1.Program Narrative

1.a. HIV/AIDS Epidemiology

- There are more people with HIV/AIDS living in the EMA than ever before.
- The urban core of the EMA is one of the twelve most impacted jurisdictions in the country, with a distinct need for a set of comprehensive HIV health, housing and prevention services.
- The HIV/AIDS case rate for the District of Columbia is twelve times that of the nation.
- Dramatic improvements in surveillance and reporting improve the understanding of the HIV epidemics in the EMA, and the ability to respond to this complex, “modern” epidemic.

Washington DC EMA is a dynamic multi-jurisdiction of urban, suburban, and rural communities, consisting of Washington DC, five counties in suburban Maryland, eleven counties and six cities in Northern Virginia, and two counties in West Virginia. These jurisdictions span 6,900 square miles and are home to approximately 5.7 million people. The EMAcomprises multiple communities which are divers relative to race, ethnicity, socio-economic backgrounds, languages, health literacy and cultures. A critical and inescapable distinction between the EMA and the rest of the country is this: the nation’s capital has this highest rate of HIV disease in the country. An estimated 3.2% of residents in Washington, DC, are diagnosed and reported with HIV[i]The estimated prevalence rate in our Nation’s Capital is more than **five times** higher than the established guidelines of **1%** prevalence rate which defines a generalized epidemic among residents in a specific geographic area as determined by the United Nations Joint Program on HIV/AIDS (UNAIDS) and the U.S. Centers for Disease Control and Prevention (CDC)[ii]. This alarming prevalence rate of HIV/AIDS, coupled with mounting economic challenges facing the EMA and the increasing cost/complexity of care of individuals with multiple chronic diseases puts extreme pressures on all service systems.

An emerging component of understanding HIV in the EMA is collecting and using information on viral load. Viral load is a concise indicator of the need for services, and is a critical component of measuring success in engagement and retention in care. The District has pioneered the collection viral load data from across all services systems used by residents of the District, and has developed robust measures of community viral load. This same data will be used to identify trends and issues with respect to improvement in health outcomes, as well as inform HAHSTA and its providers of the health status impact of services. This is a model program, and will be shared with other jurisdictions in the EMA for replication and implementation, and the role of viral load in measuring need and success will be explored.

(1) Current Status of HIV/AIDS Epidemics in Washington DC EMA

Data Sources. The HIV/AIDS epidemic in the EMA is described using newly diagnosed and reported AIDS case data (January 1, 2009 – December 31, 2010) as well as all living cases as of data category through December 31, 2010. Both cohorts are described in terms of demographic characteristics and reported route of transmission in Attachment 3. Data presented here were analyzed from the electronic HIV/AIDS Report Surveillance System (eHARS) from all EMA jurisdictions. Estimates of HIV case counts from Washington DC were computed for both the newly diagnosed AIDS cases and cases living with HIV/AIDS by demographic and exposure category. These estimates included both people who may be aware or unaware of their HIV status. The overall prevalence rate of HIV/AIDS for the EMA does mask significant differences among jurisdictions. A comparison of the epidemic by jurisdiction highlights the complexity of planning and providing services for persons within the different parts of Washington DC EMA.

HIV/AIDS Cases by Jurisdiction. The overall prevalence of people living with HIV/AIDS

(PLWHA) for the EMA (0.83%) is nearly twice the national estimated prevalence rate of diagnoses of HIV/AIDS (0.43%)[iii]. The epicenter of the EMA is in Washington DC, with 10.6% of the EMA population, but 64.41% of HIV/AIDS cases in the EMA. The number of people living with HIV infection in Washington DC is higher than ever before and has the highest prevalence rate in the EMA, followed by Maryland ,Virginia and West Virginia

Table 1: Estimated Number of People Living with HIV/AIDS by Jurisdiction 2010

Jurisdiction	Estimated Number of People Living with HIV/AIDS		Population		Estimated Prevalence (%)
	N	%	N	%	
WashingtonDC	30,449	64.41%	601,723	10.45%	**5.06%**
Maryland	9,268	19.61%	2,303,870	40.02%	**0.40%**
Virginia	7,224	15.28%	2,693,352	46.79%	**0.27%**
West Virginia	330	0.70%	157,667	2.74%	**0.21%**
Total	**47,271**	**100%**	**5,756,612**	**100%**	**0.82%**

Note: 2010 census data were applied for all analyses, except West Virginia; 2009 census data were used for West Virginia.

HIV/AIDS Diagnoses by Age. As of December 31, 2010, an estimated 47,271 persons were living with HIV/AIDS in Washington DC EMA. Of these cases, more than half (54.5%) areages30 to 49 years and another third (34.2%)ages 50 years or older. This cohort includes individuals who have been living with the disease for years, and those diagnosed later in life.

Table 2: Age at Diagnosis

Age	Prevalence as of Dec 31, 2010		
	AIDS	HIV (non AIDS)	HIV/AIDS
< 13	1%	2%	1%
13-19	3%	3%	3%
20-29	23%	24%	23%
30-39	36%	31%	34%
40-49	26%	26%	26%
50+	11%	14%	12%

Table 3: Current Age

Age	Prevalence as of Dec 31, 2010		
	AIDS	HIV (non AIDS)	HIV/AIDS
< 13	0%	1%	0.5%
13-19	1%	1%	1%
20-29	5%	13%	1%
30-39	15%	23%	14%
40-49	36%	33%	34%
50-59	31%	21%	27%
60+	12%	8%	10%

HIV care services and Early Identification of Individuals with HIV/AIDS plans (EIIHA) include targets to older residents, including older MSM. While 28.5% of the estimated living cases were diagnosed when they were aged 30 years or younger, only 11.2% were currently aged 30 years or younger as of December 31, 2010.

HIV/AIDS Diagnoses by Race/Ethnicity. The HIV/AIDS epidemic continues to ravage communities of color in the EMA. People of color account approximately half (50.5%) of the EMApopulation, however account for four-fifths (80%) of the estimated number of people living with HIV/AIDS in the EMA. Blacks account for the majority of cases at 70.0%, Whites account for 20% of the cases, Hispanic 7.2%, Asian/Pacific Islander 1.1%, and “Other”1.6%. With the exception of West Virginia, Blacks are the largest proportion of the estimated number of people living HIV/AIDS in all jurisdictions. In West Virginia, Blacks account for approximately 39% compared to 57% for Whites.

Table 4: Diagnoses of HIV/AIDS by Race/Ethnicity and Jurisdiction in 2010

	WashingtonDC		Maryland		Virginia		West Virginia		EMA	
	N	%	N	%	N	%	N	%	N	%
African American or Black	22,378	73.3	7,158	77.3	3,419	47.3	128	39	**33,083**	**70.0**
White Non Hispanic	5,499	18	1,164	13.2	2,618	36	188	57.0	**9,469**	**20.0**
Latino / Hispanic	1,788	6	684	7.4	930	12.9	12	3.6	**3,414**	**7.2**
Asian / Pacific Islander	265	1.0	84	1.0	164	2.3	1	0.3	**517**	**1.1**
American Indian	11	0.7	5	0.1	9	0.1	0	0.0	**34**	**0.1**
Other / Unknown	508	2	170	2.0	84	1.2	1	0.3	**763**	**1.6**
Total	**30,449**	**100**	**9,268**	**100**	**7,224**	**100**	**330**	**100**	**47,271**	**100**

HIV/AIDS Cases by Exposure Category and Jurisdiction. In the EMA overall, the largest exposure category is male-to-male sexual contact (MSM, 37.6%), followed by heterosexual contact (27.1%), injection drug use (IDU, 11.3%), MSM who inject drugs (MSM/IDU, 2.6%), and risk not identified (20.9%). Male-to-male sex is the leading mode of transmission in all jurisdictions except Maryland. Heterosexual transmission is the second leading exposure category in the EMA, and in the Maryland counties it is the leading mode of transmission. A significant number of cases is reported with no identified risk which is possible due to the impact of stigma on the risk of reporting. Pediatric cases account for 0.9% of the estimated number of people living HIV/AIDS in the EMA. No new peri-natal transmission of HIV from mother to child occurred in the District of Columbia during the reporting period.

Table5: Estimated Number of PLPWHA by Exposure Category and Jurisdiction 2010

	WashingtonDC		Maryland		Virginia		West Virginia		EMA	
	N	%	N	%	N	%	N	%	N	%
MSM	11,790	38.7	2,278	25.0	3,459	48.3	146	44.6	**17,673**	**37.6**
IDUs	3,885	12.7	774	8.5	629	8.8	78	23.9	**5,336**	**11.3**
MSM/IDU	792	2.6	155	1.7	256	3.6	13	4.0	**1,216**	**2.6**
Heterosexual	8,668	28.5	2,778	30.4	1,286	18.0	42	12.8	**12,774**	**27.1**
Other	24	0.1	34	0.4	48	0.7	8	2.4	**114**	**0.2**
Not Identified	5,223	17.2	3,105	34.0	1,477	20.6	40	12.2	**9,845**	**20.9**
Subtotal	**30,449**	**100**	**9,124**	**100**	**7,155**	**100**	**327**	**100**	**47,055**	**100**
Pediatric cases	226		144		69		3		**442**	
Total	**30,578**		**9,268**		**7,224**		**330**		**47,497**	

Living HIV Cases. As of December 31, 2010, an estimated 28,664 persons were living with HIV (non-AIDS) in Washington DC EMA (Attachment 3). Of these, 69.6% are male, 54.5% are between 30 to 49 years of age, while 83.4% were diagnosed between the ages of 20 and 49 and about 12.2% were>50 years at the time of diagnosis. Blacks are more than two-thirds (69.3%) of these individuals, 20.9% Whites, and 6.8% Hispanics. The leading reportedexposure category for adults and adolescents was MSM (37.6%) followed by heterosexual contact (27.1%). About 11.3% of the cases identified IDU as the mode of exposure. MSM who inject drugs accounted for 2.6% of all people living with HIV. Nearly a quarter (20.9%) of the estimate living HIV (non-AIDS) cases had no mode of transmission identified.

Newly Diagnosed AIDS Cases. For this two-year period, January 1, 2009 through December 31, 2010, a total of 1,786 AIDS diagnoses was reported in the EMA, an average of nearly five new cases of AIDS diagnosed in the EMA every single day (Attachment 3). In 2010, the prevalence rate of new AIDS diagnoses was at 0.024% in the EMA, which is twice that of the national estimated rate of 0.012% in 2008iv. Over two-thirds (66.5%) of the AIDS cases diagnosed during the two-year period were among men. Theaverage age of newly diagnosed cases in the EMA is higher than the national average. The new AIDS cases showed the aging of the population with HIV/AIDS, as 28.1% of the cases aged ≥50 years, and 55.2% aged from 30 to 49 years at diagnosis. The older age of AIDS diagnosis may be the results of improved treatment and delayed progression to AIDS diagnosis rather than the aging of the population in the EMA. Consistent with living HIV/AIDS cases, newly diagnosed AIDS cases for the two year period indicate 75.6% of the cases were Blacks, 11.2% Whites, 9.35% Hispanics, and 1.06% Asian/Pacific Islanders. Among adult and adolescent AIDS cases, 29.9% were attributed to male-to-male sexual contact, 28.3% to heterosexual contact, and 7.11% to IDU.

Living AIDS Cases. There were 18,548 persons living with AIDS in the EMA as of December 31, 2010 (Attachment 3). The number of male AIDS cases in the EMA (70.9%) was significantly higher than female (29.1%). People living with AIDS tended to be older than people living with HIV (non-AIDS), with 94.7% currently aged 30 years or older in comparison to 84.3% of estimated HIV (non-AIDS) cases. Of all livingAIDS cases, 52.6% aged from 30 to 49 and 42.2% aged 50 years or older. About 1.0% of cases living with AIDS were pediatric cases at age of diagnosis and only 0.1% were currently aged 13 years or younger. People of color were disproportionally impacted by AIDS, with 71.3% of AIDS cases in the EMA among Blacks, 7.9% Hispanics, and 1.0% Asian/Pacific Islanders, with less than 1.3% among some other race/ethnicity. Whites are 18.4% of these AIDS cases. In the EMA, the largest exposure category for adult and adolescent AIDS cases was MSM (37.2%), followed by heterosexual contact (27.6%) and IDU (15.1%). MSM who inject drugs accounted for 3.6% of the people living with AIDS in the EMA.

The Washington DC EMA has a prevalence rate nearly double that of the United States, and exceeds the national rate for every gender, racial and ethnic group. African Americans are impacted by HIV prevalence rates at one and half the rates of the nation and females living in the EMA are impacted at nearly 3 times the national rate. Tabled below is information from the CDC HIV/AIDS Surveillance Report, 2010 Vol. 20 and the EMA HIV/AIDS epidemiology table

Table 6: Prevalence Rate of PLWHA by Gender and Race, EMA and United States

	Washington DC EMA (%)*	United States (%)†	Ratio (EMA: U.S.)
Gender			
Male	0.46	0.23	1.9 : 1
Female	0.18	0.07	2.6 : 1
Race / Ethnicity			
White non-Hispanic	0.12	0.08	1.5 : 1
Black, non-Hispanic	0.94	0.54	1.8 : 1
Hispanic	0.19	0.19	1 : 1
Rate/Ratio	0.33	0.16	2.1 : 1

* Note Prevalence rate for Washington DC EMA was calculated using 2010 AIDS prevalence data and 2010 Census data

† U.S. rates were calculated on 2008 AIDS prevalence estimates using 2010 Census data.

Special Issues – HIV Late Testers. Within Washington DC EMA, "late testers" represent a range of challenges, and provide an important context in which to plan for services generally, and especially activities associated with the Early Identification of Individuals with HIV/AIDS. A "late tester" is defined as a person with an AIDS diagnosis that occurred within12 months of his/her initial HIV diagnosis. Of people with an AIDS diagnosis in the Washington DC EMA, (66%) had an AIDS diagnosis within twelve months of initial HIV diagnosis. The proportion of late testers by jurisdiction reveals the following Washington DC 68.7%, Virginia 55.5%, Maryland 75.7%. All rates of late testers in the EMA were significantly higher than that of the nation (39%)[v].Late testing by definition includes the absence of early treatment, contributing to the lower health outcomes for late testers, and increasing the likelihood of new infections resulting from the risk behavior of individuals with HIV who are unaware of their infection.

(2) Disproportionate Impact of HIV/AIDS on Certain Populations

The epidemic continues to impact disproportionately the EMA's poorest and most vulnerable communities, particularly racial and ethnic minorities, including African Americans, women, immigrants, men who have sex with men (MSM), injection drug users (IDUs), the homeless, andperi- incarceratedvi persons. Part A plays an important role in reducing disparities in access for these populations.

Race and ethnicity continue to be critical factors within the context of HIV/AIDS prevalence and incidence rates in the Washington DC EMA. People of color continue to be disproportionately impacted by HIV/AIDS. People of color are nearly four fifths (80%) of estimated number of HIV/AIDS diagnoses in the EMA, while they comprise less than half (45.3%) of the total population of the EMA. There is a demonstrated need for additional funds to serve disproportionately impacted populations as described below. Additionally, there is a need for additional funds to provide capacity for providers to increase cultural competency.

African Americans (Blacks). HIV/AIDS continues to have a stranglehold on the Black Community in the EMA, with Blacks bearing a devastatingly disproportionate burden of the disease in Washington DC EMA. The epidemic indiscriminately permeates every aspect of the Black community regardless of socio-economic, geographic and educational level. Blacks are nearly three-quarters (76.5%) of the newly diagnosed AIDS cases from January 1, 2009 to December 31, 2010, and more than two-thirds (69.3%) of the people estimated to be living with HIV (non-AIDS) in the EMA, yet they account for about one-quarter (24.8%) of the population of the EMA. Black individuals in the EMA are three times more likely to living with HIV/AIDS than their White counterparts and almost ten times more likely than their Latino counterparts.

According to the CDC[vii], today there are about 1.2 million people living with HIV/AIDS in the U.S., including more than 545,000 who are Black. The AIDS case rate for Black Men nationally is 78.0 per 100,000, the highest of any group, followed by Black women at 35.1 per 100,000. By comparison, the rate for White men was 9.8 per 100,000 and White women 6.1[viii] per 100,000. A recent CDC National HIV Behavioral Surveillance Study revealed that more than 2% of Blacks in the U.S. were HIV positive, higher than any other racial group[ix]. The CDC estimates that at some point in their lifetimes, blacks experience higher estimated lifetime risk of HIV than white: 6.23% or 1 in 16 for black males, 0.96% or 1 in 104 for white males; 3.29% or 1 in 30 for black females, and 0.17% or 1 in 588 for white females. In an EMA with a large Black population and a disproportionate impact of HIV on Blacks, it is vitally important to create targeted and culturally competentservices for Blacks to access care and be retained in care.

Immigrants. In the EMA, there is an increase in the number of immigrants, particularly those from African, Caribbean and Latin countries. Immigrants, as a sub-population, face a variety of unique service delivery challenges, including cultural and linguistic barriers when attempting to access HIV/AIDS services throughout the continuum of care. According to the 2010U.S. Census Bureau, 23% of the total population in Washington DC EMA was foreign born, nearly double the national average of 12.4%, and more than 28% of EMA foreign born residentsreport that they speak English "less than very well"[x]. Region wide, more than 100 languages are spoken[xi]. Service providers in the EMA are reporting an increasing number of immigrants from Latin America, the Caribbean and Africa. The linguistic, cultural and clinical requirements for an immigrant population require special services and additional resources.

The Planning Council has conducted various focus groups to better understand these populations, including African and Latin American immigrants. This work revealed that individuals have limited experience with seeking health care, lack of knowledge of what services are available and tended to report that they did not know how to access care. The challenge for the service continuum is t the ability to understand the culture norms, myths and taboos as well as various sub-cultures that exist. Stigma related to HIV/AIDS persists in immigrant populations. For providers as well as planners the increased emphasis on cultural sensitivity and competence training for these populations becomes vital.

Men who have Sex with Men (MSM). MSM continue to be the leading reported exposure category for HIV/AIDS. According to the CDC, MSM of color continue to be a growing population that is disproportionately impacted by HIV/AIDS[xii]. In the DC EMA, Black MSM in particular are dramatically impacted by the disease, accounting for 36.5% of all HIV/AIDS as of December 31, 2010, and in the District of Columbia, more than one in five persons living with HIV/AIDS is a Black MSM,[xiii.] In the EMA, Black MSM representnearly half (43.7%) of all those in the exposure category of MSM.

According to a nation-wide survey of health departments and AIDS program offices, the stigma associated with homosexuality and discriminatory attitudes of providers frequently impede HIV services access for Black MSM[xiv]. Focus groups were conducted to examine some of the service gaps amongst MSM of Color, particularly Black MSM. Information from the focus groups found that thesocial stigma attached to being HIV positive becomes a barrier to care, due to fear of disclosure of HIV status to family, friends, neighbors and even primary care, substance abuse and mental health providers. Participants identified a need for cultural competency training for providers relative to some of the unique needs of Black MSM. Many participants believed that more individuals would come into care if providers were better educated around stigma, particularly for young Black MSM.

HAHSTA performed a behavior study amongst MSM in DC as part of the NHBSS study, supported by the CDC, wherein 500 individuals participated[xv]. Some of the key findings, included: 1) older men and men of color had HIV positivity rates nearly three times higher than younger men and white men; and 2) Men of color who were 30 years or older had the highest rates, more than twice the overall positivity at 25% compared to 8% of white males in the same age group who participated in the study[xvi].

In the EMA MSM, including MSM who inject drugs, account for 40% of people living with HIV/AIDS in the EMA and 31% of the AIDS cases diagnosed between January 1, 2009 and December 31, 2010. The incidence of AIDS amongst MSM continues to be the highest in the EMA with 37% of newAIDS infections reported as MSM. There is a demonstrated need for additional funds to support care for MSM.

Injection Drug Users (IDU). IDU, including MSM who inject drugs, make up approximately 14.7% of people living with HIV/AIDS in Washington DC EMA. Nearly three-quarters (74.2%) of IDU living with HIV/AIDS in the EMA reside in Washington DC.

IDU has been a significant factor associated with HIV infection in major cities across the country. Nationally, new infections due to IDU have declined significantly and accounted for 12% of new infections in 2010[xvii]. Needle exchange programs have drastically reduced the spread of HIV in major cities, including Chicago, Baltimore and New York and DC[xviii].

In WashingtonDC, a federal ban on funding for needle exchange programs for almost ten years prohibited one of the most critically successful HIV prevention programs. In 2007, the federal ban on the use of DC funds to support needle exchange lifted and beginning in 2008 the District of Columbiahas allocated local fundsto support needle exchange and harm reduction services to IDUs. and has allowed HAHSTA to initiate a comprehensive harm reduction needle exchange program, affording the opportunity over the last two years to remove over 800,000 needles from DC streets, enroll more than 3,000 new clients, provide HIV testing to nearly 5,000 peopled and link 900 people into detox and drug treatment programs[xix]. Needle exchange programexist in other areas of the EMA, including Virginia and West Virginia. Officials in Maryland are exploring the possibility of working with the Maryland Board of Pharmacy to develop a strategy for establishing pharmacy based syringe access.

Peri-Incarcerated [xx]. Nearly 7 million people are under criminal justice supervision, including jail, prison, probation or parole in the U.S.[xxi.] Nationwide, the AIDS case rate was six times higher in state and federal prisons than in the general U.S. population[xxii]. Nearly a quarter (20-26%) of people living with HIV/AIDS in the U.S. has spent time in the correctional system[xxiii.] No precise count is available of HIV cases in prisons and jails. brief incarceration, limited and inadequate health services prevent identification and diagnosis of inmates with HIV infection. Arrestees may choose not to declare their HIV status. There is no national system for reporting prison HIV cases in the U.S. and CDC surveillance information does not include custody status. However, according the Bureau of Justice Statistics, 21,987 of those inmates incarcerated in state and federal prisons as of December 31, 2008 were HIV positive representing 1.9% of the prison population. It is important to note that this prevalence rate is 12 times higher than in the general population nationally[xxiv].

The Washington DC EMA criminal justice system is large and complex. Multiple correctional systems operate in the EMA—one in each of its four jurisdictions plus the federal system and numerous county and regional systems. For example, the eleven counties and six cities in Northern Virginia are home to 25 different state, county, and regional correctional and detention facilities alone. The criminal justice system plays a large role in the lives of many of the EMA residents. People of Color are disproportionately represented in the judicial system. For example, in Washington DC, 60% of the District's population is Black, but 89% of the people under justice supervision (prison, jail, probation, parole, or pretrial release), are Black according to the DC's Department of Corrections Facts & Figures 2008[xxv.]

In WashingtonDC, 21,000 people pass through correctional facilities each year. Over 2,500 former prisoners return to the EMA each year, from facilities located outside of the area. In 2009, of the individuals released from the Maryland Department of Corrections, one-quarter (16,981 individuals) resided within the five counties associated with the EMA.

A recent study on reentry from jail reveals that there are an estimated 12 million individuals released annually from U.S. Jails[xxvi]. Many of these individuals will be returning to their local communities and need assistance in successfully navigating the reentry process and getting linked to critical care services in their respective local communities.

The federal, state and local prison population within the EMA has hundreds of diagnosed cases of HIV/AIDS. According to the Maryland HIV/AIDS Epidemiological Profile 2010, there were 3,258 persons living with HIV/AIDS in the prisons[xxvii]. In Virginia, there were 389 prisoners with infected with HIV, representing 1% of the state prison population in 2009. In West Virginia, 14 prisoners had HIV infection and two had AIDS, for a rate of 0.4%[xxviii].

Creating effective re-entry and pre-release planning programs is critical for assisting peri-incarcerated individuals. It is imperative to expand programming for the large number of peri-incarcerated individuals and failure to do this may continue the spread HIV in the community.

Homeless and Unstably Housed. Stable housing is essential for successful treatment of HIV/AIDS. According to the 2011 Homeless Enumeration Report, as of May 2011, there were 11,988 homeless individuals living in Washington DC EMA[xxix]. Homelessness is defined as a person who resides in some form of emergency or transitional shelters, domestic violence shelters, runaway youth shelters and places not meant for human habitation (e.g., streets, parks, alleys, abandoned buildings and stairways); "unstably housed" includes those who are at very high risk for imminent homelessness, or who are housed inadequately with friends or family members. The number of homeless individuals has increased in the last year by 2%. There has been a steady increase in individuals who experience homelessness of approximately 6% since 2005 in the EMA, while the number of persons in families that are homeless has increased by 3% during the same time period[xxx]. Homelessness or a recent homelessness represented [13]15.3% of people living with HIV/AIDS in the EMA as of December 31, 2010.

The economic recession coupled with the lack of affordable housing assistance programs has had a devastating impact on individuals in the EMA. Many homeless individuals cannot maintain treatment regimen due to lack of housing, with no place to store or refrigerate medications, there exists an inability to create permanency for follow up appointments with providers as well as establishment of residency for benefit purposes for other federal and state programs, including CARE Act Part A Programs. Homeless individuals face considerable stigma relative to their HIV status, face constant stealing of personal property, including medications and are threaten often by physical violence, sexual assault and exploitation.

Housing dominatesas the priority need of the homelessness as supported by the Housing First Agenda. Low income housing is scarce resources for rental subsidies inadequate. Housing remains an severe unmet need high on the priority list in the EMA.

Women in the EMA. Traditionally HIV/AIDS has disproportionately affected men, particularly gay and bisexual men. However, the gender gap is gradually closing as seen in the EMA and around the country. The HIV epidemic is taking an increasing toll on women nationwide and is having a devastating impact on women in Washington DC EMA. Nationally, there were nearly 290,000 women living with HIV/AIDS[xxxi.] In 2009, females accounted for a quarter of all diagnoses of HIV infection among adults and adolescents. Moreover, there were 11,200 new HIV infections and 8,879 newly diagnosis AIDS among women[xxxii]. In Washington DC EMA, the impact of HIV on women is dramatic and increasing. Women comprise approximately 30.0% of the estimated HIV/AIDS cases in the EMA. Women comprise 33% of the AIDS cases diagnosed between January 1, 2009 and December 31, 2010 and 30.4% of the estimated number of people living with HIV (not AIDS) as of December 31, 2010.

Women of color, particularly Black women, have been especially hit hard and represent the majority of new HIV infections and AIDS cases among women nationally. Black women are most likely to be infected through heterosexual sex followed by IDU. According the Kaiser Family Foundation Report, Black women account for 57% of new HIV infections for women- nearly 15 times the rate of white women and 64% of the estimated AIDS cases among women compared to 15% white women and 18% of Latina women. [xxxiii] In the EMA, Black heterosexual women were significantly impacted, accounting for 10.1% of the total HIV/AIDS cases in the EMA and 9.2% of living AIDS cases in the EMA as of December 31, 2010.

(3) Populations Under-Represented in the CARE Act Funded System of Care

Examining the service utilization data provides insight into populations that may be underrepresented in the CARE Act Funded System of Care. The following tables compare information between the number and percentages of people living with HIV/AIDS in the EMA, and the number and percentages of individuals receiving CARE Act services by race, gender and reported exposure category The tablesshowunduplicated client counts served by CARE Act Parts

A, B, C, and D.

Whites account for 20.0% of the PLWH/A in the EMA but only 9.6% of the service recipients. This lower proportion in the CARE Act funded system may be attributed to Whites being more likely having other forms of insurance to support care.

Table 7: HIV/AIDS Cases and CARE Act Clients by Race

	Living with HIVAIDS		Receiving CARE Act Services	
	N	%	N	%
White	9,469	20.0%	1,686	9.6%
Black	33,083	70.0%	13,137	75.0%
Latino/Hispanic	3,414	7.2%	1,618	9.2%
Other	1,304	2.8%	269	1.5%
Unknown			805	4.6%
Total	45,971	100%	17,515	100%

Males comprise 70.0% of persons living with HIV/AIDS and60.9% of those receiving CARE Act funded services. This may be associated with the fact that men are less likely to seek diagnostic and health care services regularly or until symptomatic,are frequently diagnosed for HIV later in the disease progression and qualify for other forms of insurance.

Table 8: People Living with HIV/AIDS and CARE Act Clients by Gender

Gender	People Living with HIV/AIDS		Receiving CARE Act Services	
	N	%	N	%
Male	33,152	70.1%	10,661	60.9%
Female	14,118	29.9%	6,575	37.5%
Transgender	Not consistently reported		194	1.1%
Unknown			88	0.5%
Total	47,271	100%	17,515	100%

The number of transgender individuals served is likely underreported, due to some transgender individuals preferring to identify as male or female, or the inability or unwillingness of providers to accommodate the preference of a person to be recorded as “transgender.”National standards for reporting gender- and in particular, HIV/AIDS case reports to the CDC – do not allow for reporting of individuals as transgender.

Although there are no comprehensive data sets for transgender individuals, every convenience sample of the transgender population suggest extremely high rates of HIV risk and prevalence. Transgender individuals pose unique service delivery challenges for a traditional medical system, which may lack the ability to address the bio-psychosocial and cultural needs of transgender individuals.

Table 9: HIV/AIDS Cases and CARE Act Primary Care Clients by Exposure Category

Exposure Category	Living with HIV/AIDS		Receiving CARE Act Primary Care Services	
	N	%	N	%
MSM	17,673	37.6%	1,580	14.7%
IDU	5,336	11.3%	415	3.9%
MSM/IDU	1,216	2.6%	47	0.4%
Heterosexual	12,774	27.1%	2,459	22.9%
Pediatric cases	442	1.2%	337	3.1%
All other, including unknown	9,845	20.5%	5,921	55.0%
Total	45,971	100%	10,759	100.0%

CARE Act clients included a smaller than expected proportion of cases associated with male-male sex or injection drug use, and higher than expected proportions of cases associated with heterosexual contact. The EMA has a large number of cases with an exposure category as unknown, which may occur due of the lack of transmission of data among providers of services for reported cases. Stigma and discrimination attached to same sex behavior serves as a barrier to reaching those who engage in same sex behavior but do not identify as ‘gay’ or ‘bisexual’[xxxiv].

(4) Estimated Level of Service Gaps among HIV/AIDS Cases the EMA-

The EMA conducted both quantitative and qualitative needs assessments using surveys and focus group methods to discover some overarching themes throughout the EMA relative to common service gaps. The qualitative data revealed the following needs and barriers, as organized intogaps in services relative to CARE Act funded programs and other service gaps which have been identified over the last four years from the Planning Council various needs assessment activities, including community forums, survey analysis, special studies and town hall meetings. The following highlights various gaps in services in CARE Act and other services as well as psycho-social issues that have been identified through the needs assessment vehicles:

Table 10: Reported Service Needs and Issues

CARE Act System	• Better Education on Stigma related to MSM and IDU • Providing better linkages to care for newly diagnosed individuals in the Care continuum • Better integration of mental health services for IDU and the homeless • MSM services lacking in certain areas of DC and outreach targeting Latino MSM; • Mental health services targeted at young MSM
Other Systems	• Holistic care that addresses all of the peripheral issues that put MSM at risk • Homeless services and shelters that are not considered “friendly for MSM or transgender individuals • Low job skills and limited job training opportunities • Mental health disorders or addiction
Pervasive Psycho-Social Issues	• Mistrust in government and medical community; • Misconception of HIV risk, (e.g., HIV is only about gay white men) • Health and HIV are not prioritized due to a number of other issues they face or apathy toward HIV acquisition; • Perceived lack of coordination among service providers which results in difficulty navigating through the system; • Limits to what agencies can do for DC residents because they are also serving nearby Maryland and Virginia residents who come into the city for services

The Grantee estimated service gaps among those PLWH/A who utilized the CARE Act funded system in 2010. Using service utilization data and data expenditure and reallocation allocation data, the Grantee examined patterns relative to over expenditures and percentage of clients accessing services for the year of 2010.Tabled below are service categories with expenditures higher than their initial allocation, and the percentage by which the category exceeded the initial allocation based on priority setting planning data.

Table 11: Selected Service Categories, Allocations and Expenditures

Service	Amount Allocated	Actual Expenditures	Percent Over Expended
Health Insurance	139,155	170,355	12%
Emergency Financial Assistance	849,436	882,223	4%
Food Bank, Meals	1,524,153	1,547,716	2%

Based on need and demand during 2010, re-allocation up to 12% occurred in health insurance, emergency financial assistance,and food bank meals. Tabled below are those service categories in which more clients were served than estimated.

Needs Assessments

The Planning Council acknowledges that no single source of data provides sufficient context for their work and continues to incorporate needs assessment data from a variety of sources into the planning process. These data sets include client needs assessment surveys; focus groups, and community forums. In the last four years, the council has conducted two client satisfaction surveys, six special studies for particular populations, including seniors and African Immigrantsas well asthree community forums throughout the EMA. The following illustrates some of the gaps in services that clients have identified for the aforementioned projects. Please note the check marks indicate that there was agap identified in services.

Table 12: Selected Service Categories, Clients Targeted and Clients Served

	Targets	Served	Served
Core Medical Services			
Outpatient /Ambulatory Health Services	5,214	9,589	189%
AIDS Pharmacy Assistance (Local)	1,685	2,496	148%
Mental Health Services	1,089	2,413	222%
Medical Case Management	4,063	5,961	147%
Support Services			
Emergency Financial Assistance	2,280	2,884	126%
Food Bank and Home-Delivered Meals	2,230	3,314	149%
Treatment Adherence	291	843	290%

Additionally, the Planning Council has performed special focus groups and needs assessment for sub-populations, such as: PLWHAs that were over the age of 55, African Immigrants, and Latina PLWHAs. Each of the specialized focus groups utilized key informant interviews and survey design work and revealed insight into each of these sub-populations. A key concern is the waiting list for ADAP in the Northern Virginia portion of the EMA -- currently at with 239 on the list -- and waiting lists for long-term housing subsidies in throughout the EMA, a combined total of approximately 1,200 households.

Table 13: Selected Needs Assessment Activities and Results

Needs Assessment Activity	2007 Client Needs Assessment Survey	2008 Community Forums	2009 Client Needs Assessment Survey	2010 Community Forums, Special Studies
AIDS Drugs	✓			✓
Mental Health	✓			✓
Dental	✓		✓	✓
Child Care		✓		✓
Emergency Financial Assistance		✓	✓	✓
Food	✓	✓	✓	✓
Housing	✓	✓	✓	✓
Jobs Placement			✓	✓
Legal Services		✓	✓	✓
Linguistic Services	✓	✓		✓

In addition to these broad issues, specific gaps were identified and addressed for some populations and circumstances.

- A minimum of three percent of four service categories -- primary outpatient medical care, medical nutrition therapy, medical case management and food banks & home delivered meals is earmarked for older (aged 50 or more) people with HIV/AIDS.
- A minimum of five percent of primary outpatient medical care is earmarked for transgender individuals.
- A minimum of five percent of funds allocated for oral health services for prostheses.
- A target fund is established within the service category food banks & home delivered to purchase water filters.

These service directives were implemented in Grant Year 21 in the District of Columbia. A Planning Council directive to include hormone therapy for transgender individuals was excluded as disallowable in consultation with HRSA.

1.b. Impact of Co-Morbidities on Cost and Complexity of Providing Care

- Costs of care escalate due to high rates of co-morbid conditions.
- Complexity of care increases with the size, scale, breadth and depth of the epidemic.

HIV/AIDS is a complex, multi-system illness. Coping with HIV/AIDS is hampered by other life circumstances, such as general health, chronic substance abuse, multi-generational substance abuse, lack of insurance, homelessness or risk of homelessness, severe mental illness, STI. The multiple needs ofPLWHA complicateservices required and increase the cost of care.

Providing appropriate care has become even more complicated when one considers the current economic climate of the nation and individual states. According to the National Poverty Center, in 2011, 15.9% of the US population lived in poverty as of September 13, 2011[xxxv]. There have been dramatic decreases in state budgets, workforce reductions at health and social service institutions, coupled with an increase of demand for services by persons in need. In many parts of this EMA, there has been a reduction or rescission of commitment from local and state health care programs or services that serve people living with HIV/AIDS --including within Medicaid programs -- which cause increased demand for services under Part A.

Physicians,other clinicians, case managers and treatment adherence specialists spend more time trying to assist people with social economic issues that must be addressed if treatment is to be successful, including linkages to appropriate support services. Often there is no compensation for additional services needed to provide quality care for those struggling with multiple diagnoses and stressful socioeconomic circumstances.

SeeAttachment 4 for information on co-morbidities.

In 2006, Schackman, et al, estimated the monthly cost of people living with HIV from the time of beginning appropriate care (adults who initiate antiretroviral therapy at CD4 counts <350 cells/mm3) until death to be $2,100 on average or $25,200 per year[xxxvi]. The projected life expectancy of individuals, if they remain in optimal HIV care, is 24.2 years and the lifetime cost is $618,900 per person. Because many HIV infected persons are not identified early on and are not provided care until late in the course of their infection[xxxvii], late stage diagnosis results in even higher annual cost of care. There are several recognized co-morbid conditions that are often experienced among people living with HIV/AIDS, including:

Sexually Transmitted Infection (STI). Surveillance data in 2010 reflects a high prevalence rate of STI in the EMA, and reflect high rates of unprotected sexual contact and a need for additional investments in health literacy, health education and prevention for positives.People Living with HIV/AIDS in Washington DC EMA are disproportionately impacted by STI. Compared to the general population, the

Table 14: Co-morbidities, General Population and PLWHA in 2010

	General Population		PLWHA	
	No.	Rate per 100,000	No.	Rate per 100,000
Chlamydia	20,362	0.35	131	0.35
Gonorrhea	5,293	0.09	123	0.33
Syphilis	395	0.01	87	0.24
Tuberculosis	311	0.01	11	0.03
Hepatitis B	771	0.01	96	0.26
Hepatitis C	3,285	0.06	296	0.80

Note: Data from DOH in DC, MD, VA and WV were applied for estimating numbers and rates of co-morbidities for the general population. Data from 2009 were used for estimating of rates among PLWHA.

rate of syphilis among PLWHA is twenty-six times higher, and the rate of gonorrhea among PLWHA is four times higher.Co-infections with an STI increase the annual cost of care for a HIV/AIDS case.One recent study by the CDC found that each new syphilis-related HIV infection produces $207,000 in lifetime medical costs.

Tuberculosis. The rate of tuberculosis (TB) among PLWHA is three times that of the general population. The populations hardest hit are people of color, IDU, incarcerated and homeless persons, and especially foreign-born. Adherence to treatment is critical for successful TB treatment as Direct Observed Therapy (DOT) has shown to be a proven effective strategy, and is under consideration as needed for a for PLWHA co-infected with TB, and will be reviewed to assess its applicability to assist other PLWHA improve treatment adherence.MDR-TB can cost up to $137,000 annually, including medical care, DOT, contact investigations and language interpreter services.

Hepatitis. In the U.S., an estimated 1.4 million persons are infected with Hepatitis B (HBV)[xxxviii.] An estimated 5 million in U.S. are infected with Hepatitis C, with an estimated 300,000 new infections occurring annually[xxxix.] According to the CDC, nationally thirty three percent of all HIV infected persons have Hepatitis C. The prevalence rate among IDU ranges between 60-90%[xl]. Hepatitis screening, vaccination and treatment are standard in the provisions of medical care for person living with HIV. The rate of hepatitis B infection among PLWHA is twenty-eight times that of the general population, and the rate of hepatitis C infection eighteen times that of the general population.

In the District more the two thirds (68.9%) of chronic hepatitis C/HIV co-infections were among men and the vast majority (90.5%) were black. Almost two-thirds (63.7%) of the individuals suffering from chronic hepatitis C/HIV co-infections were over the age of 40. Injection drug use is the most commonly reported mode of HIV transmission (44.9%) of those with chronic hepatitis C/HIV.[xli]

Two new protease inhibitors for Hepatitis C have significant cost implications, based on the extraordinarily high costs and the relative high proportion of people with HIV and Hepatitis C. Both drugs wereapproved by the FDA based on data of treatment for mono-infected individuals and many Medicaid programs are debating including the drug. The use, acceptance and efficacy of the drugs for dually-infected infected individuals are uncertain.

Homelessness. An estimated 15.3% of people living with HIV/AIDS in the EMA are homeless or have a recent history of homelessness, complicating care and making it difficult to achieve durable viral suppression. One jurisdiction of the EMA experienced an 11% increase in homeless individuals since last year, according to the 2011 Homeless Enumeration Study[xlii].

The unemployment rates(as high as 9.8%) increases the number of persons who are homeless or who are at-risk for becoming homeless.[xliii]According to recent report by the US Census Bureau more than 43.6 million people are living in poverty in America and the national poverty rate has risen from 14.3 in 2009 to 16.5 in 2010.[xliv]

The EMA does not directly support housing services with CARE Act Part A funds and coordinates with HOPWA and other sources. However strategically deployed, HOPWA falls far short of meeting the housing needs of people living with HIV/AIDS. Funds are inadequate in all regions to meet the housing subsidy need of clients, and the EMA grapples with the issue of clients migrating to other regions to find cheaper housing[xlv].

The high cost of housing challenges low-income individuals to achieve the federal affordability standard of a maximum of 30% of income spent on housing. To achieve this, a worker earning the federal minimum wage of $8.25 would have to work more than three full-time jobs to “afford” a two-bedroom apartment at fair market rent (currently $1,407per month)[xlvi.] Seeking less expensive housing in an adjacent jurisdictioncan increasefragmentation, increase the likelihood of dropping out of care for those already challenged to remain in care, escalate the need for case management and other supportive services and otherwise increase the cost of care to the EMA.

Insurance. A lack of either public or private health insurance is a problem within Washington DC EMA, particularly for people living with HIV/AIDS and mirror the increasing problem in the nation. In the EMA, 16% residents do not have health insurance compared to 18% for people living with HIV/AIDS. The estimated total number of uninsured in the EMA is 864,995, while the number of uninsured people living HIV/AIDS is 8,073. The lack of adequate health insurance for people living with HIV/AIDS creates the need for the continuation of emergency funds to fill the gaps in the health and social service systems.

The EMA consist of four jurisdictions, complicated by the lack of standardized protocols for public and private insurance across the EMA. This is especially true for Medicaid coverage across the jurisdictions, with highly variable systems of insurance coverage and various programs vary by jurisdiction.

Persons Living Below 300% of Federal Poverty Level (FPL). More than 78% of the people living with HIV/AIDS in the EMA are living at or below 300% of FPL, with more than half (58%) living at or below 100% of FPL. Living in poverty challenge stability in health care, the durability of viral suppression and can increase poor health choices.

Peri-Incarceration. Serving incarcerated individuals is especially complex in the EMA with multiple correctional facilities, including federal, three state correctional, and numerous District, county and city jails. For incarcerated persons living with HIV/AIDS being released from prison, highest priorities typically are stable housing, a source of income, and access to medical care. Securing assistance for housing and income can be extremely difficult. It is very important to assist newly released individuals with continued access to medical care and medication, particularly if they have initiated antiretroviral treatment. Linkages among the correctional systems and the continuum of services are critical for retaining people in care and reducing the transmission of the disease.

Inadequate Funding. The economic downturn has led to increased pressure on all fiscal resources throughout the EMA, and has been exacerbated by increasing numbers and needs for services. State and Local programs serving PLWHA are being slashed and workforces for these programs have been pummeled resulting in less and less resources. Increasingly, programs for the general, low-income population such as housing, food banks and social services are challenged to remain in place, increasing the demands on services supported by the CARE Act.

The EMA continuum is designed to address the high-cost, high-complexity care required to serve these individuals. Increased funding is critical to meet the complex care for patient population living with co-morbidities.

1.c. Impact of Part A Funding

- Part A funds are critical to ensuring services to people with HIV/AIDS.
- More than 99% of Part A funds are fully utilized every year
- Scale up of services is necessary to address increased numbers and needs.

This section describes the impact of Part A funding, including the decline in CARE Act Part A formula funding, and how services and funding mechanisms are coordinated in the EMA. Furthermore, discussion of additional funding sources, such as those at the municipal level, is discussed in relation to how it works in concert with CARE Act Part A funds.

1.c.i Report on the Availability of Other Public Funding

See Attachment 5 for a summary of other public funding.

1.c.ii Coordination of Services and Funding Streams

In planning the continuum of care services and prioritizing and allocating Part A funds, consideration is given for non-Part A services funded by other sources. The Planning Council uses various strategies to incorporate key stakeholders from other funding streams. Coordination of services, especially the leveraging of services across the EMA, is a prime focus of service providers in the EMA. This year, when setting priorities and allocations for the Part A continuum of HIV/AIDS care, the Planning Council considered the impact of the following:

Medicaid. The various changes occurring in Medicaid programs in each of the jurisdictions and the impact of health care reform were major points of discussion in priority setting. Information regarding actual and anticipated program cuts in Medicaid programs and their impact on services for PLWHA was considered.

Of particular interest are the changes in Medicaid in the District of Columbia. During calendar 2010, the District expanded access for Medicaid to individuals with an income up to 200% of the federal poverty level. This is misunderstood as shifting clients from the CARE Act system to Medicaid. Nearly ninety percent of people with HIV who were enrolled in Medicaid under the expansion had been served through the Alliance, a local health insurance program.

Medicare, including Medicare Part D. Many individuals who are on Medicare Part D face challenges with the coverage gap (“doughnut hole”) and their co-pays. Local funds have been used in parts of the EMA to pay for the costs of the “doughnut hole.” Reduction in state and local fundswill result in an increased need for CARE Act funds.

Women, Infants and Children (WIC): There are 44 WIC sites located throughout the EMA. Of these, 16 are co-located with Part A service providers, making it easier for women with children to access HIV/AIDS services, and clients of HIV service providers to access WIC.

Veterans Affairs (VA): The highest concentration of veterans in the EMA resides in the two counties of West Virginia, and HIV service providers work closely with the VA facility located in Martinsburg, West Virginia, and screens every client for eligibility for services provided through the VA. Common service gaps that veterans report include dental care, specialty outpatient medical care, housing, emergency financial assistance and transportation.

Housing Opportunities for Persons with HIV/AIDS Programs (HOPWA):HOPWA is available throughout the EMA. The metropolitan statistical area (MSA) for the HOPWA program is different from that of the CARE Act Part A EMA, creating challenges in parity of services and coordination of care. Funding for housing subsidies is consistently one of the highest ranked needs of people with HIV/AIDS.

CDC Prevention: The CDC enhanced strategy relative to prevention, including counseling, testing, and referral services has radically modified the EMA ability to utilize innovative strategies through ECHHP to find and link into care newly identified PLWH/A. The EMA has emphasized the importance of pairing HIV testing and prevention with linkage to care, and providing testing in traditional and non-traditional site locations.

Local and Federal funds for substance abuse and mental health treatment services: In the second quarter of calendar 2011, the District of Columbia was awarded a three-year grant of $1.3 Million per year to support a set of activities designed to identify multiply-diagnosed (HIV and mental illness or substance abuse) individuals who are homeless, and provide a set of services to maximize long-term stability. Funded through the **Minority AIDS Initiative**, this program is managed by the Addiction Prevention and Recovery Administration of the District of Columbia, and the project offers opportunities for intensive collaboration among multiple entities within District government. Currently in development, and expect to begin services during the first quarter of calendar 2012.

Other CARE Act HIV/AIDS Program Funding: The Planning Counciltakes into consideration available services in each local area through CARE Act Part B, C, D, and F funding when assessing need, establishing priorities and setting allocations.

The **Part B** programs of each of the four states vary. Funding available for ADAP is sufficient in three of the four jurisdictions, with a troubling shortfall in Virginia. Increased enrollments and accelerating costs challenge ADAP in each state. Addition of protease inhibitors for Hepatitis C poses a significant fiscal challenge.

With one exception, each of the **Part C** funded entities in the EMA receive Part A or Part B funds. These funds are coordinated to support the overall service system, and are a critical component of fiscal solvency and programmatic continuity.A single **Part D** entity is also funded by Part A, and provides specialized services to children throughout the EMA, and supports a group of sub-contractors to expand service delivery.**Part F** funding for oral health is an important contribution, but is inadequate to support the increased needs for oral health services throughout the EMA. The single **Part F** oral health provider provides oral health services funded by Part A, and coordinates those services with other CARE Act services.

The **Part A MAI** program for the Washington DC EMA has been a catalyst for enhancing service delivery system by enrolling new, re-enrolled or highly-vulnerable clients into a cluster of services to stabilize the clients for durable viral suppression.

1.d. Assessment of Emerging Populations with Special Needs

Clients of the following six populations were identified as needing unique service components in order to be stabilized in HIV primary care. The cost data presented after each population reflects actual expenditures associated with care for these sub-populations. This data is collected to assist the Planning Council in its priority setting process.

Homeless or Unstably Housed Individuals

A significant number of persons are experiencing duress as a result of the economic downturn, rise in unemployment, shortage of affordable housing and decline in income. In turn, there is a rising in the number of individuals who are homeless or at risk of becoming homeless. According to the 2010 Annual Assessment of Homeless presented to Congress in July of 2011, there are approximately, 1.59 million people who are homeless, sheltered or under-sheltered in the nation or approximately 649,917 people experience homelessness every night[xlvii] a 1% increase from last year. The National Housing Commission recognizes the intricate relationship between HIV/AIDS and homelessness and the disproportionate number of persons living with HIV/AIDS among the DC EMA homeless population. The report further illustrated that approximately 3.9% of homeless people were HIV-positive in 2010, compared to 0.4% of adults and adolescents in the general population (CDC, 2008) and 26% report acute health problems other than HIV/AIDS such as tuberculosis, pneumonia, or sexually transmitted diseases.[xlviii].

The Homeless Enumeration Report for the Washington Metropolitan Region 2010 indicates a total of 11,744 homeless individuals in throughout the EMA, with the District having the highest impact (51.9%), and steady increases in the suburban areas of Fairfax County/City/Falls Church, VA (14.4%) and Montgomery County, MD (10.4%). Poverty rates nationally are at 15.9% and in the nation capital range as high as 21.3% in the District. Thirty-nine percent the EMA poor live in the District, more than half in suburbs surrounding the area.

Every formal and informal needs assessment or review since 2008 has identified affordable housing as a major service delivery gap. In the 2009 client survey, 54 individuals (14.4%) reporting they needed housing services but were not able to obtain housing

Barriers to Care. According to the 2010 Homeless Enumeration Report, 38% of homeless persons (excluding children in homeless family households) in Washington DC report a chronic substance abuse problem, 22% report a severe mental illness, 23% have a chronic health problem and nearly 17% were physically disabled.

In the EMA, higher rates of poverty and homelessness also are likely to lead to higher incidence of HIV. A new CDC analysis reveals a strong link between poverty and HIV infection.[xlix]The EMA is targeting those wards and regions that are most impacted by HIV/AIDS incidence for more intensive efforts, described in the EIIHA plan.

Service Gaps. Homeless individuals are more likely to have undiagnosed and untreated mental illness and substance abuse, and require more units of services to be stabilized. Housing is an important pre-condition forstabilizing people in care are achieving durable viral suppression. Homeless persons living with HIV are more likely to delay HIV care.

Estimated Costs. The estimated cost for homeless individuals is approximately $4,787,976 wherein on average individuals were enrolled in four core medical services (medical care, case management, oral health and mental health) and two support services (food bank/meals and emergency financial assistance).

Seniors (All Genders, Aged ≥50 Years)

Individuals aged 50 years or older with HIV is a growing population, composed of two cohorts: individuals who contracted the disease prior to 50 and have lived past the age of 50, and individuals who are becoming infected over 50. Despite medical advances and improved HIV treatment, for older people the naturally aging process increases co-morbidities such as diabetes or hypertension[l]. Changes in social norms, sexual behaviors and erectile dysfunction drugs can increase the risk of HIV exposure and transmission.

According to the CDC, approximately 29% of people living with AIDS were over 50 years of age, and the age group accounted for 15% of all new HIV/AIDS diagnoses in 2005[li]. It is estimated that over half of the all HIV positive Americans will be over the age of 50 by or before the year 2015[lii]. In the Washington DC EMA, 39% of living with HIV infection and 42.2% of living AIDS cases were among persons aged 50 years or older as of the end of 2010 which is substantially higher than national statistics. In this age group, men living with HIV/AIDS outnumber women living with HIV/AIDS at a rate of approximately 2:1.

Barriers to Care. New infections among older adults living may go undiagnosed as a result of the failure to incorporate HIV testing and prevention education into routine medical care, lack of age appropriate educational messages and dialogue about sexuality beyond the reproductive years, usually around 45 years of age. Older women, in particular, are vulnerable since they may choose to discontinue condom use once pregnancy is no longer an issue and may be biologically more susceptible to HIV due physical changes associated with menopause[liii]. The National Health Interview survey found that 47% of women aged 50 years and older were uninformed regarding the transmission of HIV, compared to 14% of younger women[liv].

Older adults are often diagnosed later in the progression of HIV disease and the disease sequelae prognoses are exacerbated due to complications related to aging. It is often difficult to distinguish between common symptoms of HIV disease (e.g., fatigue, shortness of breath, chronic pain, weight loss from symptoms caused by aging. For women with HIV/AIDS over 50 years, hormonal (estrogen and testosterone) changes, such as sudden rises and lowering of body temperature (hot flashes), night sweats, and depression may be misdiagnosed as normal symptoms that accompany menopause[lv], which in men could be misdiagnosed as andropause. Misdiagnoses of symptoms may delay early intervention and access to HIV health services.

While antiretroviral therapy is accepted as the norm for HIV treatment, it may cause medical complications, side effects or worsen conditions such as hypertension, diabetes, elevated cholesterol, and heart disease, particularly in seniors. Rates of heart disease, bone loss, cancer and cognitive decline are many times higher in HIV positive people in their 40s and early 50s, compared with HIV negative individuals of the same age. There is growing evidence of greater complexity of disease management associated with long-term exposure to HIV, long-term exposure to medications, aging or some combination of factors.

Service Gaps. Reported service gaps are support groups and medical care for co-occurring, and often age-related, conditions.

Estimated Costs. Service utilization in the DC EMA shows that seniors rely heavily on the CARE Act continuum of care for essential medical services including primary and specialty medical care, medical case management, oral health care, and mental health services, which accounts for $3,536,453.

Black Women continue to be pummeled by the disease HIV infection was the leading cause of death for Black women (including African American) aged 25-34. [lvi] According to the CDC, Black women are disproportionately affected by HIV/AIDS, accounting for two-thirds (66%) of the estimated AIDS cases among women yet account for 12% of the U.S. population of women[lvii]. In the Washington DC EMA, Black women comprise a quarter (25%) of the total estimated population in 2008, but they comprise more than 80% of all living AIDS cases among women. In WashingtonDC, Black women constituted 92% of all women living with HIV/AIDS even though they represent only 58% of the total female population. According to a CDC study of more than 19,500 patients with HIV in 10 cities, women were slightly less likely than men to receive prescriptions for the most effective treatments for HIV infection.[lviii]

Barriers to Care. The physical and psychological needs of Black women living with HIV/AIDS are complicated by poverty, homelessness, discrimination, stigma and isolation, lack of empowerment, competing personal and family needs such as care giving and child care, transportation issues, sacrifice of HIV treatment compliance to address the needs of family members, and domestic violence. Considerable proportions of young Black immigrant women report that their first sex was forced and that they had sex with non-spousal partners who were 10 years or older than themselves.[lix]

Rates of HIV and STI are significantly higher among Black women and teens than women of other racial or ethnic groups. According to Young Black Women: From Research to Practice, high school age African-American women are more likely to begin engaging in sexual activity earlier (61% compared to 46% of Latinas and 43% of White girls) and to have multiple sex partners (16% compared to 11% of Latinas and 10% of White girls)[lx.] This risk behavior among young women of color serves as a driver for increased infection rates in the population, according to Kaiser Family Foundation. In a recent report by Kaiser Family Foundation, it was noted that more than 6 in 10[lxi] new HIV infections among women (including White, Black and Latina women), are amongst women within the ages of 13-39.

Concurrent sexual partnerships (multiple sexual partnerships that overlap in time) have emerged as an important factor in the spread of HIV and other STI according to health experts in a recent article in the American Journal of Public Health[lxii]. Concurrent sexual partnerships promote dissemination of infection through a linked social network where the virus is present.[lxiii.]

Service Gaps. In early 2008, the EMA conducted two focus groups of Black heterosexual women living with HIV/AIDS. One was conducted in suburban Maryland, and the other in the District of Columbia. Participants in the focus groups indicated that they use most of the services in the continuum andexperience long waits for medical and dental appointments, and indicated that they had service gaps around transportation, childcare, and food assistance.

Estimated Costs. Service utilization in the EMA showed that Black women rely heavily on the CARE Act continuum of care for essential medical services including primary and specialty medical care, medical case management, oral health care, and mental health services which account for $4,848,801.

Black Men who have Sex with Men (MSM) constitute the highest proportion of MSM in Washington DC EMA and require special consideration. Approximately 10% of the 2.6 million residing in the Washington metropolitan area reported engaging in sex with other men and may be at risk for acquiring or transmitting HIV. As of December 31, 2009, Black MSM accounted for 16.1% of diagnoses of HIV/AIDS in Washington DC EMA.

According to a recent national study, young Black MSM had nine times more likely than their white counterparts to be exposed to HIV despite similar risk behaviors[lxiv]. The rate of exposure for young Black MSM increases exponentially due to relatively closed social networks where the virus is present. The CDC National HIV Behavioral Surveillance system (NHBS) reviewed data from 8,153 MSM in 2008 where HIV prevalence was 19% with non-Hispanic blacks having the highest prevalence of 28%, followed by Hispanics at 18% and non-Hispanic whites at 16%. Of those who were infected 44% were unaware of their infection. [lxv]Men who know their current HIV infection can be linked to appropriate medical care and prevention services. As the prevalence rates rise for this population, it becomes more likely that young Black MSM will be infected by the virus unless awareness of HIV status is known.[lxvi]

In July of 2005, the CDC estimated that nearly 1 in 2 Black gay and bisexual males are HIV positive nationally[lxvii]. The CDC recently iterated this same point in a new publications released in 2010. The literature suggests that there exists an increase frequency of high-risk behaviors associated with HIV and STI in the MSM population. Factors include the use of internet chat rooms and the popularity of club drugs which lessens sexual inhibitions[lxviii]. A study conducted by the CDC involved 6-cities entitled “The Young Men’s Survey: An HIV Sero-prevalence and Risk Behavior Survey of Young Men who have Sex with Men and Attend Public Venues” documents a high incidence of HIV among the sample of young MSM, specifically Black. The results of the survey reveals that of those who tested positive 32% of them were Black; 14% Hispanic/Latinos; and 17% white[lxix]. Similar local studies indicate that MSM of color have a nearly four-times greater risk of HIV infection than White MSM.[lxx] In Washington DC, MSM and MSM of color are populations that need specialized behavior interventions that address stigma, culture, racism, homophobia, sexual identity and risk factors.

Barriers to Care. Providing care for Black MSM is complex. Medical care frequently requires addressing other challenging issues, e.g., drug use, homelessness, distrust of the medical establishment, and high rates of incarceration. These factors increase the chances of less than optimal treatment adherence and poor health outcomes. Additionally, Blacks often learn of their HIV infection late, enter into care quite late, and have difficulty in accessing care.

The spread of the HIV among Black MSM in the EMA is often considered an urban phenomenon, but it also occurs in suburban and rural areas. . In urban and suburban areas, Black MSM experience unemployment, dire poverty, homelessness, and lack of access to affordable housing or medical care. In Washington DC, where 55% of residents are Black, most reside in three out of eight wards (Ward 5, Ward 7 and Ward 8), which are also the most economically disadvantaged segments of the city and those with the fewest medical and social services. In rural areas of Washington DC EMA, there are limited infectious disease specialists, forcing Black MSM to travel to urban centers to seek care and culturally competent support.

Service Gaps. In a focus group conducted in early 2008 with Black MSM residing in the EMA, participants shared that they had limited access to culturally appropriate services due to their perception of being over the income threshold for CARE Act funded services. Another group member reported an unmet need for clear treatment education services

Estimated Costs. Service utilization in the DC EMA shows that Black MSM rely heavily on the CARE Act continuum of care for essential medical services including primary and specialty medical care, medical case management, oral health care, and mental health services which accounts for $4,977,219.

Latinos/as. Washington DC EMA has seen growth and wide dispersion of the Latino population within the jurisdictions since the last U.S. census. The 2007 Census Bureau estimates that Latino/as account for more than half a million (616,775) or 11.3% of the total EMA population; of these, more than half (51.6%) reside in Northern Virginia, 39.7% in Suburban Maryland, 7.9% in Washington DC, and 0.7% in two counties in West Virginia. Latino/an immigrants in Washington DC EMA originate in various countries and regions, with nearly two-thirds (62.5%) from Central and South America.

Latinos/as comprise 7.5% of the total HIV/AIDS cases prevalence and 6.3% of AIDS cases as of December 31, 2009. The largest number of HIV/AIDS cases among Latinos/as in the EMA is found in the WashingtonDC (1,630, or 52% of the cases [N= 3,115] in the EMA) and Northern Virginia (854 or 27% of the cases). Suburban Maryland has (616 or 20% of this jurisdictions cases) of the Latino/a HIVAIDS cases and the two counties of West Virginia in the EMA have 7 cases accounting for less than 1% of the Latinos/as in the EMA living with HIV/AIDS. In northern Virginia, Latinos/as are disproportionately impacted by HIV, as the area accounts for 27% of Latino HIV/AIDS cases in the EMA.

Barriers to Care. Latinos/as tend to be detected, diagnosed and enrolled in care at later disease stages and higher acuities than members of other racial and ethnic groups. The variations in cultural norms and practices, as well as languages, among Latino/a groups are often under-appreciated, and can constitute barriers to effective prevention messages and care. Access and retention in care is further complicated by social stigma, lack of culturally appropriate HIV education, and for those who are undocumented, and the fear of deportation. Latino/a groups vary widely in their experience with seeking public assistance, and those who are foreign-born may construe anti-immigrant sentiment as a reason to avoid seeking services.

In fact, Latino/a participants in a focus group conducted in early 2011reported that increased information regarding immigration policies specific to persons living with HIV/AIDS is a high priority need. According to a report published by the National Latino/Hispanic AIDS Action Network (NLAAN), increased poverty, lack of culturally appropriate medical services and substance abuse rates also contribute to higher rates of loss to care.

For Latinas many factors contribute to higher HIV rates and poorer health outcomes. As in other racial and ethnic groups, Latinas often sacrifice their health care needs to care for the family. In addition, they are less likely to discuss sex and sexuality, are less likely to know their partner’s HIV status, and are less likely to have access to medical care, or counseling and testing information. In some cases, Latinas seek herbal medicine or other traditional healers for care, which can delay accessing medical care.

Providing health care for Latinos/as with HIV requires cultural competence and language proficiency, including an understanding of diverse cultural heritage, degree of acculturation to U.S. customs and familiar with Spanish and various dialects. Latinos/as face cultural and language barriers that hinder effective communication with health care providers. Oftentimes, an interpreter is needed, and when unavailable, a client may recruit a family member, friend or even a well-intended stranger to interpret, which can compromise the transmission of sometime complicated medical information and instruction. This also compromises confidentiality.

Service Gaps. In early 2008, two focus groups were conducted in the EMA with 21 Latino/participants. One took place in WashingtonDC and the other took place in Northern Virginia. The participants indicated unmet needs for culturally and linguistically competent medical care, dental services, , treatment education, water filters, and legal support.

Estimated Costs. Service utilization in the DC EMA shows that Latino/as rely heavily on the CARE

Act continuum of care for essential medical services including primary and specialty medical care, medical case management, oral health care, and mental health services which is $,667,578.

People Living HIV and Hepatitis C (HCV). HCV is the single most common blood-borne infection in the United States. An estimated 1.8% or 4,000,000 individuals have been infected with HCV. Among HIV-positive individuals, an estimated 16% to 25% have HCV and as many as 90% who acquired the HIV through IDU are co-infected with the HCV. In Washington DC EMA, approximately 6.4% of HIV/AIDS cases are co-infected with the HCV. U.S. Public Health Services Guidelines recommend that all people living with HIV/AIDS be tested for HCV antibodies. In Washington DC EMA, the routine offer of HCV screening is the standard of care.

Barriers to Care. HIV/HCV co-infection poses a great challenge to both medical providers as well as public health practitioners. In co-infected persons, HCV progresses faster, leading to serious liver disease. HCV treatment is costly, long in duration and has debilitating side effects including depression.

Before the advent of antiretroviral therapy many co-infected individuals died of other opportunistic infections before serious hepatitis-C related liver damage developed. Today, with increased survival due to antiretroviral therapy, the incidence of liver-related morbidity and mortality due to HCV co-infection has increased. This requires increased knowledge about treatment of HCV and coordination with HCV disease specialists for people living with HIV/AIDS. Hepatitis C viral load is necessary to confirm HCV infection. Some providers delay RNA testing until patients are considering treatment or require a biopsy. These complications can increase the costs of services for people with HIV and HCV.

Treatment of HIV and HCV has evolved with tremendous successes in the prognosis of patients. However, treating both conditions has many challenges. Optimal strategies to treat both HCV and HIV are being developed. Providing treatment and comprehensive care for HIV/HCV co-infected individuals poses a great challenge to providers who must confront client problems such as psychiatric or medical conditions, drug and alcohol addiction, and client acceptance and adjustment after HIV diagnosis.

IDU are most at risk for HIV and HCV co-infection. That means, necessarily, that treatment of HIV and HCV must combine a myriad of services designed to address adherence complications of these co-morbid factors, including treatment for substance abuse. Quite often, patients require basic stabilization and support services prior to initiation of treatment for any illness, especially before being treated for the HIV and/or HCV. Health care providers are tasked not only with providing quality care, but also with being prepared to engage clients with compassion holistically counsel to address bio-psychosocial challenges and unrelentingly encourage patient contemplation and initiation of HIV treatment. Adding to the challenge is the need to incorporate health system capacity to address the treatment needs of co-infected patients within multiple treatment settings such as correctional facilities, primary care facilities and substance abuse treatment clinics.

Service Gaps. In early 2008, Washington DC EMA conducted a focus group of people living with HIV/AIDS and Hepatitis C. Fifteen participants indicated that they generally access the full array of CARE Act Part A funded services and that they are satisfied with these services. However, they also indicated service gaps around housing, utilities, food, and transportation. Several discussed the need for co-located services, stating that it is often difficult to keep multiple appointments at different providers when living with dual or triple diagnosis (HIV, Hepatitis C, substance abuse and/or mental health) and seeking experts in different venues.

Estimated Costs. Service utilization in the DC EMA shows that these individuals rely heavily on the CARE Act continuum of care for essential medical services including primary and specialty medical care, medical case management, oral health care, and mental health services which is $6,662,912. Individuals co-infected with Hepatitis C are the most expensive group of the special populations to care for in the EMA.

1.e. Unique Service Delivery Challenges

- The epidemic is increasingly characterized as individuals with complex, co-morbid conditions, challenging the durability of viral suppression.
- Increased need and decreased or stable local funding increase pressure on CARE Act funds.
- Complex governance issues in a multi-state EMA can stall program performance.

The Washington DC EMA is uniquely challenged in delivery of CARE services to a several complex populations, across a large and geographically diverse area. The EMA has a number of extremely impoverished areas with high concentrations of substance abuse, poverty, illiteracy, and lack of health resources. In the EMA there is also a large community population of IDU and other substance abuse users who present with co-infections of hepatitis C, Sexually transmitted infections (STI)-syphilis, and with mental illness. Extremely impoverished areas throughout the EMA coupled with decrease in local, state, and federal funds for substance abuse, mental health, housing and other support services has only increased the need for a variety of resources. The following are selected areas of unique service delivery challenges for the Washington DC EMA.

Poverty. In the EMA, an estimated 51% of the PLWH/A are living below the federal poverty level. In Prince Georges County 1 of every 341 households is in foreclosure, the highest percentage in Maryland, prompting a drop in property tax revenues and an imposed furlough on county employees. Similar situations are occurring in other jurisdictions in the EMA, with federal, state and local revenues decreasing, resulting in decreases in funding for substance abuse treatment, mental health counseling, housing, interpreter services, and other social and supportive services accessed by PLWH/A, thus increasing the burden on CARE act services. Case managers must work even harder to locate appropriate referral sources to help clients met their ongoing needs for the basic necessities. Getting appropriate services to individuals who have multiple needs and who are often unable to meet their basic living necessities is a complex and expensive proposition.

Housing. In the EMA, the housing index continues to rise at a faster pace than income, resulting in a tremendous amount of displacement of low-income and affordable housing. Housing As a result, many PLWH/A are challenged to meet the expenses of daily living, some are forced to move out of their residences and relocate in other jurisdictions with the EMA. This creates difficulties in maintaining or accessing services and pose challenges as clients must consider the trade-offs between where one lives and where one seeks or prefers to receive care. Transportation can be costly and may be prohibitive when a local provider is available. Over the last year, the cost associated with Metro fair cards to ride local metro-train and cars have dramatically increased by more than 30% causing severe economic strain on those living at our below poverty. There is a 40 cents extra charge imposed on individuals that are attempting to access the metro-services over peak hours of operations, which is often the times that individuals will be seeking appointments for core and support services.

Moving is a top reason why people fall out of care. Service providers who attempt to reach out to clients to help maintain them in care are often faced with disconnected numbers and “no longer at this address” notices for their patients. This compounds the cost of care for those patients when they do return to care, often in a progressed diseases state. The EMA is working on developing a stable, flexible system of care that accommodates individuals who are negatively impacted by the lack of affordable housing and housing subsidies.

Cultural and Language Barriers. The 2010 Census reveals that the EMA has approximately 22% foreign born individuals living in the EMA and 23% of the population primary language is not English. A 2003 Brookings Institute study reveals that the Washington Metropolitan area ranked 7th of all US metropolitan areas for the number of foreign-born residents. Immigration into the area has been rapid and multi-faceted. Representing 193 countries, immigrants have come from: Latin America and the Caribbean (39%); Asia (36%); Europe (12%); Africa (11%) and many other countries (2%). In the Washington Metropolitan Area over 100 different languages are spoken. Many new immigrants arrive from developing countries where HIV is widespread, including Sub-Saharan Africa. In Montgomery and Prince Georges County, Maryland, approximately 35% of PLWH/A in care were born in Africa, prompting a recent consultation with HRSA In all, diverse PLWH/A in the DC EMA represent more than 25 different countries, cultures, languages and dialects.

A lack of culturally competent care, limited English proficiency, cultural beliefs and norms about health and sexuality influence access to and utilization of HIV/AIDS care in the EMA. Traditional and cultural norms may discourage identification and reporting of HIV/AIDS among immigrants and foreign-born citizens. Gender inequality and imbalance of power in relationships inhibit many women from accessing services freely. Oftentimes, the power imbalance in relationships increases when a couple moves from a foreign country to the U.S., where many women become even more disempowered in the new culture. Immigrants are less likely to use mainstream and preventive health services, may be more likely to depend on traditional folk medicine and home remedies and may experience cultural stigma and loss of support due to an HIV diagnosis.

Misconceptions about HIV disease persists in immigrant communities. Many believe that they can avoid infection by engaging in anal or oral sex, or by older men having sex with younger women. Contrarily, these and other sexual practices commonly used for birth control may actually increase the risk of HIV transmission. For a large segment of recent immigrants, the migration process plays a role in the increased likelihood of infection, particularly for those who have been refugees. Overcrowding, violence, rape, despair and the need to sell or exchange sex to survive characterize refugee camps. These factors haven reported by the UNAIDS Program as contributing to the increase in HIV infection. Additionally, as a result of culture shock and the stress of trying to become economically independent, many immigrants and refugees continue their risk behaviors, including substance abuse and multiple sex partners, upon arrival to the U.S.

Developing Capacity to Meet Diverse Needs. Providing culturally specific and competent services for immigrants, those who are illiterate, individuals who move frequently, and the impoverished is a major undertaking that requires specialized training, thereby incurring substantial costs. Agencies may require organizational capacity-building and providers may require continuous training and professional development in order to identify and provide quality services for individuals living with HIV disease, who, oftentimes, require services delivered by providers who have become culturally proficient, speak the languages and are knowledgeable of the cultural idiosyncrasies of the cultures being served. If not, then some clients may require translation and interpreter services providers to foster health care access.

The above presented complexities and needs are the basis for the request for increased funding to the Washington DC EMA. The Implementation Plan and the EIIHA Strategy identify initiatives that will improve the capacity of the EMA to strategically target effective services and programs to disproportionately affected populations.

1.f. Impact of a Decline in CARE Act Formula Funding

The EMA did not experience a decline in CARE Act Part A Formula funding.

1.g. Unmet Need Framework

Assessment of Unmet Need, Implemented Activities and/or Plan

The Health Services Resources Services Administration defines “unmet need” as the proportion of persons who know they have HIV/AIDS who are not receiving primary medical care. Primary medical care is further defined as evidence of receipt of a CD4, viral load, or use of anti-retroviral medications during the specified formerly-od, usually a 12-month formerly-od. The estimate of unmet need in Washington DC EMA was completed using data available at the time of this application. The four (4) jurisdictions in the EMA independently completed their met and unmet need using disparate data sets, each of which has unique limitations. The Planning Council has used the unmet need framework for developing this comprehensive plan and for formulating strategies to eliminate disparities in access and services among underserved communities; the unmet need data are under consideration in the use of formula to guide the geographic distribution of funds within the EMA.

Methodology for Estimate of Met and Unmet Need

Washington DC estimated met need primarily through linking five databases: the Medicaid, Laboratory report, AIDS Drug Assistance Program (ADAP), CARE Act HIV/AIDS Program Services Report (RSR), and eHARS. Potential limitations of this unmet need calculation may result from the incomplete laboratory data, clients moving out of jurisdiction, and unknown deceased cases.

The Virginia jurisdiction assessed unmet need by determining the proportion of persons “in care,” or those with either a viral load and CD4 test, evidence of antiretroviral therapy, or a HIV/AIDS-related health care visit during the 12-month period from 01/01/10-12/31/10. Virginia linked data from multiple sources which including e-HARS, the Virginia Client Reporting System (Ryan White Part B database), the Medical Monitoring Project, electronic lab reports, ADAP, CAREWare, and Medicaid.

In the West Virginia jurisdiction, met need was estimated from linked provider service database, Medicaid, and HARS. No new sources of data for estimation were used for the 2010 calculation.

In the Maryland jurisdiction, the Department of Health and Mental Hygiene utilized data from the CDC funded Medical Monitoring Project where patient level antiretroviral prescription was extracted from the national IMS Health LRx Database. eHARS was used to quantify the total HIV/AIDS cases in the Suburban Maryland region. Additionally, other payer mix, both public and private was used to develop a count of people who received primary medical care.

All frameworks were combined to calculate the EMA unmet need. The Planning Council deemed the results as reasonable despite differences in the calculation of each regional framework. The results were used as consideration for allocation of Part A funds across the continuum of care.

Considerations: The wide array of datasets used in these calculations has increased the chances that those in care are appropriately counted. Likewise, it may potentially increase the chances of multiple inclusions within a jurisdiction but the chances across jurisdiction are not significant since the data sources are so disparate and varied.

The HARS datasets which all the jurisdictions utilize to count HIV/AIDS cases are adequate and comprehensive. In Virginia and West Virginia, mandatory CD4 and viral load are incorporated in the reporting system. These two jurisdictions utilize mature name based reporting for HIV and AIDS. However, Maryland and DC had, until 2006, used a code based HIV reporting system and have now implemented name based reporting. Looking closer, jurisdictional results indicate regional variances:

The total number of cases estimated to have primary medical care in the EMA is 18,926. The total number of cases with an unmet need for primary medical care is 15,168. Table 21 depicts the distribution of cases of both met and unmet need by jurisdiction within the EMA, and notes the proportion of total cases for which each group accounts.

Table 15: Cases of "Met" and "Unmet" Need by Jurisdiction

Jurisdiction	"Met Need"		"Unmet Need"	
	N	%	N	%
Washington DC	10,069	58.3	7,203	41.7
Suburban Maryland	5,478	59.1	3,790	40.9
Northern Virginia	3,254	45.0	3,970	55.0
West Virginia	125	37.9	205	62.1
Total	18,926	55.5%	15,168	44.5%

These data indicate that West Virginia jurisdiction has the highest proportion of unmet need for primary medical care, followed by Northern Virginia. Washington DC still carries the highest burden of cases in real numbers.

Note that two of the jurisdictions in the EMA continue to transition from HIV code-based to names-based reporting. The transition to date and the dramatic increase in the depth and reliability of surveillance information have led to have a richer understanding of unmet need in the EMA. There are more individuals in the EMA impacted by the epidemic requiring increased funding for the EMA and a need for innovative approaches to meet the unmet needs of individuals in the EMA.

Table 16 Unmet Need Trending Analysis (2009-2010)

	2008	**2009**	**2010**
Total	**16,420**	**17,507**	**15,168**

2. Early Identification of Individuals with HIV/AIDS (EIIHA)

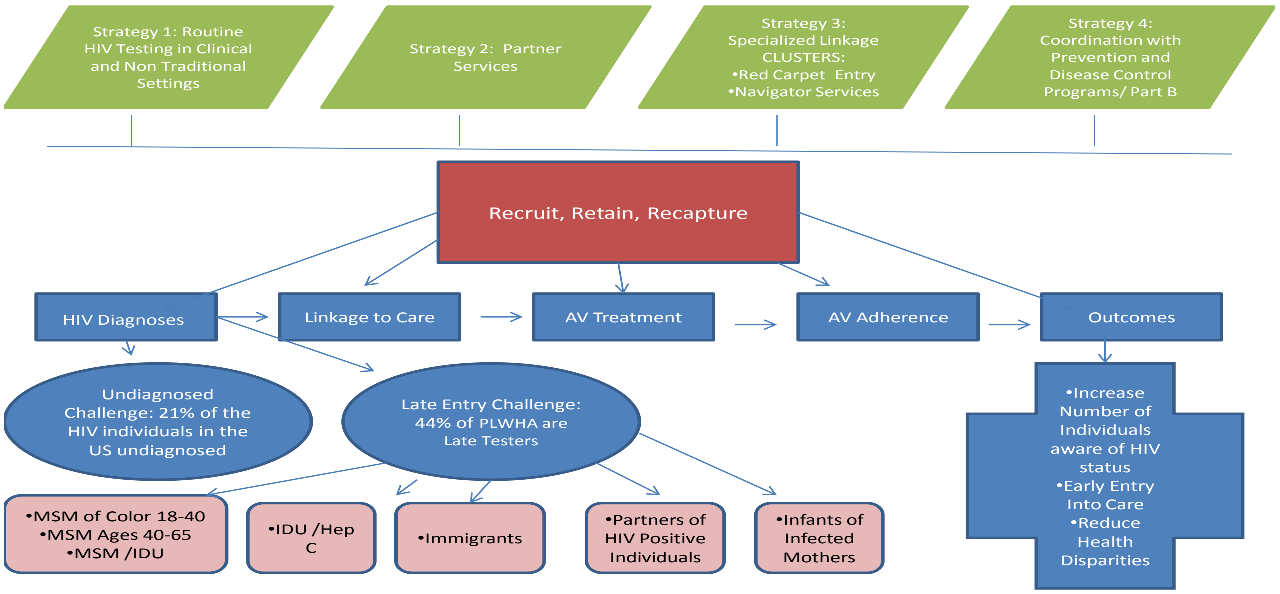
- The EIIHA Strategy mirrors the National HIV/AIDS Strategy
- The strategy ensures that individuals are aware of their HIV status, informed of their status, linked into care if HIV positive, and referred to supportive services if HIV negative.

All of the challenges in forging comprehensive strategies to identify individuals who are unaware of their HIV status are disproportionately evident in this EMA. The epidemic reaches into every socio-economic stratum in the EMA, and continues to disproportionately impact African Americans of every gender, sexual orientation and behavioral risk profile.

To increase the number of PLWHA who are aware of their status and promote early entry into care, the EMA collaborates with local, state and federal government agencies to develop a coordinated and seamless systems to increase awareness of HIV, improve the rates of HIV testing as a part of routine medical care, offer additional multiple opportunities and points of engagement for HIV testing, and most critically identifies, inform, refer and link and support previously unaware HIV positive persons to ambulatory outpatient medical care. The figure below depicts the EIIHA strategy and populations which are the focus of the strategy.

A major component of the EIIHA strategy is to increase HIV screening, testing and referral and to establish screening as part of routine care, particularly in the geographical areas of the EMA with distinctly high rates of HIV infection. These screening programs are consistent with CDC 2006 Revised Recommendations for HIV testing of Adults, Adolescents and Pregnant Women in Health Care settings.

Figure- EIIHA Strategy 2012



Each jurisdiction in the EMA coordinates testing, at some level, in various settings reaching different sub-populations, including STD and TB clinics as well as encourages medical providers to adopt guidelines for routine opt out HIV screening. Within the District, expansion of routine opt out HIV screening in medical settings has greatly increased the number of DC residents knowing their HIV status. The expansion in the number and type of providers conducting routine HIV testing, this effort could help move the Department of Health closer toward achieving its goal of finding all persons who are unaware of their HIV status. Scale up of routine testing in medical settings within the District has resulted in a 19% increase in the number of tests provided in 2010.

District laws and regulations require insurance carriers to pay for the cost of HIV testing. This is sometimes challenging in an environment with significant populations served by managed care organizations, which do not always offer optional services. At the direction of the Mayor, HAHSTA is leading an effort to improve compliance by insurance carriers.

Due to the pervasiveness of the epidemic, it is vitally important to support efforts for HIV screening, testing and linkageservices for individuals who do not seek routine medical care. The District of Columbia implemented HIV testing at a Department of Motor Vehicles office (DMV), improving access and visibility, contributing to a sense of “normalcy” for HIV testing and increasing testing for hard to reach individuals in a nontraditional setting.

The EIIHA plan includes multiple jurisdictions, and multiple sources of funding.

HAHSTA will establish an advisory workgroup from various Bureaus within HAHSTA, neighbor jurisdictions, community planning partners, including prevention, surveillance and Part B, as well as external members from the Planning Council Comprehensive Planning Committee, Part C providers and the Community Prevention Planning Group, which is a consortium of providers and programs. The workgroupwill be charged with creating a detailed and integrated EIIHA work plan that aligns itself with the Washington DC ECHPP and the EIIHA matrix.

The EMA EIIHA Matrix (Attachment 9) illustrates the framework for the EIIHA strategy highlighting the populations that are at highest risk for being unaware of their HIV status. The matrix addresses the full continuum of unaware individuals, including individuals who were tested but did not receive post test counseling or a confirmatory test, untested high risk populations unaware of their status as well as moderate and low risk individuals unaware of their status. This framework has enabled the EMA to engage in active, deliberate andcoordinated planning that is proving to produce more coordinated EMA wide activities and can result in a more efficient system. The matrix was used to allocate funding for the requests discussed in Section 3. If increased funding is awarded, we will be able to expand or implement the strategies discussed under the EIIHA plan section.

The goals and objectives of the EIIHA plan provide the framework for developing and supporting service models that promote awareness of HIV status and support rapid and sustained linkage to medical care for new positives reduce health disparities. The goals are in alignment with the National HIV/AIDS Strategy and are listed below:

Goal 1: Increase the number of individuals who are aware of their HIV status

Objective: Increase the number of individuals, particularly the EIIHA target populations receiving voluntary HIV rapid testing.

Goal 2: Promote early entry into and continuity of HIV care

Objective: Increase the number of newly diagnosed individuals who enter into primary care within three months of HIV diagnosis

Goal 3: Reduce HIV/AIDS health disparities

Objective: Increase targeted testing in high –impact communities that ensures linkage to care especially for the targeted subpopulations identified in the EIIHA plan.

(2)(A) Strategy

(2)(A)(1)(a)(i) Goals, National HIV/AIDS Strategy goals

The EIIHA strategy is designed to align with each of the goals of the National HIV/AIDS Strategy. **Increasing the number of individuals aware of their HIV** status will be achieved through innovative activities that will expand testing venues and reduce HIV transmission. **Promoting early entry into and continuity of care** will be challenging for the identified target groups, but accomplished through expansion of the effective “Red Carpet Entry” program, complemented by peer-based Early Intervention Services.

The EIIHA strategy is to deploy a strategic consolidation of service providers, service categories and funding resources. This will strengthen a coordinated approach to delivering HIV related services through documented linkages among organizations and institutions. This encourages access to medical care and critically important support services. The plan expands the capacity of providers generally to improve patient adherence to antiretroviral treatment, increasing the proportion of patients with durable viral suppression and reducing infections.

The Districtlaunched in 2009 the Red Carpet Entry (RCE) to ensure ease of a first HIV medical appointment within 72 hours following initial clinic contact. One year results of the

RCE Project indicate that 70% of persons served through RCE were confirmed in care within seventy-two hours.

(2)(A)(1)(a)(ii) Making individuals who are unaware of their HIV status aware

Promoting awareness of HIV status in a geographically large, racially, ethically and linguistically diverse region with over 5.5 million people in the face of declining prevention funding is an immense challenge

Increasing HIV screening as a part of **routine medical care** across a broad continuum of medical services is key. It is important to note that the differences in laws among the four states comprising this EMA do not permit a single. The District of Columbia has no legal or regulatory requirement specific to an HIV test, so health care providers can include HIV screening as part of a larger and more routine set of health care tests. Over two years (2008-2010), HIV testing in the District increased by 37%. In West Virginia, the Veterans Administration – a key partner in HIV services – has included the offer of an HIV test as a part of routine medical care. In Maryland, aggressive case finding strategies are encouraged in medical care settings, substance abuse treatment services, partner services for HIV positive persons through testing. In Northern Virginia, funded testing services are provided in selected adolescent clinics, Planned Parenthood sites and the local health department in addition to traditional medical care settings.

Other strategies to promote increased HIV screening include testing in **non-clinical settings**. District statistics for special populations estimate HIV rates among gay and bisexual men at 4.1%; women at 1.3%; Latinos/as at 1.4%; and IDUs at 6%. Research and experience have shown that targeted testing through non-traditional venue based testing, social networking or sexual network testing could identify more than three times as many people with HIV than routine testing at traditional venues.[lxxi] Increasing the range of services under Partner Services, including outreach to individuals who may have been exposed to HIV through a sexual or injection-related encounter with an individual with HIV enables the system to target case finding activities, thereby improving health outcomes.

Increased testing of pregnant women has produced effective results. Surveillance data from 2001-2006 reflected a higher rate of peri-natal HIV infection in the EMA than in the country as a whole, comprising comprised 9% of all peri-natal cases nationwide. Rapid HIV testing is in place in six of the seven district’s labor and delivery suites. During calendar year 2009 and 2010, no new infections were reported among infants in the District of Columbia.

(2)(A)(1)(b) Coordination with other programs/facilities and community efforts

Washington DC EMA benefits from multiple funding streams and decision makers, from multiple federal sources and through multiple administrative agents. Coordination among all the grantees and sub-grantees within and across state borders is an enormous challenge, and reflects many of the same challenges at the federal level.

ThePart A Grantee has developed and sustained strong partnerships with the EMA governmental partners, numerous governmental and nongovernmental entities to fund providers and develop strategies to improve early identification of individuals with HIV/AIDS. HAHSTA partners with 39 community organizations for the provision of CTRS in a wide variety of settings including hospitals, clinical settings, specialized, non-medical, community based organizations and upon entry into the DC Jail.

The EMA PC increased its allocation of funds for Early Intervention Services to expand support for this coordinated effort. For 2012, HAHSTA seeks opportunities to increase the availability of HIV testing to more clinical settings, and plans for fully implemented, sustainable routine HIV testing programs in all District hospital emergency departments.

In addition, HAHSTA will continue to work with managed care organizations (MCOs), Medicare, and Medicaid, as well as collaborate with the DC Primary Care Association, to promote routine, opt-out HIV testing in primary care facilities throughout the city and encourage partner jurisdictions to adopt similar strategies. HAHSTA has also entered into a collaborative relationship with the PA-Mid-Atlantic AIDS Education and Training Center that includes a component to support routine HIV screening in private dental offices, creating yet another opportunity to identify HIV positive persons who are unaware of their status. HAHSTA continues its partnership with CBOs to reach high risk individuals and make HIV screening available in non-traditional settings to reach the most vulnerable. HAHSTA will continue to encourage the implementation of innovative methods to identify persons with undiagnosed HIV infection, such as couples HIV testing and social networks recruitment.

In Northern Virginia, the Virginia HIV Community Planning Group (CPG) composed of education and service providers, clients, state agency representatives, the clergy and private citizens has developed a comprehensive HIV Care and Prevention plan for the Commonwealth of Virginia that includes the Northern Virginia area of the DC EMA. The addition of a staff member from the Northern Virginia Regional Commission to the CPG helps to keep the CPG informed of the issues specific to the northern region. This representation enhances communication, cooperation and coordination to address the epidemic in the DC EMA. This same representation also serves as a resource for HAHSTA and the DC Planning Council in its efforts to develop a cohesive EIIHA plan. This response builds on the work of the Profile Project that cited the lack of a deliberate planning process as a detriment to finding new persons needing to know their HIV status. Under the leadership of the Northern Virginia AIDS Ministry (NOVAM) and with the support of the Virginia Department of Health, along with participation from numerous HIV/AIDS public and private entities from throughout the Northern Region, the group has met for the past year and a final prevention report is pending fall 2011.

(2)(A)(1)(c) EIIHA activities and strategies and the RFP

The Planning Council has allocated FY 2012 funds to the Early Intervention Services category in support of EIIHA activities and emphasizes two principles: First, EIS services will complement, but not supplant, current HIV testing efforts. Use of EIS funding for HIV testing will be permissible, but will require demonstration that HIV testing for the high-impact, high-yield populations to be served is not otherwise available. Successful EIS applicants will be asked to demonstrate the “value added” to existing HIV testing programs, includes ensuring appropriate linkage to HIV care, along with intensive, short-term follow-up with newly identified clients to ensure maintenance in care.

Secondly, EIS funds will be deployed through a model of services to be provided by peer EIS workers. The strategic use of trained peer workers will be designed for relatively short-term (up to six months) intervention and support to ensure that newly-identified HIV positive individuals have the necessary support and other services to enroll and initiate care. This model of services is scheduled for implementation during Grant Year 22.

More generally, providers of services funded by CARE Act Part A funds will be expected to increase collaboration, co-location and coordination of services. In some cases, large primary care organizations will enter into agreements with social and support service providers to co-manage client care, and maximize the efficiency of services provided.

The Planning Council will consider directives to guide the implementation of specified activities. Program activities will be developed to meet the specific needs of each target group, in order to identify, refer and link newly diagnosed HIV positive individuals to care.

(2)(A)(1)(d) ADAP and other medication resources

Four separate AIDS Drug Assistance Programs serve residents of the EMA, which vary due to the very different underlying systems of services for low-income people and Medicaid coverage. One of the four states included in the EMA has a waiting list for ADAP, Virginia. According to Kaiser Family Foundation as of September 1, 2011, there were 957 persons on the waiting list in Virginia. Virginia has implemented a cost containment strategy of reducing prescription coverage from 90 days to 30 days, requiring reapplication more frequently.

Part A funds will be deployed during Grant Year 22 to provide a short-term “bridge” for eligible clients on an ADAP wait list.

With the current economic situation the outlook for the fiscal stability of the other three of the programs is concerning. Each partner in the EMA – grantee, administrative agents and the Planning Council – are aware of the potential need to re-allocate funds to ensure the availability of medications. Routine analyses of expenditure, service utilization and needs assessment data will be conducted in order to allow the PC to re-allocate funds during the service year.

(2)(A)(1)(e) Disparities in access and services.

Part A funds are critically needed to fill in gaps in services across the EMA, but cannot realistically be expected to eradicate disparities that inherently exist in each state. The target populations disproportionately affected by HIV/AIDS also experience disparities in access and services. The EIIHA matrix prioritizes these target populations.HAHSTA aims to decrease disparities through strategic initiatives designed to build the capacity of organizations that work with these target populations in these areas, to target services to residents of under-served geographic areas, to develop health marketing campaigns and to continue aggressive case management services throughout the EMA..

The EIIHA planning process will afford an opportunity for the EMA to develop shared assumptions and priorities. Currently, the EMA independently develops sub state regional recommendations for service categories to be funded and funding allocations which the PC rarely changes. This will help to create EMA wide service models and move toward parity.

(2)(A)(1)(f) Programmatic, systemic, and logistical challenges

Consistent with national trends, the ability of governments within the Washington, DC EMA to maintain and expand health and health outreach services 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 test.

In the EMA, some 44% of persons 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.

Logistical issues such as transportation are a challenge in the EMA because transportation is not readily availed across the EMA. The topography of West Virginia isolates one region from another and makes travel very difficult. Equally affordable transportation is a significant and persistent barrier for persons living in Northern Virginia and Suburban Maryland; less than half of the suburban Virginia jurisdictions have mass transit. There are linguistic challenges across the EMA. Immigration into the area has increased different populations from Latin America, the Caribbean, Asia, Europe, Africa and others.

(2)(A)(1)(g) Ryan White Program and routine HIV testing within the EMA

Routine testing is common among providers funded by CARE Act funds, but less common among “mainstream” providers, and not always encouraged by public or private payor sources. A social marketing campaign, supported in part by CARE Act Part B funds, encourages individuals to request an HIV test, and for providers to offer the HIV test. HAHSTA has led an effort to ensure compliance with District regulations for private and Medicaid managed care organizations to pay for HIV testing..

(2)(A)(1)(h) Coordination with Ryan White Part C program

With one exception, each of the Part C programs in the EMA are also supported by CARE Act Part A funds, and a smaller number have programs supported by Part B funds. HAHSTA has led the effort to establish a single standard of care without regard to funding source, and works with each of its provider partners to plan and implement programs by strategic deployment of all local and federal resources. Of particular significance are the joint projects with Federally Qualified Health Centers in the EMA, which support the Red Carpet initiative in the District of Columbia. CARE Act Part C providers are members of the EIIHA advisory workgroup and will serve as critical partners in implementing innovative strategies.

(2)(A)(2) Develop a matrix listing the Parent and Target Groups.

The EMA has identified four high risk parent groups and five target groups that are more likely to be untested and unaware of their HIV status as illustrated in the Attachment 9. Using the matrix structure, HAHSTA has analyzed how existing early identification methods and activities must be enhanced, expanded or modified to increase the awareness of each identified population. With limited resources, the EMA strives to maximize the extent and coverage of services by providing a two tiered model for the delivery of testing, referral and linkage services. The general public, including moderate and low risk individuals receive the base tier of services and high risk individuals receive a higher tier of services that target specific needs or issues. The EMA is also ensuring that Early Intervention Services are available in each jurisdiction.

(2)(B) Plan

(2)(B)(1) Describe the barriers which obstruct awareness of HIV status

(2)(B)(1)(a) Target Group, Respective Needs, Awareness

MSMs, immigrants and substance users are populations that present challenges because there are a myriad of social and environmental factors that shape the context of vulnerability for HIV transmission and increase their risk exposure and or compromise their ability to protect themselves from infection. The following factors give rise to barriers which obstruct awareness of the HIV status in the identified target groups:

For substance abusing MSMs of color, the drug methamphetamine is used for reasons related to sexual enhancement, and / or to meet cultural expectations and norms of sexual prowess and sexual success in the gay community".[lxxii]IDUs with hepatitis are often focused on other barriers such as housing and utility costs, declining incomes according to a 2008 focus group so HIV testing is not a high priority for this social network.

(2)(B)(1)(b) Target Group, Cultural Challenges

Stigma remains an issue for MSMs of any age as well as MSM/IDUs and immigrants. Stigma encompasses a broad range of psycho-social dynamics such as personalized stigma, disclosure concerns, negative self-image and concerns with public attitudes about HIV. It can interfere with health and risk behaviors including seeking knowledge of HIV status. Another frequently cited challenge particularly for young MSMs is the lack of a history of seeing the devastating effects of the disease; hence for the young it is no longer a priority or necessity to get tested. Stigma related to same-sex behavior and stigma related to injection drug use makes it difficult to reach MSM/IDU and IDU/Hepatitis C individuals. Some are fearful of disclosing their IDU status due to the illegal nature of their behavior.

(2)(B)(2) Barriers that obstruct awareness of HIV status.

(2)(B)(2)(a) Priority Needs

In Northern Virginia, NOVAM provides free rapid testing for 14-29 LGBTQ population. The agency also has testing services and website in Spanish. Social network strategies (SNS) are also used to case find among specific social networks. These strategies help reach individuals outside of the care system including young MSMs, MSMs 40-64, immigrants and IDUs. SNS uses persons who engage in activities that are high risk for HIV infection to act as recruiters and bring in people from their social network for HIV testing.

In the District, Crew Club is a program that targets HIV and syphilis testing in bath houses. This is a partnership with Crew Club (DC's only recreational facility with a bathhouse component) and Gilead Sciences offer HIV and syphilis testing at the venue. In 2010, positivity for HIV was nearly 4% and almost 10% for syphilis. This project will continue to use this environment to promote and conduct testing for the MSM and IDU populations.

The District also found great success with social networking. DC was one of several selected cities that implemented social networking for the CDC demonstration project in 2005-2006. The DC program yielded an average positivity of 9%.

Timeline: These efforts are in place and ongoing.

(2)(B)(2)(b) Cultural Challenges

For the target groups- MSMs of Color 18-40, immigrants, MSM ages 40-65, MSM/IDU and IDU/Hepatitis C-infected, HAHSTA uses social mobilization program to promote positive behaviors, such as increased use of condoms and increased use of routine screening for HIV. HAHSTA will continue this comprehensive marketing program to address reduction of HIV/AIDS and STDs. The strategy of the social mobilization program is to motivate members of the targeted groups through culturally appropriate messages to seek regular screening, reduce risky behaviors, and access available care, treatment, housing and drug assistance services. In the District, a five-year comprehensive social marketing program called "DC Takes on HIV" is now in year three. Specific messages were developed for each targeted groups around the issues of routine HIV testing, condom use and partner relationships and communication. HAHSTA has also supported a youth social marketing program called "REAL talk" through a community partner Metro Teen AIDS. REALtalk, launched in 2008 distributes media tools for text messaging, a web site, outreach activities and public transportation advertising around HIV and STDs. Social marketing creates a social context to reduce stigma associated with HIV testing.

Timeline: These efforts are in place and ongoing.

(2)(B(3) HIV testing in the EMA/TGA.

(2)(B)(3)(a) Coordination.

HAHSTA partners with 39 community organizations to provide CTRS in a variety of key points of entry. In calendar year 2010, there were 133,066 HIV publicly funded tests administered. In order to support the level of scale up, partnerships with private pharmaceutical companies have been critical especially with targeted screening approaches. HAHSTA has reached out to ensure scale up testing in medical settings as a part of routine medical care. In 2010, seven out of 8 emergency department settings now conduct testing in the District; promoting the use of HIV status as the fifth vital sign in primary care networks. Unity Health care has expanded this initiative to seventeen sites that serve over 80,000 primary care clients.

(2)(B)(3)(b) Describe the role of Early Intervention Services in facilitating HIV testing.

The Planning Council has worked to strengthen support for the EIIHA plan across all jurisdictions. For FY2012, the Planning Council increased the total allocation of EIS funds to 5.6% of core service funding; a significant increase.

EIS is designed to complement, but not replace, HIV testing and outreach programs by supporting necessary interventions for high-impact, high-yield populations. HIV testing is permissible if it is not provided by any other source of funds. Activities include short term intensive activities to ensure rapid enrollment of those with HIV.

Also critical is the ability of EIS providers to establish relationships with points of entry, including HIV testing sites, sexually transmitted disease clinics, homeless shelters, substance abuse programs, re-entry programs, hospital emergency rooms, mental health programs, adult and juvenile detention centers and other venues where potential clients might first learn of or disclose their positive status. A key component of this strategy is the use of community health workers who are reflective of the racial, cultural and life experiences of persons living with HIV to be connected or re-connected into care.

(2)(B(4) Identifying, Informing, Referring, and Linking

(2)(B)(4)(a) Identifying individuals unaware of their HIV status

The following matrix provides a broad overview of some of the essential/key activities in support of *Identifying, Informing, Referring and Linking* to care :1) individuals who are unaware of their HIV status; 2) individuals that have been tested in the last 12 months and 3) thosewho have not been tested in the last twelve months:

Identifying	o Routine HIV testing in clinical settings. o Promoting testing through social network affiliates of individuals who have tested recently; o Use of surveillance data to locate populations who are unaware of their HIV status and to target case finding efforts; o Increasing the range of services provided through Partner Services such as outreach to individuals who may have been exposed to HIV through a sexual or injection related encounter with an individual with HIV; o Targeted social media campaigns; o Strengthen partnerships and collaboration between CARE Act care system and points of entry and support services; o Targeted testing in high impact communities
Informing	o Rapid testing allows for immediate informing. o Preliminary positive test results create a first appointment for primary care, which confirms HIV infection. o Enhance Partner Notification o Mother receiving care
Referring [lxxiii]	o Coordinated service delivery system between key points of entry and HIV medical and support services as evidenced by written agreements; o Development of plans of care engagement for persons identified; o Monitoring the progress of clients in engaging in HIV related primary care, medical case management and other needed services; o Tracking and reporting on referrals using quality performance bench marks.

Linkage	- Upon HIV-positive result, a first appointment for ambulatory outpatient medical care is established. - A “red carpet” model has been created to facilitate easy entry into a first appointment within thirty-six hours. - A Grant Year 22 standard of care for CARE Act funded ambulatory outpatient medical providers include rapid first appointments - Increased funds in Grant Year 22 for early intervention services will support rapid entry into care - A core expectation of all providers of primary care, medical case management, substance abuse and mental health services is to conduct “in-reach” or “re-capture”

(2)(B(4)(a)(i) Essential Activities

For individuals individual who are unaware of their status, essential include:

- Routine HIV testing in clinical and non clinical settings, including promoting testing through social network affiliates of individuals who have tested recently;
- Increasing the range of services provided through Partner Services such as outreach to individuals who may have been exposed to HIV through a sexual or injection related encounter with an individual with HIV;
- Strengthen partnerships and collaboration between CARE Act care system and points of entry and support services

(2)(B)(4)(a)(i)(a) Essential Activities – Implemented Immediately

The Washington DC EMA has made some strides regarding all activities although the level of achievement varies across jurisdictions. EIS funding in FY2010 was limited to the jurisdiction District of Columbia and since has been expanded to each of the jurisdictions. For the FY2012, the PC has increased percent allocation for EIS services. As a result, each jurisdiction will have opportunities to define their strategy. However, EIS funding is limited.

Strengthened partnerships are being achieved through clustering services. premise behind clustering is that successful enrollment in medical care is dependent on a multiple set of services obtained at the same time. The cluster approach first tested under MAI services requires funded providers to guarantee access to a set of core services. During Year 21, two clusters were initiated: Primary Care and Nutritional Support.

Social marketing will continue. In DC targeted social marketing campaign, “Its Free to Treat your HIV” which promoted the availability of treatment was instrumental in increasing ADAP enrollment over 50% over an 18 month period. Maryland is planning similar efforts through the campaign called, “HIV Stops with Me”, which focuses on African American MSMs and transgender persons.

(2)(B)(4)(a)(i)(b) Essential Activities – Proposed but Not Implemented Immediately

Routine testing in multiple settings is successful in the District, but less common in the neighbor jurisdictions due to the difference in laws and regulations in the District in comparison to the other regions. Social media campaigns are uneven and dependent on additional resources.

(2)(B)(4)(a)(1)(b)(i)/(ii) Timeline/Responsibilities

Essential Activities	Responsible	Timeline
Allocated EIS funding to support identification of individuals who are unaware; clustering	HAHSTA/Advisory Workgroup	3/1/2012-9/30/2012
Developed directives around expanding clustering model	HAHSTA / Advisory Group/Planning Council	3/1/2012-6/1/2012
Expanded HIV testing in traditional and nontraditional settings	HAHSTA	3/1/2012-2/28/2013

Creation of a Needs Assessment for these targeted activities	HAHSTA/Advisory Workgroup	12/1/2012-2/28/2013
Review of Needs Assessment Data and develop recommendations	HAHSTA/Advisory Workgroup	7/1/2013-8/1/2013

(2)(B(4)(a)(ii) Coordination Ryan White Part B with individuals unaware

One of the challenges facing the Washington EMA is the inclusion of four Part B counterparts in each respective jurisdiction. While the different Part B entities coordinate with Part A as required, each jurisdiction has different priorities, perspectives and resource demands and this all results in different approaches. The PC will work with the Part B representation on the PC to improve communications to implement the EIIHA plan.

(2)(B)(4)(a)(iii) Coordination with prevention and disease control/intervention programs-

CARE Act is the dollar of the last resort and CARE Act EIS funded providers are required to coordinate with existing CTRS services. HAHSTA uses both public and private resources to maximize testing efforts and link CARE Act services to these sites. The EIIHA and the ECHPP processes will move the EMA toward more integrated HIV, hepatitis, TB and STD testing, partner services, vaccination and treatment for HIV positive and negative persons at risk of acquiring HIV and will result in integrated surveillance, programming and training for each jurisdiction.

(2)(B)(4)(b) Informing Individuals of Their HIV Status

(2)(B)(4)(b)(i) Essential Activities

The essential activities implemented to date include

1. Ensuring the provision of test results immediately through the rapid testing.
2. Providing a linkage to care in response to a preliminary positive test result. The linkage begins with a confirmation, followed by appropriate medical and support services.
3. Expand partner services for HIV positive persons targeting sexual and drug using partners of individuals who test positive for HIV and other STDs.

The essential activities to be implemented include

1. An assessment of the impact of shifting from rapid testing to less expensive modes.
2. Coordination with multiple prevention program in each jurisdiction to maximize testing.
3. Expand partner services in multiple jurisdictions, pending funding.

(2)(B)(4)(b)(i)(b)(i)/(ii) Timeline/Responsibilities

Essential Activities	Responsible Parties	Timeline
Utilizing rapid testing vehicles throughout the EMA	HAHSTA / Advisory Workgroup	3/1/2012-9/30/2012
Seek expanded partnership for payment of test via rapid HIV test kits throughout the EMA	HAHSTA / Administrative Agencies	3/1/2012-2/28/2013
Enhance Partner Notification through increased coordination with prevention programs; recommendations	HAHSTA / Advisory Committee/Planning Council	11/1/2011-2/28/2012
Review of Needs Assessment Data and developing recommendations	HAHSTA / Advisory Workgroup	7/1/2013-8/1/2013

(2)(B)(4)(b)(ii) Coordination with Ryan White Part B, Informing Unaware Individuals

The EIIHA planning process offers opportunities to collaborate with Part B partners around coordination and integration areas that would enhance systems to inform individuals unaware of their HIV status.

(2)(B)(4)(b)(iii) Coordination with Prevention, Informing Unaware Individuals

The EIIHA and ECHPP processes will create more integrated approaches to planning of resources, including monitoring strategies. The process will allow recognition of multiple epidemics in the same populations, multiple diagnoses in the same patient, and interactions between diseases and epidemics.

(2)(B)(4)(C) Referring to Medical Care and Services

(2)(B)(4)(C)(i) Essential Activities

(2)(B)(4)(C)(i)(a) Essential Activities – Implemented Immediately

To reduce a fragmented system of care, the EMA supports negotiated written agreements among service providers that articulate resources, expertise and services available at each site, roles and responsibilities regarding initiation of service and reassessment of relationships, plan for resource sharing and ongoing communication regarding the client. All primary care providers must demonstrate their ability to provide directly or indirectly mental health, medical case management and substance abuse services. These MOUs are reviewed and monitored during site visits and reporting. This is in place for each jurisdiction receiving Part A funds.

Plans of engagement are an activity of EIS services. The level of implementation varies across the EMA. The EIS service category was just funded for each of the jurisdictions last year. The development of this service category will be driven by the EIIHA plan.

Tracking of quality performance bench marks is another activity which varies across the jurisdictions. The District of Columbia is implementing MAVEN, a data management system that will allow for concatenation and comparison of data sets associated with HIV counseling and testing, HIV care and treatment, laboratory results and housing services.

(2)(B)(4)(c)(i)(b) Essential Activities – Not Implemented Immediately

While each of the essential activities is occurring to some degree in the different jurisdictions, the integration of all activities across the EMA will take time and re-organization. The EIIHA process will enable the PC, HAHSTA and other key partners to assess efforts and to improve processes and streamline.

(2)(B)(4)(c)(i)(b)(i)/(ii)Timeline/Responsibilities

Essential Activities	Responsible Parties	Timeline
Implementation of Cluster Model throughout the EMA as a condition of award for contracts	HAHSTA	11/1/2011-2/28/2012
Monitoring of Clustering MOUs during site visits	HAHSTA / Administrative Agencies	3/1/2012-2/28/2013
Develop Performance Measures regarding referral to medical care and services-(Length of Time, Re-Engagement to Care, etc.)	HAHSTA / Planning Council	11/1/2011-2/28/2012
Review during Quality Visits-integrated team approach in delivery and comprehensiveness of services delivered (substance abuse/mental health and primary care-particularly)	HAHSTA/Quality Department	3/1/2012-2/28/2013

(2)(B)(4)(c)(ii) Coordination with Ryan White Part B, referring newly aware individuals

While coordination with Part B around all aspects of EIIHA will be a challenge, the composition of the EIIHA Strategy and commitment by all CARE partners to work will improve coordination and planning. The Planning Council has set up a subcommittee of the

Comprehensive Planning Committee to guide the development of the EIIHA plan and ensure resource allocation support. This work group will be composed of a diverse membership including Part B representation from each jurisdiction.

(2)(B)(4)(c)(ii) Coordination with Prevention, Referring

A critical component of the EIIHA strategy is coordination and integration of HIV and STD providers systems. The EIIHA Plan and ECHPP is an excellent opportunity to strengthen both public and private partnerships. Cross planning and sharing of key strategy documents and representation from prevention and disease control agencies will ensure effective programs that maximize resources from each source. This coordination will help to ensure that CARE Act resources will be planned for and re-allocated in support of the EIIHA plan.

(2)(B)(4)(d) Linking to Medical Care

(2)(B)(4)(d)(i) Ensuring access to medical care

(2)(B)(4)(d)(i)(a) Essential Activities

As of this application, sufficient capacity is available to ensure entry into primary care without regard to ability to pay. This circumstance is somewhat challenged by a range of fiscal and budgetary challenges, but remains this highest priority for local planning efforts. The essential activities to ensuring access to medical care regardless of where any newly identified HIV positive individual enters include:

1. Surveillance and tracking of where persons with a new diagnosis are located, including points of entry, patient characteristics, and other key information.
2. Provision of counseling individuals with respect to HIV/AIDS diagnosis to prepare them for managing their HIV/AIDS diagnosis
3. Provision of other referrals and support services to link and engage in medical care.
4. Monitoring the progress of client in engaging HIV and other related needed services.

The implementation of these key activities is a part of the EIS service category and the extent of implementation varies across the EMA. A good performance indicator is the percentage of newly diagnosed persons entering into care at late stages. There are specialized approaches already in place that implement these essential activities.

In the District of Columbia, four projects are in place to provide intensive case management services to clients as they enter the HIV service delivery system. The projects are known as “navigator” services, and emphasize a short-term highly intensive set of medical case management interventions is intended for clients with limited resources to consume HIV services on their own. Two of the projects are supported by HIV prevention funding. One is designed to ensure ease of entry for pregnant women with HIV, and the other is designed to minimize the impact of linguistic and cultural barriers for people who speak Spanish but not English. Part B funds support two projects that provide a variant of medical case management services to HIV-positive individuals being released from custody or who are characterized by high rates of recidivism. They are designed to ensure that individuals have a plan for release in place prior to release, and are supported in the early months of release in their efforts to enroll in primary care, establish housing and generally stabilize their activities of daily living. These peri-incarcerated navigator projects liaise with the District-funded HIV care and treatment services provided to individuals in custody, and serve as a vital link to services. Those in custody with HIV include a substantial cohort of individuals who were aware of their HIV infection prior to their custody, and in many cases had some experience with HIV care and treatment. The navigators work with clients to craft a set of services that respond to their individual circumstances, and in some cases serve to re-connect the clients to an already established set of services.

The "Red Carpet" program is designed to ensure effective linkages into HIV care and treatment services. It is intended primarily for individuals who are newly diagnosed with HIV, but is also deployed to serve individuals with HIV who are not in care. The activities are part of the range of services supported in the service category Ambulatory Outpatient Medical Care. The key characteristics of the program are:

- Availability of a first appointment within seventy-two hours of request.
- A designated contact person at the agency to ensure easy entry into services.
- A communication strategy – often as simple as a "password" – for clients to use at their first appointment to ensure easy entry.

(2)(B)(4)(d)(i)(b) Essential Activities – Not Implemented Immediately

The above strategies are now available in the District and expansion of such strategies will be developed in the context of EIS services for other jurisdictions. As EIIHA is fully implemented with an action plan, more pilot projects can be targeted and resources allocated to implement in other jurisdictions. It is encouraging to note that in the state of Maryland has committed to apply its ECHPP strategies to the entire state so we will look forward to close work with the Suburban Maryland region.

(2)(B)(4)(d)(i)(b)(i)/(ii) Timeline/Responsibilities

Essential Activities	Responsible Parties	Timeline
Peer Navigation Program for EIS-RFA development	HAHSTA	10/25/2011-2/28/2012
Expansion of the Red Carpet Program in two other parts of the EMA	HAHSTA / Administrative Agencies	3/1/2012-2/28/2013
Monitoring of the Red Carpet Program for high prevalence populations-MSM, IDUS, and Immigrants	HAHSTA / Advisory Workgroup	3/1/2012-2/28/2013

(2)(B)(4)(d)(ii) Coordination Ryan White Part B, linking unaware individuals

HAHSTA is closely coordinating both Part A and Part B Programs. This is accomplished by shared planning and policy development and coordination of Part A and Part B grant funds to reduce barriers to early diagnosis and rapid linkage into treatment. A representative of the Part B program is a member of the Planning Council and participates in critical planning committees in order to strengthen coordination between the two programs. As previously, mentioned Part B fund medical case management for HIV positive individuals being released from custody.

(2)(B)(4)(d)(iii) Coordination with Prevention, Linking Unaware Individuals

A key component of this process will be to increase partnerships across funding sources to ensure effective coordination of services and for leveraging additional resources. In order to achieve the planned systems of change and maximize impact, HAHSTA will be working diligently with the stakeholders of ECHPP and EIIHA , as well as other stakeholders that provide prevention and disease control intervention services to apply resource optimization modeling and strategies for increasing coordination across the HIV prevention, care and treatment systems.

(2)(B)(4)(d)(iv) Post-Referral Activities

(2)(B)(4)(d)(iv)(a)Essential Activities:

1. Establishment of the "4R's: Recruitment, Retention, Recapture and Results" approach.
   - Recruitment or navigation into care is necessary to help many of the hard to reach populations that find the primary care system unmanageable.
   - Retention is the tracking of number of primary medical appointments attended

by a person in a 12 month period;

- Re-engagement in care entails identifying clients who were lost to care from 6 months to 2 years; determining those needing re-engagement and aggressively outreaching and trying to make contact which may take up to 15 attempts according to service data.
- Monitoring and evaluating activities and results

Aspects of all of the above activities have been implemented but there are great variations in the availability of the full range of services. Many jurisdictions have used MAI funds targeting sub populations. Many of these activities are a part of medical case management and this has been a key retention strategy among the jurisdictions. The PC supports medical case management for all jurisdictions. It is ranked second in terms of Part A funds allocation. The Standards of Care for Medical Case management has established acuity levels. This is already in place. The EMA has incorporated community health workers into the EIS strategy. Since many of the hard to reach populations need more direct and personalized assistance than what has traditionally provided. This model is a core activity under EIS now.

In 2009 and 2010 HAHSTA implemented a “Recapture” initiative for re-engagement of patients lost to care. This was funded under MAI. Data from 2009-2010 indicated that there were some 1900 clients lost to care and approximately 600 were contacted and 300 kept appointments. Other specialized approaches are discussed under the prior section.

(2)(B)(4)(d)(iv)(b) Essential Activities – Not Implemented Immediately

Full implementation of the strategy is the goal but with limited resources this will be a slow process to get full scale programs in each of the jurisdictions. The PC is allocating funds to the EIS category and looking to increase the capacity of this service category across jurisdictions.

(2)(B)(4)(d)(iv)(b)(i)/(ii) Timeline/Responsibility

Because the referral and linkage are so interrelated the timeline and responsibility tables are the same as referenced above.

Essential Activities	Responsible	Timeline
Quality Management Monitoring and Evaluation of individuals linked through specialized programs, including “Red Carpet”	HAHSTA / QMP	10/25/2011-2/28/2012
Expansion of the Red Carpet Program in two other parts of the EMA	HAHSTA/Administrative Agencies	3/1/2012-2/28/2013
Monitoring of the targeted linkage to care programs for high prevalence populations-MSM, IDUS, and Immigrants	HAHSTA/Advisory Workgroup	3/1/2012-2/28/2013

(2)(B)(4)(d)(v) Private HIV Care Providers

The following are necessary activities to form and maintain relationships with private HIV care providers for the purpose of verifying that individuals referred into private care have accessed medical care:

1. Social marketing strategies targeted at private providers regarding HIV treatment expectations;
2. Surveillance of antiretroviral prescriptions to determine persons in care;
3. Work with Chirurgical societies around HIV treatment and care protocols;
4. Promotion by Local health officers directly to medical care provider systems

(2)(B)(4)(d)(v)(a) Essential Activities- Already Implemented

The implementation of these activities varies across the EMA. The District has initiated a social media strategy promoting treatment and has designed a provider component that includes a toolkit on improving linkages and outcomes for persons coming into medical care and treatment. Also, HAHSTA has been providing a tool kit for community providers on their role in partner services. This addresses the issue of linkage to care. Because HIV/AIDS is not well integrated into the health care system, it is imperative to communicate with the private health care system. In the District, there have many efforts to create "medical homes" for persons living with HIV. However, it is more difficult in Northern Virginia and Maryland for clients to have a medical home.

(2)(B)(4)(d)(v)(b) Essential Activities – Not Implemented Immediately

Political realities prevent a uniform approach to implementing all these activities the same way. However, it is anticipated that the EIIHA process will help garner support for the development of EMA wide models to improve integration of private providers into the HIV/AIDS care system and help get local leaders on board with the overall goal of the EIIHA Plan. In the Baltimore Towson ECHPP, the plan outlines plans to develop a Maryland Internet – Based Partner Services Program that potentially could benefit the suburban region and District surveillance efforts.

(2)(B)(4)(d)(v)(b)(i)/(ii) Timeline/Responsibilities

Essential Activities	Responsible	Timeline
Social Marketing Activities	HAHSTA/ Advisory Workgroup	3/1/2012-2/28/2013
Enhance Surveillance Activities (testing, prescriptions, etc.)	HAHSTA/Administrative Agencies	3/1/2012-2/28/2013
Work with experts around HIV treatment and care protocols	HAHSTA/Advisory Workgroup	3/1/2012-2/28/2013
Promotion by Local health officers directly to medical care provider systems	HAHSTA/Advisory Workgroup	3/1/2012-2/28/2013

(2)(B)(4)(d)(vi) Legal Barriers

Each jurisdiction has in place legislation that supports routine – opt out testing for HIV. However, enforcement and compliance varies across the jurisdictions. The Baltimore Towson ECHPP cites increased training and capacity building for medical providers to include routine HIV testing in clinical settings to expand efforts.

(2)(C)Data

(2)(C)(1) Number of living HIV positive unaware as of December 31, 2009.

Table 17: Estimated Undiagnosed (National)

Proportion Undiagnosed (National)	Diagnosed and living with HIV (December 31, 2009)	Undiagnosed
21%	33,054	6,941

Tabled above is a calculation of the undiagnosed individuals in this EMA using national proportions of undiagnosed cases.

The first three cycles of the Centers for Disease Control and Prevention (CDC) National Behavioral Surveillance System (NHBS) study in Washington, DC analyzed three particular sub-populations. Nearly 50% of people with HIV were unaware of their infection before participation in the study. Tabled above are calculations based on the local estimate of HIV-unaware in these groups. 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.

Table 18: Estimated Undiagnosed (Local)

Exposure Category	Proportion Undiagnosed (Local)	Diagnosed and living with HIV (December 31, 2008)	Undiagnosed
Heterosexual	47.4%	12,099	10,903
MSM	41.2%	16,977	11,895
IDU	30.3%	5,601	2,435
			25,233

(2)(C)(2) Coordination with Part B, Data Collection and Sharing

The Ryan White Service Report (RSR) already requires coordination among Part A and B providers and the sharing of information. This system has been in place for some time. The calculation of the unmet need also has established relationships with surveillance units and has solicited cooperation in the calculation of required information.

(2)(C)(3) Coordinate with disease control and prevention /intervention.

HAHSTA is the Grantee for CDC and Part A funds, and is leading the effort towards Program Coordination and Service Integration (PCSI) within HAHSTA. Re-organization of HIV services within the jurisdictions to include the broad spectrum of HIV, STD, and Hepatitis will facilitate coordinated approaches to data generation. Within the District, the Strategic Information Bureau (SIB) leads HAHSTA's epidemiology and surveillance efforts. SIB provides one standard for data collection and produced the first ever integrated, "DC HIV/AIDS, Hepatitis, STD and TB Epidemiology Annual Report 2009" in 2010. See **Attachment 10**.

(2)(D) Enhanced Comprehensive HIV Prevention Planning and Implementation (ECHPP)

(2)(D)(1) NHAS Goals, Part A and ECHPP

Both the EIIHA and ECHPP have been developed to align and develop strategies to identify and increase the optimal combination of prevention, care and treatment activities to reduce HIV infections as envisioned by the National HIV/AIDS Strategy. HAHSTA will establish a work group within the planning council to align the goals and objectives of EIIHA with the goals and objectives of the Washington DC ECHPP.

The workgroup will be a part of the Comprehensive Planning Committee and will be responsible for implementation and development of the Washington DC EIIHA Plan. The committee will be charged with creating a detailed and integrated EIIHA work plan that aligns itself with the Washington DC ECHPP specifically targeting the EIIHA matrix. The committee will be staffed by HAHSTA and will make recommendations on a quarterly basis to the Planning Council regarding how to best align RW funds, activities and directives to achieve EIIHA goals

The following Interventions from the Washington ECHPP will be the immediate focus of the work group since these interventions directly impact RW planning in the region and should be the focus of more integrated resource allocation. The workgroup will identify collaboration with each of the identified strategies in these areas.

- Required Intervention #6: "Implement linkage to HIV care, treatment, and prevention services for those testing HIV positive and not currently in care"
- Required Intervention #7: "Implement interventions or strategies promoting retention in or re-engagement in care for HIV-positive persons"

(2)(D)(2) Part A Program and ECHPP initiative

In the development of the DC ECHPP, HAHSTA formed a core internal team to develop the plan included of staff from the Care, STD/TB, Prevention, Strategic Information and Capacity Building bureaus. The HAHSTA team also conferred with colleague DC agencies on addiction services, mental health and health care financing. HAHSTA convened a working group of community stakeholders, which included formal planning bodies (CARE Act Planning Council, HIV Prevention Community Planning Group), HIV service providers, persons living with HIV/AIDS, academic institutions, researchers and other experts. HAHSTA provided drafts of the two workbooks to the stakeholders. Dr. Mohammad N. Akhter is the Director of the District of Columbia Department of Health will reconvene this workgroup and internal members of HAHSTA to ensure that the ECHPP activities:

3. Access to HIV/AIDS Care and the Plan for FY 2012

- CARE Act funds have built and sustain a critically important set of services.
- Increased emphasis on health care outcomes guides allocation decisions and program implementation.
- DOH-HAHSTA has launched initiatives to create effective linkages, "navigate" people to care and "re-capture" those lost to care.

3.a. Established Continuum of HIV/AIDS Care and Access to Care

The EMA has a robust and comprehensive continuum of care integrated and coordinated with other funding streams, which includes all service areas permitted for CARE Act Part A and B funding. Services supported by local funds vary among the jurisdictions and are critical to providing effort to combat the disease.

During the FY 2012 Priority Setting process, the Planning Council establishes the range of services in the continuum based on epidemiological data, unmet need estimates, various needs assessments and consumer input. Prevalence data were presented to enable the planning bodies to target populations for care interventions. Information regarding incidence rates, coupled with service needs data for newly infected individuals as well as emerging populations was also presented during priority setting. There was an increased emphasis in on the increase in unmet need in the EMA and strategies to effectively meet the challenges of reaching these hard to reach populations.Moreover, there were initiatives that responded to the National HIV/AIDS Strategy, such as the decision to expand EIS services

In setting priorities and allocations, the Planning Council took into account ADAP funds, and allocated funds for pharmaceutical assistance to fill in gaps for those for whom ADAP does not meet their medication needs. Additionally the Planning Council chose not to fund housing services, due in part to restrictions on the use of Part A funds to support housing, as well as the availability of Housing Opportunities for Persons with AIDS (HOPWA). The care continuum does offer Emergency Financial Assistance under Part A funds which affords for specialized temporary rental assistance.

The FY 2012 implementation plan ensure that emerging populations as identified earlier in the application, including newly infected individuals and those disproportionately impacted communities, have access to care and remain in primary medical care. For example, the core services are coordinated with other services to reduce barriers and facilitate access to care, such as interpreter services, for those who do not speak English; or transportation and child care services which are offered to improve access to services. Many of the core services, including medical care and medical case management are co-located with HIV testing sites, so that newly diagnosed individuals can be linked directly into the continuum of services upon learning of their HIV status. Additionally, new efforts to rapidly link individuals into care through the Red Carpet, patient navigation and clustering initiatives were discussed.

The Continuum in the EMA is a collaborative effort between multiple agencies across four jurisdictions who work together to an optimal system of care. In instances when CARE Act funding is not an appropriate payer for the service, a coordinated effort with other available funding sources is essential to ensure clients receive access to necessary services.

3.b. FY 2012 Implementation Plan

The EMA consolidates planning efforts, while at the same time ensuring that MAI funds are used to serve high-need people of color with HIV/AIDS. See Attachment 7 for Implementation Plan for these six service categories.

3.c. Narrative

Table 19: Six Key Service Categories

	Amount	Proportion
Primary and Specialty Medical Care	12,349,009	37.41%
Medical Case Management	5,951,854	18.03%
Oral Health Care	2,445,365	7.4%
Mental Health Services	2,222,482	6.73%
Food Bank and Home Delivered Meals	1,636,949	4.96%
Emergency Financial Assistance	1,203,023	3.64%
Subtotal	**25,808,682**	**78.18%**

The Planning Council logically connects its latest needs assessment, comprehensive plan and service priorities to the FY 2012 Plan by conducting a carefully orchestrated planning, priority setting and allocations process. Each year, the Planning Council and Grantee undertake needs assessment activities to determine emerging trends in the EMA, levels of service utilization, service gaps, and emerging populations with unmet needs. The needs assessment activities include an extensive client survey and targeted focus groups that take place in alternating years, in addition to special studies.

Since 2008, the Planning Council has conducted focus groups with heterosexual Black females, Black men who have sex with men, people living with HIV and Hepatitis C, Latino/as, homeless individuals; “town hall” style forums in the District, Maryland and West Virginia; and a client survey. The Planning Council uses each of these data sets and supplement with additional needs assessment activities to assist in shaping its plan.

The Planning Council elected **not to allocate** CARE Act Part A funds to

AIDS Drug Assistance Program (ADAP). ADAP is funded using CARE Act Part B funds in each of the four states, but did allocate funding for AIDS Drug Pharmaceutical Assistance (Local). See the EIIHA Section (2)(1)(vi) for a discussion of the challenges.

Home Health and Hospice. With the positive health outcomes resulting from highly active anti-retroviral therapy (HAART), the need for these two service categories has decreased significantly. Third-party payer sources (especially Medicaid) support both of these services when needed throughout the EMA.

Increased access to the HIV continuum of care for minority communities

Minorities, and especially Blacks, are overwhelmingly and disproportionately impacted by HIV/AIDS in the EMA. For this reason, each of the core service categories target minority groups, and consequently, the majority of services provided in the EMA are provided to minority individuals. In order to increase access to services and decrease HIV health disparities among minorities in historically-underserved communities, the EMA created a comprehensive service system with more than 80 key points of access, whereby PLWH/A are able to enter the service system through any of these entry points and are linked to other essential services, regardless of funding source. The comprehensive array of services includes Primary and Specialty Medical Care, Medical Case Management, Oral Health Care, Mental Health and Substance Abuse Services, Medications Assistance, Housing Assistance, Transportation, Legal Services, Food Bank and Home Delivered Meals, as well as other services in the continuum. Entry points within minority communities are located directly in those areas with the highest HIV/AIDS prevalence rates in order to meet HRSA goals of increasing access to care and treatment, and decreasing HIV health disparities. Language barriers exist within the community to the large number of multi-lingual individuals, thus creating an increased need for linguistic or translation services. Additional efforts were taken this year to expand EIS services and engage in initiatives that assisted in early identification and rapid linkage into care.

The EMA also took steps to ensure that communities of color are engaged in care is to have the FY 2011 Implementation Plan activities that are directly linked to support and expanded programs funded by the Minority AIDS Initiative (MAI) funding, which addresses the critical areas targeting communities of color. These include primary care medical care, medical case management, substance abuse counseling, linguistic services, outreach, psychosocial support services and treatment adherence. Each of these services categories has specific outcomes measures relative to emphasizing inclusion of communities of color, particularly for Black, Latinos and Asian Americans. One example is outreach services within the MAI program serves as the mechanism to identify and bridge the gaps in accessing primary medical care by at-risk and vulnerable populations. The purpose of this initiative is to target those persons outside of the traditional HIV provider network.

Addressing the needs of emerging populations. The plan addresses the needs of emerging populations by offering core services to each population and identifying specific targets related to each. The populations for which targets have been established in the plan include the homeless, people co-infected with Hepatitis C, adults over the age of 50, heterosexual Black women, Black men who have sex with men, and Latinos/as. These groups were prioritized after review of empirical data and consideration of epidemiological trend and population data, as well as service utilization data. The selection further demonstrates the efforts of the Planning Council, Grantee and jurisdictional administrative agencies to utilize data in planning and responding to the diversities and complexities of the Washington, DC EMA.

Identifying HIV Positive Unaware Individuals and Linkage of these individuals into care. The EMA has made innovative strides in identifying HIV positive unaware individuals through partnering with ambulatory outpatient medical care providers and non-traditional settings. Due to the complexity of the testing laws in a multi-jurisdictional EMA coupled with density of the epidemic, one single approach is not sufficient to reach those with HIV who are unaware of their HIV status. A multi-faceted approach has been undertaken wherein routine testing and screening for HIV occurs in both traditional settings-clinic or community based hospital settings as well as non-traditional settings, such as testing in the Department of Motor Vehicle site as part of an effort to offer HIV testing to individuals who not seek medical care routinely. Additionally, the EMA has increased targeted testing in high-impact communities to allow for targeting based on recent epidemiological profiles and density of the disease by populations. For example, MSM were targeted as a testing population based on the reported prevalence rate of this exposure category being 40% of all person with HIV/AIDS in the District of Columbia reporting MSM as their mode of transmission of the disease.

District of Columbia has developed the following four innovative approaches to intensive case management services to clients as they enter the HIV service delivery system. In all cases, the initiatives armay be extended to other parts of the EMA.

Navigator. The Navigator Model was initially an initiative of the Prevention Services Bureau within HAHSTA, founded on the premise that entry into primary care is an unmanageable burden for at least some individuals testing positive for HIV infection. With the increase in the number and kinds of sites at which HIV testing is performed routinely or more frequently, positive test results are more likely to occur at service providers not affiliated with a larger organization, network, or testing program, which diagnose relatively few persons with HIV in a given year and are less familiar with how to successfully promote and ensure linkage for their clients. Nearly40% of new HIV diagnoses in DC for 2008 were made by ‘independent’ health care professionals who are not affiliated with HIV-specialty care or large provider networks.

The Navigator Model provides intensive, time-limited follow-up to ‘match’ the client with an appropriate HIV provider, mediate barriers to access, ensure initial linkage and establishment of care, and checks in at three months, six months, and twelve months to make sure that the client is retained in care. The Navigator is distinct from and complements ongoing case management services, which can and should be accessed as needed through the primary HIV care and case management service providers.

Recapture. This initiative was pioneered as part of the services supported by Part A Minority AIDS Initiative funding, and is designed to identify individuals who have dropped out of care, and recruit them to return to care.One service provider in the District of Columbia developed this model by reviewing clinic records and determining those individuals who had discontinued receiving primary care services without explanation or transfer. Staff were deployed to contact these individuals; a key component of the plan was to assign small numbers of clients to a wide variety of staff.

Staff contacted former clients and talked with them to determine whether the individual was receiving health care from another provider. Of those contacted, approximately 300 were not in care, and a staff person assigned to the client worked to make a return appointment. Intensive follow-up was deployed to encourage the client to return, and in most cases, multiple phone contacts – frequently as many as twenty – were required before the client returned to care.The initiative was by any measure extremely successful, with 75% returning to care or being determined to be in care at another agency in the EMA.

Beginning in September, 2009, HAHSTA has expanded this initiative to include an additional six providers of primary care. Approximately half of the clients who had discontinued care with a particular provider had in fact made a transition to another primary care provider. Staff of agencies is being deployed to contact the remaining clients with the goal of supporting an effective re-entry.HAHSTA anticipates that the “Recapture Initiative” will be required for a relatively short formerly-od of time, and is working with providers to develop protocols and procedures to retain clients in care and to get in touch with those at risk of discontinuing care at early and frequent intervals.

Cluster. The third approach is to work with groups of providers to develop linkage clusters among organizations. This is an effort to move beyond a set of referrals to services, and to implement strategies to address the needs of a client who may need or benefit from services from multiple service providers. The linkages are formal in nature, that is, they are deliberately institution-to-institution to ensure continuity in the presence of staff turnover or re-assignment. The models of linkages range from a transfer of a client from one organization to another, a set of referrals in which each organization works to ensure continued services and effective communication, to the ongoing co-management of client care by organizations that have complementary sets of services the client needs or chooses.

Red Carpet Entry Program. The “Red Carpet” program is designed to ensure effective linkages into HIV care and treatment services. It is intended primarily for individuals who are newly diagnosed with HIV, but is also deployed to serve individuals with HIV who are not in care. The activities are part of the range of services supported in the service category

Ambulatory Outpatient Medical Care. The key characteristics of the program are:

- Availability of a first appointment within seventy-two hours of request
- A designated contact person at the agency to ensure easy entry into services.
- A communication strategy-often as a simple as a "password" – for clients to use at their first appointment to ensure easy entry.

During Grant Year 20, HAHSTA provided a training program for providers in the District, on assisting with coordination with the aforementioned initiatives. Coordination across jurisdiction is critical to the success of any of the programs mentioned earlier.

Parity of HIV Services. The issues of achieving parity are complex in every jurisdiction, and perhaps more complex in the Washington DC EMA than any other. As described, the EMA is composed of four states, with four distinct underlying health care systems.

The definition offered by HRSA for parity is directed towards ensuring that there is parity in "access to primary medical care." There is no wait list or other barrier to primary care reported in any part of the jurisdiction. The approach taken by this EMA – and the approach planned by this EMA – goes substantially farther than the approach required by HRSA.

There is a long-standing history and practice of allocating the funds geographically, and then determining the best use of funds in each for services. This planning model becomes a set of obligations for each service provider to determine the appropriateness of funding source for a given client within the EMA. Having allocated the funds geographically, careful consideration must be given to any approach that might contravene that plan.

The exception to this practice is the allocation of a small amount of funds to three service categories that are designed to serve individuals without regard to their residence within the EMA. The first category support primary medical care for individuals with limited English proficiency, usually Spanish-speakers. The second is a category designed to provide information on available services throughout the EMA. The third is a sub-set of activities within the category "Referral for Health Care" designed to ensure that clients facing difficulties with a provider are supported in their efforts to resolve those issues and remain in care.

See the section of this application "Geographic Distribution of Funds" for a discussion of a more nuanced approach under development by the EMA to distribute funds geographically.

Relationship to the goals of the Healthy People 2020 initiative

The EMA Implementation Plan for 2020 encompasses program areas ranging from primary medical care to behavioral health services and is directly related to the broad goals of the Healthy People 2020 initiative. The Implementation Plan for Grant Year 2020 has multiple goals and objectives that are directly correlated with the following four objectives of the Healthy People 2020 initiative:

Number 13-13: Increase the proportion of individuals receiving treatment according to U.S. Public Health Service guidelines.

Number 13-14: Reduce HIV-infection deaths.

Number 13-15: Increase the interval between HIV infection and AIDS diagnosis.

Number 13-16: Increase the interval between AIDS diagnosis and death from AIDS.

The three CARE Act Part A service categories prioritized for the development of the implementation plan, which are consistent with the objectives of the Healthy People 2020 initiative are: primary and specialty medical care, medical case management and mental health services. The following table identifies and demonstrates how the Healthy People 2020 goals are specifically implemented in the implantation plan.

Table 20: Healthy People and ImplementationGoals

	Healthy People 2020 Goals	FY 2020 Implementation Goals
Primary Care and Specialty Care	Goal: 13-13: Increase the proportion of individuals receiving treatment according to US Public Health Guidelines Goal 13-14: Reduce HIV-infection deaths.	Priority 1 and Priority 2
Medical Case Management	Goal 13-15: Increase the interval between HIV infection and AIDS Diagnosis	Priority 1 and Priority 2

The overall goal of the primary and specialty medical care is to prevent or decrease HIV disease progression and incidence of related illnesses and mortality. Each primary care program in the EMA ensures that clients receive treatment according to guidelines of the U.S. Public Health Services in order to prevent the progression of HIV disease. The EMA medical services create a coordinated system of care for PLWH/A, that fosters regular medical visits, routine laboratory testing, and aggressive treatment options, aimed increasing optimal health from HIV infection to AIDS diagnosis and increasing life from AIDS diagnosis to AIDS-related mortality.

The goal of medical case management is to facilitate and coordinate access to HIV health services, treatment adherence, and required support services. The ultimate goal is increasing quality of life for PLWH/A and preventing AIDS-related deaths. The design of the EMA medical case management program leads to these outcomes, as medical case managers link individuals to medical services and ensure that clients adhere to their treatment regimen.

The goals of mental health services are to promote, or improve, mental health of PLWH/A so that participation in care and activities of daily living are optimized. Mental health services are designed to support PLWH/A with mental health problems to modify their behaviors, improve activities of daily living and actively participate in activities that will improve increase their health and wellness throughout the HIV disease spectrum.

Ensuring resource allocations for WICY. The Washington DC EMA has provided services to women, infants, children and youth in greater percentages than their composition of people living with HIV/AIDS in the EMA. Additionally, provisions for pap smears and obstetrics and gynecologic panels for women are included in the service units for primary medical care. Some service providers specialize in serving these populations, while other service providers include WICY clients in more “general” programs. Service providers throughout the EMA collaborate with CARE Act Part D funded services, and Part D providers are eligible to compete for CARE Act Part A funding to augment their programs as needed.

Minority AIDS Initiative (MAI) Funding and Activities. The Washington, DC EMA is in its tenth year of receiving Minority AIDS Initiative funding. These funds are currently used to support a cluster of services for high-need people of color. Nearly 90% of clients served through CARE Act Part A funds in this EMA are people of color.

MAI funded services are meant to enhance, but not replace, the Part A funded continuum of healthcare and support services and makes it possible for high-need clients of color to enter and remain in Part A Program services seamlessly and with the sustained presence of necessary, intensive support. The MAI services offer critically needed support to overcome barriers encountered by clients and allow service providers maximum flexibility in crafting service plans individually tailored to clients’ needs. This ensures smooth and consistent access to Part A Program support services, including transportation and emergency financial assistance; as well as transitioning clients in to Part A funded medical care and support programs.

In response to the CARE Act Amendments of 2006, services supported through CARE Act Part A Minority AIDS Initiative (MAI) funding were subject to a separate application. The EMA challenged itself to address the most appropriate use of MAI funds in this context, and developed a cluster model of services. Characteristics of the model include:

- Identification of highly-vulnerable clients. Key indicators are
- Newly diagnosed with HIV - OR --Out of HIV care for at least six months
- Limited experience with consuming health care of any kind
- Extremely low-income
- Multiply-diagnosed, that is, with persistent, severe mental illness, substance abuse, hepatitis, sexually transmitted diseases or tuberculosis, in addition to HIV
- Relatively limited social and family support system, including individuals who experience shame, stigma or fear of disclosing one's HIV status
- Challenged with regard to access. Examples of these challenges are living in a very remote or rural area, having limited proficiency with English or being housed in an unstable housing environment
- Clients will be re-assessed at least every six months to determine the need for ongoing intensive services

Ensuring a core minimum of services is available at one site, or through a close collaboration, the following:

- Ambulatory Outpatient Medical Care
- Oral Health Services
- Early Intervention Services
- Mental Health Services
- Medical Case Management
- Substance Abuse Counseling
- Linguistic Services
- Medical Transportation
- Outreach for Health and Support

Leveraging of Resources. A vitally important core of services is supported by the MAI cluster, but it remains incomplete. Applicants for and providers of cluster services are required to demonstrate their ability to provide the core services, as well as establish productive linkages with services supported by other funding sources. Flexibility on the part of the administration of the grant, and consequently on the part of the service providers, to craft a set of services designed to address the specific needs of each client. In some cases, the impact of this flexibility was to alterthe proportion or amounts of funding among services funded by CARE Act Part A MAI.

The medical case management service category is one of several portals into this cluster, serves as a conduit to each of the other six services in the cluster and monitors linkages to other services. The seven services identified in the cluster were deemed necessary basic minimum components of a healthcare system that would not only get clients into care but maintain them in care. For example, if a client is unable to get treatment for their mental health disease or substance abuse problems the likelihood of them entering primary healthcare, sustaining the treatment and becoming adherent to any prescribed medications is highly improbable.

In the last year, the standards of care for medical case management services have been updated and critical training has occurred throughout the EMA with service providers to improve the effectiveness of medical case management services and we have seen an increase in productivity and linkages with primary care as a result.

The MAI program for the Washington DC EMA continues to be a catalyst for the current service delivery system, which facilitates innovative methods to enroll clients into care, retain clients in care and recapture those lost to care. The MAI program enhances the care continuum by providing necessary services to community of color and linking them into the Part A program. Although MAI funding has been rolled into Part A funding the program is critical and efforts were made specifically by the Planning Council to ensure that the programs and services that have been established under the program remains in place moving forward by maintain contracts with the MAI providers and ensuring services to minority populations remains a priority to the EMA. The program has various methods of collecting client level data that assist with the planning of Part A funds. Progress towards outcome achievement is maintained through Express reporting system, which is the current database system. Quarterly and monthly provider reporting occurs on specific indicators established by the MAI team at HAHSTA and this information is shared with the Planning Council to assist them in establishing the goals and objectives in the FY 2011 Implementation Plan and priorities and allocations process.

4. Grantee Administration

Management of sub-grantees continues to improve, with re-designed service agreements that support and emphasize health care outcomes, standardized and improved procedures for remediation and corrective action plans, improved budgeting and payment processes.Effective billing of third-party payer sources is a key area of emphasis this year.

4.a. Program Organization

The table of organization appears in Attachment 1. The Grantee is the District of Columbia, Department of Health, represented by the HIV/AIDS, Hepatitis, STD and Tuberculosis Administration (HAHSTA), Care, Housing and Support Services Bureau.

Since the EMA covers portions of three different states outside of the District of Columbia, the Grantee manages agreements with administrative agencies in Suburban Maryland and Northern Virginia, and directly administers two counties in West Virginia. Each of the four jurisdictions of the EMA has a local planning body that meets regularly and conducts local priority setting and resource allocation processes.

The EMA-wide Planning Council is composed of members from each of the local jurisdictions, who among other responsibilities liaise with formal and informal community planning bodies in their respective jurisdictions. The Planning Council is responsible for needs assessment, priority-setting and resource allocations, and relies on partnerships with each of the local jurisdictional administrative agents and planning bodies to develop recommendations specific to their area. The Planning Council considers those recommendations in creating a consolidated set of priorities and allocations.

4B- Grantee Accountability

1. Narrative

a. National Monitoring Standards

The Grantee is developing a comprehensive monitoring tool with the HRSA Program and Fiscal Monitoring Standards for CARE Act Part A and Part B Grantees and is currently utilizing this tool for reviews of grantees. The new tool incorporates necessary programmatic and fiscal monitoring to ensure inclusion of all HRSA standards. The monitoring tools are being reviewed currently to ensure capacity and verification via a commonly used on-line system, eClinicalWorks. The tools are currently being internally beta-tested by program and grant monitors and then will be piloted during upcoming, onsite site visits, and then, streamlined to facilitate ease of implementation and to improve efficiency in information gathering. Revised tools are projected to be completed and ready for use by December 31, 2011.

b. TrackingFormula, Supplemental, MAI, and Carry over Funds

The Grantee utilizes coding indices in its master budget and control worksheets and procedures to manage fiscal data and to track amounts of initial grant awards, budget modifications, expenditures (to-date) and unexpended funds (to-date). Information is updated and reconciled routinely. . Additionally, hard copies of grant initiation documents, budgets and budget modifications are maintained in grant folders. Budgetary documents are also maintained in programmatic folders since budgeting is a shared responsibility of fiscal and program staff.

c. Timely Redistribution of Unexpended Funds

The Grantee reports each month on the status of implementation of the Part A program, including updated amounts of funds allocated, awarded and expended to date, along with an analysis of “expected” expenditures to date for review by Fiscal Oversight and Allocations Committee (FOAC) of the Planning Council, which is composed of unaligned or non-conflicted Planning Council members. Monthly FOAC meetings discuss service utilization, projected fiscal targets as well as over and under-expenditure of funds, their causes and implications for being off-target. Recommendations to modify current allocations are proposed as necessary, subject to review by the FOAC and approval by the Planning Council.

Beginning with the sixth month of the Grant Year, the Planning Council considers recommendations of the FOAC to redistribute, or reprogram, funds among service categories. During the final quarter, administrative agents are authorized to reallocate unexpended funds to service categories that are overspent or have the ability to spend down funds with a requirement to report modifications to the Planning Council.Part A sub-grants and contracts require each sub-grantee or contractor to project costs throughout the course of the year to assist in interpreting expenditure data.

d. Fiscal and Program Monitoring

Fiscal and program monitoring is conducted throughout the grant year. Generally, each service provider is reviewed onsite at least annually. The Office of the Chief Financial Officer (OCFO) conducts annual site visits with the Grantee, focusing on the sub-grantee scope of work, implementation plan, grant agreement, budgets, and financial management requirements. Comprehensive site visits focus on programmatic and fiscal management requirements.

All sub-grantees with expenditures of federal funds in excess of $500,000 are assessed through external, independent financial auditors for OMB A-133. These audits are submitted annually to the District of Columbia OCFO for the District; and to the Grantee from the Suburban Maryland, Northern Virginia and West Virginia Administrative Agencies. A total of 24 sub-grantees of the EMA qualified for OMB Circular A-133 audits during the grant year. All audits were completed with findings submitted for follow up and tracking. During the past year, none of the sub-grantees were reported as significantly non-compliant with the audit requirement of the OMB Circular A-133.

e. The Frequency of Fiscal and of Programmatic Monitoring Site Visits

The EMA has used a three-tier system for fiscal and programmatic monitoring. Consistent with the National Monitoring Standards, HAHSTA now conducts a minimum of one site visit per sub-grantee each year.

Tier I. Monthly and quarterly reports are routinely reviewed through internal desk reviews by Program Officers and Grants Management Specialists to assure successful sub-grantee progress toward achieving programmaticand fiscal targets and to identify barriers that may impede ability to deliver planned services, achieve proposed client targets and timely expenditure of funds. All sub-grantees receive a comprehensive site visit, at least, annually.

Tier II. On the Administrative Agency level, sub-grantee site visits are conducted annually by the Grantee with a focus on deliverables of funding mechanisms known as Inter-Governmental Agreements (IGA) between the District and respective administrative agencies of suburban Maryland and northern Virginia, each with specific scope of work, work plan, and budget. Program Officers and Grants Management Specialists conduct comprehensive site visits,which specifically focus on administrative level operations and fiscal management. Administrative Agencies of each jurisdiction of the Washington DC EMA conduct Tier I site visits for their respective sub-grantees.

Tier III. The Quality Assurance (QA) program conducts Comprehensive Quality Assurance (QA) Site Visit, designed to assessclinical standards, with a focus on assessing the current HRSA-identified legislative and programmatic requirements of core clinical health services. The main objective is to assesscurrent clinical practices to ensure quality of HIV treatment and care, and then, to make recommendations for improvement of practices to obtain optimal results according tothe most restrictive legislative and federal expectations and requirements (as well as best practices) while assuring for congruence with respective state standards.

f. Corrective Actions

Jurisdictional administrative agencies notifytheir sub-grantees of identified fiscal concerns. In turn, the sub-granteesare required to re-submit corrected invoices and explain unusual circumstances. Invoices, budget modifications requests and advances are not processed until all necessary corrections are made and approved by administrative agencies, which may also refer sub-grantees for technical assistance or make recommendations for diagnostic audits to assist in achieving grant compliance. Administrative agencies may also require that sub-grantees institute organizational changes to assure compliance with grant requirements as a condition for future awards.

When financial concerns are identified during site visits, the financial officer of the administrative agency sends a Deficiency Report to the GrantsManagement Specialist and notifies the sub-grantee of the financial deficiency in writing. Thereafter, sub-grantees are required to submit Corrective Action Plans (CAP) within 15 days and to correct financial deficiencies within 90 days. Administrative agencies and financial officers conduct Follow-Up site visits at the end of this period to ensure that issues contained in the CAP have been resolved. If cited financial deficiencies remain, then again, administrative agencies may make appropriate referrals for technical assistance, which may include diagnostic audits or fiscal penalties for non-compliance. When additional corrective action is required, sub-granteesmay be required to meet with the Senior Management Team of the Grantee and the Chief Financial Officer. The Senior Management Team determines considers the identified corrective actions and makes final decisions in order to assure compliance with financial requirements. The sub-grantee must then correct all issues identified in the CAP. Such compliance becomes conditional for grant renewal.

If Program Officers identify programmatic concerns or issues in the review of monthly programmatic reports (desk monitoring), they initiate contact with sub-grantees to seek remediation. Communication could be informal for minor concerns and are most always conducted in writing for clarity of issues that may be substantive.

The sub-grantee has 15 business days to respond and submit any information requested by the Program Officer. If the concern continues, then Program Officers may initiate “for cause” site visits and may request submission of a more detailed work plan based upon programmatic findings and areas of improvement. Sub-grantees have up to 30 days to submit a Corrective Action Plan (CAP) to resolve any cited deficiencies. Administrative agencies may also require sub-grantees to institute programmatic revisions to assure compliance with grant requirements.

When programmatic concerns are identified during site visits, Program Officersreport findings and recommendations to sub-grantees, which must submit CAP within 30 working days. In turn, sub-grantees have 90 days to demonstrate significant efforts to bring the program into compliance.

Program Officers conduct Follow-Up Programmatic Site Visits to ensure that providers have made the necessary corrections. If the cited program deficiencies have not been fully rectified, or if there is no evidence that substantial efforts have been made to redress the deficiencies, then Program Officers may exercise one of three options:

- Refer sub-grantees for technical assistance (TA) provided by the administrative agencies or Grantee (HAHSTA);
- Refer sub-grantees to the regional AIDS Educational Training Center (AETC) for technical assistance; or as a last resort
- Refer sub-grantees to the Senior Management Team of the administrative agency for disciplinary action.

All outcomes resulting from such findings are considered for grant award continuation or contract renewal.

g. Number and Percentage of Contractors funded

In GY 2011, the DC EMA had a total of 42 Part A sub-grantees (24 in DC; 9 in Northern Virginia and 9 in Suburban Maryland. Of those, a total of 38 (90%) have to date received comprehensive fiscal/ programmatic site visits 21 (88%) in DC; 8 (89%) in Northern Virginia and 9 (100%) in Suburban Maryland received a programmatic site visit during the grant year.

h. Number and Percentage of Contractors with Corrective Action Plans

The DC EMA had a total of 12 (29%) sub-grantees with corrective actions plans (three in DC; none in Northern Virginia and nine (100%) in Suburban Maryland).

i. Improper Charges or Other Findings in FY 2011

In FY 2011, examples of programmatic and fiscal areas for improvement include: thoroughness in documentation of client eligibility in clinical records, consistency in fiscally determining *payor of last resort* provisions, compliance with meetings clinical and case management expectations (e.g.,number of medical visits); and collecting and reporting outcome indicators. Nevertheless, sub-grantees are reminded that optimal compliance is a *process* and appropriate encouragement and commendation are made for diligent efforts to move toward achieving such a monumental goal.

Results of Site Visits) reflect concerted efforts of sub-grantees to shift the focus from process to outcome assessment. Evidence of this systematic paradigm shift within our provider-base to optimize the quality of services for clients includes the following:

- Quality Improvement Plans are required for all sub-grantees.
- Quality Improvement teams have been or are being established by service providers.
- Findings from QA CSV are being incorporated into Quality Improvement Plans.
- Greater focus is placed upon gap identification and service delivery processes to improve service delivery outcomes.
- Interdisciplinary team meetings are routinely held to discuss clinical issues as well as programmatic and fiscal accomplishments and challenges.
- Formalized policies and procedures have been established or are in development/revision.

j. The Number of Contractors that received Technical Assistance (TA).

In FY 2011, 21 (88%) Part A sub-grantees received technical assistance in the District of Columbia; eight (89%) in Northern Virginia and six (67%) in Suburban Maryland.

The following describes the typical technical assistance provided: formalized programmatic guidance through written communication; issue-specific guidance, individualized and targeted meetings, referrals to other expert sources such as the regional AETC; and provision of information on available training, provided free to the public. The Grantee also provides monthly *Brown Bag* presentations made by subject matter professionals and community members to share recent research, findings and information on specialized subjects.

In addition, the Grantee held a series of specialized training on Medical Case Management to inform sub-grantees of purposeful integration of HIV case management and HIV treatment adherence programs with HIV medical care, mental health, substance abuse, HIV supportive services, and entitlements information (e.g. SSI/SSDI Outreach Access and Recovery (SOAR) to maximize successful treatment outcomes (e.g. suppressed viral load and increased CD4 T cells counts).

k. Compliance with OMB Circular A-133.

The Grantee has diligently ensured compliance with the federal A-133 audit report requirement. In FY 2011, a total of 24 (57% of total) sub-grantees of the DC EMA were required to submit audits in accordance with OMB Circular A-133; 15 (63%) of sub-granteesin DC; four (44%) of sub-grantees in Northern Virginia and nine (100%)in Suburban Maryland).

l. Findings in A-133 audit reports.

In FY 2011, all sub-grantees required to submit A-133 audit reports met thefederal A-133 requirement. None had substantive findings that required corrective action.

m. The Process of Receiving Vouchers/Invoices.

Sub-grantees submit monthly invoices with supporting documentations by the 10th business day of each month for reimbursement of expenditures for the preceding month. The invoices are date/time stamped and entered into the invoice tracking database. Invoices are accompanied by supporting documents and a copy of the general ledger reflecting all expenditures. In addition, sub-grantees are required to submit statistical and narrative programmatic reports with monthly invoices as defined in sub-grant agreements and contracts.

n. The Process of Payment made to Contractors/Subcontractors.

Grants management staff review all charges for compliance with fiscal, programmatic and regulatory requirements and approved budgets. Next, approved invoices are forwarded to Accounts Payable, where they are processed for payment. Finally, checks are disbursed within 30 days of receiving complete and accurate invoices.

o. Compliance with the Federal Funding Accountability Transparency Act

The Grantee will continue to ensure compliance with the FFATA of 2006 by maintaining transparency in spending. Currently, the Grantee regularly discusses CARE Act expenditures with members of the DC Planning Council and FOAC committee. In addition, the Grantee, as District Administrative Agency, routinely responds to budget requests of District Legislature and has honored many in-depth and urgent requests to disclose government spending to the general public and media by responding to numerous, highly politicized Freedom of Information Act (FOIA) requests. Similarly, jurisdictional administrative agencies are required to respond to legislative and FOIA requests.

2. Fiscal Staff Accountability

i. Roles and Responsibilities of Program and Fiscal Staff

Grants Management Specialists and Program Officers of the Grantee collaborate and share a joint-responsibility to monitor and track expenditures. Grants Management Specialists are primarily tasked with accounting obligations to ensure fiscal accuracy and sufficiency. On the other hand, Program Officers regularly review the master expenditure spreadsheet on the shared drive while assuring for programmatic allowances according to HRSA-defined monitoring standards. Any disallowances are discussed by grants and program monitors and explained to sub-grantees.

ii. Ensuring Adequate Reporting, Reconciliation, and Tracking.

Grants Management Specialists and Program Officers of the Grantee routinely and periodically meet to discuss and monitor the monthly, quarterly, mid-year, and end-of year closeout expenditures of sub-grantees. The open, bull pen environment allows for frequent dialogue and interaction. Serious matters are discussed in team meeting rooms and conference rooms. Recommendations are regularly discussed and officially communicated to sub-grantees by Grants Management Specialists. End-of-year expenditure reporting, grant closeout and reconciliation activities are conducted by Grants Management Specialists.

4) Third Party Reimbursement

The EMA uses a multi-step process to ensure that all CARE Act funds always serve as the payer of last resort. From the standpoint of service planning, the Planning Council undertakes a comprehensive analysis of all other funding and service delivery systems in the process of establishing priorities and allocations for funding. The Planning Councils uses objective priority-setting steps designed to address gaps in Medicaid, Medicare and other systems to design the Part A Plan. Notwithstanding this effort, the Grantee utilizing contractual provisions that require any agency that does business with the Grantee to ensure that CARE Act remains the payer of last resort.

The District of Columbia HIV/AIDS Administration serves as the Grantee, Administrative Agent for the District of Columbia and manages three Intergovernmental Agreements with entities that serve as Administrative Agent for their respective jurisdictions:

The Prince George’s County Health Department on behalf of five counties located in three regions defined by the State of Maryland, including Suburban Maryland (Montgomery and Prince George’s counties), Southern Maryland (Calvert and Charles counties) and Western Maryland (Frederick County).

The Northern Virginia Regional Commission (NVRC) on behalf of six cities and eleven counties of Northern Virginia, including the following cities (Alexandria, Fairfax City, Falls Church, Fredericksburg, Manassas, and Manassas Park) and counties (Arlington, Clarke, Culpeper, Fairfax, Fauquier, King George, Loudoun, Prince William, Spotsylvania, Stafford, Warren).

a) Sub-Contractors Agreement Documentation

The Grantee emphasizes in its published Request for Applications and subsequent sub-grant and intergovernmental agreements that sub-grantees adherence to the federal requirement to ensure that CARE Act funds are payer of last resort. Critical to implementation of this are requirements ensuring that every potential client is screened for eligibility for other programs. In addition, all provider agreements for services that are eligible for Medicaid are required to demonstrate Medicaid certification.

The service agreement signed by each sub-grantee includes this language:

"The sub-grantee agrees to accept clients for service or appropriate referral after the Grantee determines that the clients meet the following minimum requirements:

- *They are not eligible for the same services under a private or public insurance program including Medicare, the Medical Assistance Program (Medicaid) or any other state compensation program; or*
- *They are eligible but awaiting approval of an application for private insurance, federal or state health benefits program(s), or for any other service that provides health benefits on a prepaid basis."*

The Grantee monitors screening for eligibility in both programmatic and fiscal site visits. Additionally, the Grantee reviews each service category to identify services that may be eligible for reimbursement by the District of Columbia Medicaid program, any of the three state Medicaid programs, or federal Medicare programs of the EMA.

Documentation that clients have been screened for and enrolled in eligible programs (e.g., Medicare, Medicaid, private health insurance or other programs) to coordinate benefits and to ensure that CARE Act HIV/AIDS Program funds are the payer of last resort.

b) Program Income.

Nearly ninety-five percent of clients receiving CARE Act Part A funded services in the Washington, DC EMA are assessed for eligibility through the initial client intake processes that include screening for HIV status, residency and income according to federal poverty level requirements of the CARE Act grant. All sub-grantees are required to bill, collect and report all revenue from third-party payor sources, and to return the revenue as program income to beneint the HIV program.

For clients receiving case management services, documentation of eligibility screening appears in the client record. Case managers assist clients in completing and submitting application for Medicaid, Medicare and other insurance programs if there is a change in client income or disability status.

When clients who are not receiving case management services apply for CARE Act Part A funded services, the service provider conducts the client intake and eligibility screening assessment. The intake form includes client information regarding the primary care provider, insurance, income, financial benefits/entitlements received, special needs, housing needs, and other client information. The provider is required to determine client eligibility for all other payor sources, and to bill, collect and return revenue from those sources as program income.

If it is determined that a client may be eligible for Medicaid, then Medicaid is billed for CARE Act services received during the presumptive eligibility period. During the client eligibility determination process, clients receive appropriate services. If clients have been determined to be eligible for financial benefits or entitlements through another source after utilizing CARE Act funds, then those funds, previously covered by CARE Act Party A, are requested for reimbursement, or recouped.

The processes used is a quarterly report of third-party revenue by funding source, and a review of client files to test the presence of screening.

Administrative Agency for Maryland: Prince George's County Health Department

All individuals new to Suburban Maryland CARE Act Part A funded services are screened at intake for eligibility prior to receiving services. The Client Eligibility form is completed to document client eligibility requirements. All acceptable, supporting documentation such as copies of pay stubs or copies of SSDI and/or SSI letters are attached to the form. In addition, to the eligibility screening for CARE Act funded services, clients receiving Outreach and/or Case Management services receive a more thorough needs assessment, incorporating eligibility screening for appropriate local, state and federal programs. Checklists are used to identify the services/programs/support that clients are currently receiving. The checklists may also be used to track client applications completed and submitted by case managers and agency staff members, who, oftentimes, assist clients with completing and submitting applications for various insurance and social programs.

Clients who report they are uninsured are assisted in completing a Medicaid, Maryland Health Insurance Program (MHIP), or other appropriate insurance applications. Medicare and Medicaid status can be checked through the Centers for Medicaid and Medicare Services (CMS) Eligibility Verification System (EVS). A small number of individuals who are not eligible for Medicaid or private insurance (such as some clients born abroad) are assisted in applying for other state and locally funded programs. Client eligibility and needs are reassessed, at least, every six months.

The Suburban Maryland Grant Agreement requires sub-recipients that provide services that are reimbursable through Medicaid and/or any other insurance to bill those insurers. Sub-recipients who charge for services are required to implement a sliding fee scale with clients whose income is greater than 300% of the federal poverty level prior to using CARE Act funds to cover eligible services.

Administrative Agency for Northern Virginia: Northern Virginia Regional Commission (NVRC)

All persons applying for CARE Act Part A services in Northern Virginia are screened by service providers to determine eligibility for services. Documentation of HIV diagnosis is maintained. Proof of income, including verification with public income benefit programs such as SSI and Veterans benefits, is reviewed and periodically verified. County residency is also verified. Sliding fees scales are utilized. Once a medical diagnosis has been made, and proof of income and residency has been verified, applicant insurance status is assessed. Private insurance benefits for which the applicant is eligible are reviewed, including premiums, co-pays and deductibles, and the scope of coverage for HIV-related conditions also is determined. Additionally, case managers screen clients for eligibility for public programs such as Medicaid, Medicare, ADAP, State Pharmacy Assistance Program (SPAP), and veterans' benefits, make appropriate referrals, conduct follow-up on applications for these benefits, and ensure payment of last resort requirements.

Medicaid eligibility in Virginia is available to certain aged, blind and disabled persons, and to certain children, women, and low-income families. Depending on the type of Medicaid service requested, income limits for eligibility range from 80% -133% of the federal poverty level. Persons who are between 16 and 65 also may be eligible if their income does not exceed 80% of the federal poverty level.

Program Income

During a site visit in July, 2009, staff and consultants of HRSA expressed concern regarding the collection of third-party reimbursement, including Medicaid. During calendar

2010, the EMA received technical assistance from HRSA regarding program income, third party payor, sliding fee scales and cap on charges.

In August 2010, HAHSTA prepared a draft policy regarding these issues, subject to HRSA review and scheduled for implementation for Grant Year 21.

(4)(D). Administrative Assessment

During Grant Year 21 and at the suggestion of the Grantee, the Planning Council worked to develop a system of routine monthly reports that characterize the efficiency of the administrative mechanisms. The reports routinely include by service category and geographic area the total allocated by the Planning Council, the amount awarded to date by the Grantee or Administrative Agent, and the expenditures to date. Analyses provide compare and project expected and expended funds, and offer the opportunity to explore re-direction of resources. Context and background information on anomalies are provided. Refinements to these routine reports include a listing by service categories of invoices received and paid by month.

In conducting its assessment during Grant Year 21, the Planning Council reviewed these reports. The Planning Council also requested a summary of the length of time required for payment of invoices, and will complete its assessment by the end of the calendar year. Preliminary data indicate that more than eighty-five percent of invoices were paid within thirty days of receipt, and nearly one hundred percent paid within sixty days.

5) Planning and Resource Allocation – Criterion (5 points)

- The quality of data used for planning and resource allocation continues to improve.
- Planning and Resource (Re-)Allocation are year-round activities of the Planning Council.
- The EMA expended approximately 84% of service funds on core medical services.

5a. Letter of Assurance from Planning Council Chair(s). See Attachment 2.

5.b.. Description of Priority Setting and Resource Allocation Process

The Washington, DC EMA is a diverse and complex EMA covering more than 6,900 square miles and includes portions of three states (suburban Maryland, northern Virginia, and West Virginia) in addition to the entire District of Columbia. To assure input from all segments of the population, a series of three meetings were held within each of the four jurisdictions of the EMA. Particular consideration was given during the planning process to the needs of those persons unaware of their HIV status, historically underserved populations and those disproportionately impacted by the disease. To enhance the process, a standard description of priority setting procedures was utilized in each of the jurisdictions. The same process was then conducted with the Planning Council, a total of 15 meetings throughout the EMA.

Step 1.Presentations on

- Epidemiology
- Review of needs assessment analyses from a variety of sources,
- Trends and changes and key issues for consideration in the EMA
- Service utilization data
- Other sources or funding
- Needs assessment data from needs assessment activities of the Planning Council, including special populations studies on Black MSM, Immigrants, and Latinos

Step 2. **Priority setting**, during which participants designated service priorities and recommended priorities for each jurisdiction, based upon the particular services available within each jurisdiction.

Step 3.Allocations, including careful consideration of epidemiological, cost, expenditure, utilization, quality assurance, unmet need data and an estimation of those unaware of their HIV status, during which participants recommended amounts and proportions of funding for services in each jurisdiction.

Step 4.Refinement. Following the allocations of funds to service categories, the Planning Council developed a series of programmatic directives. Some of that work – in particular, a new service priority for a peer-based Early Intervention Service – remains in development for implementation during Grant Year 22.

Geographic Distribution of Funds. One of the key challenges f is the geographic range, distance and diversity that comprise the EMA. The Planning Council has used living reported HIV/AIDS cases from each of the states that comprise the EMA to guide allocations of funds. This simple formula has been applied to total funds available for services after a modest allocation of funds for services without respect to area of residence within the EMA.

To date, the Planning Council has concurred on the need for more responsiveness to the current epidemic, and is making slow but steady progress towards a thorough review of the many and complex issues. One approach is to develop a formula to achieve an appropriate balance between ensuring consistency with the federal formula (that is, the use of living AIDS and HIV (non-AIDS) cases), and, on the other, responding to locally determined need. Indicators of need for service include the distribution of cases among jurisdictions, the distribution of cases in rural areas, the distribution of emerging populations of people in need of services, the distribution of cases that comprise the Unmet Need Estimate, the distribution of cases of poverty and the distribution of a "gap" created by uneven Medicaid, calculation of the those that are unaware of their HIV status, and other health care system investments.

Additional key considerations:

- The multiple and inconsistent state programs, including Medicaid and ADAP, and especially highly variable rates of Medicaid expansion.
- The disparate financial contributions to HIV care services by local governments, that is, the states, cities and counties that comprise the EMA. A formula that targets federal funds to jurisdictions with limited local contribution could constitute a "disincentive" for local contributions.
- The calculation of those unaware of their HIV status across the EMA
- The extent to which increased portability of services may benefit mobile clients, but adversely impact clients with limited access to transportation and other resources.

Needs of Persons Not In Care. Identifying individuals not in care and linking them to outpatient primary medical care services is a key activity of every service category that supports contact with clients and potential clients. As part of the FY 2012 planning process, the Planning Council reviewed studies conducted by HAHSTA and its partners, and reviewed all available indicators of the extent of persons not in care in the EMA, the populations that were disproportionately represented by persons not in care, the service needs reported by persons not in care and the services that were most effective in reaching out of care PLWHA and linking them to care. This information was integrated into the Priority Setting, and is manifested in

- Refinements to service categories to improve indicators of successful linkages
- Commitment to analyses that will highlight population(s) with ongoing challenges
- Increases to the allocations of funds for Early Intervention Services
- Proposal of a peer-based model of Early Intervention Services, scheduled for implementation during Grant Year 22, to support intensive, short-term interventions for clients in need of additional support during the initial phases of enrollment into care, or

support for re-enrollment into care.

Needs of Unaware of their HIV Status. The Planning Council has reaffirmed its commitment to identifying individuals unaware of their HIV status and linking them to care in FY 2012. To this end, at priority setting they examined the total population of those unaware and the Planning Council included in its FY 2012 Plan an emphasis on early intervention services with HIV testing and linkage to care, allocating additional dollars in base funding, including targeted funding for high prevalence populations. In addition, the procurement of EIS will include consideration of the established and available HIV testing programs, seek to minimize duplication of those services and maximize the specific contribution of EIS for high-need populations. Preliminary refinement to these services recommends that funds be used for linkage to care services in licensed medical and community based settings.

Description of Priority Setting and Resource Allocation Process

PLWH/A Involvement. At least eighty one PLWH/A participated in the priority setting and allocations process. They attended data presentations, and then deliberated with providers and other stakeholders in the priorities and allocations process. PLWH/A input guided the discussions in each jurisdiction, and the final priorities were set using the tallies from their ballots. The final priorities and allocations for the entire EMA reflect a consolidation of the priorities and allocations from each jurisdiction. The Planning Council voted to accept this consolidated list as their final priorities and allocations, thus preserving integrity of the input from each local jurisdiction and each PLWH/A involved in the process at the local level. In an effort to increase participation of PLWHA, there were substantial amount of recruitment activities that occurred prior to each set of priority setting activities at various local venues, the Consumer Access Committee and other sub-committees. Advertisement about priority setting was established through each of the jurisdictions. Additionally, the Planning Council added member caucus after priority setting to identify challenges, barriers and successes.

Each of the four jurisdictions and the full Planning Council distributed and discussed data related to cost, expenditures, service utilization, demographics, epidemiology, unmet need, findings needs assessment data, prior to voting on priorities and allocations.

Each person who voted in the priorities and allocations processes was required to attend a data presentation prior to doing so. This ensured that each participant was familiar with the data and was prepared to set priorities and allocations in a methodical manner, rather than based on speculation, anecdotal evidence or personal needs. Information from the relevant Statewide Coordinated Statement of Need was discussed to assist participants in focusing on needs identified within their state to ensure that the final, comprehensive priorities and allocations for the EMA are in alignment.

In response to the data and specifications of The CARE Act HIV/AIDS Treatment Modernization Act of 2006, several jurisdictions proposed increases to the allocations for primary medical care and re-prioritized some of the supportive services to facilitate client access to care, thereby reducing disparities for targeted populations.

How Data Were Used in Priority Setting. The Planning Council's decision making process is driven by accurate, up-to-date data. The Planning Council considered all available data to assign scores to all service categories in the Council's planning tool. The following types of data were considered:

- Service Gaps and Other Needs Assessment Data
- Focus Group Data
- Service Utilization Trends
- Emerging Populations with Special Needs

- Broad Trends in Health Care financing and Delivery
- Homeless and Economic Trending Data

All of this data assisting in understanding the increased demand for services for high risk populations and afforded the EMA to respond by allocating additional funding for early intervention services to assist in services those who are unaware of their HIV status, target disproportionately impacted populations, including African Americans and MSM.

Changes and Trends in HIV/AIDS Epidemiology Data. The EMA epidemiologic data for the year has shown consistent high rates of HIV/AIDS among Blacks, men who have sex with men, homeless individuals, Latinos/as, and adults over the age of 50. The Planning Council used these trends to prioritize services for these targeted populations throughout the EMA.

Cost Data. In order to allocate funding adequately across service categories, participants in the jurisdictional meetings considered current expenditures, number of clients served, service utilization data from the past year, and local and federal expenditures by service category. These figures were then used in conjunction with unmet need, epidemiological, and current service utilization and cost of services to determine the amounts needed in each service category. This method served as the starting point in the allocations process. After completing this process, the Planning Council determined that more funds were needed than available. Therefore, adjustments to the allocations were made based upon service priorities, in consideration of the availability of other funding sources (e.g., CARE Act Part B, Medicaid, Medicare, local programs) with a focus on the core medical services.

During Grant Year 21, significant improvements were evident in the data collected and reported from third-party payor sources, and especially from Medicaid. Some of those data remain inconsistent among the four Medicaid programs in the EMA, and in the District is somewhat unreliable given the rapid expansion of Medicaid. The impact of third-party payor sources on the calculation of cost of services provided is complex and remains a key challenge.

Unmet Need Data. Unmet need data were presented at each jurisdictional data meeting as well as during the full Planning Council data presentation. Each local jurisdiction considered unmet needs, with an emphasis on increasing medical access for those who know their HIV status and are not in care, when setting priorities and allocations. This is reflected in the final priorities and allocations approved by the Planning Council, including an increase in EIS to reach those out of care, particularly hard to reach populations. Note the section "Geographic Distribution of Funding" for a proposed use of Unmet Needs Data in a formula.

Planning Council, Funding Increases or Decreases. Each jurisdiction conducts priority and allocation setting processes based on three scenarios: level funding, 10% increase and 10% decrease. This application is for an increase of ten percent.

Planning permits for increases and decreases between these levels for each geographic area and for services EMA-wide. For each funding scenario, the Planning Council determine the allocations for each service category, while maintaining priority for the 13 core medical service categories. The Planning Council approves the consolidated priorities and allocations, including the different funding scenarios. Upon notification of the award amount, the appropriate formula is applied as determined in each local jurisdiction. This process affords the greatest utilization of local input into the allocation of shifting funding amounts across a large, diverse EMA.

How MAI Funding Was Used. The Planning Council re-affirmed its commitment to deploy MAI funds to serve high-need, fragile people of color with a cluster of services designed to support stability and initiation into care. This model of services has demonstrated significant positive outcomes in each part of the EMA, and is described above.

Needs of Persons Unaware of their HIV Status. A priority of the Planning Council is identifying individuals unaware of their HIV status and linking them to care. The Planning Council relied on data that was provided by HAHSTA which utilized several sources of data on persons unaware of their status in planning, including epidemiological and community data to prioritize population for the Planning Council to make decision about prevention strategies. HAHSTA analyzes geographic and demographic changes in new infections and concurrent HIV diagnosis to indicate populations disproportionately unaware of their status

See Attachment 8 for the proposed allocations of funds for services.

6. Budget and Maintenance of Effort (MOE)

6.a. Budget.

See Attachment 1 for a listing of staff positions supported by this grant application and the attached Budget Justification.

6.b. Maintenance of Effort

The total maintenance of effort amount is $841,714 for the EMA, which was reported incorrectly in the Grant Year 21 application. The HAHSTA budget includes an allocation of local funds in the amount of $300,000 for food bank and home delivered meals s to people with HIV in the budget sub-heading “Locally Fund Sub-Awards (Care).” City and county budgets in Northern Virginia include specific line items for the costs tabled. Not included in the MOE are the administrative costs contributed in-kind by each jurisdiction, nor any one-time allocation of funds for services.

Table 21: Maintenance of EffortElementsand Amounts

Jurisdiction	Agency	Category	FY2009	FY 2010
District of Columbia	HAHSTA	Food Bank	300,000	300,000
Northern Virginia	Alexandria	Outreach, Primary Medical	93,701	97,709
Northern Virginia	Arlington Co.	Medical Case Management	75,831	81,991
Northern Virginia	Fairfax Co.	Outreach, Primary Medical, Medical Case Management, Health Education	352,709	362,014
TOTAL			**822,241**	**841,714**

The total maintenance of effort amount is $841,714 for the EMA, which was reported incorrectly in the Grant Year 21 application.The HAHSTA budget includes an allocation of local funds in the amount of $300,000 for food bank and home delivered meals s to people with HIV in the budget sub-heading “Locally Fund Sub-Awards (Care).” City and county budgets in Northern Virginia include specific line items for the costs tabled. Not included in the MOE are the administrative costs contributed in-kind by each jurisdiction, nor any one-time allocation of funds for services.

7. Clinical Quality Management

- Implemented standardized reporting template for collection of HAB measures.
- EMA Quality Management Structure through the DC EMA Cross-Part Collaborative.
- Plans to expand the range of performance measurement data

7a. Description: Structure, Vision, Mission, and Goals

The Care, Housing and Support Services (CHSS) bureau within HAHSTA represents the grantee for CARE Act Part A, Part B and HOPWA services is this EMA. HAHSTA has an established Quality Improvement Program (QIP) that, in accordance with the CARE Act, is responsible for the oversight and management of quality improvement activities throughout the dynamic, multi-jurisdictional area. HAHSTA has dedicated personnel and resources as its commitment to monitoring performance and developing strategies for improvement in durable viral suppression. The grantee works closely with the CARE Act Planning Council, HAHSTA Housing Assistance Division and the DC EMA Cross-Part Collaborative.

The QIP seeks to ensure the highest quality of services for all clients served by agencies that receive Part A funding and that clients receive equal and accessible HIV health care and supportive services. The Program systematic quality improvement with the goals of:

- Providing cost-effective, quality services that meet and exceed the needs of persons living with HIV/AIDS
- Assessing the extent to which service providers are achieving key health outcomes for HIV-positive patients throughout the EMA

- Creating and sustaining the capacityto use data to monitor programs and continuously improve the care and service delivery systems

The QI team consists of eight key HAHSTA staff that coordinate and oversee operations of the Program. Team members identify and participate in quality activities. assess improvements in organizational and operational performance, develop/revise standard of care protocols, conduct site visits; and oversee the remediation process when programmatic and service delivery concerns arise. The key staff involved are listed below, and include positions not funded by the CARE Act Part A.

- Deputy Director of Programs: The overall authority on care and treatment standards.
- Chief and Deputy Chief for the CHSS Bureau (2): Leadership and technical assistance to program staff. Ensure that QIP activities are consistent with applicable guidelines. The Bureau Chief is the Part A administrator.
- CHSS Bureau Monitoring and Evaluation Manager: Provides technical oversight and leads HIV/AIDS clinical quality reviews, establishes and monitors quality improvement goals, organizes outcome research, and supervises Data Managers.
- HAHSTA Quality Improvement Staff (2): Responsible for internal and external QI capacity building and training activities.
- Data Managers (2): Responsible for the collection, analysis, reporting, and dissemination of client-level and QM data to internal program staff, planning bodies, providers, and funders.

The entities below are fundamental components of the quality infrastructure:

Clinical Quality Chart Review (Contractor):conducts on-site client record chart reviews for the clinical service categories, and evaluates the provisions of services to clients, along with recommendations for improvement in programs and service delivery. The contract for this service is under review for Grant Year 21.

Jurisdictional Administrative Agents: implement jurisdictional sub-grantee specific monitoring of programmatic and fiscal compliance. The intergovernmental agreement requires that providers be monitored at least annually, with a semi-annual report on provider progress.

Program Officers: perform the routine sub-grantee program oversight and monitoring through review of monthly reports, desk audits and site visits. Program Officers assist with the alignment of quality improvement activities with U.S. Public Health Guidelines and federal expectations, assist in addressing identified issues, and interface with QI staff to follow-up on deficiencies.

DC EMA Cross-Part Quality Improvement Response Team: leadership group of the EMA Collaborative that defines the structure and framework for QM and performance monitoring activities within the Collaborative. More detail provided below.

Planning Council Care Strategies and Coordination of Services (CSCS) Committee: works with the Grantee to standardize and approve quality assurance protocols, monitoring tools, outcome indicators, and other quality management activities of the Planning Council. The CSCS Committee includes members of the Planning Council, PLWH/A's, providers and representative of the jurisdictional administrative agencies.

Established Quality Management Program

In previous years, HAHSTA, with coordinated efforts of the administrative agents and jurisdiction program officers, implemented activities to assess the quality of services provided by sub-grantees. Activities such as routine reporting of provider and system level indicators, quality assurance and programmatic site visits and follow-up improved provider operations and services delivered to clients. Evidence of improvements made by the EMA providers, relative to the emphasis on health outcomes, include the following:

- Quality Improvement Plans by all providers.
- Inclusion of findings from Quality Site Visits into quality improvement planning process.
- Interdisciplinary team meetings are occurring to discuss client issues and accomplishments.

EMA Quality Management Structure

In January 2011, CARE Act grantees and sub-grantees in the EMA began participation in the DC EMA Cross-Part Quality Improvement Collaborative. The Collaborative provides an opportunity to further align performance measures with HRSA HIV/AIDS Bureaus' (HAB) Performance Measures and strengthen the regional capacity for collaboration across CARE Act HIV/AIDS Programs opportunity to meet the CARE Act HIV/AIDS Program mandates, conduct joint quality improvement activities to across constituencies within a region, and to coordinate QQI activities among Parts. The Part A grantee continues to play a leadership role in the Collaborative whose objectives are to:

- Initiate and maintain a joint quality improvement project across all participating grantees.
- Foster alignment and collaboration among regional grantees and stakeholders.

- Advance the quality improvement infrastructure across the EMA, including advance quality management competencies.
- Improve the quality, coordination and efficiency of data collection by providers.

A**Response Team** was established to provide oversight and support of the Collaborative, work with members to establish a quality management plan, define the structure and framework for quality management and performance monitoring activities, identify and prioritize quality improvement projects, coordinate data analysis and reporting activities, and provide the technical support necessary to implement identified quality initiatives.

The Response Team accomplishes its work through interaction with Collaborative members through a sub-committee structure. The following sub-committees have been established and leads for each have been identified:

Data Management Team is led by the CHSS Monitoring and Evaluation manager, and is responsible for:

- Advising on improvements to the data collection and performance monitoring initiatives.
- Collecting performance measures data from grantees and sub-grantees.
- Compiling, analyzing, and reviewing data for trends in program outputs and data validity;
- Providing technical assistance and training on data integrity, collection, and use.
- Developing and distributing provider performance reports for each data submission.
- Assisting the Collaborative with identifying potential data improvement projects;

Quality Improvement Team is responsible for:

- Setting Collaborative goals for each improvement project/
- Providing technical assistance and other support around QI activities.
- Managing effective communication of best practices.

Quality Management Plan Team is responsible for:

- Establishing shared measures and standards.
- Developing, maintaining, and reviewing the HIV QM Plan and work plan.
- Reporting the HIV QM Plan implementation outcomes.

Provider Capacity Development Team is responsible for:

- Developing and implementing QM training opportunities based on identified needs.
- Facilitating providers' and consumers' ability to conduct QM activities.
- Supporting the development of DC Cross-Part QI activities by linking training and TA.

The Consumer Capacity Development Team will be responsible for:

- Providing an effective means of QI communication to the consumers;
- Increasing public awareness of the status of the Collaborative activities.

The Response Team revised the DC EMA Quality Management Plan (QMP) to establish a jointly developed DC EMA Cross-Part QMP. Collaborative participants were invited to contribute to quality management priority and timeline setting, to be reviewed and updated at least annually. The QM Plan will be finalized by the end of calendar 2011.

The Collaborative includes consumer representation to advise other members on QI processes and has done so from the inception of the Collaborative. Consumers are equal partners in the QI process and are active members of any QI initiative related to the Collaborative.

Collection and analysis of 15 HAB performance measures (further described in the Performance Measurement section) began in May 2011. Data are collected from a variety of sources and, to the extent possible, existing data sources are utilized including the eClinical Works, General Electric (GE) Centricity, Virginia Client Reporting System (VACRS), CAREWare, locally developed programs, custom agency databases in Access or Excel. The data collected are 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 are provided to each participant after each data submission.

The Collaborative selected a Group 2 HAB HIV Core Clinical Measures to focus on for their QI project – the percentage of adult clients with HIV-infection who had a test for syphilis performed in the measurement year. Findings for QM activities are reported to the Quality Improvement Team which will provide technical assistance to low performing sites and identify best practices of high performing sites for distribution.

The Collaborative utilizes strategies outlined in the HAB's HIV/AIDS Core Clinical Performance Measures for Adults and Adolescents document to measure selected key performance indicators for HIV health care. RW grantees, sub-grantees, contractors and subcontractors will be required to report data on these selected key performance indicators. Compiled findings will be shared with HIV providers, the Response Team and HRSA faculty, consumers, grantees, and others, as deemed appropriate.

Planning and implementation of services supported by the Minority AIDS Initiative MAI are fully incorporated into the service system supported by CARE Act Part A funds. Generally, these clients consume a portfolio of services that include – but are not limited to MAI. Clients who received ambulatory outpatient medical care or medical case management services supported by MAI will be included in the cohort of client reported.

Standardized Use of Performance Measures Across the EMA

In 2009, HAHSTA began shifting its focus to measuring health outcomes for clients. Simultaneously, HAHSTA expanded its assessment of quality care to include all HIV care services in the EMA, regardless of payer source. This renewed approach was a driving force behind the decision to develop and implement a new, comprehensive HIV/AIDS system. This integrated management information system (MIS), or MAVEN, will enable HAHSTA to:

- Track clients across the continuum of care and across time periods.
- Improve the quality of the data.
- Complete more in-depth analysis of health outcomes.
- Improve efficiency and accuracy of sub-grantees reporting.
- Allow more rapid response to ongoing requests and/or changes in federal requirements.

Given that provider and laboratory data are critical components that inform the quality program, Maven will enhance real-time 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 will support the Collaborative in systematically monitoring, evaluating and continuously improving the quality of HIV care and services provided to consumers in the DC EMA. Throughout the 18-month Collaborative timeframe, HAHSTA will work towards implementing a MIS, Maven, that will simplify the collection and reporting of core services performance data, and help sustain the continued success of the Collaborative.

See below for a selection fromfifty indicators in five service categories. A complete list of indicators is available on request. Data for these indicators are collected bi-monthly through the Collaborative (C) or Planned (P) for collection during Grant Year 22. The first corpus of data collected on the "planned" measures will be used to determine benchmarks and future EMA quality improvement projects.

Table 22: Indicators for Core Services

Focus	Outpatient Ambulatory Medical Care	Status
Medical Visits	% of clients who received two or more ambulatory care visits, at least three months apart	C
CD4 test	% of clients who had two or more CD4 T-cell counts performed at least three months apart	P
VL suppression	% of clients who had a suppressed viral load (<200 copies/ml)	C

AIDS HAART	% of clients with AIDS prescribed HAART	P
Pap	% of women who had a Pap screen	P
Pregnant ART	% of pregnant females prescribed ART	P
Syphilis	% of clients who had a test for Syphilis performed	C
Treatment Adherence	% of clients on ART assessed and counseled for adherence two or more times	P
HERR	% of clients who received HIV risk counseling within the measurement year	P
Mental Health	% of new clients who had a mental health screening	P
Substance Abuse	% of new clients who had a substance use (alcohol and drugs) screen	P
Oral Exam	% of clients who received an oral exam by a dentist during the measurement period	C
Focus	**Performance Measure – Medical Case Management**	**Status**
Medical Visits	% of MCM clients who received two or more ambulatory care visits, at least three months apart	C
CD4 test	% of MCM clients who had two or more CD4 T-cell counts performed at least three months apart	P
VL suppression	% of MCM clients who had a suppressed viral load (<200 copies/ml)	C
Oral Exam	% of MCM clients who received an oral exam by a dentist at least once during the measurement period	C
Care Plan	% of MCM clients who had a MCM care plan developed and/or updated two or more times	P
Treatment Adherence	Number of clients receiving treatment adherence counseling as part of their MCM visit	P
Focus	**Performance Measure – Substance Abuse**	**Status**
Medical visits	% of substance abuse clients who received two or more ambulatory care visits, at least three months apart	P
VL suppression	% of substance abuse clients who had a suppressed viral load (<200 copies/ml)	P
Treatment Completion	Percentage of substance abuse clients, with HIV infection who complete an outpatient treatment program	P
Focus	**Performance Measure – Mental Health**	**Status**
Medical visits	% of mental health clients who received two or more ambulatory care visits, at least three months apart	P
VL test	% of mental health clients who had a viral load test performed at least every six months	P
VL suppression	% of mental health clients who had a suppressed viral load (<200 copies/ml)	P
Treatment Completion	Percentage of mental health clients, with HIV infection who complete an outpatient treatment program	P
Focus	**Performance Measure – Mental Health**	**Status**
Dental Treatment Plan	Percentage of HIV-infected oral health patients who had a dental treatment plan developed and/or updated at least once in the measurement period	P
Medical visits	% of oral health clients who received two or more ambulatory care visits, at least three months apart	P
VL suppression	% of oral health clients who had a suppressed viral load (<200 copies/ml)	P
Periodontal Exam	Percentage of HIV-infected oral health patients who had a periodontal screen or examination at least once in the measurement period	P

7b. Description of Data Collection and Results

Current Level of RSR Data Capabilities and Management Information Systems

All EMA providers have the capability and functionality to collect and report data at the client level. XPRES remains the Grantee's current electronic database system for collecting client and service level information. Although, as mentioned, HAHSTA is in the process of rolling out a new system, MAVEN, that will enable DC-DOH to manage all HIV/AIDS, STD, Hepatitis and Tuberculosis surveillance, prevention, care and treatment data in one client-centered, outcome focused database.

As part of this consolidation, HAHSTA is refining its ability to use all sources of data – laboratory, Medicaid, third party payer systems– to support linkages, efficiencies, and health outcome improvement. Because Maven is a client-centric system, utilization data across all HAHSTA programs, CARE Act sources, HIV Prevention, Tuberculosis, STD and Hepatitis, can be used to improve understanding of co-morbidities, facilitate early identification and linkage to care of individuals with HIV, and to assess efficiencies and gaps in the service delivery system.

HAHSTA is currently working with several grantees in the EMA who have adopted electronic medical records systems (EMR) to maximize the efficiency of those systems, and create a mechanism for routine, automatic upload of client-level data into Maven.Deployment of MAVEN for the purposes of sub-grantees funded through CARE Act is expected at the beginning of calendar 2012 and required by May 2012.

QM Data Collected and Summary of Results

Performance measurement is a central component of the QM Program. Collaborative performance measurement data will be 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.

Performance data for the Collaborative will be collected from all CARE Act funded agencies within the DC eligible metropolitan area. Providers will use the established standardized reporting template and submit their aggregate data through the secure web-based portal on Project Space. The data collection efforts will place as minimal a burden as possible on the providers; minimize any interference with the routine operations of provided services; and utilize existing data sources (including clinical chart abstraction and consumer interviews).

Individuals involved with the collection of data will be bound by local, state, District, federal, and other applicable regulations regarding confidentiality and security. Appropriate training will be provided to any individual that is involved in data analysis process relative to the confidentiality and security of data, and other ethical issues.

The Collaborative is responsible for the regular collection, analysis and reporting of QM data. This data includes, but is not limited to:

- Chart abstractions from client medical records (paper and/or electronic);
- Clinical databases;
- Demographic databases;
- Management Information Systems - XPRES, CAREWare, MAVEN, ADAP database;
- Administrative/Programmatic monitoring tools;
- Client satisfaction surveys/interviews;
- Focus group summaries; and
- Unmet Needs Assessments;

Utilization of QM Data

The Collaborative is designed to strength quality improvement activities across the EMA. Providers are supported with a myriad of opportunities to enhance their ability to report data and the overall quality of the services provided in

Table 23: Key Results from Collaborative Reports – Rounds II

Provider Type	Measure	Performance
HIV Medical care: Adolescent/Adult (17 sites)	Medical Visits	87%
	Viral Load Monitoring	77%
	Viral Load Suppression	83%
	PCP Prophylaxis	90%
	Syphilis Screening (#5)	74%
	Oral Exam (#7)	30%
HIV Medical Care: Pediatric (1 site)	Viral Load Monitoring (#2)	94%
	Oral Exam (#7)	43%
	Pediatric: Medical Visits (#1)	86%
	Pediatric: PCP Prophylaxis (#13)	100%
Medical Case Management (2 sites)	MCM: Medical Visits (#12)	82%
	MCM: Viral Load Monitoring (#8)	73%
	MCM: Viral Load Suppression (#9)	78%
	MCM: PCP Prophylaxis (#10)	68%
	MCM: Oral Exam (#11)	59%
ADAP (3 sites)	ADAP Application (#14)	74%
	ADAP Recertification (#15)	33%

the form of quarterly in-person meetings, quality improvement trainings, and technical assistance calls/webinars.

After each data submission HAHSTA develops and distributes EMA-wide, agency-specific, jurisdictional and consumer performance reports. These reports highlight the successes and areas for improvement, as well as performance relative to the EMA, jurisdiction, and sites of similar client population. Program-specific data reports are provided to each program for the purpose of enhancing their QM Program and to allow for comparison across the jurisdictions and DC EMA. The EMA-wide report is shared with the non-participating sites to keep them informed of the Collaborative's progress with the hope that the tangible feedback will entice participation moving forward. The jurisdiction reports are shared with the administrative agents along with a list of non-participating sites. The Data Team collaborates with the consumer representatives to develop a data reports for their use. More specifically, the reports provide:

- Feedback to address performance, data quality and completeness, and reporting issues.
- A breakdown of the lowest and highest performers throughout the EMA, by performance measure
- A comparison of the performance by site with the EMA, jurisdiction, and comparable client population size.
- Measure performance stratified by race/ethnicity.
- Trending and directional change, by measure, for each round of data submission.

The Collaborative utilizes strategies outlined in the HAB's HIV/AIDS Core Clinical Performance Measures for Adults and Adolescents document to measure selected key performance indicators for HIV health care. RW grantees, sub-grantees, contractors and subcontractors will be required to report data on these selected key performance indicators. In addition, compiled findings are shared with the Response Team and HRSA faculty, consumers, grantees, and others, as deemed appropriate.

To date, three rounds of data submission (May, July, and September) have occurred. In Round III, 22 sites reported data, inclusive of >50,000 unduplicated client records. Participation is improving steadily and included three of the four ADAP programs and nearly three-fourths of primary care programs, compared to one-quarter of medical case management programs.

HAHSTA's Quality Improvement Program team has developed a comprehensive work plan to assist the team members in implementing, monitoring and evaluating their progress towards planned objectives. Quality Improvement Program shares findings with the jurisdictional agencies and Planning Council as part of the planning process. The Grantee provides information related to population demographics, service utilization, creation of new points of access, coordination of services, and health outcomes.

The EMA will continue to refine its approach to these critical quality improvement activities. Beginning in 2012, the EMA expects to expand the range of performance measurement data collected (to include mental health, substance abuse, and oral health), and conduct on-site clinical quality reviews to verify the results of the provider's reports.

Footnotes and references are available on request.

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