indicators and utilization data. At the most core level of impacting the HIV disease, during the planning cycle, HAHSTA collaborated with non-medical government agencies to establish testing sites that impact a broader swath of the population.

Challenges: There were some important challenges. Some planned efforts related to systems changed were no longer feasible based on analysis of client and program data because of delayed implementation of the planned Maven client-level data system; once the system is fully implemented, these tasks will be implemented. The lack of a reliable client-based data system continues to limit the availability and quality of service utilization data needed by HAHSTA for optimal data-based decision making.

Lessons Learned: The importance of external factors was clearly demonstrated during the 2009-2011 period. The 2009 Ryan White legislation brought new requirements for the Ryan White program in addressing HIV-positive/unaware individuals (EIIHA), and the National HIV/AIDS Strategy provided a new focus and is bringing significant changes in strategies and priorities for HIV prevention, testing, and care. The passage of health care reform legislation has led to some short-term changes in health care systems and intensive planning for a significantly changed health care safety net – with implications for Ryan White and for HIV services unlikely to become clear until after the Supreme Court’s decision is announced. The proposed work plan for the 2012-2014 comprehensive plan attempts to take these lessons into account.

Figure 37: 2009-2011 Comprehensive Plan Goals and Objectives: Progress, Challenges, and Lessons Learned

Objective	Activity	Time Line	Progress, Challenges, and Lessons Learned
Goal 1. *Ensure HIV-positive persons learn their HIV status, enter care early through the promotion of effective strategies that enable individuals to access care and remain connected.*			
Objective 1.1 Examine issues of retention in care and lost-to-care for special populations	• Identify special populations out of care and use data to create a base line. • Develop a monitoring tool to guide scope of work. • Conduct pilot projects to examine out of care issues.	• Annually • Annually • 4th Quarter 2010	• Baseline data has been established on special populations • Monitoring tool has not been developed, as much of the information to be collected will originate from MAVEN, new monitoring tools will be implemented along with MAVEN. • There have been blitz recapture activities and data matches with each of the Primary Medical Care organizations to develop a list of individuals who are out of care. Five major HIV public sector providers participated in the initiative. Based on the criteria identified, the providers pursued 1,365 clients identified as lost-to-care. 366 of which were found to be active in the database within the prior 6 months, 642 found to be active but last activity was greater than 6 months prior, 328 were not found at all, and 29 were identified as deceased. The providers attempted to contact 982 clients. Of the 404 that were contacted. 230 (41%) of that number were found in be in care, and 186 (46%) were scheduled for appointments.

Objective	Activity	Time Line	Progress, Challenges, and Lessons Learned
Objective 1.2 Continue to monitor and implement early intervention strategies targeting special populations.	• Identify special populations and non-traditional venues to ensure early access to care. • Fund, through the RFP process, specialized projects that target non-traditional entry points. • Create a baseline with epidemiological surveillance and utilization data around target populations • Identify existing best practices • Create monitoring tools and assess efficacy through feedback.	• Ongoing • 2nd Quarter 2010 • 2nd Quarter 2009 • Ongoing • 4th Quarter 2009	• Early Intervention Service (EIS) providers target special populations like Latinos or individuals who frequent Crew Clubs. EIS efforts are combined with targeted treatment adherence. • While non-traditional entry points have not been targeted through an RFP, testing at non-traditional entry points have been facilitated through the Department of Motor Vehicles (DMV). Test kits are also given to the Income Maintenance Administration (IMA) who has shown higher positivity rates. • With recent maturation of the HIV database, better data are available for the establishment of this baseline. • Best practices include in-reach activities that go beyond targeting the newly diagnosed. The practice also looks at individuals lost-to-care. These activities are now a part of the EIS scope’s expanded definition. • HAHSTA staff is working on the development of monitoring tools that are consistent with HRSA/HAB Programmatic and Fiscal Monitoring Tools.
Objective 1.3 Improve coordination of care by improving the effectiveness of case management.	• Review changing case management models in other jurisdictions. • Conduct quarterly case management provider trainings. • Facilitate the certification of case managers around treatment adherence. • Review and update case management protocols.	• Quarterly • Quarterly • 2nd Quarter 2009	• Models from Ohio, Florida and New York were examined prior to the update of the Medical Case Management Guidance. • Quarterly trainings are provided via the Case Management Operating Committee (CMOC). The CMOC is a sub-group of medical case managers and supervisors which was convened to update the Medical Case Management Guidance. Quarterly training on various topics related to the Guidance continues. • Contract with Center for Minority Studies which provides roundtables for medical case managers that offer certifications. • Medical Case Management Guidance updated by the CMOC. Upon implementation of the new Guidance, three full day training sessions were conducted. Quarterly training on various topics related to the Guidance continues. Additionally, periodic reviews

Objective	Activity	Time Line	Progress, Challenges, and Lessons Learned
			of the Guidance are conducted where additional updates are considered.
Goal 2. *Ensure improved health outcome and access to medical and support services*			
Objective 2.1 Assess the changing needs of individuals who are in care.	• Review epidemiological, surveillance and utilization data to identify service utilization trends of persons in care. • Compile, analyze and interpret survey and focus group data to determine barriers to care affecting individuals in care. • Present key findings to the D.C. Delegation. • Monitor provider's response to serving specific populations. • Review focus interview groups (FIGS) to assess provider responsiveness to clients. • Prepare the Annual Progress Report for Part B Services.	• Annually • Annually • Annually • Annually • Biannually • Annually	• The Medical Case Management Guidance requires a reassessment of individuals who are in care every 6 months. • Upon reassessment of eligibility, individuals who qualify for Medicaid based on Medicaid expansion are moved into that system. • Upon reassessment of eligibility, individuals who gain employment move to other insurance. • New tools for those with substance abuse or mental health issues are under review, done in collaboration with Addiction Prevention Recovery Administration or Department of Mental Health. • Providers are required to monitor viral suppression.
Objective 2.2 Continue to conduct quality assurance activities to assure improved health outcomes and cost	• Review and update existing protocols and measures. • Continue to review and update Standards of Care.	• As needed • Annually • Quarterly • As needed	• Renewed approach in evaluating programs and quality of services was a driving force behind the decision to initiate the development and implementation of a comprehensive HIV/AIDS monitoring and evaluation system. This system will enable HAHSTA to:

Objective	Activity	Time Line	Progress, Challenges, and Lessons Learned
efficiency	• Report on primary medical care and case management outcome measures. • Provide quality assurance training and technical assistance to sub-grantees for the purpose of refining practices and identifying best practices.	and/or annually	• Track clients across the continuum of care and across time periods, • Complete more in-depth analysis of health outcomes, • Evaluate cost and cost-effectiveness of programs and services, • Improve the quality of the data, • Adapt more quickly to future requests and/or changes in federal requirements. • Enhance electronic reporting mechanisms, such as electronic laboratory reporting (to allow for clinical indicator, CD4 and VL, monitoring), and availability of core medical, support service, and housing utilization information. • HAHSTA in 2009 convened a workgroup of stakeholders from medical case managers, staff and the HIV/AIDS community to develop guidance to provide standardized medical case management in the District Guidance set a minimum level for the provision of quality medical case management (MCM) services provided in D.C. with an emphasis is on • Achievement of good health outcomes, • Importance of viral load suppression for those on antiretroviral treatment, • Treatment adherence at every stage of the Medical case management process , • Engagement in a primary medical home and • Coordination of linkages to service More than three hundred medical case managers, nurses, social workers and caseworkers in the District and surrounding jurisdictions trained on use of tool. The completed Guidance was launched in March 2010 and has been implemented by all funded organizations. Multiple tools developed include:

Objective	Activity	Time Line	Progress, Challenges, and Lessons Learned
			- A Comprehensive and mini client assessment tool - A four level Acuity Scale - A SMART 'MCM' service plan guide - A Supervisor's worksheet - Program and client monitoring and tracking tools Tools were implemented in phases over a 12-month period. Before the launch of the guidance, a trial utilization and feedback period allowed for broad community input, enhancement of the final product and informed collaborative development of training sessions for over 300 medical case managers. All MCM programs submit approved indicators on monthly and quarterly basis to HAHSTA. HAHSTA continues to organize quarterly trainings on the guidance and provide technical assistance to all providers implementing the medical case management guidance in the district and its surrounding jurisdictions. - Since 2009, HAHSTA has been collecting data on modified HAB performance measures on a monthly and quarterly basis. Standardized collection and analysis of 15 HAB performance measures began in May 2011 through the DC Cross-Part Collaborative. Data submitted using a standardized reporting template and used to identify and prioritize QI activities, develop and disseminate best practices and standards, and implement key activities to minimize/eliminate barriers in communication between providers and consumers. Site-specific performance reports provided to each participant for the purpose of tracking performance overtime and enhancing the quality of respective programs. In March 2012, HAHSTA expanded collection of both primary medical care and case management HAB performance outcome

Objective	Activity	Time Line	Progress, Challenges, and Lessons Learned
			measures to identify and prioritize QI projects, to routinely monitor the quality of care provided to consumers, and to evaluate the impact of changes made to improve the quality and systems of HIV care. • Since 2009 HAHSTA has worked with the local AIDS Education Training Center (AETC), providers, and consumers to identify training needs, as well as deliver training and technical assistance. HAHSTA has, increased capacity around standards of care, leadership support for quality projects, utilizing programmatic and quality performance data, and implementing quality improvement initiatives. • HAHSTA also provided guidance on existing quality management programs, and refining written quality management plans, offered, in collaboration with the AETA and the District of Columbia Case Management Operating Committee, a Cervical Cancer Screening webinar with continuing education credits for clinicians and a Quality Management 101 training series. In addition, the compilation and sharing of best practices is occurring through the National Quality Center's secure, web-based platform. Providers are encouraged to share information on Plan Do Study Act (PDSA) improvement cycles conducted within their facilities, as well as, connect to the peer-to-peer support network.

Objective	Activity	Time Line	Progress, Challenges, and Lessons Learned
Goal 3. *Maximize resources throughout the EMA through increased linkages and coordination among Ryan White programs and non-Ryan White programs (including Medicaid, Medicare, prevention, housing, District programs including APRA, Maternal Health and Child Health, Mental Health).*			
Objective 3.1 Increase capacity of service providers to participate in the Ryan White continuum.	• Assess the capacity of providers for delivering quality services. • Support capacity-building activities that will strengthen provider infrastructure.	• Quarterly • Annually	Monitoring and Evaluation team has gone out to conduct quality reviews at various agencies. The site visits consisted of: • A review of a sample of charts from all organizations providing outpatient ambulatory medical care. The review included primary medical care and medical case management services provided by the organization and included clients receiving these services even when they are paid for by a source other than Ryan White funds. • A review of each organization's capacity and effectiveness in delivering HIV primary medical care and medical case management services. • A review of each organization's effectiveness in implementing services in accordance with the U.S. Public Health Service Guidelines and HRSA Monitoring Standards. • The identification and report on areas of strength and any areas for improvement in service delivery. • A summary report to HAHSTA and the Care Strategies, Coordination and Standards Planning Council Sub-Committee of findings and recommendations for improvement. • HAHSTA conducts sub-grantee forums and trainings to provide technical assistance with reporting program income, ensuring Medicaid billable services, understanding HRSA monitoring tools and other subjects that will strengthen agencies.
Objective 3.2 Ensure that all eligible clients are enrolled in	• Review ADAP rolls to make sure that people are not eligible for or currently	• Monthly	• Prior to ADAP enrollment, clients are assessed to determine if they are eligible for Medicaid enrollment. Every 6 months ADAP rolls are reevaluated to determine if any clients have become

Objective	Activity	Time Line	Progress, Challenges, and Lessons Learned
comprehensive health care programs, clients adhere to treatment and medical care appointments and providers appropriate bill third parties.	enrolled in Medicaid. • Enhance case management systems to be sure that eligible persons are enrolled in D.C. Alliance health care. • Assess third party billing capacity of funded providers and develop recommendations to improve third party reimbursement.		Medicaid eligible. • The enhanced Medical Case Management Guidance and trainings have been adopted as the standard of care. • Provide and facilitate technical assistance to enhance provider billing capabilities.
Objective 3.3 Continue collaboration and planning with the D.C. Delegation to ensure shared goals and objectives through joint needs assessments, epidemiologic profiles, and community planning forums.	• Conduct routine and regular community wide meetings. • Work and provide training to the D.C. Delegation. • Evaluate efforts on a yearly basis.	• Monthly • Quarterly • Annually	• In the past, regular community wide meetings were conducted monthly via the D.C. Delegation to discuss Ryan White issues and concerns. A variety of community engagements are used to capture impact from consumers including: town halls, local community planning bodies, surveys, and focus groups.
Objective 3.4 Develop an effective monitoring system that scrutinizes program targets and expenditures.	• Develop effective monitoring tools for sub-grantees. • Annually review conditions of awards to ensure all necessary contract language for adherence to HRSA requirements.	• Annually • Annually	• Development of these tools is in progress. The appropriate programmatic and fiscal staff is working on the development of monitoring tools that are consistent with HRSA/HAB Programmatic and Fiscal Monitoring Tools. • Completed annually.

Objective	Activity	Time Line	Progress, Challenges, and Lessons Learned
Objective 3.5 Increase linkages and coordinate services with other disciplines and organizations in the District of Columbia.	• Increase co-location and integration of HIV services with other organizations through the development of MOUs.	• Ongoing	• A current HIV testing campaign coordinates sites at the other city agency locations including the DMV and IMA. There is also an ongoing Hepatitis-C and HIV testing drive conducted at one local pharmacy. • HAHSTA is a participant in the 12-Cities Initiative which is a top down effort to promote coordination at the local level by coordinating initiatives among federal funders. Various federal agencies including: HRSA, CDC, SAMHSA, CMS, NIH, and the PHS seek to end duplication of care and maximize efficiencies.
Goal 4. *Improve the operation of the D.C. Delegation to ensure that the system of care in Washington D.C. addresses the needs of communities affected by the disease and fulfill the legislative requirements.*			
Objective 4.1 Increase participation of stakeholders in the Delegation.	• Implement recruitment of participants on the belief that the opinions, experiences and expertise of individuals infected and affected by HIV are essential in the District's development of strategies to respond to the epidemic.	• 1st Quarter 2009	• A variety of community engagements are used to capture impact from consumers including: town halls, local community planning bodies, surveys, and focus groups.
Objective 4.2 Clearly Define what the Delegation's role is in the District's response to HIV.	• Develop a work plan calendar that will assist in guiding long range planning. • Establish policies that provide guidance on committee eligibility, participation and governance.	• 1st Quarter 2009 • 2nd Quarter 2009	• A variety of community engagements are used to capture impact from consumers including: town halls, local community planning bodies, surveys, and focus groups. • Job descriptions have been developed that establish the role of participants.

Objective	Activity	Time Line	Progress, Challenges, and Lessons Learned
Goal 5. *Ensure the availability of emerging and state of the art pharmaceuticals and treatments in Washington, D.C.*			
Objective 5.1 Integrate forecasting of program costs and service utilization into program planning across the Ryan White Continuum.	• On a routine basis, develop forecasting reports for pharmaceuticals based on projected population needs. • Give regular updates to the D.C. Delegation regarding forecasting reports and assess the impact on ADAP participation.	• 3rd Quarter 2009 • Biannually	• HAHSTA Pharmaceutical Warehouse staff continually monitors the utilization and inventory of the ADAP pharmaceutical stock and adjusts purchasing accordingly. This task requires the staff to forecast program needs to ensure that an adequate stock of medicines is always on hand to replenish pharmacies' inventory. • Currently ADAP has a robust surplus inventory to draw upon and there is no indication that the availability of pharmaceuticals will be in jeopardy in the future.
Objective 5.2 Continue modernizing the ADAP application process.	• Continue the development of the electronic filing system. • Develop a writeable PDF so clients can complete the ADAP application online.	• Completed • 3rd Quarter 2009	• The electronic filing system has been completed. All the District of Columbia ADAP applications are stored in a secure electronic database. • The writeable PDF application project has not been completed. This project was halted when ADAP began development of the MAVEN system. MAVEN will allow medical case managers to submit ADAP applications online. ADAP staff may re-visit the writeable PDF option, but prior to implementation the application will need to be updated to reflect program changes.
Objective 5.3 Stimulate feedback loops among physicians, pharmacists and treatment adherence staff.	• Determine methods for improved data sharing around client adherence for improved health outcomes.	• 4th quarter 2009	• HIV/AIDS Drug Assistance Committee is comprised of Pharmacists, physicians, and treatment adherence staff and they meet regularly.
Objective 5.4 Increased retention of	• Devise strategies to outreach to clients who have not	• 3rd quarter 2009 • Ongoing	• Medical case managers working at HAHSTA-funded agencies perform outreach to clients who have not recertified. New

Objective	Activity	Time Line	Progress, Challenges, and Lessons Learned
clients in ADAP and care.	recertified or filled prescriptions. - Improve collaborations between ADAP and Medicaid to obtain accurate and meaningful data on enrollment and utilization.		strategies will be implemented along with the MAVEN system. - ADAP staff members now have access to the Automated Client Eligibility Determination Systems (ACEDS) which enables them to verify if clients are enrolled in the District of Columbia Medicaid Program before determining eligibility for ADAP. Clients enrolled in Medicaid are not eligible for ADAP services.
Objective 5.5 Maximize appropriate utilization of antiretroviral.	- Establish quality control mechanisms to improve drug utilization review activities that will allow for real-time interventions on antiretroviral use.	- 4th quarter 2009	- ADAP has increased the “edits” in the pharmacy benefit management system to ensure that claims cannot be processed for medications that may negatively interact with other medications. Furthermore, now all overrides to allow these transactions to be processed must be approved by DOH pharmacists.
Objective 5.6 Track ADAP client outcomes.	- Devise strategies to integrate laboratory data collected by the Surveillance Bureau with ADAP utilization data.	- 2nd Quarter 2009	- Service utilization is reviewed routinely.

Section 2: Where Do We Need to Go?

Chapter 7: A Description of an Ideal System of Care for the District

Overview

This chapter describes an “ideal” system of care in the District. It identifies characteristics and components of a refined system of care, defined by HAHSTA, with input from PLWH through the DC Delegation, collaborations with the Ryan White Planning Council and service providers through town hall meetings and forums.

HAHSTA recognizes that the health care system is changing, and HIV/AIDS services will change in response. Despite uncertainty about implementation of the health care reform legislation, it is clear that third party reimbursements will be a growing part of the HIV/AIDS system care, and that medical and support services for many if not most clients will be funded for by multiple sources. This makes it particularly important that a coordinated, HIV-centered but comprehensive system of care be developed – using a medical home/health home or similar model. Because the District has a diverse system of care, the model must be flexible enough to incorporate the successful components of the current system.

Given that numerous providers are responsible for HIV testing, linkage to care, and retention in care, HAHSTA envisions a system that integrates prevention and testing with care and treatment. Such system integration is also necessary in order to address fully the goals and priorities of the National HIV/AIDS Strategy – from testing and early entry into care to effective treatment leading to positive clinical outcomes and elimination of health disparities.

A. Guiding Principles and Values

The District of Columbia’s population is diverse with a high rate (41.7%) of unmet need. African Americans and other communities of color (including African immigrants and Latinos) are severely and disproportionally affected by the epidemic, and continue to suffer from health outcome disparities. Although the District of Columbia has the highest per capita public health expenditures in the nation it has reduced public health and human service expenditures as a way of addressing revenue shortfalls.

Yet the District places great value on increasing testing and providing for prompt linkage to care – which in turn require increased capacity to provide medical care, case management, medications, and the wraparound services necessary to keep PLWH in care and adherent to treatment.

In a time of diminishing resources and growing needs, the District is guided in its planning by the goals of NHAS, which it fully shares, and by a strong belief in several guiding principles:

1. **Coordinated care,** regardless of funding streams. As the health care system changes and – as health care reform moves forward – many PLWH become Medicaid eligible or enroll in insurance provided through insurance exchanges, the need for case management and care coordination will increase. Some form of medical home, comprehensive care center model or related type model of care will be developed and tested. HAHSTA will engage providers serving diverse populations, regardless of their funding sources, including community-based organizations with special capacity to support and serve high-priority populations who may face significant health disparities – from transgenders to young African American MSM, immigrants, and the multiply-diagnosed.
2. **Access to information.** The District will increase awareness and understanding of HIV disease and of prevention, testing, and care resources, **–** so residents better understand the disease and so that PLWH can easily learn where to get tested and how to obtain care, especially if they require free or low-cost services.
3. **Maximum PLWH participation.** HAHSTA will collaborate with the community partners to leverage the efforts to engage more PLWH – as peer community health workers (CHWs) in multiple service categories, staff at all levels within provider organizations, and volunteers who link HAHSTA's programs throughout the community to ensure more PLWH are engaged in getting and retaining PLWH in care.
4. **Communication and collaboration at all levels** – improve communication among prevention, testing, and care; between funded and non-funded providers; between HIV/AIDS specialists and the general health care safety net; and throughout the District.
5. **Improved data access, sharing, reporting, and use** – for evaluation of client outcomes and assessment of the system of care and for coordinating client care, with data collected through the planned Maven data system/warehouse analyzed, and used for HAHSTA programs and providers, so that decisions at all levels can be truly data-based.

B. Components and Characteristics of an Ideal System of Care

An “ideal” system of care for the District – a system maximizing capacity to address the NHAS goals and to meet the needs of a diverse community – should have the following components and characteristics:

1. **Integration of prevention, testing, and care** into a seamless system that begins with prevention education and continues through testing, health and HIV literacy, referral and linkage to care, navigation within and among the systems of care, treatment adherence, retention in care, and achievement of positive clinical outcomes including viral suppression. This system will have common definitions for service activities, service outcomes, clear delineation of roles, communications and data sharing, recognition of the importance of treatment as prevention, as well as coordination of prevention and care planning to the extent feasible. Such integration will help maximize both routine and community testing and as well as early entry into care, retention in care, and positive clinical outcomes.
2. **Medical home service model**, so an individual with HIV disease obtains comprehensive services through an organized system of direct services and referrals that provides access to HIV-related medical care, primary medical care, medications, medical case management, specialty care, and other “wraparound” services necessary to achieve viral suppression and ongoing good health. If a PLWH obtains services through more than one payer – e.g., Medicaid, Medicare, private insurance, Ryan White, and perhaps other public programs – these services will be coordinated and managed through a single entity – the “medical home” or comprehensive care center, physical or virtual. There will generally be multiple providers, every effort will be made to ensure each PLWH has choice among service providers, and on-clinical providers have the opportunity to provide services that support medical treatment. An emphasis will be placed on ensuring that community-based organizations continue to be an integral part of the model because of their special expertise with specific population groups.
3. **Partnering and funding organizations to employ peer community health workers (CHWs) and other HIV-positive individuals throughout the system,** in every service categories where feasible, this includes involvement of peer CHWs to help people get tested, learn about living with HIV disease, enter care, learn to navigate the system, adhere to treatments, and remain closely linked to care. It also includes support for the employment of all kinds of positions and facilitating

ways to incentivize hiring of peers and other PLWH and will ensure that they receive appropriate training and career training opportunities.

4. **A centralized and well publicized source of information about HIV testing, and care throughout the District,** which provides up-to-date service information and is available to both consumers and providers, including private physicians. The system should be accessible online through a variety of means and in other ways.

5. **Expanded testing,** especially routine testing and also testing in non-traditional settings to increase early diagnosis and reduce transmission. Currently, nearly 80% of HIV testing or HIV positive results in the District is conducted in clinical settings and HAHSTA has proposed a three tier strategy to continue & expand high volume, routine HIV screening programs in medical settings, including current hospital facilities that are in various stages of implementation of HIV screening. The District will expand the level of HIV screening in clinical setting through a pilot that targets expansion of routine screening activities in dental offices, pharmacies, mental health and substance abuse facilities, and private primary care practices. The goal in year one is to target 20 additional District medical providers, pharmacies and dental offices as well as Department of Health substance abuse and mental health direct service providers (detox, residential treatment). The District of Columbia will work with the providers to identify high-volume screening technologies and alternative and cost-effective methods to ensure increased screening while reducing provider reliance on publicly supported HIV test kits.

   Also existing routine screening activities will be leveraged to expand upon the current network of testing providers and HAHSTA will competitively fund up to six medical providers, from hospitals to community health and managed health care networks to do comprehensive testing, linkage and navigation.

   In addition, HIV testing in non-healthcare settings will be expanded. Although clinical settings identify more positive, non-clinical settings have higher positivity rates among some populations.[53] The District of Columbia will maintain support for non-health care setting as an important strategy to reach targeted populations through innovative approaches. HAHSTA will focus this outreach testing among social networks and in non-traditional venues. The District of Columbia was one of the cities that implemented social networking for HIV screening as part of a CDC demonstration project that yielded a peak of over 10% positivity rate. Continuing this model will increase

HAHSTA's ability to reach previously unreached or hard to reach groups for testing, linkage to care and other prevention services. An innovative model that will continue has been the District of Columbia's popular testing at a Department of Motor Vehicle (DMV) office.

Additional attempts by HAHSTA to expand routine screenings in non-traditional settings and normalize HIV screening that will continue include a newly formed public-private partnership with the DMV, Family and Medical Counseling Service (FMCS) and Gilead Sciences to implement a pilot program offering HIV testing in the DMV Penn Branch Office. The Pen Branch office is located in Ward 7 next to Ward 8, two District areas with the highest prevalence of HIV/AIDS. FMCS has also proposed to expand HIV testing to target Black/African American men and women to include HIV testing at the District's Income Maintenance Centers (locations where eligibility for a variety of District social services is determined).

6. **Rapid access to medical care** with minimal waiting time for both newly diagnosed individuals and PLWH who have never been in care or dropped out of care; strengthening the Red Carpet Entry and expanding immediate-access processes across the District, adopting other changes to minimize waiting time for first appointments for PLWH who are newly diagnosed or re-entering care, encouraging or requiring medical providers to save some time slots for same-day access to care without an appointment for current clients, and perhaps other strategies.
7. **Bridge programs that enable special populations to make necessary transitions into and across care services.** Some people with HIV disease – such as formerly incarcerated PLWH returning to the community and young adults aging out of pediatric care – are forced to change providers, but need skilled support to become fully linked to appropriate services. HAHSTA will continue the effort began over the last three years in conjunction with the local AIDS Education Training Center (AETC), providers and consumers to identify training needs and deliver training and technical assistance to ensure the needs of special populations can be addressed.
8. **Services and providers with expertise to provide culturally competent and expert care that maximizes retention,** with the capacity to meet the needs of diverse clients, among them transgenders, MSM, IDUs, African and Latino immigrants, adolescents, older PLWH, and women. Funding providers with specific expertise, including CBOs, and increased flexibility to allow PLWH to access services from appropriate providers, also providing supports to providers including access to training for clinicians, case managers, peer CHWs, front desk personnel, and

other staff to develop the cultural competence and skills to effectively serve individual clients from various PLWH populations.

9. **Institutional systems and procedures to maximize retention,** such as referral and collaboration procedures that provide prompt access to needed medical-related and support services and lead to treatment adherence and positive clinical outcomes**.** HAHSTA will support retention or re-engagement in care for HIV-positive persons with a comprehensive treatment support system that will focus on connection to care, prevention as treatment, viral suppression, long-term adherence, recapture and return to care. Special emphasis will be placed on newly enrolling and then retaining in care those clients who are aware of their HIV status but not in care, and recapturing those clients out of care for six months or more.

10. **Active consumer involvement and input,** leveraging partnerships with consumer organizations, outreach volunteers and regular members of quality management teams. This may requires a variety of training opportunities and structured initiatives.

11. **Data sharing to improve care,** through full implementation of the Maven client-level data system, adoption and full implementation of electronic medical records (EMR) by service providers, and support to ensure “meaningful use” of health information technology by HIV/AIDS service providers, This will include sharing of medical data among providers and with hospitals, with appropriate confidentiality protections, to improve care and avoid service delays or repeating of medical tests. It also includes use of client and program data to determine treatment outcomes, assess system effectiveness, and refine services.

C. Exploration of an HIV-focused Medical Home Model

An “ideal” system of care as described by PLWH/A, providers, and other concerned community members is one that seamlessly provides and coordinates HIV-related medical care; other preventive, primary, and specialty care; various medical-related core services; and support services. HAHSTA is exploring the development of a service model that can provide the following:

- A single, system-wide intake and recertification process, so PLWH/A can establish eligibility for services once and don’t have to provide the same documentation to every provider.
- Coordination of care that enables PLWH to obtain both HIV-related and general medical care and the “wraparound” services needed to help them stay in care and adherent to treatment – this

includes both other core medical-related services such as mental health and substance abuse treatment and support services like transportation, housing assistance, and groceries, regardless of the funding streams.

- Use of comprehensive care centers, where services are available in or near a central location or through use a variety of approaches, and multiple providers (including community-based organizations) are welcomed.
- Coordination that is available to PLWH who are enrolled in Medicaid, Medicare, or private insurance within a health insurance exchange, as well as any other source of HIV-related care.
- A network of providers that together ensure multicultural competence (the ability to provide culturally and linguistically appropriate services to various PLWH/A populations), which is achieved partly by involving community-based organizations that are expert in serving particular populations as partners in the service system.
- Close, formal links with HIV prevention and testing.
- Joint funding or collaborative agreements that ensure real coordination and cross-referrals with a range of entities where the coordination contributes to improved clinical outcomes.
- Documentation of treatment outcomes and evaluation of the quality of care.

HAHSTA will work towards its ideal system of care by exploring the feasibility of an HIV-care-centered “medical home.” This will have some but not necessarily all the characteristics of a patient-centered medical home (PCMH) as recognized by the National Center for Quality Assurance (NCQA).[54] HAHSTA recognizes that collaboration will be needed to create and support medical homes to serve PLWH, given the requirements for specialty care and other capacities. In exploring this model, the District will benefit from the experiences of a growing number of HIV service providers and other clinics that have become or are becoming PCMHs. It will also learn from program, grants, and demonstration efforts in neighboring states such as the legislatively-based Maryland Medical Home Pilot[55] and the Commonwealth Fund and Qualis Health-led Safety Net Clinic Medical Home Initiative. This initiative is assisting 65 FQHCs in five states across the U.S. to become PCMHs.[56] It’s practical assessment tools and analyses will help HAHSTA expand its understanding about medical home issues. HAHSTA will also seek lessons from metro area grant programs supporting safety-net health care providers in their efforts to become medical homes, such as recent grants from medical insurance companies like CareFirst.[57]

The chart that follows (Figure 38) outlines some key characteristics of such a model, with the understanding that it might be organized differently due to the uncertainty of healthcare reform. However, the operating model must provide for coordination of HIV-related and other medical care and various wraparound services for individual PLWH.

Figure 38: Medical Homes Model as a Strategy for HIV Care

Three-Year Goal	Establish and maintain a coordinated, integrated continuum of prevention, testing, and care that provides coordinated services for individual PLWH/A and results in viral suppression
Objective	Create and begin to implement an accessible, comprehensive, longitudinal, coordinated, multiculturally competent system of care for PLWH/A in the District.
Background/ Context	• Extensive literature on the added value of medical homes in primary care, including medical homes for high-need vulnerable clients and individuals with chronic care
	• "Best practices" implementation of medical homes
	• Collaboration for use of support services to achieve medical outcomes: Ryan White Treatment Modernization Act (CARE Act Amendments) of 2006, Section 2604(d),defines support services as those "needed for individuals with HIV/AIDS to achieve their medical outcomes… those outcomes affecting the HIV-related clinical status of the person with HIV/AIDS"
Methodology	Create a "medical" home that: • Provides a core set of primary care and closely related clinical services • Has an established, documented ability to provide a set of supportive services through either internal or external partners • Ensures specialized supports and services to individuals, populations and sub-populations most vulnerable to interruption of care, through either internal or external partners • Ensures culturally competent services and links to the community • Is adjusted as needed so that it can be implemented throughout the District, given differences in the levels of provider capabilities.
Components to Address	In planning the service system and procuring service providers, particular care will be given to ensuring the capacity to accommodate: • Social vulnerabilities and potential barriers to care • Chronic/acute health conditions associated with HIV disease • Health conditions unrelated to HIV disease (by referral) • Effective patient environment, including availability of clinical staff, reasonable wait times for services, responsiveness to need for urgent care • Maximum opportunity and ability of the client to be an active participant in organizing his/her care • A customer service approach that is high quality and consistent with the cultural experiences of clients served • Use of peers as staff, volunteers, and advisory board members

Figure 38: Medical Homes Model as a Strategy for HIV Care

Requirements	Care teams that can expertly provide coordinated care and assume responsibility for ongoing coordination of a particular patients care
Outcome	High-value care, and improved health status including viral load suppression
Monitoring and Evaluation	Demonstrated integration and service provision mechanisms as evidenced by: • **Process** − Client interviews, focus groups, and other means to assess service gaps, satisfaction with services − Clinical inspection visits • **Output** − Percentage continuously in care − Percentage with support service needs met
	• **Outcome** − Client viral load − Longevity and continuity in care − Quality of life

D. Meeting the Challenges from the 2009-2011 Plan

In 2009, HAHSTA began shifting its focus to measuring health outcomes for HIV-infected clients as a method of enhancing quality improvement efforts. Simultaneously, HAHSTA expanded its assessment of quality care, Quality Improvement Site Visits, to include all HIV care services. This renewed approach in evaluating programs and quality of services was a driving force behind the decision to develop and implement MAVEN, a comprehensive HIV/AIDS monitoring and evaluation system, enabling HAHSTA to:

- Track clients across the continuum of care and across time periods,
- Complete more in-depth analysis of health outcomes,
- Evaluate cost and cost-effectiveness of programs and services,
- Improve the quality of the data,
- Adapt more quickly to future requests and/or changes in federal requirements.

HAHSTA will continue and expand use of outcome-based measures of program success, including increasing use of viral load measures, continue and enhance rapid linkage to care for newly diagnosed PLWH, and fully implement the MAVEN system.

Once implemented, Maven will enhance electronic reporting mechanisms, such as electronic laboratory reporting (to allow for clinical indicator, CD4 and VL, monitoring), and availability of core medical, support service, and housing utilization information. Access to this information will allow HAHSTA to improve and expand coordination of service among sub-grantees, and monitor the spectrum of HIV-related illnesses and trends in the local epidemic.

The next plan reflects these expectations, as well as a focus on preparing for health care reform, integrating prevention and care and developing a coordinated service model.

E. Reducing Unmet Need

HAHSTA places great priority on helping PLWH enter and remain in care. It has adopted several service models designed to prevent unmet need and to assist individuals who are out of care – including both PLWH who never became connected to care after diagnosis and those who dropped out of care. Reducing unmet need is a key component of Goal 2 in this comprehensive plan: *Improve – and consistently measure – service linkage, retention, quality, and health care outcomes.* Among the most important are the following, which are reflected in the "ideal" system of care and the objectives and work plan:

- Plans for increasing access to information about available services, so a PLWH who wants to enter or re-enter care and easily identify an appropriate service provider.
- Expanding the Red Carpet Entry model and "treatment on demand" initiatives, designed to provide rapid access to care. This includes exploring ways to ensure that medical providers ensure some access to medical care for PLWH without an appointment.
- Expanding initiatives for hiring of peer community health workers and other PLWH at all levels, based on their demonstrated capacity – in numerous chronic care environments – to help people enter and remain in care.
- Improve augmentation of standards of care, including liaison with neighboring states

Many of these efforts help reduce unmet need in two ways. They help PLWH who are out of care to re-enter and become closely linked to care, and they help prevent current clients from dropping out of care.

F. Making Individuals Aware of their Status

Helping to diagnose HIV-positive unaware individuals and linking them to care is a specific objective of HAHSTA. Together with the Ryan White Planning Council, HAHSTA will continue to developed strategies for the Early Identification of Individuals with HIV and AIDS (EIIHA). This legislative requirement, along with NHAS and the new CDC prevention strategy, make close collaboration between prevention and care a necessity. Over the next three years, HAHSTA plans a number of actions to meet EIIHA. For example, HAHSTA will accomplish the following:

- Linkages between prevention and care planning bodies.
- Development of common terminology and definitions and sharing of data between prevention and care.
- Coordination between the ECHPP program and the Ryan White Part A program – that includes communications around testing, linkage to care, prevention for positives/risk reduction efforts, and retention in care, and treatment outcomes. In addition, ECHPP principles and linkages with Part A programs will be a priority.

G. Closing Gaps in Care

The medical home providing comprehensive HIV care is a key feature of HAHSTA's ideal system of care provides an opportunity to close gaps in care by bringing providers together across funding streams and giving specific responsibility for ensuring that individual PLWH do not suffer from gaps in care.

The various initiatives designed to address unmet need, eliminate HIV-related health disparities, and improve coordination among providers will all help close gaps in care and use resources efficiently.

HAHSTA recognizes that with budget cuts at the federal level, there is the potential for some gaps in care; however, probably the greatest hope for closing gaps in care is the implementation of health care reform, so that more PLWH become insured and through third party payer source contribute to the foundation on which medical homes can be built and sustained.

H. Addressing Overlaps/Duplication in Care

Given the recession and extensive cuts in health and human services budgets at the federal level, overlaps and duplication in care have been reduced over the past several years.

There is now deliberate – and potentially valuable – overlap in the responsibility for testing, linkage to care, and retention in care between prevention programs and Ryan White programs. For example, the ECHPP program includes prevention for positives services that appear very similar to the Part A EIS. The shared responsibility can be valuable, but it will also be important to ensure that funds are used efficiently and are coordinated.

The focus on collaboration in the new plan should help to reduce undesirable service overlaps or duplication. This is most directly addressed through the following focus areas:

- Strengthen, operationalize, and monitor required linkage agreements between Part B providers and other entities.
- Explore ways to ensure that case managers have the knowledge and time to provide referrals for a variety of services.
- Provide for close coordination between ECHPP and Part A particularly with regard to areas of shared responsibility such as testing, linkage to and retention in care, and prevention for positives.

In addition, continue to technical assistance to providers in order to minimize the overlaps in service delivery.

I. Preparing for Health Care Reform

As noted previously, preparations for health care reform are greatly complicated and to some extent delayed by the uncertain outcome of the Supreme Court case. The District has already expanded its Medicaid program and is in the process of developing health insurance exchange entities.

Understanding the uncertainties, the HAHSTA has explored issues related to implementation, and will provide leadership in educating PLWH, and providers about health care reform and its implications for HIV/AIDS services, through regular briefings and training. HAHSTA will provide guidance to providers to prepare them for a variety of health care reform requirements.

This will include such actions as the following:

- Planning which includes discussion on pursuing funds for a dedicated healthcare policy full-time-equivalent that will collaborate with HAHSTA's Deputy Director of Operations and the Healthcare Finance Administration (HCFA) to increase ability for clinical providers to bill managed care organizations for services provided to PLWH.
- Exploring mechanisms to enable community-based organizations to partner with medical providers or obtain some other source of assistance in obtaining and implementing electronic medical record systems.

J. Summary of Goals and Solutions

Each goal of the comprehensive plan is designed to address key needs and challenges facing the District, prepare for changes in the health care system, and contribute to the NHAS goals. Their ultimate intent is to move the District towards its ideal system of care, and to begin measuring success through the use of some form of "treatment cascade" that focuses on outcomes including viral suppression. The goals focus on the following:

- **Health care reform:** Ensuring a seamless transition for PLWH to new funding and service systems such as Medicaid and private insurance, through preparing providers, consumers, and PLWH groups for playing informed and active roles in the process. This includes education, training, and technical assistance as well as joint planning and decision making that recognizes similarities and differences across the medical spectrum.
- **A coordinated, integrated continuum of prevention, testing, and care:** Refining the current system of care so that it encompasses prevention and testing as well, provides for a high level of communication and collaboration, and better provides comprehensive and coordinated care to PLWH. This includes exploration and hopefully adoption of one or more medical home/comprehensive care center models that are HIV-centered and practical for implementation.
- **Service linkage, retention, quality, and outcomes:** Implementing a variety of service models that maximize testing, ensure support for PLWH including those with the greatest barriers to testing and care, and help PLWH enter care promptly, remain in care, adhere to treatments, and reach viral

suppression. This includes adopting a set of outcome measures and using them to assess success in testing, linkage to care, retention in care, and clinical outcomes.

- **Effective planning and decision making:** Strengthen information sharing and collaboration between Part B providers; and continue collaborative planning between prevention and care. Doing this successfully requires maximizing consumer engagement at all levels, with increased information sharing and training for PLWH groups.

HAHSTA recognizes that the next three years are likely to be extremely challenging due to changes in the health care system, continued budget challenges, and – given the commitment to increased testing and improved access to care – an increasing demand for HIV-related services. The goals, objectives, and work plan presented in this comprehensive plan are designed to meet these challenges, explore multiple options, and provide practical solutions. Improved client- and program-level data, which will become available based on full implementation of the Maven system, are expected to facilitate greater data-based decision making and enhance HAHSTA's ability to make sound decisions during a time of change and uncertainty.

Chapter 8: Coordination Efforts

Overview

Creating the “ideal” system of care described in the previous chapter requires an intense focus on coordination and collaboration across the District. This must occur among all District providers regardless of the funding source and at many levels, including Ryan White funded and non- funded providers; across District agencies; between prevention and care as well as include private partners. This effort will be key to not only ensure PLWH clients have access to the health care services they need, but also to minimize any adverse impact of anticipated changes in the overall health care system as a results of health care reform. In addition, coordination and collaboration will facilitate a better understanding of the various program & services available to PLWH clients and forge additional strategies, funding streams and ways they can contribute to ensuring overall access to care.

Understanding of other funding streams has always been important for Ryan White programs because Ryan White is by law the payer of last resort. With health care reform and the increased use of third-party reimbursements for funding health care and other services, increased coordination with public and private insurance providers will become essential. Moreover, this coordination is not limited to billing. There is a critical need for coordinated planning as well as informal and formal collaboration in the delivery of services, and a medical home model will require codified relationships among providers as more emphasis is made on a medical home model, these relationships must demonstrate a coordinated contribution to improved client outcomes.

This chapter describes the kinds of coordination and collaboration the District has in place and proposed efforts to be implemented as part of the next three year plan to move the District in conjunctions with the surrounding jurisdictions towards an ideal system of care.

A. Coordination with Other Care Providers

Ryan White Part B coordinates with several different categories of service providers:

- **Other Part B providers –** there are numerous activities underway that facilitate testing and service coordination in addition to those mentioned in earlier chapters like the Promote, Offer, Test & Link (POT-Link) Program model implemented through the DMV. HAHSTA funded provider, Family Medical and Counseling Services through collaboration with La Clinica Del Pueblo proposes to facilitate and/or coordinate testing and linkage to care efforts at three Income Maintenance Centers in the District. In the proposed program, FMCS will conduct a fully integrated HIV testing program at the 2100 Martin Luther King Jr. Avenue using the POT-Link model and conduct extensive HIV testing promotion and linkage to services at Fort Davis.

- **Providers funded under other Ryan White "parts,"** including Parts A, C, and D, and Part F – Dental programs. For example, HAHSTA will partner with the Infectious Disease Center of Care, United Medical Center (UMC) to establish neighborhood pharmacy testing programs to reach previously untested or hard to reach groups. Negotiations have begun with CVS Pharmacies to take advantage of the chain's locations that include Minute Clinics where primary medical care is delivered onsite. The partnership also proposes to negotiate with Walmart to include this service in its business plan and structural development of four new stores in the District of Columbia.
- **Providers that have no Ryan White funding.** This includes providers that receive other federal funds, such as substance abuse and mental health providers and community health centers and other federally qualified health centers, which often provide medical-related services needed by PLWH. Also included are free clinics and other safety net clinics. In addition, there are smaller, often community-based, providers that offer needed services**,** often support services, and those receiving funds through district appropriations or be privately funded, such as food pantries.

As coordination efforts are strengthened, health care resources like the providers types above become an integral part of the coordination strategy.

All Providers: Providers throughout the District are required to collaborate with each other, and to establish written agreements with points of entry to care and other funded and non-funded providers. The typical focus is cross-referrals, but sometimes providers closely coordinate care for particular populations or individuals. Medical providers and medical case managers work closely with ADAP staff, and case managers may refer clients to all Ryan White "parts" Part A, B, C, and D providers, and to Part F dental programs, based on needs. Part B funding is typically coordinated with Part A funding and other type funding to fill gaps and avoid duplication of effort. Many Part B providers also receive funding from other Ryan White parts and other public and private sources, so the provider decides which "part" will pay for services to a particular client.

Part B providers differ considerably in the extent to which they (generally their case managers) refer clients to other providers, especially those without Ryan White funding. Among the determining factors are client needs, service gaps the provider itself cannot fill, the availability of other providers, and case manager knowledge of and contacts with such providers. Most clients receive only medical case management – and both PLWH and providers reported considerable variation in their knowledge of and focus on making referrals for support services such as housing. Since non-Ryan White providers do not necessarily have funds set aside to serve PLWH, access to their services often depends on relationships and agreements.

Part A Providers: With regard to Part A providers, HAHSTA manages Part A funding through sub-grant agreements. This role is often carried out through training and technical assistance, health care forums and quality management and oversight.

In addition, some providers already work together very closely. This is somewhat common among providers in the District, since providers are likely to make frequent referrals to other healthcare networks. Moreover, there is an opportunity for active participation by providers in prevention and care planning bodies. HAHSTA as well as Administrative Agents provide meetings and training for funded providers in each jurisdiction. Through the Case Managers Operating Committee, a quasi-regional body, case managers participate in quarterly training that is mandatory for District sub-grantees receiving case management funding and is voluntary for case management providers in other jurisdictions. In addition, CMOC also holds monthly meetings that allow for voluntary participation.

Cross-Part Collaboration: This program, described in greater detail on the following pages, is a comprehensive multijurisdictional collaborations effort. HAHSTA and Ryan White Part B programs are an important component of the collaborative. The Northern Virginia Regional Commission administers both Part A funding in the Virginia segment of the EMA and Part B funding for Northern and Northwestern Virginia. As Figure 39 shows, there are ten Part C providers in the EMA, two Part D programs, two Part F dental providers (although the Washington Hospital Center reimbursement grant is very small), and one Part F Special Projects of National Significance (SPNS) grant. The SPNS grantee has evaluated and provided technical assistance to eight demonstration projects designed to get young MSM of color into care, but none of the pilot projects was in the EMA.

Figure 39: Ryan White Part C, D, and F Providers and Support Entities in the EMA

Part C	Part D	Part F – Dental	Part F - AETC	Part F - SPNS
District of Columbia				
Carl Vogel Center	Children's National Medical Center	Howard University College of Dentistry [Dental Reimbursement Program[	Pennsylvania/ Mid-Atlantic AETC – Howard University Local Performance Site	George Washington University Medical Center YES Center (Evaluation Center)
Family Medical and Counseling Service		Washington Hospital Center Department of Oral and Maxillofacial Surgery [Small Dental Reimbursement Program]		
Howard University Hospital Comprehensive Clinic				
Unity Health Care				
Whitman Walker Health				
Suburban Maryland				
Greater Baden Medical Services			Pennsylvania/ Mid-Atlantic AETC - Johns Hopkins University and University of Maryland/Baltimore Local Performance Sites	
MedStar Research Institute				
Northern Virginia				
Inova Health System	Inova Health System		Pennsylvania/ Mid-Atlantic AETC – Inova/ Northern Virginia Local Performance Site	
Mary Washington Hospital/Medicorp Health System				

Figure 39: Ryan White Part C, D, and F Providers and Support Entities in the EMA				
Part C	**Part D**	**Part F – Dental**	**Part F - AETC**	**Part F - SPNS**
West Virginia – Eastern Panhandle				
West Virginia University			Pennsylvania/ Mid-Atlantic AETC - West Virginia University Local Performance Site	

There is at least one AETC local performance site in each of the surrounding jurisdictions. All the Part C and D programs except the MedStar Research Institute Part C program are also Part A funded (Shenandoah Valley Community Health Center, the West Virginia Part A provider, is a part of the West Virginia University Part C Project). Referrals between Part A and Part D are well established; the Part D provider in Washington, DC also provides Part A services in the District of Columbia, Maryland, and Virginia. Howard University provides oral health services under both Part A and Part F.

DC Quality Management Cross-Part Collaborative: The most intensive cross-part collaboration in the region is occurring through DC Quality Management Cross-Part Collaborative. HRSA/HAB sponsored the development of this 18-month initiative, and it was facilitated by the National Quality Center (NQC). Its purpose is to strengthen the regional capacity for collaboration across Ryan White Parts (A, B, C, D and F), for alignment of quality management goals to jointly meet legislative mandates, and for joint quality improvement activities to advance the quality of care for people living with HIV across constituencies within a region and to coordinate HIV services seamlessly across Parts.

As part of the Cross-Part Collaborative, HAHSTA participates on a Response Team that includes, sub-grantees, and client representative from across the region assembled to coordinate and guide Collaborative activities. HAHSTA serves as the Data Lead for this initiative and is responsible for analyzing the data from the participating sites (which include both medical and case management providers), reporting aggregate data to the Response Team, Collaborative faculty (HAB and NQC staff), and consumers, as well as communicating with individual providers regarding their performance and quality improvement project progress.

Participating sites have been submitting data every two months since May 2011, using 15 HAB Performance Measures. The Collaborative Response Team uses performance measurement data to identify and prioritize quality improvement projects, routinely monitor the quality of care provided to clients, and evaluate the impact of changes made to improve the quality and systems of HIV care.

The Collaborative is helping to strengthen quality improvement activities across the region. Through this effort, providers are supported with a myriad of opportunities to enhance their ability to report data and the overall quality of the services provided in the form of quarterly in-person meetings, quality improvement training, and technical assistance calls/webinars. An important benefit of the Collaborative is the interaction among providers across jurisdictions and Parts, which has contributed to information sharing and collaboration on other issues. There is strong interest in continuing the Collaborative beyond the two years of support HRSA/HAB will provide; it is not yet clear how that can be accomplished, but exploring possibilities will be a part of the new comprehensive plan.

AETCs: HAHSTA works closely with the Howard University's AETC, supporting provider trainings. AETCs have consistently offered their assistance for needed training and have been key to educating providers on the effective delivery of HIV treatment and care. AETC representatives provide valuable input to discussions around standards of care and clinical issues.

Non-Ryan White Providers: Coordination with providers who can serve the needs of PLWH for services that are not available through their primary care provider is important to quality clinical outcomes for PLWH. Sometimes Ryan White funds to support these efforts are insufficient, sometimes other funding streams have traditionally been tapped to provide services. In addition, there is a continuing need to coordinate HIV-related medical care with non-HIV-related primary and specialty care, which is not paid for by Ryan White. Such care is often provided by CHCs/FQHCs – many of which are not Ryan White providers but do receive other federal funding – or by other safety net clinics including free clinics and other population- or service-focused clinics, which may or may not have federal funding and vary in their resources and capacity. As we move toward greater coordination and collaborations across the District and surrounding jurisdictions, a few services and issues of particular importance are summarized below.

Substance Abuse and Mental Health Services: Of particular importance for coordination and collaboration are outpatient substance abuse treatment and mental health services. These are services frequently needed by HIV clients. In the District, both federal and local funds support substance abuse treatment through the Addiction Prevention and Recovery Administration (APRA) which certifies substance abuse treatment centers and funds about 30 treatment programs that include outpatient treatment, as well as some detoxification and residential care. The District of Columbia Department of Mental Health administers most of its mental health services primarily through contracts with community-based providers that employ mental health clinicians. A continuing challenge is how to arrange appropriate services for PLWH in light of funding challenges and providers/clinicians may have limited experience with this population. Coordination and collaboration includes encouraging training of such clinicians, by the AETCs or other sources, to provide services to individuals who are multiply diagnosed.

Assisted Care: As the PLWH population ages, assisted care is expected to increase. The District is the only jurisdiction that funds Home and Community-based Health Services, and only for non-medical day programs; there is no HIV related funding for home health aide services. Some Part A services can be provided in housing facilities, but most assisted care is neither HIV-specific nor Ryan White funded. Collaboration with other providers and payers is required in order to arrange such services. Sources may include assisted housing programs, Medicaid and Medicare, Area Agencies on Aging, Veterans' Affairs, Social Services block grant recipients, and various social service organizations with public and private funding, including United Way support. HOPWA provides some support services for its clients. The federal Shelter Plus Care program includes a small set-aside for people with HIV disease; it provides rental assistance for hard-to-serve homeless persons with disabilities and includes supportive services that are funded through sources outside the program. PLWH on disability who are Medicare recipients may receive home-based services. Medicaid provides some Home and Community-based Services under waiver programs and may provide Home Health Services, but resources are generally limited and sometimes services are not available; home-based services may be available only to people receiving disability income or other federal income assistance. Hospice care is an optional Medicaid benefit covered in most states; however it is often difficult for small community-based organizations providing assisted housing, or home-based care to qualify for Medicaid or Medicare certification. Finding ways to establish ongoing organizational relationships and improve referrals that meet the needs of PLWH is expected to be a growing priority and a continuing challenge going forward.

Coordination with Other Testing Facilities: In addition to HIV testing sites, Ryan White programs need to coordinate with sources of other kind of testing, particularly STI clinics, to ensure that PLWH have access to needed testing. The need to integrate HIV, other STDs, hepatitis and TB screening is essential. Specifically in the District as shown in Figure 40, persons living with HIV are often infected with other communicable diseases. Of the 840 cases of HIV diagnosed in 2010, 16% were identified as having a co-infection. Seven percent were co-infected with chronic hepatitis C, followed by chronic hepatitis B at 4%. Over 2% of new HIV diagnosis had a chlamydia or gonorrhea diagnosis in 2010 and 1.1% were infected with syphilis. There were slight differences among PLWHA who were co-infected. They are more likely to be Black (85.7%), MSM (39.1%) and over the age of 40 (50.4%). Figure 38 is characteristics of co-infected and mono-infected HIV cases in the District of Columbia.

Figure 40: Characteristics of Co-infected and Mono-infected HIV Cases, DC 2010

	Co-infected		**Mono-infected**	
	N	**%**	**N**	**%**
Gender/Sex				
Male	98	73.7	504	71.3
Female	35	26.3	203	28.7
Missing	0	0.0	0	0.0
Total	133	100.0	707	100.0
Race/Ethnicity				
White	14	10.5	97	13.7
Black	114	85.7	536	75.8
Hispanic	5	3.8	52	7.4
Other	0	0.0	22	3.1
Total	133	100.0	707	100.0
Mode of Transmission				
MSM	52	39.1	255	36.1
MSM/IDU	1	0.8	37	5.2

	Co-infected		Mono-infected	
	N	**%**	**N**	**%**
IDU	5	3.8	13	1.8
Heterosexual	31	23.3	152	21.5
RNI/Unknown	44	33.1	244	34.5
Other	0	0.0	6	0.8
Total	133	100.0	707	100.0
Age at Diagnosis				
13-19	6	4.5	20	2.8
20-29	35	26.3	212	30.0
30-39	25	18.8	173	24.5
40-49	27	20.3	171	24.2
50-59	36	27.1	91	12.9
≥ 60	4	3.0	40	5.7
Total	**133**	**100.0**	**707**	**100.0**

The coordination of testing for co-infections in the District and surrounding jurisdictions will require rigorous coordination with other testing sites as well as hospitals and other clinical providers; the District in conjunction with the surrounding jurisdictions is committed to having systems in place to ensure that appropriate testing is regularly available to clients.

Key Role of Case Managers: The primary point of contact between Ryan White “parts” and other providers at the operational level is generally the case manager. Medical case managers face considerable demands on their time, given the breadth of their medical-related responsibilities – not only developing individualized patient plans and providing referrals for needed services, but also coordinating with clinicians and providing treatment adherence counseling. Some medical case managers have extensive community knowledge and contacts; others tend to focus more narrowly on meeting clients’ medical-related needs.

Providers often have formal linkage agreements with other providers, generally involving cross-referrals – they may call for these entities to refer PLWH to provide services to clients. Sometimes these agreements are a basis for active cooperation; sometimes they exist only on paper. They are most meaningful where case managers have personal contacts and working relationships with provider staff. Typically case managers have informal relationships with a variety of providers. For example, many case managers are aware and work regularly with substance abuse treatment programs that serve PLWH, mental health providers with an understanding of HIV/AIDS issues, and clinics that provide non-HIV-related medical care and reproductive health services. Many are aware of HOPWA services; fewer know about other housing assistance options. Most have some awareness of local food banks; some know their eligibility and use criteria and when food is available. A smaller number of medical case managers are familiar with community-based organizations that provide psychosocial services like support groups or other assistance.

Where medical case managers lack the time, knowledge, and/or contacts to make referrals for all needed wraparound services, including non-medical services, PLWH may find it very difficult to access them – and this may negatively affect their ability to remain in care and adhere to treatments.

HAHSTA recognized this challenge and in 2010 developed comprehensive HIV Medical Case Management guidelines. These guidelines are part of an ongoing effort to provide regular medical case management technical assistance trainings. In addition, a priority under the new comprehensive plan is finding additional ways to expand this effort.

B. Coordination with Prevention and Testing, including ECHPP

Importance: A combination of factors makes coordination between prevention and testing and care and treatment a very high priority for the District and the surrounding jurisdictions. At the national level, they include the new responsibility for Early Identification of Individuals with HIV/AIDS assigned to Ryan White programs in the 2009 Ryan White legislation, the National HIV/AIDS Strategy, the new CDC prevention strategy, and Enhanced Comprehensive HIV Prevention Planning, implemented in the District. All these factors have made testing a responsibility of Ryan White as well as Prevention programs, and linkage to care, risk reduction for positives, and retention in care a responsibility of Prevention programs as well as Ryan White. At the regional level, the severity of the epidemic has created an ongoing focus on HIV testing and entry into care. The District of Columbia, with the highest incidence and prevalence rates, is the leader in testing, with a combined focus on routine and other types of testing including community testing in non-traditional settings; DC allocates consider local funding to this effort, and has established public-private partnerships as well. The Female Condom Project was managed by the Washington AIDS Partnership, a philanthropic collaborative, and has a large grant from the MAC AIDS Fund. If the epidemic is to be controlled and new transmissions are to be minimized, close coordination between prevention and care is essential. This includes coordination in planning and program implementation and assessment.

Priorities for Coordination and Collaboration, Including ECHPP: Initial priorities for the District and surrounding jurisdictions for coordination include the areas with shared responsibility, such as testing, linkage to care for newly diagnosed PLWH, and prevention for positives, particularly (as with ECHPP) where that encompasses not only risk reduction but also treatment adherence and retention in care strategies. This means coordination among personnel – for example, Partner Notification and Early Intervention Services personnel, Part A providers engaged in risk reduction and in retention in care and Prevention-funded personnel of prevention for positives initiatives. It is not yet clear to what extent actual overlapping services – funded by both prevention and care – are projected in the future, versus shared planning and an agreement on which body will fund which services – greater coordination must take place to minimize duplication of efforts. If funding coordination involving shared support of particular services is determined desirable, this will require agreement and action by the Planning Council, since it allocates Part A funds. This effort will require collaboration in both planning and program implementation to address these issues.

Coordination with ECHPP is a key requirement for the District. Some of the models proposed for ECHPP are still in development, and there are opportunities for joint development and implementation of linkage/retention models, such as peer-based models that have generated considerable interest and are gaining support. It appears that prevention for positives programs being planned under ECHPP may be similar in scope to the peer EIS model that will be tested by Part A starting in June 2012. Another priority that affects planning and services is agreement on some common language and development of shared definitions for terms that prevention and care have traditionally defined differently, such as what constitutes entry into care or retention in care. This is a necessary part of coordination with ECHPP, to ensure some common outcome measures for ECHPP and Part A.

Discussions are under way in the District of Columbia about how best to link prevention and care planning and provide for ongoing coordination between ECHPP and the District of Columbia component of the Part A program through linking the Planning Council and the CPG. HAHSTA is facilitating exploration of models used by other Part A programs to merge prevention and care planning. However, no other EMA covers part of four states.

C. Coordination with Other Payers, including Public and Private Insurance

Coordination with other payers is always a priority for HAHSTA. With health care reform, it has become a key consideration.

Coordination with other payers involves HAHSTA policies and monitoring as well as provider capacity and action. Providers are encouraged to maintain an emphasis on Medicaid certification where possible to ensure PLWH has access to comprehensive HIV care. HAHSTA emphasizes strategic deployment of CARE Act funds for utilization as payor of last resort.

HAHSTA encourages the use of other payers to the maximum possible extent to support the whole program. This effort will continue to require increased planning, providing capacity-building assistance, and policy guidance, particularly in the next three years, as the health care funding model changes. Critical payers throughout the District will require specific attention over the next three years include the following:

- **Medicare:** Medicare eligibility is increasingly important for providers serving PLWH with disability, as a growing number are eligible for Medicare. In addition, as the PLWH population ages, a growing number are becoming eligible for Medicare. As well, the fastest growing numbers of PLWH 65 and over are in the District.
- **Medicaid:** In addition to a continued emphasis on maintaining Medicaid certification, providers are encouraged to enter into contracts with Medicaid managed care organizations. In the District, the majority of PLWH on Medicaid are served through Medicaid fee-for-service, but some are being assigned to MCOs. It appears that MCOs may be the presumptive primary or sole mechanism for Medicaid coverage under the health care reform expansion. Providers may need assistance in understanding their potential roles in MCOs and in seeking contracts with one or more MCOs in their jurisdiction.

- **State Children's Health Insurance Programs (SCHIP)**, which, like Medicaid, vary by jurisdiction in their coverage. SCHIP is a source of funding for services to children and adolescents and pregnant women with HIV disease who are not eligible for regular Medicaid. In some states, SCHIP also covers the parents of eligible children. In the District, the SCHIP program is administered as an expansion of Medicaid, so providers who are Medicaid-certified can obtain reimbursement for covered services to such individuals. The District's program covers children under 19 with family incomes below 300% of the federal poverty line. In the District pregnant women up to 300% of poverty are covered. The District's program also covers parents of eligible children with incomes below 300% of poverty. Moreover, the District expects its providers to be familiar with SCHIP programs and eligibility, ensure that eligible clients are enrolled, and appropriately bill the programs. This will continue to be a priority for providers serving women, children, and adolescents with HIV disease. The role of SCHIP is expected to change under health care reform, and the HAHST will provide guidance to ensure that providers are informed of such changes and their implications.
- **The DC Alliance,** which pays for HIV-related medical care, medications, other medical care, and some other Ryan White-eligible services for District residents with incomes below 200% of the federal poverty line. When the District implemented expanded Medicaid (up to 200% of poverty) in 2011, many DC Alliance clients were transitioned to Medicaid. The Alliance continues to be a safety-net for those who do not qualify for Medicaid.
- **Private insurance.** Some Ryan White medical, mental health, and substance abuse providers, including CHCs/FQHCs, accepts private insurance. Also, some Ryan White clients have private insurance, and sometimes Ryan White pays their premiums or copayments. Many providers do not accept private insurance. If health insurance exchanges are established as planned under health care reform, more providers will need to develop agreements with insurance providers in the exchanges and establish necessary billing and record-keeping capacity. HAHSTA will work with providers and their staffs to facilitate guidance related to capacity-building assistance in this effort.

Section 3: How Will We Get There?

Chapter 9: Proposed Strategy, Plan, Activities, and Timeline

Overview

This chapter presents the 2012-2014 work plan for the District's Part B Comprehensive Plan & SCSN, including major goals, objectives, and strategies/tasks/activities, responsibility, and timeline for completion. It also identifies expected outcomes of these efforts for the system of care and for PLWH in the District.

The work plan includes specific tasks/activities required to work toward an ideal system of HIV/AIDS services, address identified needs, and meet comprehensive plan requirements. The chapter provides additional explanation regarding how the plan addresses requirements such as coordinating efforts, Healthy People 2020 Objectives, NHAS goals, and implementation of health care reform. Since the District's system of care is closely linked within the EMA, this plan also incorporated the jurisdictional relationships and also relates the plan to the statewide coordinated statement of need and discusses how the implications of any additional or unexpected federal budget cuts in the system of care may impact services.

A. Chart of Goals, Strategies, Plan, Activities, and Timeline

Figure 41, attached, is the District's work plan. It includes 5 major goals, 13 related objectives, and a set of specific strategies and tasks/activities required to reach these objectives and goals. In addition, it specifies what entity has primary responsibility for each strategy/task/activity, the timeline for completion, and expected outcomes. These outcomes reflect the District's commitment to assessing progress and success based not simply on completion of activities, but also on system changes and client outcomes.

HAHSTA has developed a comprehensive and challenging work plan to address expected changes in the epidemic, systems of care, and the broader health care delivery system in the city and the region. Some of these changes, particularly those related to health care reform, remain less than fully defined. Appropriate HAHSTA Bureaus in conjunction other health care partners will explore the feasibility of proposed strategies and tasks and make every effort to effectively implement each goal and objective.

B. Work Plan for Comprehensive Plan, Chapter 9

Figure 40: Work Plan for Comprehensive Plan

Goals, Objectives, and Strategies/Tasks	Lead Responsibility	Deliverable	Timeline	Expected Outcome
Goal 1: Establish and maintain a coordinated, integrated continuum of prevention, testing, and care that provides for coordination of services for individual PLWH and results in viral suppression.				
Objective 1.1 – Establish and maintain ongoing collaboration among prevention, testing, and care. **Strategies/Tasks/Activities:**				• Prevention and care planning bodies and providers that are aware of each other's work, consult on decisions in areas of shared responsibility, and work together to maximize testing and linkage to care • Improvements in treatment cascade measures by end of 2014, including increased testing, reduced late
a. Work with prevention & planning bodies throughout the District to establish ongoing information sharing and collaborate on planning decisions.	Care Housing and Support Services Bureau Prevention	Regular quarterly meetings	Ongoing beginning fall 2012	
b. Establish mechanisms between testing and care that contribute to increased and better targeted HIV testing in both clinical and non-clinical settings; this includes coordination with ECHPP and other CDC and jurisdiction-supported testing efforts.	Care Housing and Support Services Bureau Prevention	Written agreement/MOU	2012	

Figure 40: Work Plan for Comprehensive Plan

Goals, Objectives, and Strategies/Tasks	Lead Responsibility	Deliverable	Timeline	Expected Outcome
c. Prevention and care officials in the District will agree on shared operational definitions and measures that will allow for documentation and evaluation of testing and care outcomes; included are terms such as referral to care, linkage to care, treatment adherence, and retention in care.	Care Housing and Support Services Bureau Prevention	Set of agreed-upon definitions, disseminated to prevention and care providers throughout the EMA	2013	testing, increased entry into care within 90 days and one year, and improved outcomes such as viral suppression
Objective 1.2 – Establish and implement an operating model in the District that provides for coordination of care for individual PLWH, through the use of medical homes, comprehensive care centers (“one-stop shops”), and/or other mechanisms. **Strategies/Tasks/Activities:**				• Implementation of system of care improvements that provide coordinated care using a medical home or related model. • Collection of baseline and initial implementation data measuring impact of new models and system changes on PLWH entry into care, retention in care, and clinical outcomes such as viral suppression
a. The District of Columbia will establish medical homes or similar models appropriate to the District that provide for the coordination of medical care and the availability and coordination of medical-related and support services for all Ryan White consumers.	Care Housing and Support Services Bureau	Roundtable and work sessions; documented model or models for testing	Development - 2012-2013 Pilot implementation – 2014	
b. The District of Columbia will explore & promote strategies for establishing “Medical homes” and encourage providers that target specific populations to participate.	Care Housing and Support Services Bureau	Roundtable and work sessions; agreement on specific actions		

Figure 40: Work Plan for Comprehensive Plan

Goals, Objectives, and Strategies/Tasks	Lead Responsibility	Deliverable	Timeline	Expected Outcome
c. The District of Columbia will explore and adopt case management refinements, renewed use of non-medical case management, and/or other procedures that enable PLWH to obtain the wraparound services (both core medical-related and support) they need to remain in medical care and adhere to treatment, whether these services are provided through Ryan White or other funding streams.	Care Housing and Support Services Bureau	Appropriate action based on recommendations		
d. The District will explore the use of peers as members of interdisciplinary clinical teams as a means of ensuring care coordination and consumer access to needed services.	Care Housing and Support Services Bureau	Appropriate action based on recommendations	2013	

Figure 40: Work Plan for Comprehensive Plan

Goals, Objectives, and Strategies/Tasks	Lead Responsibility	Deliverable	Timeline	Expected Outcome
Objective 1.3 – Improve the use of client data and health information technology as a means of coordinating and improving care. **Strategies/Tasks/Activities:**				• Client-level data will be generated by providers and used to evaluate services provided and treatment outcomes • Data will be appropriately shared among Ryan White funded providers, with all HIPAA requirements met • Appropriate non-Ryan White providers will share data to ensure coordination of care and prevent duplication of medical tests, with all HIPAA requirements met
a. The District will ensure the full implementation of the Maven client-level data system throughout the District.	Strategic Information Bureau	Data reports from all specified providers throughout the District & surrounding jurisdiction	2013	
b. The District will support the adoption and full implementation of electronic medical records (EMR) by service providers, and support to ensure “meaningful use”[58] of health information technology by HIV/AIDS service providers; included will be sharing of medical records among providers and with hospitals, with appropriate confidentiality protections.	Care Housing and Support Services Bureau	Protocols and models	2013-2014	

Figure 40: Work Plan for Comprehensive Plan

Goals, Objectives, and Strategies/Tasks	Lead Responsibility	Deliverable	Timeline	Expected Outcome
c. The District will support and encourage maximum use of shared data systems within the network and between Ryan White providers and hospitals, community health centers, and other safety-net providers.	Strategic Information Bureau	Guidance to providers; meetings and technical assistance	2013-2014	
Goal 2: Improve – and consistently measure – service linkage, retention, quality, and healthcare outcomes.				
Objective 2.1 – Improve linkage to care rates among funded providers. **Strategies/Tasks/Activities:**				• Linkage Rates • New objectives for linkages
a. The District will collect linkage rates among providers to set a baseline for the number of clients linked from diagnosis to treatment.	Care Housing and Support Services Bureau Strategic Information Bureau	Each provider submits report on current linkages.	August 2012	
b. The District will use the baseline identified in Strategy 2.1 and to establish measurable objectives for improvement.	Care Housing and Support Services Bureau	Develop new objectives	August 2012	
Objective 2.2 – Initiate recapture activities among providers. **Strategies/Tasks/Activities:**				• List of clients for

Figure 40: Work Plan for Comprehensive Plan

Goals, Objectives, and Strategies/Tasks	Lead Responsibility	Deliverable	Timeline	Expected Outcome
a. The District will review client data to determine who is out of care. Collect active client list from sub-grantees and match with HARS database.	Strategic Information Bureau	List of clients who are in care at another site. List of clients who know their status but are out of care.	2012	recapture • Recapture clients into care • Improved data on linkages
b. The District will conduct recapture activities.	CHSS/SIB/Sub-grantees	List of clients recaptured.	September 2012	
c. The District will report outcomes.	CHSS/Strategic Information Bureau	Presentation to key stakeholders.	December 2012	
Objective 2.3 – Improve retention rates among funded providers. **Strategies/Tasks/Activities:**				• Retention rates • New objectives for retention
a. HAHSTA will collect current retention rates to set baseline.	CHSS/ Sub-grantees	Each provider submits report on current retention.	December 2012-March 2013	
b. Use baseline to establish measurable objective for improvement.	CHSS	Develop new objectives	December 2012-March 2013	
Goal 3: - Enhance planning and decision making based on improved data systems and quality and enhanced collaboration.				

Figure 40: Work Plan for Comprehensive Plan

Goals, Objectives, and Strategies/Tasks	Lead Responsibility	Deliverable	Timeline	Expected Outcome
Objective 3.1 – Strengthen working relationships among all funded Titles in the region. **Strategies/Tasks/Activities:**				• Positive and mutually beneficial relationship between bureaus and providers representing various Titles, • Positive and mutually beneficial relationship between Grantee and Planning Council
a. HAHSTA will convene semi-annual meetings of all Titles to promote and strengthen working relationships among all Titles.	Care Housing and Support Services Bureau	Annual or Biannual Meeting	Annually 2013, 2015	
b. The District will reinvigorate local planning bodies to enhance planning and decision making processes and strengthen working relationships amongst all Titles.	Care Housing and Support Services Bureau	Meeting between HAHSTA and planning body leadership; Written recommendations	2012-2013	
Objective 3.2 – Implement collaborative planning and information sharing with prevention planning groups in the region. **Strategies/Tasks/Activities:**				• Collaboration across the region on at least some specified aspects of prevention and care • Improved coordination of prevention and care services within the District, with emphasis on testing and linkage to care
a. The District will explore the feasibility of developing some form of shared prevention plan or agreement on collaborative prevention/testing efforts in the region, to facilitate coordination of shared responsibilities and seamless referral of newly diagnosed PLWH into care.	Care Housing and Support Services Bureau	Meeting of prevention personnel recommendations based on meeting(s)	2012	
Goal 4: Initiate New Quality Improvement Activities Among Ryan White Sub-Grantees.				

Figure 40: Work Plan for Comprehensive Plan

Goals, Objectives, and Strategies/Tasks	Lead Responsibility	Deliverable	Timeline	Expected Outcome
Objective 4.1 – Implement Sub-grantee Quality Improvement Plans **Strategies/Tasks/Activities:**				
a. The District will distribute a quality improvement plan instructions and a template to sub-grantees.	Care Housing and Support Services Bureau	Distribution to Sub-grantees	May 2012	• Development of Sub-grantee quality improvement plan • Submission of Sub-grantee quality improvement plan • Approval of quality improvement plan
b. The District will provide technical assistance in developing quality statements, goals and objectives.	Care Housing and Support Services Bureau	Technical assistance and program monitoring provided to Sub-grantees	May-June 2012	
c. The District will develop an approval process for the quality improvement plan.	Care Housing and Support Services Bureau	Approved plan submitted by Sub-grantees, revisions to plan resubmitted as required	June-July 2012	

Figure 40: Work Plan for Comprehensive Plan

Goals, Objectives, and Strategies/Tasks	Lead Responsibility	Deliverable	Timeline	Expected Outcome
Objective 4.2 – Improve Quality Infrastructure among Sub-grantees. **Strategies/Tasks/Activities:**				
a. The District will support Sub-grantees in identifying internal resources for quality improvement.	Care Housing and Support Services Bureau	Technical Assistance and Program Monitoring	October 2012	• Establishment of internal quality team by the sub-grantees • Delineation of resources and plan to engage external resources
b. The District will support Sub-grantees in identifying external resources for quality improvement.	Care Housing and Support Services Bureau	Technical Assistance and Program Monitoring	October 2012	

Figure 40: Work Plan for Comprehensive Plan

Objective 4.3 – Identify the Critical Aspects of Care Provided by Sub-grantees. **Strategies/Tasks/Activities:**				• Prioritization of 5-7 indicators identified in the Sub-grantee quality improvement plan • Summarized submission of detailed outcomes desired as a result of implementation of quality improvement plan.
a. The District will assist Sub-grantees in selecting 5-7 quality indicators to prioritize.	Care Housing and Support Services Bureau	Technical Assistance and Program Monitoring	May-June 2012	
b. The District will provide technical assistance in identifying outcomes.	Care Housing and Support Services Bureau	Technical Assistance and Program Monitoring	May-June 2012	
Goal 5: System Navigation and Linkage to Care				
Objective 5.1 Train Medical Case Managers in Methods to Assist Newly Diagnosed Older Adults in Obtaining Necessary Services. **Strategies/Tasks/Activities:**				• Medical case managers with a greater understanding of the needs of older adults. • Wide distribution of resource guide among the aging population.
a. Quarterly training of medical case managers on older adults.	HAHSTA in collaboration with the District's Case Management Operating Committee	Quarterly Trainings	FY13-15	
b. Work with Office on Aging (AOA) to distribute resource guide.	HAHSTA in collaboration with AOA	Distribution of resource guide	FY13-15	

Objective 5.2 Provide Age Appropriate Care to Older Adults **Strategies/Tasks/Activities:**				- Two additional providers with special emphasis on older adults. - Network of providers who are well trained in administering HIV care to older adults.
a. Create funding opportunities for HIV care providers targeting older adults.	HAHSTA Part A and B	Scope of Work for services for older adults	FY13	
b. Create training opportunities for HIV care providers targeting older adults.	HAHSTA/AETC	Guidance to providers targeting older adults	FY14	

Section 4: How will we monitor our progress?

Chapter 10: Plans for Monitoring and Evaluating Progress

Overview

This chapter describes HAHSTA's plan for monitoring and evaluating progress towards the goals and objectives of the 2012-2014 comprehensive plan. The comprehensive plan will be integrated into the work plans and calendars of each HAHSTA bureau and will provide for regular reporting of progress as part of each bureau's reporting.

Progress reports will be made quarterly, outcome measures presented biannually, and overall progress assessed annually. Community & provider input and response sessions are already a part of HAHSTA's ongoing work, and will provide for feedback on ways to improve program services.

A. Monitoring and Evaluation Plan and Timeline

Monitoring and evaluation will be led by the Care Housing & Support Services Bureau (CHSS), but will be a shared responsibility across the HAHSTA, as shown in Figure 41 below. The development of appropriate reporting forms and protocols for monitoring will be established.

Figure 41: Monitoring and Evaluation and Timeline

	Monitoring & Evaluation Task	**Description**	**Responsibility**	**Timeline**
1	Agreement on responsibilities for implementation of the comprehensive plan	Review of work plan and finalizing of assignments of each objective and strategy to the appropriate bureau	Each HAHSTA Bureau, led by CHSS	July 2012
2	Development of an evaluation measures master chart for each objective and strategy	Development of a chart that shows each goal, objective and strategy/tasks/activities, and identifies specific monitoring and evaluation measures (based on the expected results already in the work plan) to guide the monitoring and evaluation process	CHSS	August 2012
3	Establishment of reporting requirements for each strategy/task	Develop and approve the process and format for quarterly reports on work plan progress.	CHSS	August 2012

Figure 41: Monitoring and Evaluation and Timeline

	Monitoring & Evaluation Task	**Description**	**Responsibility**	**Timeline**
4	Integration of plan responsibilities and reporting into work plans	Comprehensive Plan tasks and planned outcomes added to CHSS Bureau's work plan	CHSS and HAHSTA's Senior Management	September 2012
5	Quarterly review of progress	Review of reports of progress and challenges and report to HAHSTA's Director of Programs	CHSS/Director of Programs	Quarterly (covering each 3-month period) November 2012 February 2013 May 2013 August 2013 November 2013 February 2014 May 2014 August 2014 November 2014 February 20015
6	Biennial outcomes data review	Data on outcomes measures provided by Deputy Director of Program, plus use of by Cross-Part Collaborative data if feasible; data review	CHSS Bureau & HAHSTA's Director of Programs	January 2013 July 2013 January 2014 July 2014 January 2015
7	Annual summary of progress	Data from Deputy Director of Program & Quality Team aggregated, analyzed, reviewed and presented to CHSS	CHSS Bureau	February 2014 February 2015
8	Analysis of outcomes	Outcomes data analyzed along with program reviews to assess	Quality Teams with SIB	March 2013

Figure 41: Monitoring and Evaluation and Timeline				
	Monitoring & Evaluation Task	**Description**	**Responsibility**	**Timeline**
		success of programs		March 2014 March 2015
9	Community (PLWH and provider) feedback sessions	Conduct presentations to the community on accomplishments and outcomes and input sessions held to obtain community perspectives on both program changes and outcomes – to include providers and consumers	CHSS in conjunction with the Planning Council	April 2013 and 2014
10	Assessment of community response	Inclusion of questions on comprehensive-plan-based program changes to be included in program reviews, PLWH surveys, focus groups and key informant sessions	CHSS in collaboration with the Ryan White Planning Council	May 2013 and May 2014
11	Adjustments in work plan	Review of progress and outcomes used to identify needed changes in the work plan objectives and strategies and obtain HAHSTA's approval for any needed changes	CHSS recommendations	March 2013 March 2014 (New Plan 2015)

B. Tracking Changes/Progress

In the past, progress towards comprehensive plan goals and objectives has been measured primarily through documenting the completion of tasks and activities. While this continues to be necessary, HAHSTA is committed to measuring the ultimate success of efforts to improve program services by determining the extent to which these changes are affecting clinical outcomes for clients. The intent is to identify a set of outcome measures that reflect a form of treatment cascade, use data gathered for the comprehensive plan as baseline measures, and them assess changes regularly – with some data available quarterly and other data annually – using these measures.

Many of the measures used for the Gardner Treatment Cascade will be used. However, since the intent is to assess service system outcomes following changes in the system of care, measures will be supplemented and used differently. For example, current treatment cascade data are presented for a 5-6 year period. Annual treatment cascade data are needed to measure progress on the plan, since it covers only three years. In addition, to fully understand the system's retention performance, it will be necessary to identify individuals who move or die.

Measures will be reviewed and refined during 2013, but are expected to include most of the following. They include the data being used to measure progress on EIIHA, widely used treatment outcomes data, and some additional ECHPP measures and HRSA/HAB performance measures as used by the Cross-Part Collaborative. Data for some measures will be available only after MAVEN is fully implemented. Following are the desired measures:

1. Number of individuals tested
2. Number and percent of these individuals receiving test results
3. Number and percent of these individuals testing positive
4. Number and percent of these individuals who were late-tested (diagnosed with AIDS at time of testing or within 12 months after testing)
5. Number and percent of individuals testing negative successfully referred to prevention services
6. Number and percent of newly diagnosed HIV-positive individuals who entered care within the following periods after testing: less than 1 month, 1-3 months, 3-6 months, 6-12 months, and more than 12 months; and number and percent who did not enter care within one year after diagnosis (the current definition of linkage to care is the reporting of a CD4 or viral load test to surveillance; additional measures are needed if feasible, such as first visit with a clinician who has prescribing privileges).
7. Number and percent of those connected to care who obtain antiretrovirals (and length of time after entry into care before antiretrovirals therapy begins).
8. Number and percent of those connected to care who remain connected to in care (to be assessed annually); several measures needed, probably including two laboratory tests during the year, at least three months apart (the current measure), and two medical visits at least three months apart (used by ECHPP), and/or other ECHPP-consistent measures.
9. Number and percent of those prescribed antiretrovirals who remain on antiretrovirals, as measured by regularly obtaining prescribed medications (requires data from ADAP)
10. Number and percent of all diagnosed and of those retained in care with viral suppression.

Data will be reported by SIB and broken down by race/ethnicity, age at diagnosis, gender, and mode of transmission. This will ensure availability of data needed for decision making about PLWH targeting and the system of care.

If the Cross-Part Quality Management Collaborative continues, its aggregate data on 16 HRSA/HAB performance measures will also be considered in the context of system changes. This will provide some measures related to items like oral health screenings and Hepatitis C screenings, as well as clinical outcomes.

The ECHPP program uses several additional measures of care coordination and referrals that is useful, such as increased linkage of PLWH to substance abuse and mental health services. Once the MAVEN system is implemented, such additional measures should be available to assess PLWH care.

C. Community Feedback

As described in the monitoring and evaluation plan and the description of the use of data, community input and feedback will be an integral part of monitoring and evaluating progress on the comprehensive plan goals and objectives. The CHSS will conduct community sessions in conjunction with the Ryan White Planning Council as a source of information about how the system of care is working for clients. In addition, the CHSS has begun to use provider forums to obtain their perspectives on the practical implications of system and policy changes.

CHSS will use several existing mechanisms including collaborations with the Ryan White Planning Council for reporting to the community on its efforts to strengthen the system of care and for receiving community feedback on how these changes are working for them. The CHSS will collaborate with the Planning Council's Consumer Access Committee to links to the community. In Program Year 22, the CHSS Bureau will collaborate closely with the Planning Council to leverage their monthly meetings as a means to obtain community input. Through this group's regular monthly meetings, HAHSTA will be able to reports back to these entities and receives their input several times a year, and will make comprehensive plan feedback and input a part of these meetings twice a year. In addition, the HIV prevention community planning group will be another key collaboration to solicit community feedback. We expects to increase communications with these entities as part of the commitment to prevention planning and use these contacts to continuously provide feedback and seek input from these entities regarding comprehensive plan progress.

When providing feedback and seeking input from the community, we will always:

- Plan well ahead and publicize the event to maximize attendance
- Prepare a substance presentation, usually involving a PowerPoint plus content handout(s)
- Develop specific feedback questions designed to facilitate in-depth discussion about key issues
- Document the discussion and present a summary to findings.

D. Use of Monitoring Results in HAHSTA Decision Making

All the monitoring and evaluation data will be reviewed, and linked where feasible to the timing of changes made in the service system, to identify correlations, and to provide information for use throughout HAHSTA in determining appropriate action to further strengthen the system of care. The monitoring and evaluation process is set up so that the data generated are integrated into HAHSTA's regular annual decision-making cycle. Most HAHSTA Bureaus play active roles in this process.

Current monitoring tools are being adapted to the new HRSA monitoring and evaluation standards released early in FY 2012.

Information from the monitoring and evaluation of comprehensive plan progress serves as necessary data input to all these decisions.

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[1] 2010 U.S. Census

[2] 2010 U.S. Census

[3] Small Area Health Insurance Estimates, 2009, U.S. Bureau of the Census. See http://www.census.gov/did/www/sahie/data/2009/tables.html.

[4] HAHSTA's 2011 Annual Report

[5] 2010 U.S. Census

[6] The terms *Hispanic* and *Latino* are used interchangeably in the report. Being Hispanic is considered an ethnicity, and Hispanics may be of any race. The Ryan White Services Report (RSR) separately counts race and ethnicity, so each client is counted once under race and once as either Hispanic or not Hispanic. The Centers for Disease Control and Prevention's surveillance data and some other local data categorize Hispanic status along with race, so individuals are categorized as *Hispanic, non-Hispanic White,* or *non-Hispanic Black*, etc.

[7] www.neighborhoodinfodc.org Neighborhood profiles, Accessed May 2012.

[8] www.neighborhoodinfodc.org Neighborhood profiles, Accessed May 2012.

[9] Unemployment Rates for Large Metropolitan Areas – March 2012, Bureau of Labor Statistics, May 2, 2012. See http://www.bls.gov/web/metro/laulrgma.htm.

[10] Consolidated Federal Funds Report for Fiscal Year 2009, *Ibid.*

[11] Consolidated Federal Funds Report for Fiscal Year 2009. See http://www.census.gov/prod/2010pubs/cffr-09.pdf . See also "Virginia Compared to the Other States: National Rankings on Taxes, Budgetary Components, and Other Indicators, 2011 Edition, Joint Legal and Tax Commission, http://jlarc.virginia.gov/reports/Rpt410.pdf.

[12] The District amount is very high, largely because this figure counts federal employee salaries, wages, benefits, and retirement and disability payments, the federal payment to the District, as well as grants.

[13] Kaiser Family Foundation. FY 2008 data from Kaiser State Health Facts. See http://www.statehealthfacts.org/medicaid.jsp. FY 2007 data on Medicaid clients with HIV from "Medicaid and HIV: A National Analysis," October 2011. See http://www.kff.org/hivaids/upload/8218.pdf.

[14] See "2012 HHS Poverty Guidelines," at http://aspe.hhs.gov/poverty/12poverty.shtml. For rates at various percentages of poverty, see "2012 Federal Poverty Level" charts prepared by Families USA at http://www.familiesusa.org/resources/tools-for-advocates/guides/federal-poverty-guidelines.html

[15] Small Area Health Insurance Estimates, 2009, U.S. Bureau of the Census. See http://www.census.gov/did/www/sahie/data/2009/tables.html.

[16] *HIV Surveillance Report: Diagnoses of HIV infection and AIDS in the United States and Dependent Areas, 2009*, Centers for Disease Control and Prevention, HIV/AIDS Basic Statistics, from the CDC. See http://www.cdc.gov/hiv/topics/surveillance/basic.htm#hivest.

[17] "AIDS among Women." CDC Fact Sheet. See http://www.cdc.gov/hiv/topics/women/index.htm.

[18] CDC. *MMWR,* Vol. 60, No. 47; 2011.

[19] "HIV Testing and Diagnosis among Adults – United States, 2001-1009." Centers for Disease Control and Prevention, *Morbidity and Mortality Weekly Report*, December 3. 2010. See http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5947a3.htm?s_cid=mm5947a3_w.

[20] See Edward M. Gardner, Margaret P. McLees, John F. Steiner, *et al.*, "The Spectrum of Engagement in HIV Care and its Relevance to Test-and-Treat Strategies for Prevention of HIV Infection." *Clinical Infectious Diseases*, 2011; 52(6):793-800. See http://cid.oxfordjournals.org/content/52/6/793.long.

[21] See "A Practical Guide to Estimating and Assessing Unmet Need," updated by Mosaica, August 2009; original Guide prepared by the University of California, San Francisco, in 2003.

[22] "HAHSTA Part B Application"

[23] "Compendium of Services"

[24] Ryan White 2011 Part A Guidance, page 1.

[25] *HAHSTA Final Progress Report GY 20*

[26] 12 Cities Project Overview

[27] *Ibid,* plus data provided in the EMA's FY 2012 Part A Application .

[28] HAHSTA, "2011 Annual Report"

[29] "Initiation of Antiretroviral Treatment Protects Uninfected Sexual Partners from HIV Infection (HPTN Study 052)," May 12, 2011. See http://www.hptn.org/web%20documents/PressReleases/HPTN052PressReleaseFINAL5_12_118am.pdf.

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[30] Statement by Mohammed Akhter, Director of the DC Department of Health. See "District's Top Doc Says in 2012, Take Responsibility for Your Own Health," in Talib Karim's Blog, January 5, 2012. See http://talibkarim.wordpress.com/2012/01/05/districts-top-doc-says-in-2012-take-responsibility-for-your-own-health/.

[31] "State Mental Health Cuts: A National Crisis, National Alliance on Mental Illness, March 2011. Available at http://www.nami.org/Template.cfm?Section=state_budget_cuts_report,

[32] Kaiser Family Foundation, "HIV/AIDS at 30: A Public Opinion Perspective," June 2011. A report based on Kaiser Family Foundation's 2011 Survey of Americans on HIV/AIDS. Available online at http://www.kff.org/kaiserpolls/upload/8186.pdf.

[33] "HIV among African Americans," Centers for Disease Control and Prevention, November 2011. See http://www.cdc.gov/hiv/topics/aa/PDF/aa.pdf.

[34] "Early Linkage and Retention in Care: Findings from the Outreach, Linkage, and Retention in Care Initiative among Young Men of Color Who Have Sex with Men." Lisa B. Hightow-Weidman, Karen Jones, *et. al*., the YMSM of Color SPNS Initiative Study Group, AIDS Patient Care and STDs, August 2011, 25(S1): S31-S38. See http://online.liebertpub.com/doi/abs/10.1089/apc.2011.9878?journalCode=apc.

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[38] "HAHSTA 2011 Annual Report"

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[40] Trust for America's Health. "Reducing Infectious Diseases in the U.S.: Focus on HIV/AIDS and Hepatitis." April 2009. http://healthyamericans.org/assets/files/InfectiousDisease050709.pdf (accessed April 26, 2010).

[41] "The Increasing Burden of Mortality from Viral Hepatitis in the United States between 1999 and 2007." Kathleen N. Ly, Jiang Xing, et. al., Annals of Internal Medicine, Vol.156:4, pp 271-278, February 2012. Available at http://www.annals.org/content/156/4/271.abstract.

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[53] Enhanced Comprehensive HIV Prevention Plan SWOT

[54] NCQA's Government Recognition Initiative focuses on helping FQHCs and military treatment facilities become patient-centered medical homes. See http://www.ncqa.org/tabid/1271/Default.aspx.

[55] See "Maryland's Patient Centered Medical Home Pilot At-a-Glance," at http://www.governor.maryland.gov/ltgovernor/documents/mdpcmhfacts.pdf.

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[57] List of grantees, including several Ryan White providers, is available at http://member.carefirst.com/wcmresources/Content-Member/assets/attachments/Grantee_List_and_Summaries.pdf.

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