Washington DC Regional
Eligible Metropolitan Area

2012-2014 Comprehensive HIV Care Plan

Metropolitan Washington
Regional
Ryan White Planning Council

GOVERNMENT OF THE DISTRICT OF COLUMBIA
DOH
DEPARTMENT OF HEALTH
Promote. Prevent. Protect.

Letter of Concurrence

Metropolitan Washington Regional Ryan White Planning Council

899 North Capitol Street, NE Fourth Floor Washington, DC 20002

May 21, 2012

Barbara Aranda-Naranjo, Director
Division of Service Systems, HIV/AIDS Bureau
Health Resources and Services Administration
U.S. Department of Health and Human Services
5600 Fishers Lane
Rockville, MD, 20857

Dear Ms. Aranda-Naranjo,

On behalf of the Metropolitan Washington Regional Ryan White Planning Council, I am delighted to present the Washington, DC Part A comprehensive plan for 2012-2014.

The plan reflects a coordinated effort led by the Planning Council, with extensive community input and the support and assistance of the EMA's partners and stakeholders. This includes the Grantee, the HIV/AIDS, Hepatitis, STD, and Tuberculosis Administration (HAHSTA) within the DC Department of Health, and the Administrative Agents, the Prince George's County, MD Health Department and the Northern Virginia Regional Commission (NPRC). In preparing the plan, we obtained detailed input in all four of the jurisdictions within our Eligible Metropolitan Area (EMA), consulting with more than 200 people living with HIV disease (PLWH), service provider staff, state and local health departments, and other interested residents.

We have developed a challenging work plan to strengthen our system of care, prepare for health reform implementation, address the goals of the National HIV/AIDS Strategy, and increase coordination between prevention and care and between Ryan White and other providers. The EMA will explore the use of a medical home or related model to provide a comprehensive, coordinated system of care for PLWH whose care may be supported by multiple funding streams. To facilitate rapid entry into and retention in care and positive clinical outcomes for diverse PLWH in our large and complex EMA, we will continue to expand the use of peer community health workers.

We look forward to working with the HIV/AIDS Bureau as we meet the challenges of a changing health care system.

Sincerely,

Stephen Bailous
Planning Council Chair

Letters of Support

Government of the District of Columbia
Department of Health

Office of the Director

May 18, 2012

Dear Colleagues:

It is my pleasure to congratulate the members of the Metropolitan Washington Regional Ryan White Planning Council (MWRRWPC) for their tireless efforts to prepare the 2012-2014 Comprehensive Plan for HIV care and treatment for the metropolitan region. Impending health care reform, stakeholders focus and demand for improved efficiencies, all underscore the need for evidence-supported, high-impact, and cost-effective modalities to controlling and eventually ending the epidemic in the in the greater Washington, DC region.

I am glad to see that under the leadership of MWRRWPC and with technical guidance and support of from HIV/AIDS, Hepatitis, STD and TB Administration (HAHSTA), all parties involved are supporting "Patient Centered Medical Home (PC-MH)" model as the future modality of service delivery. This thoughtful review of issues is critical to the judicious implementation of federal funds for HIV medical care, treatment and support services establishes a firm foundation for improving the response to ending the HIV/AIDS epidemic.

I am particularly pleased that the Plan contributes to the core priorities of the Department of Health by placing much-needed emphasis on the simultaneous goals of promoting healthy behaviors, preventing the spread of disease and protecting the well being of those we serve. I extend my appreciation to the Planning Council and to my co-workers in HAHSTA. I look forward to supporting the implementation of this critical plan for the health of the residents of the District of Columbia and the region.

Sincerely,

Mohammad N. Akhter, MD, MPH
Director

899 North Capitol Street, N.E., 5th Floor, Washington, D.C. 20002 • Phone (202) 442-5944 • Fax (202) 442-4795

GOVERNMENT OF THE DISTRICT OF COLUMBIA
Department of Health

HIV/AIDS, Hepatitis, STD and TB Administration

May 18, 2012

Dear Colleagues:

I congratulate the members of the Metropolitan Washington Regional Ryan White Planning Council (MWRRWPC) for their commitment and vision in the preparation of the 2012-2014 Comprehensive Plan for HIV care and treatment for the metropolitan region. On behalf of the District of Columbia Department of Health HIV/AIDS, Hepatitis, STD and TB Administration (HAHSTA), I convey my support for the plan and confidence that it will help the metropolitan area achieve a comprehensive, coordinated system of care.

With the changing landscape of public health, I commend the Planning Council for preparing a plan that can respond to developing needs and health care systems. The 2012-2014 Comprehensive Plan addresses the emerging issues in HIV care and treatment:

- ***Health care reform*** – the Plan anticipates the tremendous opportunities through the Affordable Care Act by leveraging public and private insurance and the effective use of information technology. I am particularly pleased the Plan recognizes the promising model of "Patient-Centered Medical Homes" as a cornerstone of successful entry and retention in care.
- ***National HIV/AIDS Strategy*** – the Plan effectively integrates the Strategy's goals and measurable objectives in reducing new transmissions, getting people into care and optimizing clinical outcomes, and eliminating HIV-related health disparities, as well as ensuring a coordinated response to the epidemic.
- ***Treatment as Prevention*** – the Plan incorporates the increasing direction of coordination between prevention and care planning and services, and meeting the 2009 legislative requirements for Ryan White to address the Early Identification of Individuals with HIV/AIDS (EIIHA).
- ***Unmet Need*** – the Plan continues to address unmet need, by getting persons living with HIV who know their status back into care and by using program models that help prevent persons living with HIV from leaving care.
- ***Evaluation*** – By focusing on evaluating the success of changes in the system of care based on "treatment cascade" measures such as early testing, prompt entry into care, retention in care, early access to antiretrovirals, and clinical outcomes including viral suppression, the Plan moves the bar in terms of improved health outcomes for persons living with HIV.
- ***Region*** – the Plan factors jurisdictional differences sensitively along with a commitment to parity in access to care for all persons living with HIV throughout the region, irrespective of urban, suburban, or rural settings.

I add my thanks to the volunteers on the Planning Council who partnered with HAHSTA to create the 2012-2014 Comprehensive Plan. I look forward to working together to improve the lives of our residents living with HIV and decrease the impact of the epidemic on our communities.

Sincerely,

Gregory Pappas, MD, PhD
Senior Deputy Director

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Fairfax, VA 22031
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Northern Virginia Regional Commission

May 11, 2012

Stephen Bailous, Chair
Metropolitan Washington Regional Ryan White Planning Council
899 North Capitol Street, NW, 4th Floor
Washington DC 20002

Dear Mr. Bailous:

As the administrative agent for the Virginia portion of the Ryan White Part A program in metropolitan Washington, Northern Virginia Regional Commission (NVRC) is committed to ensuring that people in our community living with HIV have continued access to high quality comprehensive services.

In its role defined in the CARE Act legislation, the Metropolitan Washington Regional Ryan White Planning Council (the Planning Council) must develop a comprehensive plan every three years. NVRC contributes to this activity, providing relevant information on Virginia specific needs and trends.

We find the strategy in this year's plan for identifying individuals with HIV/AIDS who do not know their status and assisting them into services, as well as the foci on reducing barriers to routine testing and disparities in access to services for minorities and underserved members of our community to be critical in addressing the epidemic as it plays out in our part of the region. The 2012- 2014 Comprehensive Plan of the DC Eligible Metropolitan Area (EMA) outlines a path to high quality services with a focus on improved health outcomes.

As a partner in this process, I express our support and intention to participate in the implementation of the 2012-2014 Comprehensive Plan for the Washington, DC EMA.

Sincerely,

Michelle Simmons
Director, Human Services

HEALTH DEPARTMENT
Prince George's County

Office of the Health Officer

May 14, 2012

Mr. Stephen Bailous, Chair
Metropolitan Washington Regional
Ryan White Planning Council
899 North Capitol Street NW, 4th Floor
Washington, DC 20002

Dear Mr. Bailous:

The Prince George's County Health Department supports the Metropolitan Washington Regional Ryan White Planning Council's efforts as detailed in the Part A Comprehensive Plan. The various strategies outlined therein will certainly assist the Washington, DC Eligible Metropolitan Area in its work toward the achievement of a comprehensive and coordinated system of care capable of meeting the demands associated with the care and support for individuals with HIV/AIDS.

Despite the uncertainty relative to the Affordable Care Act, the Plan addresses the challenges and need for health care reform and skillfully weaves all of the important elements of the health care delivery system, including the importance of health insurance reform, third party reimbursement and the important role of information technology to enhance care coordination. One of the highlights of the Plan is the effective way it addresses the National HIV/AIDS strategy which touts reducing transmission, getting people into care and optimizing clinical outcomes. The need to eliminate HIV related health disparities, as well as, to ensure a coordinated response to the epidemic is of vital importance. By clearly addressing the need to increase the coordination between prevention, treatment and care planning, the document presents a convincing way to integrate these critical elements to meet the 2009 legislative mandates for the Ryan White Program.

As the Acting Health Officer for this county which has a significant HIV/AIDS burden, I am committed to working with the Council through agency representation on the Planning Council and also in the agency's role as the Administrative Agency to combat this serious public health problem.

Sincerely,

Pamela B. Creekmur

Pamela B. Creekmur
Acting Health Officer/Director

cc: Mark Fisher, Planning Council (fischerwdc@gmail.com)
Dr. Shaikh, DC Dept. of Health (irshad.shaikh@dc.gov)
Devi Ramey, Suburban Maryland Ryan White Part A Administrative Agency

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Acknowledgments

The Metropolitan Washington Regional Ryan White Planning Council took primary responsibility for the development of the 2012-2014 comprehensive plan for the Eligible Metropolitan Area (EMA). Planning Council members and technical and support personnel all worked hard to engage and obtain input from both people living with HIV disease (PLWH) and other stakeholders throughout the EMA.

The Needs Assessment and Comprehensive Planning (NAEP) Committee played a lead role in plan development, along with an ad hoc Comprehensive Planning Core Group of Planning Council members, Grantee and Administrative Agent representatives, and community volunteers. NAEP Committee Chair Henry Bishop oversaw the process, and Bylaws, Policies, and Procedures Chair Mark Fischer played a crucial liaison and coordinating role, with ongoing advice and leadership from 2012-2014 Planning Council Chair Laurence Smith.

The Consumer Access Committee and the jurisdictional PLWH Groups helped arrange and facilitate town hall meetings and other input sessions. All Planning Council members helped to review the draft plan.

Emily Gantz McKay wrote the plan, with extensive support from Sharron Harris and the Thompson, Cobb, Bazilio, and Associates and Mosaica logistics and technical support contractor team.

The Planning Council is particularly grateful to Dr. Irshad Shaikh, HAHSTA's Deputy Director for Policy and Programs, for his personal involvement and professional assistance.

The plan was developed by the 2010-2012 Planning Council, and completed just after the appointment of the 2012-2014 Planning Council. Many of the new members participated in work sessions and attended Planning Council meetings prior to their appointment, providing valued input to the process.

Special thanks are due to the following:

Planning Council Members, 2010-2012
Laurence Smith, Chair
Henry Bishop, Chair, Needs Assessment and Comprehensive Planning Committee
Mark Fischer, Chair, Bylaws, Policies, and Procedures Committee
Keith Callahan, Co-Chair, Northern Virginia HIV Consortium
Barbara Chinn
Maureen Deely, Chair, Maryland PLWH Group
Geno Dunnington, Chair, Consumer Access Committee
Debra Frazier
Dr. Patricia Hawkins, Chair, Care Strategy, Coordination, and Standards Committee
Orlando Xavier Hixon

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Executive Summary

Overview: The 2012-2014 comprehensive plan of the Washington, DC Regional Ryan White Part A Eligible Metropolitan Area (EMA) describes this complex EMA, its population and health care systems, the regional HIV epidemic as of 2010, the current linked but largely separate systems of care in each of the four jurisdictions, and service needs and gaps of the diverse population of people living with HIV disease (PLWH) throughout the region. It explores likely changes in the nation's and the region's health care systems and funding streams, and outlines an "ideal" system of care for the region. Then it presents a three-year plan for system changes and service improvements to enhance testing, entry into care, retention in care, and positive clinical outcomes for PLWH. Its goals are designed to meet regional needs and contribute to the National HIV/AIDS Strategy goals of reducing new infections, increasing access to care and improving health outcomes for PLWH, eliminating HIV-related health disparities, and achieving a more coordinated national response to the epidemic.

The EMA: The Metropolitan Washington EMA is the most geopolitically complex in the country. It includes the District of Columbia plus 11 counties and 6 independent municipalities in Northern and Northwest Virginia, five counties in Suburban Maryland, and two counties in the Eastern Panhandle of West Virginia. It covers the Washington metropolitan area plus one additional county in West Virginia (Berkeley). The jurisdictions vary greatly not only in the size and face of the HIV epidemic, but also in such characteristics as race and ethnicity, income levels, poverty, cost of living, unemployment, and expenditures on health. The EMA includes urban, suburban, and rural communities, spans 6,900 square miles, and was home to about 5.7 million people as of the 2010 Census. Its population grew by one-sixth from 2000 to 2010, with the greatest growth in the outer and distant suburbs. About half the residents of the EMA (49%) were White non-Hispanics, one-fourth (25%) Black, one-seventh (14%) Hispanic, one-eleventh (9%) Asian, and the rest (3%) mixed race and other. The DC metro area ranked 14th nationally in percent of foreign-born residents. As of 2010, more than 1.2 million residents – nearly 22% of the population – were immigrants, an increase of nearly 48% from 2000. A large majority – 86% – lived in the suburbs.

Economic status and public health expenditures and systems vary greatly across jurisdictions. While the economic situation has had significant negative impact in the EMA – especially in DC and West Virginia – as of March 2012, the Washington, DC metro area as a whole had the second lowest unemployment rate among the 49 metro areas with populations of at least one million – 5.5%. Unemployment rates varied from a low of 3.5% in Arlington County, VA to a high of 9.8% in DC. The jurisdictions also differ in their public health systems and expenditures. As of 2009, DC had the highest per capita expenditures on health in the country. West Virginia ranked 12th in per capita health expenditures despite ranking 47th in the nation in median household income. Maryland ranked 15th in per capita Medicaid expenditures and 4th in household income, and Virginia ranked 41st in per capita health expenditures and 6th in income. DC had the lowest uninsurance rate in the EMA (7%), followed by Maryland (10%), Virginia (11%), and West Virginia (15%). In planning services for people living with HIV disease, both HIV/non-AIDS and AIDS (PLWH), the EMA and its Planning Council must consider these

differences, as well as four widely varying HIV prevention, Medicaid, and AIDS Drug Assistance Programs (ADAPs).

The Epidemic: The Metropolitan Washington EMA has one of the most severe HIV/AIDS epidemics in the nation. Data describe the epidemic as of December 31, 2010. There are 34,094 individuals living with HIV* in the EMA. Just over half (51%) of all HIV cases (including HIV/not AIDS and AIDS) are in DC, 27% in Suburban Maryland, 21% in Northern Virginia, and 1% in West Virginia. The most urbanized areas in the EMA have the highest rates of HIV. Both DC and Suburban Maryland have HIV prevalence rates higher than the U.S. as a whole. Prevalence is higher in the District of Columbia than in any of the 50 states and is 7-14 times that of the other EMA jurisdictions. The known infection rate is 3.2% for all DC adults and adolescents, 4.7% for African Americans, and 7.4% for residents aged 40-49. Characteristics of PLWH EMA-wide are summarized below:

- *Gender:* 70% of PLWH in the EMA are men, and 30% are women. Maryland has the highest proportion of women at 38%; and women are 30% of PLWH in DC, 25% in Virginia, and 19% in West Virginia.
- *Race/Ethnicity:* 69% of PLWH in the EMA are Black non-Hispanic, 20% are White non-Hispanic, and 8% are Hispanic/Latino. Another 1% are Asian/Pacific Islander, a fraction of a percent are American Indian/Alaska Native, and about 2% are of mixed or unknown race/ethnicity. At least three-fourths of PLWH in Suburban Maryland (77%) and DC (75%) are African American, while the majority in the two counties in West Virginia (57%) are White non-Hispanic. In Virginia, nearly half (47%) are African American, more than one-third (36%) are White non-Hispanic, and 13% are Hispanic.
- *Age:* More than one-third (35%) of PLWH in the EMA were diagnosed when they were between 30-39, and about one-quarter each were 20-29 or 40-49. Only 4% were diagnosed before their 20th birthday, and 12% were diagnosed at age 50 or older. PLWH in Maryland and Virginia tend to be somewhat younger at diagnosis than PLWH in West Virginia and DC. Given increasing survival rates, it is not surprising that the current PLWH population is older. Well over two-thirds (71%) are 40 or older, and more than one-third (36%) are 50 or older.
- *Exposure Category:* For all living PLWH in the EMA, the most frequent exposure category is men who have sex with men (MSM) (37%), followed by heterosexual exposure (26%) and IDU (12%). About half of adult and adolescent PLWH in Virginia and West Virginia are MSM or MSM who are also injection drug users (IDUs). MSM is also the most common risk factor in DC. In Maryland, however, there are more heterosexual cases. The proportion of IDUs is highest in West Virginia (24%).

New AIDS Diagnoses: There has been a steady reduction in new AIDS cases in the EMA over the past five years, with the number of new cases dropping from 1,320 in 2006 to 872 in 2010. Reductions have been greatest in Suburban Maryland (45%) and DC (32%).

Late Testing: Late testing is measured by the percent of people who have AIDS when they are first diagnosed with the HIV virus or who convert to AIDS within 12 months following

*All HIV and AIDS cases are referred to as "HIV cases." HIV-only or HIV, not AIDS, cases are referred to as "HIV/not AIDS." This change is consistent with CDC HIV Surveillance Reports.

diagnosis. EMA data included in the Part A application submitted in late 2011 indicate that, excluding West Virginia, the late testing rate was 66% for the EMA – nearly double the national rate of about 32%. Recent data indicate that the late testing rate from 2006-2010 averaged 39% in the West Virginia counties and 62% in Northern Virginia. The annual late testing rate in DC decreased from 55% in 2005 to 40% in 2009.

Unmet Need: Unmet need is the need for HIV-related health care by individuals with HIV who are aware of their HIV status but are not receiving HIV-related primary health care. An estimated 44.5% of PLWH in the EMA had an unmet need for care.

HIV-positive/Unaware: Nationally, the Centers for Disease Control and Prevention (CDC) estimates that about 21% of individuals living with HIV are unaware of their status. Using that percentage, 9,063 individuals with HIV disease in the EMA as of December 31, 2010 were unaware of their status. However, DC's HIV/AIDS, Hepatitis, STD, and Tuberculosis Administration (HAHSTA) believes that the percent of undiagnosed individuals in this EMA is much higher than the national estimate, based on findings from CDC's National HIV Behavioral Surveillance System (NHBS) study in Washington, DC, which analyzed three subpopulations – heterosexuals, men who have sex with men (MSM), and injection drug users (IDU). HAHSTA estimates based on 2008 NHBS data that the number of undiagnosed individuals in these three categories alone is 25,233.

Current Continuum of Care: The Washington EMA does not have a single continuum of care operating throughout the region. Instead, it allows for a somewhat different continuum of care in each jurisdiction. The vast majority of Part A service dollars (96.5% in 2012) are allocated to the four jurisdictions based on each jurisdiction's percentage of the EMA's living HIV/not AIDS and AIDS cases. HAHSTA, within the District of Columbia's Department of Health, serves as Grantee on behalf of the DC Mayor. It oversees the entire Part A program and directly manages the program in DC and the West Virginia counties. Administrative Agents in Northern Virginia (the Northern Virginia Regional Commission or NVRC) and Maryland (Prince George's County Health Department) are responsible for contracting with service providers including local health departments to provide services in their respective jurisdictions.

Geographic Limits: Except for a small number of services made available across jurisdictions through "off-the-top" allocations for EMA-wide services, Part A services are jurisdiction-specific. PLWH are expected to obtain services within the jurisdiction in which they live. In some cases local health departments are the primary or only Ryan White service provider, which means they obtain services in their own county.

Jurisdictional Differences: The continuum of care is different in each jurisdiction because of differing PLWH demographics and considerable variations in public health and nonprofit health and human service infrastructure, policies, and resources. Within jurisdictions, there are variations in service accessibility, with rural areas offering the greatest transportation challenges. Inventories of funded and non-funded providers show the greater number and diversity of HIV/AIDS-related service providers in Washington, DC compared to the other jurisdictions. In addition, eligibility for Ryan White Part A services differs somewhat by jurisdiction, as does eligibility for other Ryan White programs and Medicaid.

Availability of Services: In most of the EMA, people living with HIV disease can obtain core medical services and some supportive services, and major initiatives focus on assisting newly

diagnosed PLWH as well as individuals who have been out of care to be linked to, supported, and retained in care. In addition, the Ryan White Planning Council has been exploring and is testing a number of methods, including "off the top" EMA-wide funding allocations, to increase parity in access to care throughout the EMA, as well as choice and portability of care.

Prevention and Testing: Describing the current system of prevention and testing in the EMA is challenging because it is in transition. The states are in the process of developing prevention plans that will reflect CDC's new national prevention strategy. All four jurisdictions say that much of the current funding for prevention efforts based on behavioral interventions will be redirected by the end of 2012. Maryland plans to decrease funding for intensive behavioral risk reduction interventions targeting HIV-negative individuals except in the highest prevalence areas. Virginia will be ending funding for its current high-risk youth and adult grant program. West Virginia is ending current funding of evidence-based behavioral interventions and – as a low-incidence state – reported a 50% cut in CDC prevention funds. DC has an Enhanced Comprehensive HIV Prevention Planning (ECHPP) grant; the Baltimore area also has ECHPP funding, and plans to apply key concepts and strategies to the entire state.

Service Needs and Gaps: Needs assessment findings indicate that the most important service needs identified by PLWH are HIV-related medical care and medications, medical case management, and oral health services, with mental health and substance abuse services also needed by many. Most needed support services include housing, emergency financial assistance, food bank/home delivered meals, and support groups (psychosocial services). In some areas, medical transportation is identified as necessary to ensure access to care.

Core medical-related services are available to most PLWH in the region; the important exception is the waiting list for ADAP in Virginia. The most frequently mentioned service gap throughout the EMA is housing, given high housing costs, low turnover in HOPWA slots, and limited PLWH access to other housing assistance. PLWH also report a need for consistent access to "wraparound" services, both medical-related and supportive, that help people enter and stay in care, remain adherent to medications, and live healthy and productive lives. These service gaps are seen as partly related to resource limitations and partly to other factors. There is a widely perceived lack of centralized, updated, readily available information about available services. In addition, some medical case managers are reportedly not fully aware of referral resources, and Part A provider referral relationships with non-Ryan White funded providers are sometimes limited.

Specific service needs and gaps vary somewhat by jurisdiction, and more significantly by population group. The Planning Council has identified 13 PLWH population groups that have special needs and may require special attention to ensure appropriate services – such as transgenders, formerly incarcerated people returning to the community, IDUs, older PLWH, immigrants, and young PLWH, including those transitioning from adolescent to adult care.

An "Ideal" Continuum of Care for the EMA: The EMA recognizes that the health care system is changing, and HIV/AIDS services will be a part of that change. Despite uncertainty about implementation of the health care reform legislation, it is clear that third party reimbursements will be a growing part of the funding for HIV/AIDS care, and that medical and support services for many if not most clients will be paid for by multiple sources.

Medical Home: The changing health care environment makes it particularly important that the EMA be able to provide coordinated, HIV-centered but comprehensive care. The Grantee is exploring the applicability of a medical home model to HIV-focused care, as well as related models such as the comprehensive care center (with services co-located physically or linked through collaborative agreements). Because the EMA includes municipalities with four different Medicaid programs and very different public health systems – and are likely to have very different health insurance exchanges under the Affordable Care Act – the model must be flexible enough to work in all of them.

Linking Prevention, Testing, and Care: Given the shared responsibilities for HIV testing, linkage to care, and retention in care, the EMA also envisions a system that integrates prevention and testing with care and treatment, and places high priority on expanded testing and rapid access to medical care for the newly diagnosed. System integration is also necessary so that the EMA fully addresses the goals and priorities of the National HIV/AIDS Strategy – from reducing new infections and early entry into care to effective treatment leading to positive clinical outcomes and elimination of health disparities.

Other Priorities: In addition to the medical home concept and linking prevention and care, the following priorities influenced comprehensive plan goals and objectives:

- Employment of peer community health workers (CHWs) and other HIV-positive individuals throughout the system, in many service categories
- A centralized and well publicized source of information about HIV testing, and care throughout the EMA
- Expanded testing, including routine testing and testing in non-traditional locations, to increase early diagnosis and reduce transmission
- Rapid access to medical care with minimal waiting time for newly diagnosed individuals and PLWH who have never been in care or dropped out of care
- Increased choice, portability, and parity in access to care throughout the EMA for all PLWH, regardless of their characteristics or their place of residence
- Bridge programs that enable special populations (such as adolescent and young adult PLWH) to make necessary transitions into and across care services
- Services and providers with expertise to provide culturally competent and expert care that maximizes retention
- Institutional systems and procedures to maximize retention, including referral and collaboration
- Services specifically designed to help PLWH adapt to the changing health care system and make the transition to services provided through managed care or other insurance
- Active consumer involvement and input, not only as staff, but also as program and outreach volunteers, Planning Council and committee members, and regular members of quality management teams
- Data sharing to improve care, based on full implementation of the Maven client-level data system/data "warehouse" throughout the EMA

Coordination and Collaboration: The EMA recognizes that strengthening the system of care requires an intensified focus on coordination and collaboration at many levels: among Part A providers, between Part A and other Ryan White and non-Ryan White funded entities, and between prevention and care. A medical home model requires codified relationships among providers. With health care reform and the increased use of third-party reimbursements for

funding health care and other services, increased coordination with public and private insurance providers is essential. Moreover, this coordination is not limited to billing. The EMA requires coordinated planning as well as informal and formal collaboration in the delivery of services.

Plan Goals and Priorities: The EMA has prepared a three-year work plan with specific goals, objectives, strategies, and tasks required to strengthen the continuum of care, address identified EMA needs, and meet comprehensive plan requirements. Following are the five goals that will guide the work of the EMA through 2014:

1. Prepare the EMA for changes in the health care system so that people living with HIV and AIDS make a seamless transition to new funding and service systems such as Medicaid and private insurance.
2. Establish and maintain a coordinated, integrated continuum of prevention, testing, and care that provides for coordination of services for individual PLWH and results in viral suppression.
3. Improve – and consistently measure – service linkage, retention, quality, and outcomes.
4. Work towards full access, parity, and portability of care for PLWH throughout the EMA.
5. Enhance EMA planning and decision making based on improved data systems and quality and enhanced collaboration between the Planning Council, Grantee, and Administrative Agents.

Monitoring Progress and Measuring Outcomes: The Planning Council will integrate the comprehensive plan into committee work plans and calendars, and will provide for regular reporting of progress as part of committee reports. Monitoring and evaluation will be led by the Planning Council, through the Needs Assessment and Comprehensive Planning (NACP) Committee, but will be a shared responsibility of the Planning Council and the Grantees and Administrative Agents.

The EMA intends to measure the ultimate success of efforts to improve the system of care by documenting changes in the clinical outcomes for clients. It will agree on a set of outcome measures that can be reported consistently by all four jurisdictions, use data gathered for the comprehensive plan as baseline measures, and then assess changes using these measures. It Measures will follow the logic of a "treatment cascade" that follows PLWH from diagnosis through linkage to care, retention in care, initiation of anti-retroviral therapy (ART), and continued use of ART to clinical outcomes such as viral suppression. Annual analysis of data is necessary to measure progress. Data will be reported for the EMA and by jurisdiction, overall and broken down by race/ethnicity, age at diagnosis, gender, and mode of transmission.

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

Progress reports will be obtained quarterly, outcome measures presented biannually or annually, and overall progress assessed annually and used as input to the needs assessment and priority setting/resource allocations (PSRA) process. Community input and response sessions with the Consumer Access Committee and jurisdictional PLWH groups are already a part of the Planning Council's ongoing work. Regular consultations with these groups and with providers and other stakeholders will ensure feedback on system changes resulting from the comprehensive plan.

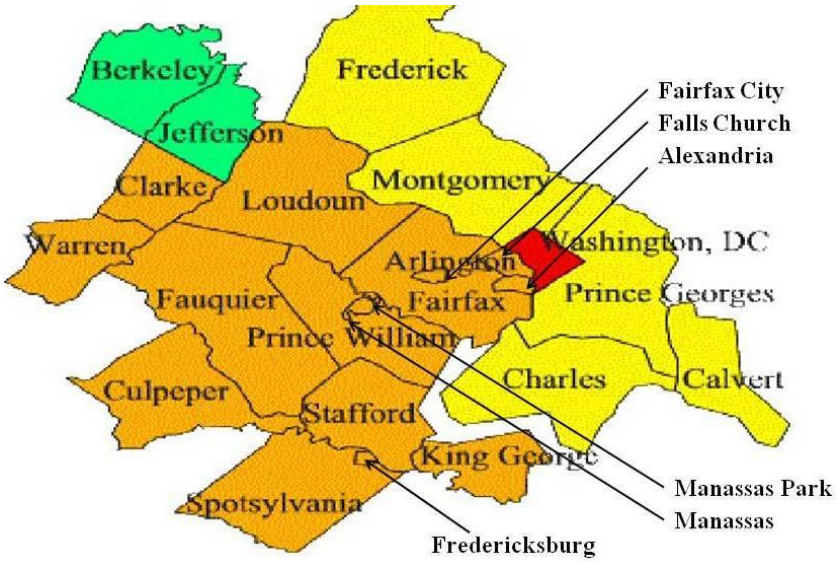
Section 1. Where Are We Now?

Chapter 1: Introduction

A. Overview

This comprehensive plan, prepared for the Health Resources and Services Administration's HIV/AIDS Bureau (HRSA/HAB), presents data about the HIV/AIDS epidemic in the Metropolitan Washington Ryan White Part A Eligible Metropolitan Area (EMA), how services are currently structured and delivered, the EMA's conception of an "ideal" system of care, and the EMA's plan for working towards that ideal from 2012 through 2014. The foundation for a sound and achievable comprehensive plan for the EMA is an understanding of this large and extremely diverse Part A service area in 2012, as well as its historical response to the epidemic in its early years. This chapter provides a necessary context for discussion of the current system of HIV/AIDS education, prevention, testing, and care.

The Metropolitan Washington EMA is the most geopolitically complex in the country, including both the District of Columbia and 24 independent municipalities in Virginia, Maryland, and West Virginia. Its geographic coverage is very similar – but not identical – to the Washington metropolitan area as designated by the U.S. Bureau of the Census. The states and local jurisdictions vary greatly not only in the nature of the epidemic, but also in such characteristics as race and ethnicity, income levels, poverty, level of federal aid, cost of living, unemployment, and expenditures on health. In planning services for people living with HIV disease, both HIV/non-AIDS and AIDS (PLWH), the EMA and its Planning Council must consider four different state public health systems – as well as widely varying HIV prevention, Medicaid, and AIDS Drug Assistance Programs (ADAPs).



The Washington region was among the first metro areas to be affected by the epidemic, with the District of Columbia and its inner suburbs becoming engaged first. District government began to provide reporting, regulations, and resources for addressing the disease in 1983, along with the Whitman Walker Clinic. Other community-based providers and informal groups became involved in the suburbs very soon after. Washington was one of the first 16 EMAs funded after passage of the Ryan White CARE Act in 1990, and is now in its 22nd year of managing a regional response to the epidemic.

B. Socio-Economic Description of the EMA

The EMA: The Washington, DC Eligible Metropolitan Area (EMA) includes the entire Washington, DC metro area, or in Census terms the Washington-Arlington-Alexandria, DC-VA-MD-WV Metropolitan Statistical Area (MSA), plus one additional county in the Eastern Panhandle of West Virginia (Berkeley).* It encompasses Washington DC plus 18 counties and 6 independent cities in Maryland, Virginia, and West Virginia, as shown in Figure 1, below.

Figure 1: Components of the Metropolitan Washington Eligible Metropolitan Area (EMA)

Jurisdiction	Subdivisions (Counties and Independent Cities)
District of Columbia	(8 wards)
Maryland	**5 counties:** Calvert, Charles, Frederick, Montgomery, Prince George's
Virginia	**11 counties:** Arlington, Clarke, Culpeper, Fairfax, Fauquier, King George, Loudoun, Prince William, Spotsylvania, Stafford, Warren **6 cities:** Alexandria, Fairfax, Falls Church, Fredericksburg, Manassas, Manassas Park
West Virginia	**2 counties:** Berkeley, Jefferson

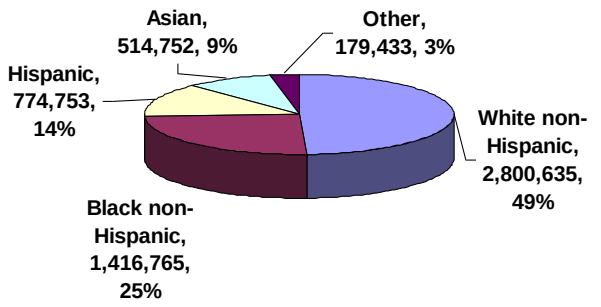
Population and Growth: Each county or city in the EMA – as well as each state-level jurisdiction – is distinct geographically, demographically, socioeconomically, and politically. The EMA includes urban, suburban, and rural communities, spans 6,900 square miles, and was home to about 5.7 million people as of the 2010 Census. The metro area is the seventh largest in the country. It grew by 16.4% from 2000 to 2010,[1] and reportedly had the largest growth rate of any Northeastern metro area (3%) in 2008-2009.[2] Between 2000 and 2010, significant growth occurred in every segment of the metro area, with a 7% population increase in the urban core (DC, Arlington, and Alexandria), 10% in the inner suburbs (Montgomery, Prince George's, and Fairfax Counties and related cities), 45% in the outer suburbs (Frederick, Loudoun, and Prince William Counties and related cities), and 26% in the remaining "far flung" jurisdictions. The lowest rate of growth was in the District of Columbia (5.2%), the highest in Loudoun County (84.1%). However, 70% of the region's population remains in the core and inner suburbs.[3]

Both West Virginia counties are growing rapidly. Berkeley County, once a part of the Washington EMA but now in the Hagerstown-Martinsburg MD-WV metro area, is the second most populous county in West Virginia. Berkeley County's population grew by 37% from 2000-2010; Jefferson's by 27%. Martinsburg, the county seat of Berkeley County, is the fastest growing city in West Virginia.

* Berkeley County, WV was part of the Washington, DC metro area until 2003, when the federal Office of Management and Budget combined Morgan and Berkeley Counties with Washington County to form a new three-county Hagerstown-Martinsburg, MD-WV Metropolitan Statistical Area (MSA). However, Berkeley County remains a part of the Metropolitan Washington Ryan White Part A service area. See "The Shape of Things to Come," at http://www.workforcewv.org/lmi/ECONSUMM/Shape.pdf.

Race and Ethnicity:[*] The EMA is racially and ethnically diverse, with the White non-Hispanic population making up about half the population (See Figure 2). The White non-Hispanic population grew by nearly one-third in the District of Columbia between 2000 and 2010, and also increased in Loudoun County and the outer suburban jurisdictions in Northern Virginia. In the other suburbs, most growth was due to increases in the minority population. For example, in Loudoun County, the White non-Hispanic population increased by 44% between 2000 and 2010, but the Hispanic population nearly increased by almost 300% and the Asian population by almost 400%.[4]

Figure 2: Racial/Ethnic Composition of the Metropolitan Washington EMA, 2010
Source: 2010 Census



Income and Poverty: Income and poverty levels vary greatly by jurisdiction. The EMA includes ten of the highest income counties and independent cities in the United States, based on medium household income from 2005-2009. They include five Northern Virginia counties (Loudoun [#2], Fairfax [#3], Arlington [#11], Stafford [#15], and Prince William [16]) and two independent cities (Falls Church [#1] and Fairfax [#10]), plus three suburban Maryland counties (Montgomery [#13], Calvert [#14], and Charles [#21]).

The table below provides averaged state data for 2008-2010.[5] The District of Columbia has both a relatively high median income level and a high rate of poverty. Income and poverty rates by state also vary considerably, as the table shows. State income and poverty levels influence the services provided in the various jurisdictions and the need for a health care safety net.

Figure 3: Income and Poverty: U.S., District of Columbia, and States in the EMA

Jurisdiction	Median Household Income, 2008-2010	Income Ranking among States (#1 = Highest Median Household Income)	Percent of Residents Living in Poverty, 2010	Poverty Ranking among States (1 = Highest Poverty)
District of Columbia	$55,280	Not ranked	18.8%	Not ranked
Maryland	$64,596	4	9.7%	45
Virginia	$61,544	6	10.6%	39
West Virginia	$40,824	47	15.7%	12
United States	$50,599	--	15.1%	--

Cost of Living: Cost of living varies considerably by and within states. Virginia has the 20th lowest overall cost of living among U.S. states (though costs are considerably higher in the Northern Virginia suburbs of Washington), West Virginia ranks 26th, Maryland 43rd, and the

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

District 50th – a higher cost of living than any state except Hawaii.[6] DC's cost of living is high largely because of its housing costs, which create severe challenges for PLWH.

Unemployment: While the economic situation has had significant negative impact in the EMA, especially the District of Columbia and West Virginia, in March 2012, the Washington, DC metro area as a whole had the second lowest unemployment rate among the 49 metro areas with populations of at least one million – 5.5% (Oklahoma City was lowest at 4.4%).[7] However, rates varied considerably by jurisdiction, from a low of 3.5% in Arlington County, VA to a high of 9.8% in DC. For example: unemployment was 4.1% in Fairfax County, VA, 5.0% in Montgomery County, MD, 5.7% in Calvert County, MD, 6.0% in Warren County, VA, 6.6% in Prince George's County, MD, 8.3% in Fredericksburg, VA, and 8.7% in Berkeley County, WV.[8] Statewide unemployment rates fell in all four jurisdictions from December 2011 to March 2012; The March unemployment rates were 5.6% in Virginia, 6.6% in Maryland, and 6.9% in West Virginia.[9]

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

Figure 4: Per Capita Federal Expenditures and Federal Grant Funding for EMA Jurisdictions, FY 2009[10]

Jurisdiction	Per Capita Federal Expenditures, FY 2009		Per Capita Federal Grants, FY, 2009	
	Federal Expenditures	Ranking (1 = Highest Funding)	Grant Funding	Ranking (1 = Highest Funding)
District of Columbia	$83,196*	Not Ranked	$16,107	Not Ranked
Maryland	$16,169	4	$2,071	38
Virginia	$19,734	2	$1,607	49
West Virginia	$10,885	20	$2,705	16
50-state Average	$10,929	--	$2,550	--

As Figure 4 shows, the District, Virginia, and Maryland benefit from very high per capital federal expenditures, partly because of their proximity to federal agency offices. The per capita figures include "grants, procurement, salaries and wages, retirement and disability payments, and other direct payments (such as Medicare benefits, the Supplemental Nutrition Assistance Program, and student financial assistance)."[11] If only federal grants are counted, Virginia ranks 49th, Maryland 38th, and West Virginia 16th.[12] This reflects both the fact that Virginia and Maryland have relatively low poverty and unemployment levels – so they receive less formula grant funding where formulas are poverty-based – and the important role of Medicaid expenditures. Virginia spends less per capita on Medicaid than the other states, and these low per

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

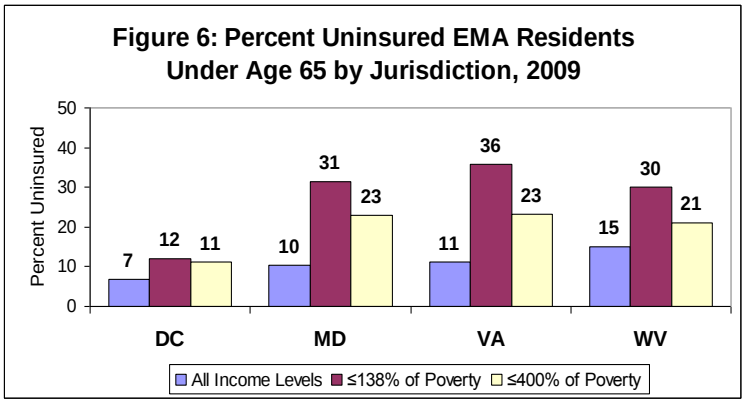
capita payments mean correspondingly low federal matching payments. West Virginia, with a much higher poverty rate, receives higher needs-based formula grant funding.

Figure 5 below shows both Medicaid expenditures and overall state expenditures for health. The Medicaid data (for FY 2007 and 2008) include both overall per capita expenditures and per capita expenditures for Medicaid clients who are disabled, since many people with HIV disease are eligible for Medicaid because they are disabled (Categorical requirements will be removed for Medicaid expansion under health care reform). As indicated, as of 2009, the District of Columbia had the highest per capita expenditures on health in the country (Massachusetts was second) and was third in the nation in per capita overall Medicaid expenditures. West Virginia also ranked high in per capita health expenditures (12th) despite its high rate of poverty and relatively low median household income. Maryland ranked 15th in per capita Medicaid expenditures and 10th in health spending, while Virginia ranked 24th in Medicaid expenditures and 41st in public health expenditures. Expenditures on Medicaid clients with HIV ranged from $10,938 in Virginia to $31,624 in Maryland. These payment differences reflect considerable state differences in the services provided under Medicaid.

Figure 5: Per Capita Medicaid and Health Expenditures for EMA Jurisdictions

Jurisdiction	Per Capita Medicaid Expenditures[13]			Total and Per Capita Expenditures on Health, 2009		
	Disabled (FY 2008)	**HIV** (FY 2007)	**Total** (FY 2008)	**Overall Ranking** (1 = Highest Total Expenditures)	**Expenditures**	**Ranking** (1 = Highest Per Capita Expenditures)
District of Columbia	$19,901	$27,100	$8,309	3	$10,349	1
Maryland	$19,590	$31,624	$7,071	10	$7,492	15
Virginia	$14,550	$10,938	$5,758	24	$6,286	41
West Virginia	$10,118	$17,490	$5,615	27	$7,667	12
United States	$14,840	$24,867	$5,337	--	$6,815	--

Uninsurance: A key determinant of the demand for Ryan White services, particularly primary care and medications, is uninsurance rates. Because of health care reform, knowing the number and percent of uninsured residents in each jurisdiction is necessary for planning. Figure 6, calculated by using Census Bureau Small Area Health Insurance Estimates (SAHIE) for each of the jurisdictions in the EMA, summarizes uninsurance rates for the EMA residents in each major jurisdiction, by income level.[14] It provides a sense of the differences in uninsurance rates among residents under 65 in each segment of the EMA. The figures exclude people 65 and over because, except for undocumented or recent immigrants, they are typically covered by Medicare. A full chart of the number and percent of uninsured in each EMA county and city is provided in Appendix 2. According to the federal poverty guidelines, in 2012, the poverty level is $11,170 for a single-



person household and $23,050 for a four-person household.[15] As indicated, as of 2009, the District of Columbia had the lowest rate of uninsurance at all income levels – as well as the highest per capita expenditures for health. At 138% of poverty, approximately the income level that will become eligible for coverage under Medicaid expansion, DC – with the DC Alliance – had an uninsurance rate of 12%, compared to 36% for Virginia, 31% for Maryland, and 30% for West Virginia segments of the EMA.* (Local DC data, calculated differently, indicate even lower uninsurance rates.) At 400% of poverty – the cut-off for federal subsidies of insurance premium under the proposed health insurance exchanges – the uninsurance rate is lower than for the lower-income group but still above 20% for all jurisdictions except the District of Columbia (400% of poverty is $44,680 for a single person household and $92,200 for a family of four). Uninsurance rates vary by race and ethnicity. Figures 7 and 8 show the percent of uninsured EMA residents of each jurisdiction by race/ethnicity with incomes under 138% of poverty and 400% of poverty. For residents under 400% of poverty, uninsurance rates are slightly lower in DC; the differences are greater in other jurisdictions. In terms of race and ethnicity, uninsurance rates are somewhat lower for African Americans and Hispanics, and considerably lower for White non-Hispanics when higher-income individuals re included. At 138% of poverty, uninsured rates are much higher for Hispanics than for other groups. This may reflect the fact that many Hispanics are both low income and recent immigrants or undocumented; they are unlikely to have employer-based insurance and ineligible for public insurance. It may also indicate low participation in public insurance despite eligibility.

Figure 7: Percent Uninsured Residents Under Age 65 with Incomes ≤ 400% of Poverty, by Jurisidction and Race/Ethnicity, 2009

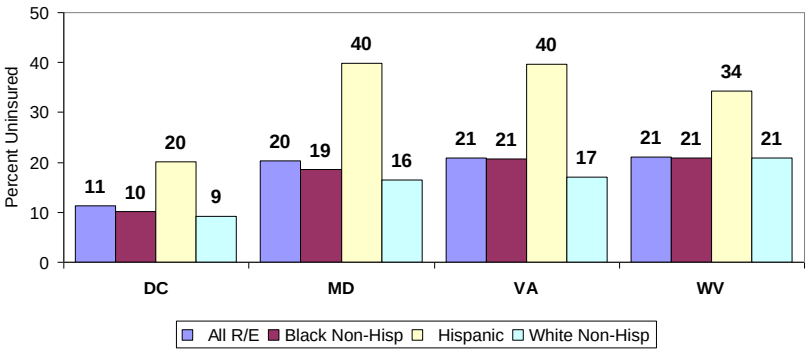
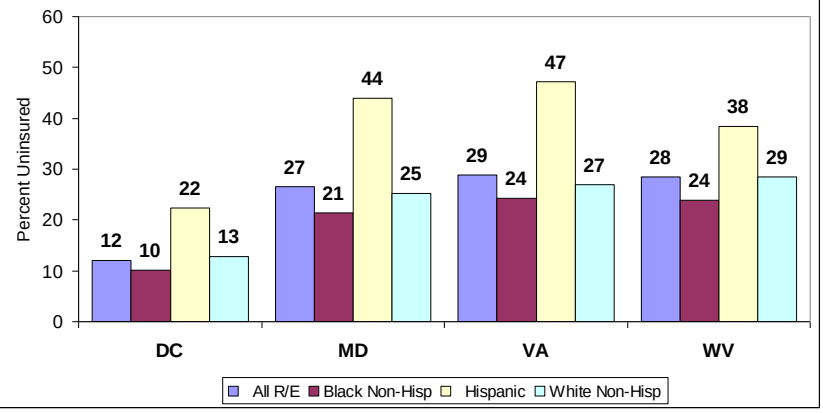


Figure 8: Percent Uninsured Residents Under Age 65 with Incomes ≤138% of Poverty, by Jurisdiction and Race/Ethnicity, 2009



* DC implemented Medicaid expansion in 2011.

C. Early EMA Response to HIV/AIDS

The early history of the HIV/AIDS epidemic and the response to it in the National Capital Region helps provide an understanding of the current systems of education, prevention, testing, and care – and a context for planning for the next three years.

Each jurisdiction's response to the epidemic reflects its geographical, socio-economic, political, public health, and cultural environment. However, there have been important similarities. Each has mobilized a multi-agency response, worked to link prevention and treatment, showed genuine concern for those infected and affected, and collaborated with other jurisdictions to overcome barriers in prevention, testing, and care. Public health agencies and nonprofits have demonstrated both commitment and compassion in seeking to serve diverse at-risk populations that are often low-income and marginalized. A few historical highlights are provided below for each jurisdiction.

District of Columbia: In 1983, less than two years after the Centers for Disease Control and Prevention (CDC) weekly Morbidity and Mortality Report made the first medical report on what would come to be known as HIV/AIDS, the District of Columbia began a structured public/ private response to the disease. That year, the Whitman Walker Clinic (WWC) – established in November 1973 as the Gay Men's Venereal Disease Clinic, a component of the Washington Free Clinic – launched an AIDS Education Fund, a Buddy program, and an HIV/AIDS prevention advertising campaign. WWC held the first Forum on AIDS at George Washington University in April; 1,200 people attended. It was followed by a second forum in September, focusing on people of color. In August, WWC received funding from the DC government – the first public funding for HIV/AIDS in the country – to support an AIDS Hotline. Reporting of all AIDS cases became a regulatory requirement in October 1983, and DC regulations were amended to permit financial assistance for payment of health benefit premiums for unemployed people with HIV/AIDS.

In 1984, WWC opened the first gay, community-based medical unit in the country devoted exclusively to diagnosing and evaluating individuals with AIDS; it treated 55 patients during its first year; half had AIDS. In 1985, the Mayor established the Office of AIDS Activities and obtained legislative authority to address the disease. The following year, City Council legislation required the development of a comprehensive AIDS health-care response plan, investigation of the need for a residential health care facility for AIDS patients, and establishment of an AIDS Coordination Office. Also in 1986, the WWC AIDS treatment center became a full-time clinic, known throughout the region. Over the next few years, City Council passed several laws to encourage testing, protect confidentiality, and prevent housing discrimination against people living with HIV/AIDS.

Suburban Maryland: Starting in 1983, groups were established across the state to address AIDS issues at the local level. From the beginning, there was a multiagency response, with early state agency collaboration among the Alcohol and Drug Abuse, Family Health, Community Health, and Mental Hygiene administrations. The intent was to ensure an integrated approach to care for persons living with HIV/AIDS. The AIDS Partnership Council of Maryland was established in 1987, bringing together providers and PLWH from across the state on a regular basis to discuss issues, develop advocacy strategies, and increase public awareness. The AIDS

Administration of the Maryland Department of Health and Mental Hygiene (DHMH) was established in 1987 to spearhead efforts throughout the state. At the local level, county and city health departments offered prevention, counseling and testing, and later treatment services. In 1989, DHMH created the HIV Services Coordinators Network, enabling program staff from across the state to come together to improve service delivery and raise public and agency staff awareness in coordination with state officials. As the epidemic progressed, HIV/AIDS care and treatment became increasingly complex. A cadre of specialized HIV/AIDS programs and resources emerged and a continuum of care was formed in Maryland. The University of Maryland Institute of Human Virology and the Johns Hopkins University Infectious Disease Program spearheaded new treatments and standards of care. PLWH also came together and became advocates for prevention and treatment services.

Initially, HIV services were funded through state general funds and federal HIV demonstration grants. As the rate of new of diagnoses grew, the need for HIV-specific support services was met by the growth of community-based organizations (CBOs). Local health departments subcontracted with CBOs to serve specific targeted communities and (after 1990) provided technical assistance and capacity building to assist CBOs in becoming independent Ryan White-funded vendors.

Virginia: The first case of AIDS was reported in Virginia in 1982. The Virginia Department of Health began its first HIV prevention services in 1985 with the establishment of an AIDS Hotline. In 1986, Virginia became the first state to offer routine HIV testing in sexually transmitted disease or infection (STD/STI) clinics. The public health departments in Northern Virginia joined forces with interested nonprofits in 1988 to establish the Northern Virginia HIV Consortium and provide an integrated, comprehensive response to HIV/AIDS in Northern Virginia. A system for HIV testing was developed, almost exclusively at local health departments. With the advent of Ryan White funding, individuals testing positive at the health department were immediately referred to treatment services.

An Example of HIV Stigma in Rural Areas in the Early Years of the Epidemic

In many rural areas throughout the country, people living with HIV disease faced ignorance, fear, and discrimination during the early years of the epidemic. In November 1987, Oprah Winfrey aired a one-hour TV show about a situation in West Virginia that came to symbolize the stigma and discrimination against gays and people with AIDS in small town America.

Mike Sisco, a young gay man from Williamson, a coal mining town in southwestern West Virginia, had moved away after facing discrimination in his home town because of his sexual orientation. He returned home after becoming ill with AIDS. He was shunned by many residents, including some family members, in a community where many residents believed people could contract AIDS from casual contact.

One hot day in July 1987, Mike Sisco went swimming in the town's public swimming pool, and other swimmers fled the pool in fear. The pool was later closed, emptied, drained, and scrubbed with disinfectants. The State Department of Health later told the Mayor that there was no danger and the town had overreacted.

The incident received national publicity, culminating in the *Oprah Winfrey Show,* in which local residents expressed their fears and anger about AIDS and about homosexuality. Mike Sisco later moved to Charleston, WV and then to California. He died in 1994. The *Oprah Winfrey Show* returned to Williamson in 2010 for a follow up. Many local residents said they regretted the lack of compassion shown the young man and there was much greater awareness of HIV/AIDS and its transmission, but anti-gay stigma remained.

West Virginia: In the early years of the epidemic, there was considerable stigma and discrimination affecting PLWH in many parts of the U.S., including West Virginia. One nationally publicized incident in a small town in West Virginia in 1987 came to symbolize the challenges faced by PLWH and their caregivers in rural parts of the nation (See box). Berkeley and Jefferson Counties, now part of the EMA, did have a largely volunteer AIDS services organization, the AIDS Network of the Tri-State Area (ANTS), by the time the first Ryan White legislation was enacted. In 1991, ANTS, then described as "a volunteer community-based service and education organization," received a small three-year grant from the West Virginia Bureau for Public Health to provide outreach, HIV prevention education, a buddy program, and an HIV support group. After the two counties were added to the Part A service area in the mid-1990s, ANTS became a Part A service provider. It closed in 2010.

Early Regional Collaboration: HIV/AIDS-related services grew in all jurisdictions during the mid-1980s. In 1989, the Metropolitan AIDS Services Coalition (MASC) was established to bring together AIDS service providers and PLWH from the District of Columbia, Maryland, and Virginia to meet monthly. This group discussed issues, made recommendations to public officials, advocated for services, carried out planning activities, and raised concerns.

The Washington, DC EMA was among the first 16 areas funded under Title I (now Part A) of the Ryan White Comprehensive AIDS Resources Emergency (CARE) Act after its enactment in 1990. At that time, the EMA included the District of Columbia and close-in Northern Virginia and Maryland suburbs. In the spring of 1991, the Ryan White Planning Council was established, along with the states' Title II consortia. MASC became the foundation for the Planning Council and played a key role in the planning activities that led to the Comprehensive Plan for 1992-1996.

As legislatively required, DC signed an Intergovernmental Agreement with Prince George's County, MD. Concerns were raised about having a single regional EMA, but the value of a cross-jurisdictional service area was also recognized, since residents frequently moved from one jurisdiction to another. Partly to address these concerns, the District of Columbia decided to allocate funds to administrative agents in Suburban Maryland and Northern Virginia rather than administering all EMA funds centrally. Prince George's County Health Department was selected as the administrative agent for funds allocated to services in the Maryland communities of Prince George's and Montgomery Counties. The Northern Virginia Regional Commission (NVRC) became the administrative agent for Northern Virginia.

In 1995, the EMA was expanded because of an increase in the counties included in the metropolitan statistical area and Ryan White reauthorization made the EMA boundaries permanent. This increased the population size and diversity of the EMA and its PLWH population, almost tripling the geographic area and adding both outer suburbs and largely rural counties. This expansion led to increased availability of services in the suburban and rural counties. The establishment by the Planning Council of the Washington D.C. EMA Rural Set Aside Fund was instrumental in improving access to specialty HIV/AIDS treatment services for PLWH living in the rural areas of Virginia, West Virginia, and Maryland. Providers and systems have changed over the years, but a network of support service and treatment providers remains in place that is committed to ensuring the widest range of services available to PLWH no matter where they live in the EMA.

D. Organization of the Comprehensive Plan

The comprehensive plan has four sections and 12 chapters, including this one.

Section I: Where are we now? The remainder of this section provides information about the current epidemic and the current system of care.

- *Chapter 2* provides an epidemiologic profile for the EMA as well as estimates of unmet need – the number and percent of people in each jurisdiction and the EMA as a whole who know they are HIV-positive but are not in care – and of HIV-positive/unaware – the number of PLWH who do not yet know their status.
- *Chapter 3* describes the current continuum of care in the EMA – or what might be better described as four linked systems of care in the four jurisdictions.
- *Chapter 4* discusses current service needs, gaps, and barriers to testing and care, based on a variety of quantitative and qualitative measures and sources.
- *Chapter 5* describes the process used by the Metropolitan Washington Regional Ryan White Planning Council to carry out its legislative responsibility for priority setting and resource allocation – identifying the Ryan White-eligible core medical-related and support services most needed by PLWH in the EMA and allocating Part A funds to priority services, with the understanding that Ryan White is the payer of last resort.
- *Chapter 6* charts and describes progress and challenges in implementing the work plan from the 2009-2011 comprehensive plan, as well as lessons learned.

Section II: Where do we need to go? describes an "ideal" system of care for this EMA.

- *Chapter 7* identifies important components of an "ideal" system of care, with emphasis on development of an HIV-centered medical home or similar model that can provide coordination of both medical-related and support services even when a PLWH is receiving services supported through multiple payers. The chapter also summarizes how refinements to the system of care will address the National HIV/AIDS Strategy goals, help address the Early Identification of Individuals with HIV and AIDS (residents of the EMA who are HIV-positive but unaware of their status), reduce unmet need by getting people who know their status into (or back into) care, address the challenges of a multi-jurisdictional EMA, and apply the lessons learned over the last three years.
- *Chapter 8* describes coordination efforts either already in place or necessary to strengthen the system of care, including relationships and joint efforts among providers (among Part A service providers and with providers funded under other Ryan White "parts" as well as non-Ryan White providers), including substance abuse treatment programs, as well as coordination between prevention/testing and care and between Ryan White and other payers, including public and private insurance.

Section III: How will we get there? presents goals, objectives, and strategies/tasks/activities through which the EMA will work to strengthen the EMA's system of care and prepare for changes in the health care system. *Chapter 9* includes a detailed work plan as well as narrative summaries of the following: planned implementation of coordination efforts, and how the plan prepares the EMA for implementation of the Affordable Care Act, addresses Healthy People 2020 goals, reflects existing Statewide Coordinated Statements of Need (SCSNs) within the four EMA jurisdictions, addresses the NHAS goals, and addresses possible budget cuts.

Section IV: How will we monitor our progress? describes how the EMA will monitor and evaluate progress towards the plan's five goals, 17 objectives, and specific strategies and tasks. *Chapter 10* presents the EMA's monitoring and evaluation work plan including responsibilities and timeline, describes plans for community feedback that are integrated into ongoing PLWH input and feedback processes, and use of monitoring results in Planning Council decision making. It identifies the clinical and performance measures the EMA plans to use in assessing changes in the system of care, with a strong focus on clinical outcomes for clients.

Chapter 2: Description of the Local HIV/AIDS Epidemic

A. Overview

This chapter describes the HIV/AIDS epidemic in the EMA as a whole and in each of the jurisdictions that are a part of it – the District of Columbia, Suburban Maryland, Northern Virginia, and two counties in West Virginia. It provides an overview of the population living with HIV in the EMA, including the characteristics of people living with HIV, comparisons across EMA jurisdictions, trends in new AIDS diagnoses, late testing, and a "treatment cascade" that describes the proportion of newly diagnosed PLWH who enter and remain in care and attain viral suppression. In addition, it provides estimates of the number and percent of PLWH in the EMA and the individual jurisdictions who know their status but are not receiving HIV-related medical care. Finally, it estimates the number of individuals who have HIV or AIDS but are unaware of their status.

B. HIV Epi Profile for the EMA, 2010

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

- HIV diagnosis or case refers to a person with HIV infection who has not progressed to AIDS.
- An AIDS case refers to a person with a diagnosis of HIV infection and a later diagnosis of AIDS, or a person with a concurrent diagnosis of HIV infection and AIDS.
- AIDS is defined by CD4 counts less than 200 cells/µL or an AIDS defining opportunistic infection.
- Reports of confirmed HIV and AIDS cases only are accepted, and anonymous tests are not reported. Reports are received from a variety of sources including hospitals, private physicians' offices, community-based organizations, clinics, and laboratories.
- Data on HIV and AIDS cases are currently entered into the federally issued enhanced HIV/AIDS Reporting System (eHARS) and de-identified case information is shared with the Centers for Disease Control and Prevention (CDC) monthly. CDC then uses these data to prepare national surveillance reports.
- This epi profile uses some new terminology. All HIV and AIDS cases are referred to as "HIV cases." HIV-only or HIV, not AIDS, cases are referred to as "HIV/not AIDS." This change is consistent with CDC HIV Surveillance Reports.

Transition to Name Based Reporting: HIV/AIDS surveillance has evolved over the past two decades. AIDS surveillance began as confidential name-based reporting; cases were reported by name. HIV (not AIDS) surveillance began as code-based reporting. A unique identifier was generated for each HIV report that was a combination of the person's last name, date of birth, gender, and social security number. These reports were then entered into a separate database known as the Unique Identifier System (UIS). Code-based reporting systems had a number of limitations. For example, the code created to report HIV cases was not evaluated for the uniqueness of the code elements or redundancy. Moreover, the reported HIV data were not

complete. As a result, there was a potential for duplicative reports both within the code-based HIV reporting system and between the individual HIV and AIDS reporting systems. For example, individuals may have been tested more than once, perhaps under a different name; they may have moved or died; or they may have been diagnosed with AIDS.

The transition to name-based HIV reporting leads to a drop in HIV prevalence estimates because the jurisdiction no longer includes code-base HIV cases in the overall number of living cases.

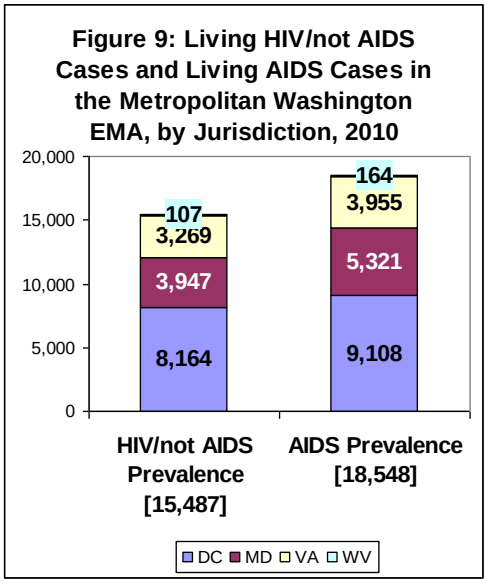
All four EMA jurisdictions now use name-based reporting. West Virginia has used name-based reporting since January 1989, Virginia since June 1989. The District began implementing HIV reporting by name in November 2006; Maryland began name-based reporting in April 2007. In addition, DC laboratories are now required to report all viral load tests, CD4 counts, and other tests indicative of HIV infection or an AIDS diagnosis.

The CDC estimates that it takes approximately five years for the name-based HIV reporting system to "mature." Therefore the DC name-based reporting system was fully mature as of November 2011. Maryland's system will become fully mature in 2012, but the state is already using only name-based data. Both jurisdictions will now only report name-based cases captured in the eHARS database.

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

The Epidemic in the EMA: The epidemic in the Metropolitan Washington EMA is described below, in terms of the characteristics of people living with HIV/not AIDS and AIDS) and new AIDS cases, for the EMA as a whole and by jurisdiction. The summary reviews trends in AIDS incidence and key indicators such as late testing and timing of entry into care. In addition, it reviews co-morbidities such as Hepatitis C and sexually transmitted infections (STIs). Some data are not available for all jurisdictions, but generally the data provide a snapshot describing the HIV epidemic in the EMA as of December 31, 2010, plus some trend data ending as of that date. More detailed epi data for the EMA and the individual jurisdictions are provided in Appendix 2. Unless otherwise noted, all data come from the state surveillance units of the jurisdictions that make up the EMA. Some desired data were not available for inclusion in this profile; in such situations, available data are included and missing data identified.

Figure 9: Living HIV/not AIDS Cases and Living AIDS Cases in the Metropolitan Washington EMA, by Jurisdiction, 2010



People Living with HIV: According to the most recent data, there are 34,094 individuals living with HIV in the EMA. Figures 9 and 10 show their distribution across the EMA. Just over half of all HIV/not AIDS and AIDS cases (51%) are in DC, 27% in Suburban Maryland, 21% in Northern Virginia, and 1% in West Virginia. In the EMA, 54% of all reported HIV (HIV/not AIDS and AIDS) cases are people living with AIDS (PLWA). Nationally, there are more people living with HIV/not AIDS than with AIDS. In the 40 states and five other jurisdictions with mature HIV

testing, there were almost 683,000 people reported as living with HIV/not AIDS as of December 31, 2009; in the U.S. as a whole, nearly 491,000 people were living with AIDS.[16]

Figure 10: People Living with HIV (HIV/not AIDS and AIDS) in the Metropolitan Washington EMA as of December 31, 2010

Status	DC		MD		VA		WV		EMA	
	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent
HIV/not AIDS	8,164	47%	3,947	43%	3,269	45%	107	32%	15,487	45%
AIDS	9,108	53%	5,321	57%	3,955	55%	164	50%	18,548	54%
Unspecified							59	18%	59	0%
Total Cases	17,272	100%	9,268	100%	7,224	100%	330	100%	34,094	100%
Percent of EMA Cases		51%		27%		21%		1%		100%

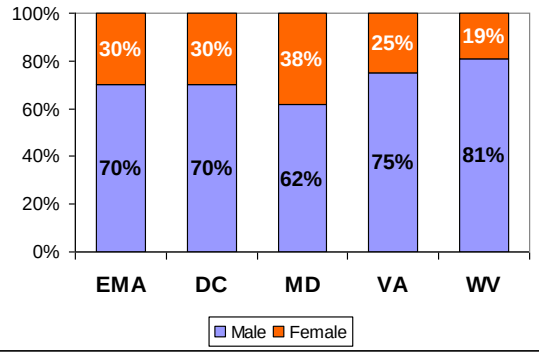
The estimated HIV (HIV/not AIDS and AIDS) prevalence rates (number of cases per 100,000 population) for the EMA, by jurisdiction, are shown in Figure 11. Prevalence is higher in the District of Columbia than in any of the 50 states – nearly 3% of DC residents have been diagnosed with HIV. DC has only about 10% of the population of the EMA but over half the HIV cases. In DC, a little less than 3% of the entire population has been diagnosed with HIV. The known infection rate is 3.2% for all adults and adolescents, 4.7% for African Americans, and 7.4% for residents aged 40-49.

Figure 11: Metropolitan Washington EMA HIV Prevalence Rates by Jurisdiction, 2010

Jurisdiction	People living with HIV/not AIDS and AIDS		2010 Population		Prevalence Rate
	#	%	#	%	
District of Columbia	17,272	50.7%	601,723	10.5%	287.0
Suburban MD	9,268	27.2%	2,303,870	40.0%	40.2
Northern VA	7,224	21.2%	2,693,352	46.8%	26.8
West Virginia	330	1.0%	157,667	2.7%	20.9
Total EMA	34,094	100.0%	5,756,612	100.0%	59.2
United States	960,000		308,745,539		31.1

The most urbanized areas in the EMA have the highest rates of HIV. Both DC and Suburban Maryland have HIV prevalence rates higher than the U.S. as a whole.

Figure 12: Gender of People Living with HIV in the Metropolitan Washington EMA, by Jurisdiction, 2010 [N = 34,093]



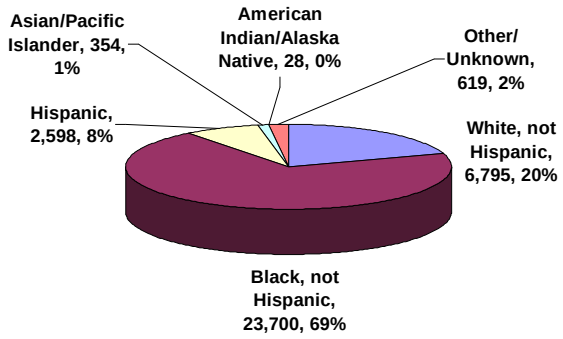
These prevalence rates do not include people with HIV who do not know their status (Those estimates are provided in Part D of this Chapter).

Gender: Seventy percent of PLWH in the EMA are men, and 30% are women, but there are significant differences by jurisdiction as shown in Figure 12. Maryland has the highest proportion of women at 38% and West Virginia the lowest, at 19%.

The proportion of women with HIV is higher in

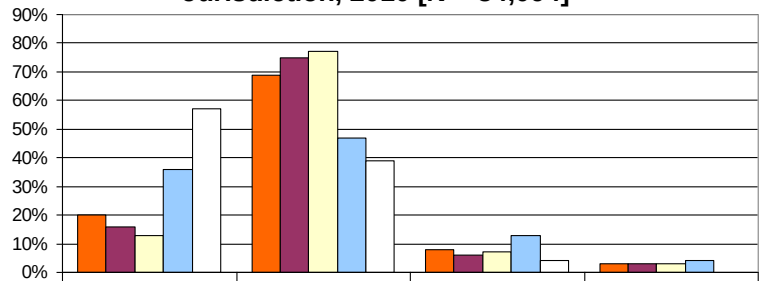
the EMA than nationally. Data are not available for transgenders since the CDC does not separately identify transgenders in surveillance reporting. For the United States as a whole, about 24% of people living with HIV are women, and women accounted for 23% of new diagnoses in 2009. According to the CDC, one in 139 U.S. women will be diagnosed with HIV during her lifetime; the likelihood ranges from 1 in 32 African American women to 1 in 106 Latinas and 1 in 526 White and Asian women.[17]

Figure 13: Race/Ethnicity of People Living with HIV in the Metropolitan Washington EMA, 2010 [N = 34,094]



Race/Ethnicity: Race and ethnicity also vary by jurisdiction. As Figure 13 indicates, 69% of PLWH in the EMA as a whole are Black non-Hispanic, 20% are White non-Hispanic, and 8% are Hispanic/Latino. Another 1% are Asian/Pacific Islander, a fraction of a percent are American Indian/Alaska Native, and about 2% are mixed or unknown race/ethnicity. Again, there are significant differences in race/ethnicity by jurisdiction, as shown in Figure 14. As the bar charts indicate, at least three-fourths of PLWH in Suburban Maryland (77%) and DC (75%) are African American, while the majority in the two counties in West Virginia (57%) are White non-Hispanic. In Virginia, nearly half (47%) are African American, more than one-third (36%) are White non-Hispanic, and 13% are Hispanic. Virginia has the largest proportion of Hispanic PLWH in the EMA, and West Virginia the lowest.

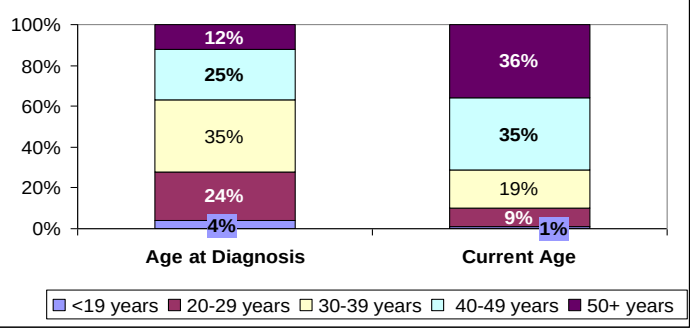
Figure 14: Race/Ethnicity of People Living with HIV in the Metropolitan Washington EMA, by Jurisdiction, 2010 [N = 34,094]



	White non-Hisp	Black non-Hisp	Hispanic	Asian/Other/ Unknown
EMA	20%	69%	8%	3%
DC	16%	75%	6%	3%
MD	13%	77%	7%	3%
VA	36%	47%	13%	4%
WV	57%	39%	4%	0%

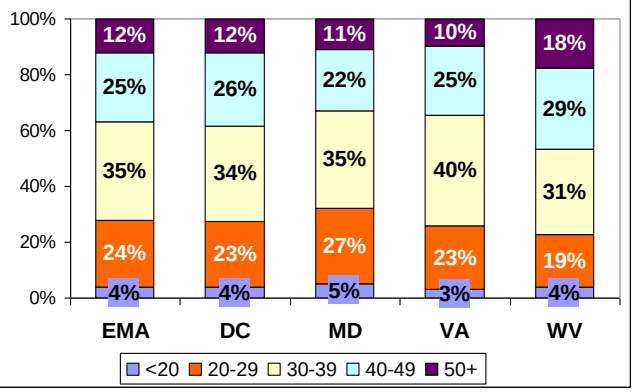
Age: Figure 15 shows age at diagnosis and current age of PLWH in the EMA. Available data for age at diagnosis provides only one category for age 50 and older, but current age data split 50-59 and 60+ populations. A very small number of individuals of unknown age are excluded from these charts. As the charts indicate, more than one-third (35%) of PLWH were diagnosed when they were between 30-39, and about

Figure 15: Age at Diagnosis and Current Age of People Living with HIV in the Metropolitan Washington EMA, 2012 [N = 34,083]



one-quarter each were 20-29 or 40-49. Only 4% were diagnosed before their 20th birthday, and 12% were diagnosed at age 50 or older. Given increasing survival rates, it is not surprising that the current PLWH population in the EMA is older. As the second bar indicates, well over two-thirds (71%) of PLWH are currently 40 or older, and more than one-third (36%) are 50 or older. Separate current age data are available for PLWH 50-59 versus 60 and older; 26% are 50-59, and over 10% are 60+. About 9% are under 20, and 19% are 20-29. The continuing growth of the older (50+) PLWH population has important implications for HIV care.

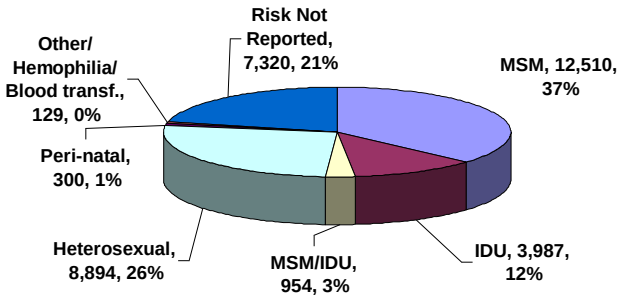
Figure 16: Age at Diagnosis for People Living with HIV in the Metropolitan Washington EMA, by Jurisdiction, 2010 [N = 34,058]



As Figure 16 shows, there are also differences by jurisdiction; PLWH in Maryland and Virginia tend to be somewhat younger at diagnosis than PLWH in West Virginia and DC. Nearly one-third of PLWH in Maryland were diagnosed before their 30th birthday, compared to about one-fourth in DC and Virginia, and less than one-fourth in West Virginia.

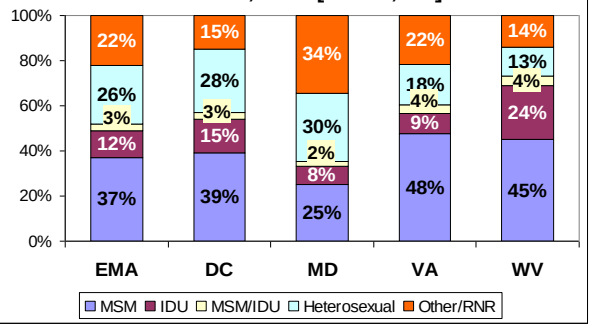
Exposure Categories: Figure 17 shows exposure categories for all PLWH, including pediatric cases, which are largely peri-natal (mother with or at risk for HIV infection) or Risk Not Reported. For all living PLWH in the EMA, the most frequent exposure category is men who have sex with men (MSM) (37%), followed by heterosexual exposure (26%) and IDU (12%).

Figure 17: Exposure Category for People Living with HIV in the Metropolitan Washington EMA, 2010 [N = 34,083]



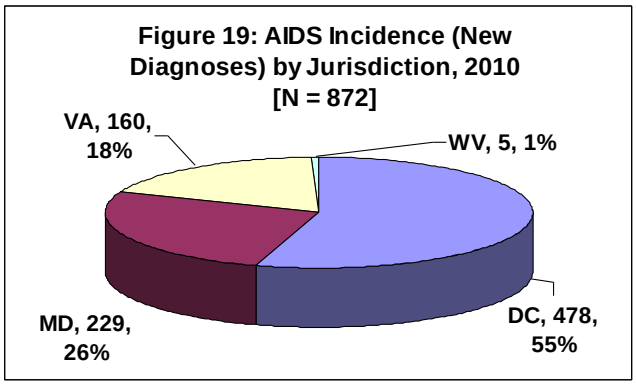
Exposure category also varies by jurisdiction, as shown in Figure 18. This chart shows only adolescent and adult PLWH (aged 13 and older). About half of PLWH in Virginia and West Virginia are MSM or MSM who are also injection drug users (IDUs). MSM is also the most common risk factor in DC. In Maryland, however, there are more heterosexual cases. The proportion of IDUs is highest in West Virginia (24%). Health officials in that state note that a special situation influences the proportion of IDUs in the West Virginia segment of the EMA (24%). Veterans Affairs operates a residential substance abuse program in Berkeley County. Participants may be diagnosed with HIV either during or after treatment. A number of veterans settle in the county after completing treatment, attracted by the community, its lower cost of living compared to larger cities or inner suburbs,

Figure 18: Exposure Categories for Adolescents and Adults Living with HIV in the Metropolitan Washington EMA, by Jurisdiction, 2010 [N = 33,652]



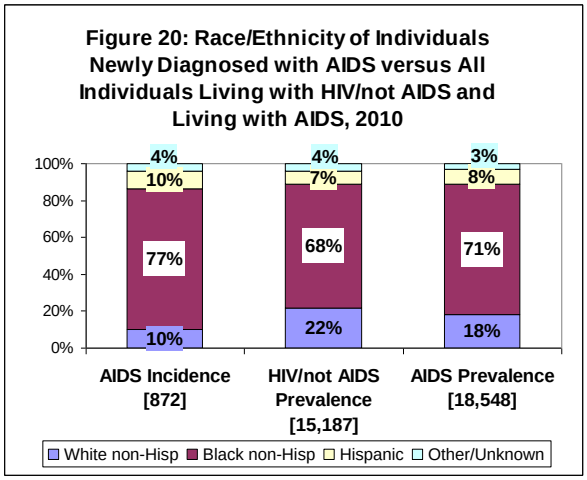
and ready access to VA services. Statewide, 18% of all PLWH have IDU as a risk factor, and 60% are MSM.[18]

Summary: People living with HIV in the EMA are predominantly male African Americans. Since people with HIV now live much longer lives, the current age profile of the PLWH population is substantially older than the profile at diagnosis, with well over one-third of PLWH aged 50 and older. There are considerable variations among jurisdictions: DC's prevalence rate is 7-14 times that of the other jurisdictions. In West Virginia, the majority of PLWH are White non-Hispanic; Blacks make up the majority of PLWH in DC and Maryland, and almost half in Maryland. MSM is the most common exposure factor except in Maryland, where there are more cases related to heterosexual contact. Maryland has the highest proportion of women among its HIV population (38%). PLWH in Maryland and Virginia were diagnosed younger than in the other jurisdictions.



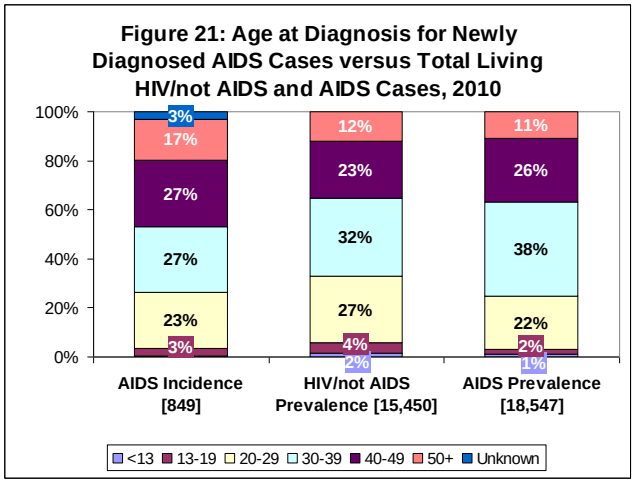
Recent AIDS Diagnoses: Because DC and Maryland did not have mature HIV name reporting until 2011 and HIV incidence data were not available for all jurisdictions, the data presented here do not include new HIV cases, but instead describe new AIDS cases reported throughout the EMA in 2010. As Figure 19 shows, 872 residents of the EMA were diagnosed with AIDS that year. The majority (55%) were in DC, which had 51% of all living cases (HIV/not AIDS and AIDS). Maryland had 27% of all cases and 26% of new AIDS cases in 2010, while Virginia had 21% of all cases and 18% of new AIDS cases. About 1% of all cases and 1% of new AIDS cases lived in the West Virginia segment of the EMA.

Race/Ethnicity: The race/ethnicity of people diagnosed with AIDS in 2010 was somewhat different from that of all people living with HIV/not AIDS and all people living with AIDS in the EMA, as Figure 20 shows. The newly diagnosed included a much smaller proportion of White non-Hispanics (10%), a larger proportion of Latinos (10%), and a larger proportion of African Americans (77%). In the EMA overall, new AIDS cases included 6 Asian/Pacific Islanders, 3 Native Americans/Alaska Natives, and 23 people of other or unknown race/ethnicity.

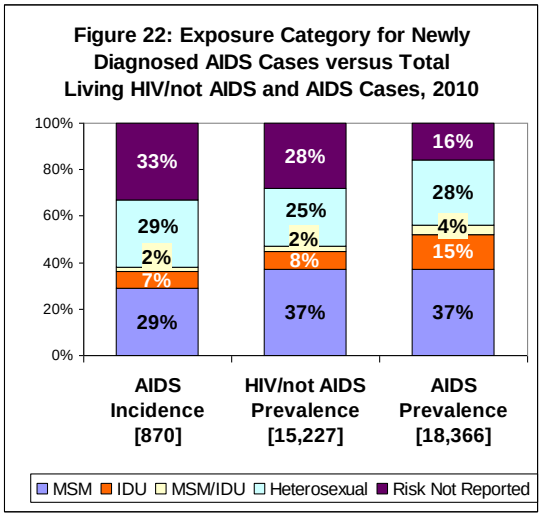


Gender: Newly diagnosed people with AIDS were 34% female – well above the 29% of women within the overall AIDS population and slightly above the 32% for the overall HIV/not AIDS population. In Maryland 43% of new AIDS cases were among women, compared to 38% of all Marylanders living with HIV.

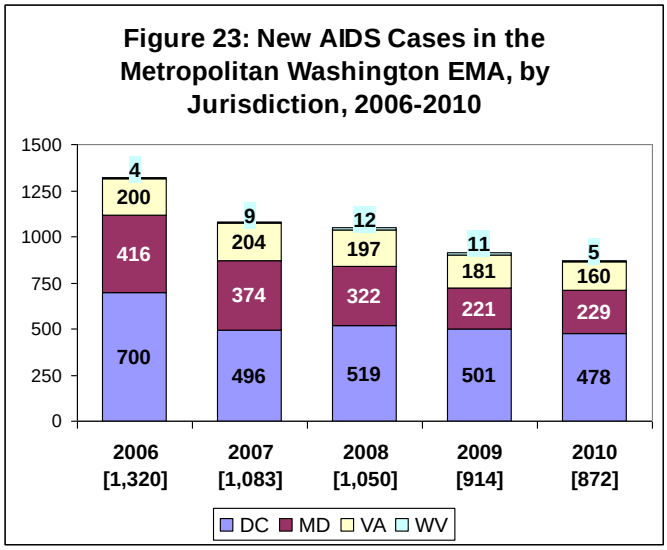
Age: As Figure 21 shows, adolescents and adults diagnosed with AIDS in 2010 were diagnosed at a somewhat older age than people living with HIV/not AIDS or living with AIDS in the EMA. There were more people diagnosed in their 40s or later and fewer people diagnosed in their 30s – 27% of new AIDS cases were 30-39, compared to 32% of all people living with HIV/not AIDS and 38% of all people living with AIDS (PLWA). Forty-four percent of people diagnosed with AIDS in 2010 were 40 or older at diagnosis, as were 35% of people living with HIV/not AIDS and 37% of all PLWA. Fewer were diagnosed before their 30th birthday – though one-fourth of newly diagnosed AIDS cases were under 30. Two people under the age of 12 were diagnosed with AIDS in the EMA in 2010.



Exposure Factor: Figure 22 shows reported exposure category for adolescents and adults newly diagnosed with AIDS in 2010. While one-third had unknown/unreported risk, the newly diagnosed group was less likely to report MSM as a risk factor. Only 7% of newly diagnosed reported IDU as the primary risk factor; the proportion was approximately the same as for the HIV/not AIDS population (8%), but much higher (15%) for all PLWA.

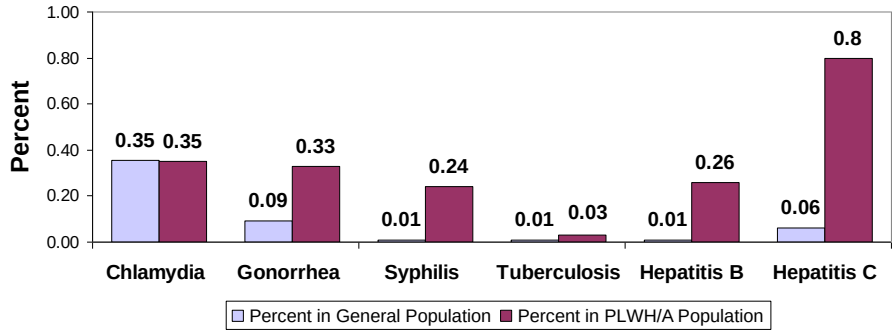


Trends: One of the most important, and encouraging, trends in the epidemic is the reduction in new AIDS cases. Figure 23 shows the number of new AIDS cases reported in each EMA jurisdiction from 2006 through 2010. As the bar chart indicates, there has been a steady reduction in new AIDS cases over the past five years, with fewer new AIDS diagnoses in the EMA each year. Reductions have been greatest in Suburban Maryland (45%) and DC (32%). Trend data on HIV diagnoses, which will become available with the maturing of the DC and Maryland name-based HIV reporting systems, are needed to better understand to what extent these changes reflect earlier testing versus a possible reduction in new infections.



Summary: The data indicate that, compared with the total population living with HIV and the total population living with AIDS in 2010, newly diagnosed people with AIDS were slightly older, more likely to be African American, more likely to be female, and less likely to have MSM as their primary exposure category. The number of new AIDS cases decreased by 33% between 2006 and 2010.

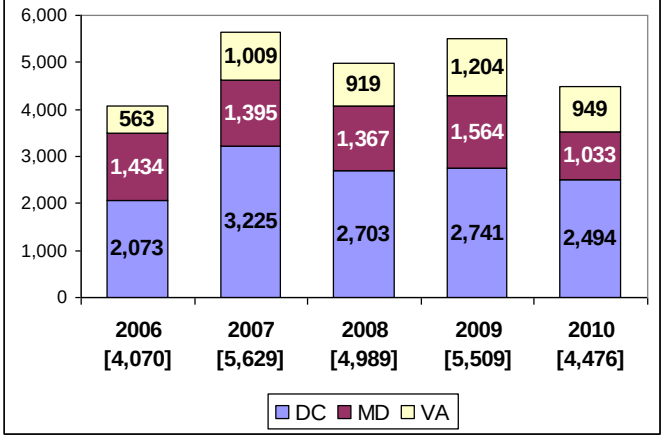
Figure 24: Percent of General Population and Population with HIV/AIDS Diagnosed with STDs and TB, Metropolitan Washington EMA, 2010



Co-Morbidities: People living with HIV often have co-morbidities that complicate their care. Weakened immune systems make PLWH more susceptible to some diseases, and the risky behaviors that led to HIV infection may also place them at risk for other diseases. Figure 24 shows the percent of the general population living with several sexually transmitted infections (STIs), Tuberculosis, Hepatitis B, and Hepatitis C, compared to the percent of people living with HIV in the EMA who are co-infected. As the figure indicates, as of 2010 PLWH were 26 times as likely as the general population to have Hepatitis B, 24 times as likely to have syphilis, more than 13 times as likely to have Hepatitis C, and almost 4 times as likely to have gonorrhea. The infection rate for PLWH and the general population were roughly the same only for chlamydia.

As Figure 24 shows, the most frequently occurring of these co-morbidities within the PLWH community has been Hepatitis C. An important concern of the Planning Council is ensuring access to testing for both PLWH and individuals whose behavior places them at risk for Hepatitis C. Figure 25 shows the number of Hepatitis C cases diagnosed in each of the last five years in the EMA, by jurisdiction (Data for just the two EMA counties in West Virginia were not available). As the figure shows, the number of new cases ranged from a low of 4,070 in 2006 to a high of 5,629 in 2007, but there were no clear trends either in number of cases or in increases or decreases by jurisdiction.

Figure 25: New Hepatitis C Cases in the Metropolitan Washington EMA by Jurisdiction, 2006-2010 [N = 24,673]



Late Testing: An important measure of success in HIV prevention, education, testing, and risk reduction is the extent of early testing. The sooner after infection people learn their HIV status, the sooner they can enter care, begin antiretroviral therapy as appropriate, and attain viral suppression. In addition, national data indicate that people who do not know their status are much more likely to transmit the virus to others – 3.5 times as likely, according to one

study.[19] Late testing is measured by the percent of people who have AIDS when they are first diagnosed with the HIV virus or who convert to AIDS within 12 months following diagnosis. Nationally, the rate of late testing was 37% in 2004 but decreased to 32% in 2007.[20] Data for the EMA are based on several different time periods. Data included in the Part A application submitted in late 2011 indicated that, excluding West Virginia, the late testing rate was 66% for the EMA – nearly double the national rate – and that the rate in Maryland was 76%. Surveillance data provided to the Planning Council in 2011 indicated that the DC late testing rate decreased from 55% in 2005 to 40% in 2009; more recent data were not available. More recently reported five-year data indicate that from 2006-2010, the West Virginia component of the EMA had a late testing rate of about 39% and Virginia a rate of 62%. Data from Virginia show the variations in late testing by client characteristics, as summarized in Figure 26. Virginia's data indicate that men are more likely than women to test late, and that Hispanics have a much higher late testing rate than other racial/ethnic groups in Virginia (79%). Individuals using injection drugs appear to be tested earlier than individuals with other exposure categories. The data also indicate that youngest and oldest PLWH (13-29 and 60+) are most likely to be late testers. Similar information would be extremely useful from all jurisdictions, to suggest particular populations that need to be targeted for HIV education and testing.

Figure 26: Percent of Late Testers in Virginia, by Characteristic, 2006-2010 [N = 595]

Characteristic	Percent Late Testers
Gender	
Male	64%
Female	55%
Race/Ethnicity	
White, Non-Hispanic	60%
Black, Non-Hispanic	55%
Hispanic	79%
Other	67%
Mode of Transmission	
MSM	62%
IDU	37%
MSM/IDU	33%
Heterosexual Contact	54%
Risk Not Identified	74%
Age	
13-19	75%
20-29	70%
30-39	64%
40-49	57%
50-59	55%
60+	67%
Total	**62%**

Entry into Care: Entry into care is an important measure of program success. An individual who tests positive for HIV should be linked to care as quickly as possible and begin treatment, usually including antiretrovirals, to minimize damage to the immune system, achieve viral suppression, and optimize health outcomes. With "treatment as prevention" now a reality, early entry into care contributes to reduced transmission of the virus. The EMA is working hard to help newly diagnosed individuals access care within 30 days, and to provide similarly quick access for individuals who have known their status for some time and want to enter or re-enter care. Jurisdictions currently measure time between first contact with an individual and reporting of a viral load or CD4 test to the surveillance program. One measure of the success of Early Identification of Individuals with HIV and AIDS (EIIHA) for the EMA is the percentage of newly diagnosed individuals who enter care within three months after diagnosis. The Planning Council is developing additional specific measures such as time before first appointment with a clinician with prescribing privileges.

Available data indicate that in the District of Columbia, 71% of people newly diagnosed with HIV in 2009 entered care (as measured by a reported CD4 or viral load test) within three months of diagnosis, 6% in 3-6 months, 6% in 6-12 months; the other 17% had not entered care a year after diagnosis. In Maryland, 56% of newly diagnosed PLWH entered care within three months, using the same measure. A total of 60% had received a CD4 count within 12 months. The data suggest that newly diagnosed PLWH who do not enter care within the first 3 months after

diagnosis are in danger of remaining out of care for a year or more. Of the 29% of DC newly diagnosed PLWH who did not enter care within the first three months, less than half (12% of the total group of newly diagnosed) entered care in the next nine months. More information is needed to better understand this situation.

Treatment Cascade: Use of a treatment cascade provides a means of tracking PLWH from diagnosis through entry into care to retention in care and viral suppression over a period of one or more years. Use of such a treatment cascade measures treatment success but also identifies points within the "cascade" when individuals are lost to care – points in the continuum of care that need to be strengthened in order to increase the proportion of all PLWH who achieve viral suppression and other positive clinical outcomes. A number of different measures can be used. Figure 27, below, shows the results of using Gardner's Treatment Cascade[21] to track newly diagnosed PLWH in DC, Northern Virginia, and West Virginia from diagnosis to linkage to care, retention in care, and viral suppression. Data from Maryland were not available. As indicated, 6,318 individuals were diagnosed with HIV in these EMA jurisdictions between 2005 and 2010. Of this group, 83% were linked to care, but only 25% were retained in care as of 2010, as measured by having had two laboratory tests reported during 2010, at least three months apart. Of those who remained in care, 84% had achieved viral suppression. Viral suppression rates were highest for MSM (90%) and lowest for adolescents (64%).

Figure 27: Treatment Cascade, 2005-2010, District of Columbia, Northern Virginia, and West Virginia

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

* Evidence of at least 1 CD4 or viral load test reported to the surveillance program by 12/31/2010 and conducted on or after the date of HIV diagnosis,
** Defined (based upon HRSA definition) as having had 2 laboratory tests (CD4 or viral load) between 1/1/2010 and 12/31/2010 and at least 3 months apart.
‡ Based on use of the last viral load test reported in 2010; viral suppression is defined as ≤400 copies/mL.

Providers participating in the DC Quality Management Cross-Part Collaborative are using 16 HRSA/HAB Performance Measures, including the proportion of all clients with defined medical visits, viral load monitoring, viral suppression, PCP prophylaxis, syphilis screening, oral exams, and ADAP application and recertification, and are also applying some of the measures them to pediatric clients and MSM.

Regularly tracking late testers, linkage to care, retention in care, and clinical outcomes including viral suppression is a key priority for the EMA, to provide objective outcome measures for assessing the success of changes in the system of testing and care.

C. Estimate of Unmet Need

HRSA's framework for estimating unmet need calls for estimating the number of individuals in and out of care based the following operational definitions:[22]

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

The estimation approach is straightforward. Specify the number of people diagnosed and living with HIV/not AIDS and the number of people living with AIDS (PLWA) as of a particular date in time, using surveillance data. Subtract the number of PLWH/not AIDS and PLWA who received a viral load test or CD4 count or a prescription for ART during the specified 12 months. The result is the number of PLWH/not AIDS and PLWA who have an unmet need for HIV-related medical care. Among the practical challenges are how to ensure that people in both public and private care are included, to link data so that double-counting of individuals is minimized, and to avoid counting people as out of care when they have moved to another jurisdiction or died.

Estimation of unmet need is a particular challenge in this EMA, since the process requires separate estimates from the District of Columbia, Maryland, Virginia, and West Virginia for their segments of the EMA, and each jurisdiction has different data systems, resources, and capacity to develop the estimate. The estimate developed for inclusion in the Part A application submitted in the fall of 2011 is a compilation of the four jurisdictional elements. Each jurisdiction used different methods and data sets for its estimate. Most used multiple data sets to identify people in care. Virginia reported using seven linked databases, DC five, and West Virginia three. At least one jurisdiction apparently used data on medical visits along with the HRSA-specified measures. Maryland used data from the CDC-funded Medical Monitoring Project. Virginia and West Virginia have mature HIV name reporting, and document reported laboratory tests into their HIV/AIDS Reporting System (HARS). The District of Columbia and Maryland did not have mature HIV name reporting when these estimates were made. Combined HIV/not AIDS and AIDS data seemed most reliable, so they were provided for use in planning, rather than separate HIV/not AIDS and AIDS data. Figure 28 shows estimated meet and unmet need for each jurisdiction and for the EMA as a whole, as of 2010.

The table indicates that unmet need is above 40% in all the jurisdictions, and that it is lowest in the District and Maryland and highest in West Virginia. It is not clear whether the West Virginia estimate included laboratory or ART data from Veterans Affairs, which provides a great deal of care for PLWH in the two EMA counties. If not, this could have inflated the unmet need estimate.

Figure 28: Estimate of Met and Unmet Need, Metropolitan Washington EMA by Jurisdiction, 2010					
EMA Jurisdiction	Met Need, CY 2010 (HIV/not AIDS and AIDS)		Unmet Need, CY 2010 (HIV/not AIDS and AIDS)		Total
	Number	Percent	Number	Percent	
Washington, DC	10,069	58.3	7,203	41.7	17,272
Suburban Maryland	5,478	59.1	3,790	40.9	9,268
Northern Virginia	3,254	45.0	3,970	55.0	7,224
West Virginia	125	37.9	205	62.1	330
Total	18,926	55.5	15,168	44.5	34,094

While there may have been changes in methodology, and certainly have been changes in the population of diagnosed individuals living with HIV in the EMA, unmet need data for the past three years indicate that 16,420 people were out of care in calendar year 2008, 17,507 in 2009, and 15,168 in 2010.

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

Nationally, the CDC estimates that about 21% of individuals living with HIV are unaware of their status. Using that estimate, there were approximately 43,157 individuals with HIV in the EMA as of December 31, 2010, of whom 34,094 were aware and 9,063 were unaware of their status. Figure 29 provides estimates by jurisdiction, using the CDC 21% estimate of HIV-positive/ unaware.

Figure 29: Estimated HIV+/Unaware Population in Washington EMA Using National Estimate of 21% Unaware as of December 31, 2010			
Jurisdiction	Actual HIV Aware/Diagnosed	Estimated HIV+/Unaware (21% of Total)	Estimated Total, HIV+/Aware and Unaware
District of Columbia	17,272	4,591	21,863
Suburban Maryland	9,268	2,464	11,732
Northern Virginia	7,224	1,920	9,144
West Virginia	330	88	418
Total	34,094	9,063	43,157

HAHSTA believes that the percent of undiagnosed individuals in this EMA is much higher than the national estimate. The first three cycles of the CDC's National HIV Behavioral Surveillance System (NHBS) study in Washington, DC analyzed three subpopulations – heterosexuals, men who have sex with men (MSM), and injection drug users (IDU) – and found that 30-47% of people with HIV in these categories were unaware of their infection before participation in the study. Figure 30, below, includes those calculations based on the December 2008 diagnosed HIV/not AIDS and AIDS cases. The estimated number of undiagnosed individuals among these three categories alone is 25,233, more than triple the estimate derived from national proportions of undiagnosed.

Figure 30: Estimated HIV+/Unaware by Risk Factor, National HIV Behavioral Surveillance System Analysis as of December 31, 2008				
Risk Category	**Proportion of HIV+/Unaware/ (Local - NHBS)**	**Number Diagnosed and Living with HIV/ not-AIDS and AIDS**	**Estimated Number of HIV+/ Unaware**	**Estimated Total, HIV+, Aware and Unaware**
Heterosexual	47.4%	12,099	10,903	23,002
MSM	41.2%	16,977	11,895	28,872
IDU	30.3%	5,601	2,435	8,036
Subtotal	42.1%	34,677	25,233	59,910

Chapter 3: Description of the Current Continuum of Care

A. Overview

This chapter describes the current continuum of care in the Metropolitan Washington Eligible Metropolitan Area – or what might better be described as four linked but separate jurisdiction-specific systems of care, located in the District of Columbia, Suburban Maryland, Northern Virginia, and two counties in Eastern Panhandle of West Virginia.

The continuum of care is different in each jurisdiction because of differing PLWH demographics and considerable variations in public health and nonprofit health and human service infrastructure, policies, and resources. DC has many nonprofit safety net clinics and community-based HIV/AIDS service providers; the city supports a nonprofit safety net rather than providing medical care through public clinics. The other jurisdictions depend more on local health departments – and in Northern Virginia, a large nonprofit hospital-based clinic system – as service providers. Within jurisdictions, there are variations in service accessibility, with rural areas offering the greatest transportation challenges. Inventories of funded and non-funded providers show the greater number and diversity of HIV/AIDS-related service providers in Washington, DC compared to the other jurisdictions. In addition, eligibility for Ryan White Part A services differs somewhat by jurisdiction, as does eligibility for other Ryan White programs and Medicaid.

In most of the EMA, people living with HIV disease can obtain core medical services and some supportive services. Major initiatives focus on assisting newly diagnosed PLWH as well as individuals who have been out of care for some time to be linked to, supported, and retained in care. In addition, the Ryan White Planning Council has been exploring and is testing a number of methods, including "off the top" EMA-wide funding allocations, to increase parity in access to care throughout the EMA, as well as choice and portability of care.

The Washington EMA has maintained approximately the same level of Ryan White funding for the past three years, but state and local jurisdictions have been significantly affected by the economic downturn. The demand for services has increased as employed PLWH have lost jobs and become dependent on Ryan White services, and budget cuts in public health continue. The greatest impact has been in Virginia, where public health expenditures are traditionally lowest. Virginia's AIDS Drug Assistance Program (ADAP) waiting list has hovered around 1,000 for some months, and 219 PLWH in the Virginia portion of the EMA were on a waiting list as of April 19, 2012.

B. The Current Continuum of Care

HRSA Expectations: The Health Resources and Services Administration's HIV/AIDS Bureau (HRSA/HAB), which oversees Ryan White Part A funding, expects each Part A program to establish and maintain "a comprehensive continuum of high quality, community-based care for low-income individuals and families with HIV." That continuum is expected to include (but not

necessarily use Ryan White funds to support) "the 13 core medical services specified in law, and appropriate support services that assist PLWH in accessing treatment for HIV/AIDS infection that is consistent with the Department of Health and Human Service (DHHS) Treatment Guidelines. Comprehensive HIV/AIDS care beyond these core services may include supportive services that meet the criteria of enabling individuals and families living with HIV disease to access and remain in primary medical care and improve their medical outcomes."[23]

Multiple Systems of Care: Establishing, maintaining, and planning for a continuum of care is especially complex in the Metropolitan Washington EMA because it includes all or part of four different state jurisdictions. In addition, unlike most other EMAs that cross state lines, the Washington EMA has significant numbers of people living with HIV disease in three of the four jurisdictions, and almost half the reported HIV/AIDS cases were diagnosed outside the central jurisdiction. This means four Medicaid systems, four Part B and ADAP programs, four different systems for providing health and human services.

The Washington EMA does not have a single continuum of care operating throughout the region. Instead, it allows for a somewhat different continuum of care in each jurisdiction. Based on decisions made soon after the first Ryan White legislation was passed, the vast majority of Part A service dollars (96.5% in 2012, according to the planned allocations, all but $939,548 of $26,516,318 in service funds) are allocated to the four jurisdictions – the District of Columbia, Northern Virginia, Suburban Maryland, and West Virginia's two counties – based on each jurisdiction's percentage of the EMA's living HIV/not AIDS and AIDS cases. (Until 2010, only living AIDS cases were considered.) The HIV/AIDS, Hepatitis, STD, and Tuberculosis Administration (HAHSTA), within the District of Columbia Department of Health, serves as Grantee on behalf of the DC Mayor. It oversees the entire Part A program and directly manages the program in the District and the West Virginia counties. Administrative Agents in Northern Virginia (the Northern Virginia Regional Commission or NVRC) and Maryland (Prince George's County Health Department) are responsible for contracting with service providers including local health departments to provide services in their respective jurisdictions. Except for a small number of services made available across jurisdictions through "off-the-top" funding for services throughout the EMA, determined before funds are allocated to the jurisdictions – such as a demonstration peer-based Early Intervention Services Program – services are jurisdiction-specific. PLWH are expected to obtain services within the jurisdiction in which they live. In some cases local health departments are the primary or only Ryan White service provider, which means they obtain services in their own county.

This decentralized approach has a number of benefits. It facilitates coordination among Part A and Part B services, and PLWH must, of course, obtain AIDS Drug Assistance Program services in their state of residence. Each jurisdiction offers a somewhat different set of services based on its own perceived needs and priorities. PLWH and providers in each jurisdiction, under Planning Council guidance, refine service priorities and recommend to the Planning Council their preferred resource allocations, which are rarely changed by the Council. This approach allows for consideration of state and local funding streams and health-related policies, which vary considerably by jurisdiction.

However, this approach also limits an individual's choice of providers. A resident of one jurisdiction who works in another jurisdiction cannot choose to obtain services near his/her place of employment. A PLWH cannot seek out a provider that seems particularly suited to his/her

needs – due to language skills, cultural competence, or expertise with co-morbidities – but is located in another jurisdiction. A consumer who moves from one jurisdiction to another – which is extremely common – typically must change providers. This can negatively affect continuity of care. The greatest choice is available for residents of the District of Columbia, which in GY 22 funds 20 entities to provide Part A services, compared to 9 in Suburban Maryland, 10 in Northern Virginia, and 1 in West Virginia (See Figure 37, the Ryan White Part A Service Provider Inventory, later in this section).

Shared Principles: The systems of care, particularly in the three large EMA jurisdictions – DC, VA, and MD – are based on shared principles and reflect EMA-wide needs assessment and planning, but are significantly different in structure and provider mix. All jurisdictions are committed to encouraging early entry into care following diagnosis, making care accessible through "one-stop shops" and other strategies, providing high quality care to diverse populations, meeting critical needs for core medical services – particularly ambulatory medical care, medications, and medical case management – and providing support services necessary to help PLWH enter and remain closely connected to care.

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

- Setting standards that require rapid entry into care for the newly diagnosed. In 2011, the Planning Council adopted a directive that "all outpatient ambulatory medical care programs must schedule an appointment for all newly diagnosed HIV+ clients, identified by them or referred to them, for medical services within 72 hours, with the appointment to occur within 30 days." This requirement has been made a part of the Standards of Care (SOC) for the outpatient ambulatory medical care service category.

- Facilitating early and successful entry into and full connection to care through expansion of Early Intervention Services (EIS), a service category that is now funded in all EMA jurisdictions except West Virginia. EIS replaced Outreach in Maryland because of the benefits of a core service model that can provide a mix of services. The program links closely with testing (not paid for by Part A), and provides for health literacy/education, referral to care, and linkage to care – including navigation and other assistance to ensure that each client becomes well connected to care. In 2011, the Planning Council adopted a pilot EMA-wide peer community health worker (CHW)-based EIS model, funded "off the top," which will begin in June 2012; Northern Virginia has also adopted a peer-based EIS model. Rather than considering "success" to be a referral or a first medical or case management visit, these models call for peers to continue following and assisting new clients for up to six months. (The Planning Council supports use of peer community health workers associated with other service categories such as Medical Case Management or Ambulatory/Outpatient Medical Care services to increase long-term retention in care.)

- Taking other steps to facilitate rapid access and entry into care. DC has implemented a "Red Carpet" initiative designed to enable both newly diagnosed and out-of-care Ryan White eligible PLWH to obtain a medical appointment within two business days with a DC Red Carpet Entry medical care provider.

- Facilitating access to needed services through encouraging "one-stop shops" where feasible. Sometimes (particularly outside DC) this is accomplished by funding a single provider to offer both core medical and support services. But the EMA is also committed to models that encourage multiple providers to work together to provide services in a single or nearby locations through outstationed staff and other collaborative efforts, including use of telemedicine where appropriate.

- Improving choice, portability, and parity in access to care throughout the EMA. Given the complexity of the EMA, this continues to be a considerable challenge. The Planning Council has increased its use of "off-the-top" allocations – made before the bulk of the service dollars are allocated to the four jurisdictions – to ensure that some critical service are available to PLWH throughout the EMA. In 2011, such funding was provided for the pilot peer-based EIS program, for support groups open to residents of all jurisdictions (funded through Psychosocial Services), and for a Local Pharmacy Assistance Program to provide short-term medications to PLWH where an ADAP waiting list or other situation is delaying access to medications. There is also MAI funding that enables limited English proficient PLWH to obtain medical and case management services from a provider with both multicultural competence and very diverse language capacity. The Planning Council continues to consider other ways to increase parity and ensure that clients with special service needs can cross geographic boundaries when necessary to obtain services that meet those needs.

- Working to ensure similar standards of care in all jurisdictions. The Planning Council has now adopted standards of care for all core medical-related services, and is working on support services. One of its directives in 2011 was that "the Planning Council shall develop and the Grantee supported by Administrative Agents in all Jurisdictions shall implement standards for Food Vouchers that are consistent in all jurisdictions across the EMA. The standards will specify service eligibility criteria, requirement for connecting clients to primary food assistance sources, distribution frequency, voucher amount, annual funding caps, and accommodations for families. The Care Strategy, Coordination, and Standards (CSCS) Committee has taken responsibility for this effort, and has led SOC development. CSCS obtains provider and consumer input to standards and procedures through roundtables with providers, practitioners, and consumers that focus on specific service categories such as Oral Health and Medical Transportation.

- Collaborating to improve service quality. Over the past two years, the Washington EMA's Cross-Part Collaborative has worked to assess and improve service quality. It has adopted quality measures that all the EMA's medical care and medical case management providers are implementing, which include treatment cascade measures such as viral suppression. In addition, the Collaborative has trained consumers to participate in quality improvement efforts and serve as members of quality management teams throughout the EMA.

Services Funded by Jurisdiction: Figure 31 shows services provided in each jurisdiction with regular Part A and Minority AIDS Initiative (MAI) funds.

Figure 31: Funded Ryan White Service Categories, Metropolitan Washington EMA Regular Part A and Minority AIDS Initiative (MAI) Funding						
GY22 Priority	**Service Category**	**EMA-Wide**	**DC**	**MD**	**VA**	**WV**
Core Medical-related Services						
1	Outpatient/Ambulatory Medical Care	M	B	B	B	X
2	AIDS Drug Assistance Program *[No projected Part A funding for Grant Year 22]*					
3	Medical Case Management	M	B	B	B	X
4	Oral (Dental) Health Care		X	B	B	X
5	Mental Health Services	M	B	B	B	X
6	Substance Abuse Services - Outpatient		B	X	B	X
7	AIDS Pharmaceutical Assistance – Local	X		X	X	X
13	Medical Nutrition Therapy		X	X		B
15	Early Intervention Services	X	X	X	X	
16	Health Insurance Premium & Cost Sharing Assistance			X	X	X
18	Home & Community-based Health Services		X			
Support Services						
8	Case Management – Non-Medical			X		
9	Emergency Financial Assistance					
	Food Vouchers		X	X	X	X
	Housing		X	X		X
	Utilities		X	X		X
11	Food Bank/Home Delivered Meals		X	X		
12	Medical Transportation Services	M	X	X	X	X
14	Treatment Adherence counseling		X			
17	Outreach Services	M	M		M	X
19	Psychosocial Support Services	B	B		X	
21	Legal Services		X			
23	Linguistic Services	M	X	X	B	X
27	Child Care Services		X	X		
Key: X = Regular Part A M = MAI B = Both regular Part A and MAI						

As the figure suggests, there are considerable similarities in use of funds, given related needs, but some important differences. For example:

- Allocations for core medical services are similar across jurisdictions.
- ADAP is a very high priority, but it has generally been supported out of Part B funds. Since in November 2010, however, Virginia has had a waiting list for ADAP. As of February 6, 2012, the waiting list included 1,080 people statewide and 267 in Northern Virginia. The EMA redirected unused Quality Management funds late in Grant Year 21 (the 2011 program year) to Virginia to help address this problem, and the Planning Council established a new "off-the-top" local AIDS Pharmacy Assistance program beginning March 1, 2012 to provide short-term medications wherever needed in the EMA; it will be used for Northern Virginia in 2012.
- Because of the ADAP shortfall, adjustments were made in Northern Virginia so that more Part B funds are used for ADAP, most Part A funds are used for core medical-related services and a small number of support services, and HOPWA funds help pay for supportive

services. Unlike the other two large jurisdictions, Virginia does not currently fund the following with Part A funds: Medical Nutrition Therapy, Emergency Financial Assistance for Housing or Utilities, Food Bank/Home Delivered Meals, and Child Care Services.

- Only the District of Columbia allocates Part A funds for Home and Community-based Health Services, Legal Services, and Treatment Adherence Counseling.
- Only Maryland currently funds Non-medical Case Management.
- Maryland and West Virginia do not fund Psychosocial Support Services.
- West Virginia focuses on meeting varied service needs in two relatively rural counties. It uses most of its funds for core medical services. It includes Outreach but not Early Intervention Services. It also does not fund the support services of Food Bank/Home Delivered Meals, Psychosocial Support, and Child Care.

Housing Assistance: As the funded services categories chart indicates, Part A funds are not used to provide housing assistance except emergency rental assistance and utility assistance under the Emergency Financial Assistance category. Housing services to PLWH are provided primarily through HOPWA (Housing Opportunities for Persons with AIDS). PLWH are also served in regular Section 8 and other housing assistance programs, and some are eligible for other special housing programs for the mentally ill, elderly and disabled, or substance users. The District of Columbia serves as the grantee for HOPWA funds for the Washington, DC metropolitan area, except for Frederick and Montgomery Counties in Maryland, which are separately funded. In addition, Berkeley County, WV is part of the EMA but no longer part of the metro area, and its HOPWA services are provided through the State of West Virginia, not through the metro area grant.

HOPWA originally provided housing for periods of up to two years. That limitation no longer exists, and HIV disease has become a chronic illness. HOPWA resources have not been adjusted to reflect this reality; there have been cuts in recent years; for example, Montgomery County experienced a 16% reduction for 2012. There is very little transition out of HOPWA-supported housing, and waiting lists remain long and show minimal movement. Figure 32, shows types of housing services provided under each of the three HOPWA service categories during the 2011 program year and provides client data where available. Only DC provides facility-based assistance. In addition to direct housing assistance, HOPWA supports Housing Information and Referral Services including Intake, Assessment, and Linkage Services, and Support Services. All jurisdictions except Prince George's, Charles, and Calvert Counties report using some HOPWA funds for support services, with services most often including housing case management and transportation. In addition, organizational linkages are used to make support services available using other funding streams. In the three Maryland counties, all HOPWA funds are used for housing services because of the great need for housing support; supportive services are provided entirely through linkage agreements. Client data are incomplete for the parts of the EMA that have HOPWA programs not funded through HAHSTA.

Figure 32: Types of Services Provided under HOPWA by Jurisdiction, October 1, 2010 – September 20, 2011 (Client Data Included Where Available)						
Service Category	**Types of Housing Services**					
	DC	**Northern VA**	**Suburban MD**		**WV**	
			Prince George's, Calvert & Charles Counties	**Montgomery & Frederick Counties**	**Jefferson County**	**Berkeley County**
Tenant-based Rental Assistance	331	175	101	99*	5	Yes
Facility-based Housing Assistance	166	No	No	No	No	No
Short-term Rental, Mortgage, & Utility Assistance	282	56	66	No	8	Yes
Housing Information and Referral Services	Yes	Yes	Yes	No	No	Yes
Support Services: Direct HOPWA Funds and Organizational Linkages	Both	Both	Organizational Linkages	Both	Both	Both
Waiting List	968	153	240	N/A	0	N/A
* Client data for Montgomery County only, as of May 31, 2011; includes 60 PLWH and 39 additional family/household members in 54 housing units						

Eligibility for Services: Figure 33 shows the eligibility requirements for Part A, Part B, Medicaid, and other special state-specific health care programs in each of the four EMA jurisdictions, as provided by each jurisdiction. The data are accurate as of March 2012. As the table indicates:

- There are considerable differences in eligibility for Part A services as well as Part B and ADAP services by jurisdiction. The District of Columbia generally has the most generous eligibility, followed by Maryland.
- Eligibility is different (with higher income limits) for the Washington EMA than for other Part A programs in Virginia and Maryland.
- There are differences by jurisdiction in care available for low-income people. Both DC and Maryland have public insurance programs designed to cover health care costs for individuals who are not eligible for Medicaid. Virginia provides premium assistance to some low-income people through the federal Pre-existing Condition Insurance Plan (PCIP). It also has a hospital-based indigent care program, although neither of the hospitals is within the EMA. West Virginia does not have such programs.

The Planning Council is working towards consistency in eligibility across jurisdictions within the EMA.

Figure 33: Health Care System Eligibility (March 2012)*

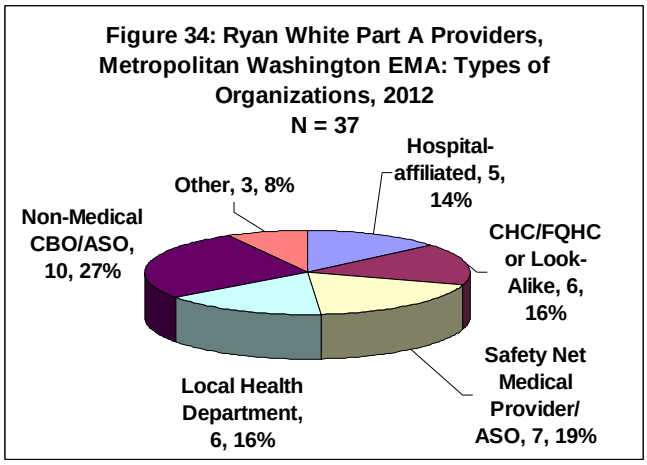
Part / Source	District of Columbia	Virginia		West Virginia		Maryland	
		Within DC EMA	Outside DC EMA	Within DC EMA	Outside DC EMA	Within DC EMA	Outside DC EMA
Part A	• Fills gaps • Generates Program Income • 500% of FPL • Eligibility for services based on whether client qualifies for other coverage	• Fills gaps • Eligibility based on whether client qualifies for other coverage • 400% of FPL	• Norfolk TGA • 300% of the FPL	• 300% of FPL • For above 300% of FPL, access to core medical only. • Residency • In medical care as shown by lab reports • Re-certified annually	• No other Part A programs	• Fills gaps • 500% of FPL with exception of EFA – 300% of FPL • Eligibility based on whether client qualifies for other coverage	• Baltimore EMA-300% of FPL
Medicaid	• 200% of FPL without regard to disabling condition	• 80% of FPL • Includes an asset assessment and formulation • Must also meet at least one categorical eligibility criterion such as aged, disabled, or blind • Limited coverage - no dental		• 100% of SSI rate • Asset test • If CD4 is 400 or below, Medicaid given presumptively without any disability screening • If CD4 is above 400, additional disability screening required		• **Medicaid (MA):** 128% of FPL for working adults; 75% of FPL for aged, blind &/or disabled; recipients of SSI, TCA, foster care or other public assistance. - Full health coverage**,** not Rx co-pays • **MA for Families and Pregnant Women**: 116% of FPL for families with children, or 250%of FPL for pregnant women - Full health coverage**,** not Rx co-pays • **Primary Adult Care** (PAC): 116% of FPL for uninsured adults (≤19yrs) - Good drug formulary, but does not cover HIV care visits, labs, or inpatient care	
ADAP	• 500% of FPL • Rapid enrollment • Pays for insurance premiums, co-payments and deductibles • Direct drug procurement	• 400% of FPL for the Northern Health Region • SPAP program that pays gaps in coverage for individuals on Medicare Part D	• 300% of FPL	• 325% of FPL • No asset test • All anti-retrovirals covered but no lab testing		• **MADAP**: 500% of FPL & not eligible for MA or PAC; for HIV Rx on formulary: **-** Pays for Rx for those with no insurance **-** Pays co-pays & deductibles for those with insurance • **MADAP Plus**: Eligible for MADAP & responsible for ≥50% of insurance premium *Note:* insurance must have: **-** Medical w/Rx or Rx coverage; **-** Formulary = MADAP; **-** Coverage cap $2,500; and **-** Deductible less than $1,000	

Figure 33: Health Care System Eligibility (March 2012)*

Part / Source	District of Columbia	Virginia		West Virginia		Maryland	
		Within DC EMA	Outside DC EMA	Within DC EMA	Outside DC EMA	Within DC EMA	Outside DC EMA
Part B	• Fills gaps • Generates program income • 500% of FPL • Eligibility for services based on whether client qualifies for other coverage	• 333% of FPL for the Northern Health Region	• 300% of FPL	• 250% of FPL for direct services • 300% of FPL for the insurance continuation program		• 400% of FPL • Money allocated to counties in a block grant; counties establish budgets & submit back to IDEHA • Most of dollars budgeted for Outpatient/ Ambulatory Medical Care & Medical Case Management • Cecil County included in Wilmington, DE TGA	
Other	• **DC Healthcare Alliance** -200% of FPL for individuals not eligible for Medicaid - Locally funded primary care insurance - Not HIV specific - Does not pay for HIV medications	• **Indigent Care Fund** - Two hospitals (in Charlottesville and Richmond) have been funded to provide comprehensive medical care to indigent residents throughout the State: - Free for people up to 100% of FPL - Sliding scale fee for residents between 101% and 200% of FPL • **Premium Assistance Program** - Expanded fund to help with insurance premiums, deductibles and co-pays; funds may be used to pay for Pre-Existing Condition Insurance Plans (PCIP)		• No other insurance programs		• **MD Children's Health Insurance Program** (MCHIP): Children aged ≤19, not Medicaid eligible, family income up to 300% of FPL, whose parent's employer does not provide family coverage. - Full health coverage. - If between 200-300% of FPL, may pay monthly premium • **MD Health Insurance Plan** (MHIP) - State-run, high risk insurance pool open to people who cannot qualify for other insurance based on pre-existing conditions - Comprehensive healthcare coverage - Has deductibles and co-payments (which can be covered by MADAP, if individual is eligible) • **MD Senior Prescription Drug Assistance Plan** (MSDAP) - Medicare Part D eligible individuals - Pays $35/mo. subsidy for Rx co-pays - Pays 95% of drug costs per year for Rx in donut hole • **State General Funds** - Used to fund Seropositive Clinics in rural areas to provide HIV specialty care • **Medicare**: ≥65 yrs. or <65 yrs. with certain disabilities; may also qualify for **MD Senior Health Insurance Assistance Program** (SHIP), which helps through: - QMB $928/mo (1 person) - SLMB $1246/mo (1 person) - Extra Help w/RX $10,890/yr (1 person)	

* Source: Information provided by each jurisdiction.

Service providers: The EMA currently has 37 Ryan White Part A-funded service providers, several of them with funding in more than one jurisdiction. They reflect a mix of types of organizations, as shown in the pie chart in Figure 34; 21or 58% of them are CBOs – 6 are community health centers/federally qualified health centers (CHCs/FQHCs) or FQHC "look-alikes," 7 are other nonprofits that provide ambulatory/ outpatient medical care, often along with substance abuse treatment or other services, and 10 provide a range of core and support services but not medical care. Another 6 (17%) are local health departments, one of which subcontracts to a CHC for medical care and other medical-related services; 5 (14%) are hospital-related; and 3 (8%) are other nonprofits. There will be at least two additional EMA-wide providers by June 1, 2012, when new providers will be selected to provide EMA-wide Peer EIS and Psychosocial Support Services.



Jurisdictional Systems of Care: Each jurisdiction has a continuum of care that reflects its health care and human services system and resources, differing PLWH population groups, and its own service priorities, and allocations.

- **The District of Columbia** has a wide range of ambulatory medical care providers and nonprofit organizations providing other core medical and support services. About two-thirds of the EMA's service providers are located in DC; several have contracts with suburban jurisdictions because there is no comparable provider in their service area. DC has no public hospitals or clinics, but offers a great deal of choice in ambulatory medical care providers, which include three of the District's four community health centers (CHCs), an FQHC look-alike, other community-based clinics, and hospital clinics. Providers of other core medical and support services include both AIDS service organizations (ASOs) and non-AIDS-specific grassroots nonprofits that serve the general population and in some cases target particular populations – among them the lesbian, gay, bisexual, and transgender (LGBT) community, Latinos and other immigrants, adolescents, women, sex workers, injection drug users, and the homeless. Given its extremely high rate of HIV disease, DC does extensive testing and works hard to link testing and care. It uses its Red Carpet Entry model to link PLWH to care through many medical providers. Many PLWH need wraparound services from Ryan White but receive their medical care and medications through the already expanded Medicaid program or through the DC Alliance, an insurance-like system that provides care to individuals with incomes up to 200% of poverty who are not eligible for Medicaid, including recent immigrants and the undocumented. HAHSTA recently reported that the number of ADAP clients dropped in 2011 from nearly 2,000 to about 800, as 1,198 were enrolled in Medicaid.[24] Many others moved from the DC Alliance to Medicaid.

- **Northern Virginia** funds several local health departments that provide or contract for medical care, as well as community health centers and a network of hospital-linked HIV/AIDS clinics. A number of free clinics and several CHCs/FQHCs are important sources of free or low-cost primary medical care but are not funded Ryan White providers. There are only a few community-based HIV service providers in the region. Several cities or counties – including Alexandria City and Fairfax County – use local funds to support primary medical care for low-income uninsured residents. Alexandria has traditionally done this through its Casey Clinic and a high school-based clinic; it is now collaborating with a CHC to take over much of the direct medical care. Fairfax County supports a network of clinics run by a for-profit entity to serve residents with incomes below 200% of poverty. For HIV disease, some medical providers offer a "one-stop-shop" where PLWH can obtain multiple services in the same location. In rural counties, PLWH may have to travel some distance for certain services. Virginia is the only state in the EMA with an ADAP waiting list. Medical Case Managers have worked hard to find Pharmaceutical Assistance Programs (PAPs) to cover critical medications for Northern Virginia PLWH on the waiting list. Virginia plans to reduce the waiting list by enrolling many of its PLWH in the health care reform-related Pre-existing Condition Insurance Program (PCIP); Virginia uses the federal PCIP. Because of the high priority placed on ensuring the availability of core medical-related services, Northern Virginia has chosen to use HOPWA funds to cover many support services previously supported through Part A. Traditionally, Part A funds have not been used to help support ADAP, but during Program Year 2011, some funding previously earmarked for Quality Management was reallocated to Virginia's ADAP.

- The **Suburban Maryland** HIV/AIDS continuum of care varies considerably by county. In Prince George's County, the second epicenter of the EMA's epidemic, medical providers include a county clinic, a nonprofit hospital clinic, and a community health center. The same CHC provides services in Charles County as well. Prince George's County has one funded community-based provider. In the other counties, the primary providers of HIV/AIDS care are local health departments. In Montgomery County, all Part A services are provided by a county clinic that offers a "one-stop shop." The other three Maryland counties have smaller populations and fewer HIV service providers. PLWH from the more rural counties often come into Montgomery and Prince George's Counties for oral health services. Non-Ryan White funded health and human services providers are most numerous in Montgomery County. A county-funded network of safety-net clinics, coordinated by the nonprofit Primary Care Coalition of Montgomery County, provides primary care and behavioral health services. Many focus on particular populations such as Latinos, Asians, and Muslims; others serve residents of particular communities. Community-based providers in both Prince George's and Montgomery County offer HIV prevention and testing services as well as non-HIV-specific substance abuse treatment and other human services. Montgomery County has a particularly large variety of human service providers, many with county funding, and the County also supports a network of nonprofit safety-net clinics to serve uninsured residents.

- In **West Virginia** two counties, Berkeley and Jefferson, are part of the EMA. Though rural by EMA standards, they are among the most populous and fastest-growing counties in West Virginia. Health and human service providers are located primarily in Martinsburg, the largest municipality. Services are available, but resources and choices are limited. There is one funded Part A provider, a community health center, which offers and coordinates a variety of services. West Virginia's University Positive Health Clinic makes available an

infectious disease specialist from Morgantown who oversees HIV-related medical care for patients; the University also has Part C funding. About one-third of the PLWH in care are veterans, who obtain HIV-related medical care through Veterans Affairs (VA) facilities. The Part A provider screens all new patients to identify veterans eligible for such services. The Martinsburg VA facility provides case management on site, but transports patients with HIV disease into Baltimore or Washington, DC for HIV-related medical care. Veterans transported to Baltimore for specialty care can also obtain dental services, through a Part F-funded program at the University of Maryland's Baltimore College of Dental Surgery. The VA operates a residential substance abuse treatment program in Berkeley County. A Martinsburg-based community-based organization provides HOPWA services; Jefferson County is a part of the metropolitan DC HOPWA program, while Berkeley County's HOPWA funds come through the state. Rental assistance is reportedly easier to obtain in Jefferson than in Berkeley County. The same agency provides some HIV-specific housing for women and small children and runs a homeless shelter. There are no Part B providers in the two counties; there are non-Ryan White-funded social service providers, including several food pantries. One is a faith-based project of a collaborative of more than 70 local congregations. Some PLWH obtain care in Morgantown or outside the state, since the two counties are on the far northeastern panhandle of West Virginia, bordered on the south by Virginia and on the northeast by Maryland. Services are available in Winchester, VA and Hagerstown, MD, but neither is within the EMA, although Berkeley County is part of the Hagerstown-Martinsburg metropolitan area.

Other Funding Streams: All jurisdictions in the EMA have other funding for HIV/AIDS care from other Ryan White "parts," Medicaid, Medicare, and other public and private sources. The most important are Medicare, Medicaid, and ADAP (Part B). Medicare expenditure data for the EMA are not available.

Medicaid: It is challenging to determine the level of funding for HIV/AIDS services under Medicaid, since a number of clients are served through managed care organizations (MCOs) rather than fee for service (FFS) structures, and MCO costs are based on a capitated rate – a monthly fee for services that includes all health care, not just HIV-related services. The three largest jurisdictions (DC, Suburban Maryland, and Northern Virginia) each provided some data on the number of Medicaid clients with HIV disease, and DC and Virginia provided some estimates of expenditures for HIV/AIDS care for FFS clients. This information is summarized in Figure 35. Note that the DC data include client information for HIV/AIDS clients served by the DC Healthcare Alliance, which serves individuals with incomes up to 200% of poverty who are not eligible for Medicaid. Because the Alliance is supported entirely through local funds, Ryan White funds can be used to supplement Alliance reimbursements, with those reimbursements counted as program income. Expenditure data provided by DC and Northern Virginia cover claims paid for fee-for-service only. Total expenditures for medical services are provided, as well as costs for several specific Ryan White-eligible services. EMA-specific expenditure data were not available from Maryland. The total expenditures shown for FFS claims for HIV/AIDS clients are considerably greater than the aggregate amount for the specified services because they include additional medical services, including inpatient care that are not covered by Ryan White.

Table 35: PLWH Served through Medicaid: Number of Clients and Estimated Expenditures for DC, Suburban Maryland, and Northern Virginia					
Jurisdiction and Services	**Unduplicated Clients**			**Notes**	**Expenditures – Fee for Service Only**
	Fee for Service	**Managed Care**	**DC Alliance**		
District of Columbia (FY 2011)	Total HIV/AIDS Medicaid and Alliance Clients: 7,107 [Some have no HIV/AIDS claims during FY 2011 so are not included below]			Some clients moved between programs during the year and may be counted twice	
All Primary and Specialty Medical, inpatient and outpatient, including emergency, except for clinical services	2,848	3,160	600	• Medicaid Managed Care and DC Alliance operate on a capitated (cost per month) basis; cost estimates not available • No current Medicaid benefit for substance abuse services	$44,581,364
Medical Services, excluding inpatient	2,797	3,111	596		$5,280,521
Pharmacy	3,032	N/A	N/A		$13,838,647
Dental	1,011	1,002	209	Use of dental services by managed care clients considered very high	$1,736,523
Home Health	759	58	0		$12,798,775
Mental Health	1,010	N/A	N/A		$4,549,515
Hospice	45	4	0	Hospice	$459,620
Northern Virginia	Total HIV/AIDS Medicaid Clients: 675				
All Services, including inpatient and outpatient medical care	393	282			$2,787070
Outpatient Ambulatory Medical Care	292	261			$176,080
Pharmacy	171	197			$525,549
Home Health	7	N/A			$120,275
Mental Health	9	13			$6,691
Hospice	4	N/A			$39,394
Suburban Maryland (as of March/April 2012)	Total HIV/AIDS Clients:1,670				
Calvert	9	14		Capitation rates (monthly) for Medicaid Managed Care (HealthChoice) range from $651 to $1,819	N/A
Charles	29	38			
Frederick	46	22			
Montgomery	210	173			
Prince George's	642	487			
Subtotal	936	734			

Changes in Funding Streams: Perhaps the largest change that has occurred in other funding streams involves the expansion of Medicaid in DC, accomplished largely during the second half of 2011. PLWH previously served under the DC Alliance and Ryan White (including ADAP) were shifted to Medicaid. While an estimated 90% of PLWH were previously receiving services

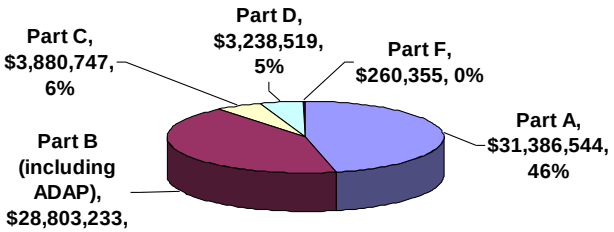
from the DC Alliance rather than Ryan White, enrollment in ADAP fell by nearly 1,200 in 2011, and weekly medication costs were reduced from $325,000 to $150,000 per week.[25]

As the eligibility chart indicates, Maryland Medicaid covers low-income childless adults up to 116% of the poverty level. Primary Adult Care coverage includes medications but excludes HIV-related medical visits, laboratory tests, and inpatient care.

Other Ryan White Funding: Figure 36 shows Ryan White funding from all parts as of 2011. Note that information on Part B and C funding for the two counties in West Virginia were not available.

Figure 36: Ryan White Funding by Part, Metropolitan Washington EMA, 2011

(Excludes WV non-Part A)



Other Funding: Several jurisdictions have special funding for particular populations and services that complement Ryan White services. For example:

- The District of Columbia has a three-year, $1.3 million a year federal grant to identify and provide a mix of services to homeless PLWH multiply diagnosed mental illness or substance abuse.
- Positive Pathways, a DC-based project funded through the Washington AIDS Partnership with federal support from AIDS United and the federal Social Innovations Fund, has trained and deployed 12 peer community health workers within HIV/AIDS service providers to help HIV-positive African Americans living in Wards 5-8 enter and remain in HIV-related care; its special focus is on women and their partners.
- Virginia will continue to fund the Comprehensive HIV/AIDS Resources and Linkages for Inmates (CHARLI) program, which provides pre-release prevention services including testing and post-release case management, linkage to care, and retention to care services for HIV-positive former inmates of federal and state prisons, and jails. There is currently one funded CHARLI project in Northern Virginia and geographic distribution will continue to be a factor in new awards; total funding includes $120,000 in CDC funds and $395,000 in state funds.

C. Ryan White Part A-Funded HIV Care and Services Inventory

Figure 37 provides an inventory of Part A-funded HIV/AIDS care and service providers. Since most providers are funded to serve a particular jurisdiction, the chart identifies them by jurisdiction and indicates the medical-related and support services for which they have funding, as well as other services they provide that are not Part A-funded.

D. Other (Non-Part A) HIV Care and Services Inventory

Figure 38 provides an inventory of non-Part A-funded providers of services to people with HIV disease, again by jurisdiction. It includes providers that do not have Part A funding but do receive Part B or other Ryan White funds as well as HOPWA providers, plus entities that serve PLWH but receive no Ryan White or HOPWA funds.

Figure 37: Ryan White Part A Providers and Services Inventory

Note: *Part A providers are listed by jurisdiction (DC, MD, VA, WV), since contracting is done separately. Providers that have separate contracts to provide services in more than one jurisdiction are listed in each jurisdiction, since they may provide different services in different jurisdictions. The EMA-wide providers, funded centrally to serve PLWH from all jurisdictions, are listed first. Two additional EMA-wide providers are to be selected to begin services by June 1, 2012.*

Key: DC = DC Appropriations; Prevention = Centers for Disease Control Funding, directly or through the State
[Italics] = Services not funded through Part A

Figure 37: Ryan White Part A-Funded Providers and Services Inventory Includes Providers with Part A Regular and Minority AIDS Initiative (MAI) Funding						
	Provider Name	**Location(s)**	**Funding from RW Part(s) and Other Sources**	**Core Medical-Related Services Provided**	**Support Services Provided**	**Does HIV Testing**
	EMA-wide					
1	La Clinica del Pueblo	2831 15th St., NW, Washington, DC	A, B, DC, Prevention, federal Bureau of Primary Health Care	Outpatient/Ambulatory Medical Care, Mental Health Services, Medical Case Management	Linguistic Services, Medical Transportation, Outreach, Psychosocial Services	Yes
2	TBD (expected June)		A	Early Intervention Services		No
3	TBD (expected June)		A		Psychosocial Support Services	No
4	Northern Virginia Regional Commission	3060 Williams Dr #510 Fairfax, VA	A, B, HOPWA	AIDS Drug Assistance (Local)	*Administrative agent for HOPWA and Part B funds*	No
District of Columbia						
5	AIDS Healthcare Foundation: Blair Underwood	2141 K St., NW, Suite 606 (Also mobile testing unit)	A, B	Outpatient/Ambulatory Medical Care, Early Intervention Services, Medical Case Management		Yes

Figure 37: Ryan White Part A-Funded Providers and Services Inventory Includes Providers with Part A Regular and Minority AIDS Initiative (MAI) Funding						
	Provider Name	**Location(s)**	**Funding from RW Part(s) and Other Sources**	**Core Medical-Related Services Provided**	**Support Services Provided**	**Does HIV Testing**
6	Andromeda Transcultural Health	1400 Decatur St, NW (Also medical mobile outreach clinic)	A, B, Prevention	Outpatient/Ambulatory Medical Care, Early Intervention Services, Mental Health Services, Medical Case Management, Outpatient Substance Abuse Services	Medical Transportation, Psychosocial Support, Treatment Adherence Counseling	Yes
7	Carl Vogel Foundation	1012 14th St, NW, Suite 700	A, B, DC	Outpatient/Ambulatory Medical Care, Early Intervention Services, Mental Health Services, Medical Nutrition Therapy, Medical Case Management, Outpatient Substance Abuse Services	Food Bank/Home Delivered Meals, Outreach, Psychosocial Support	Yes
8	Children's National Medical Center	111 Michigan Ave., NW	A, B, D	Outpatient/Ambulatory Medical Care, Early Intervention Services, Mental Health Services, Medical Nutrition Therapy, Medical Case Management (*including Family-centered Medical Case Management)*, Outpatient Substance Abuse Services	Child Care, Medical Transportation, Psychosocial Support, Treatment Adherence Counseling	
9	Christ House	1717 Columbia Rd. NW	A	Outpatient/Ambulatory Medical Care, Medical Case Management	Medical Transportation, *Residential Care*	
10	Community Family Life	305 E St., NW	A, HOPWA	Medical Case Management		
11	Damien Ministries	2200 Rhode Island Ave., NE	A, B, HOPWA	Medical Nutrition Therapy, *Medical Case Management*	Food Bank/Home Delivered Meals	
12	DC Care Consortium	1112 16th St., NW, Suite 400	A,B, HOPWA, DC	*Health Insurance Premium and Cost-Sharing Assistance*	Emergency Financial Assistance, Medical Transportation	

Figure 37: Ryan White Part A-Funded Providers and Services Inventory Includes Providers with Part A Regular and Minority AIDS Initiative (MAI) Funding						
	Provider Name	**Location(s)**	**Funding from RW Part(s) and Other Sources**	**Core Medical-Related Services Provided**	**Support Services Provided**	**Does HIV Testing**
13	Family & Medical Counseling Services	2041 Martin Luther King., Jr. Ave., SE, Suite 105	A, B, HOPWA, Prevention	Outpatient/Ambulatory Medical Care, Medical Case Management, Medical Nutrition Therapy, Mental Health Services, Outpatient Substance Abuse Services, *Medical Case Management – Peri-Incarcerated*	Food Bank/Home Delivered Meals, *Treatment Adherence*	Yes
14	Food and Friends	219 Riggs Rd., NE	A	Medical Nutrition Therapy	Food Bank/Home-Delivered Meals	
15	Howard University Hospital Healthcare	2225 Georgia Ave., NW, 3rd Floor	A, B, Prevention	Outpatient/Ambulatory Medical Care, Oral Health Care, Medical Case Management *(including Family-centered)*, Mental Health Services, Outpatient Substance Abuse Services; *Inpatient and specialty care*		Yes
16	Joseph's House	1730 Lanier Place, NW	A, B, HOPWA	Home & Community-based Health Services, *Medical Case Management*	Transitional Housing, *Hospice*	
17	La Clinica del Pueblo	2831 15th St., NW, Washington, DC	A B, DC, Prevention	Outpatient/Ambulatory Medical Care, Early Intervention Services, Medical Case Management, Mental Health Services, Outpatient Substance Abuse Services	Linguistic Services	Yes
18	Mary's Center for Maternal and Child Care	2333 Ontario Rd. NW, 3531 Georgia Ave., NW [Also 9709 Flower Ave., Silver Spring, MD, and a mobile van]	A, Department of Mental Health, federal Bureau of Primary Health Care	Oral Health Care, *Medical Care, Mental Health Services*		

Figure 37: Ryan White Part A-Funded Providers and Services Inventory Includes Providers with Part A Regular and Minority AIDS Initiative (MAI) Funding						
	Provider Name	**Location(s)**	**Funding from RW Part(s) and Other Sources**	**Core Medical-Related Services Provided**	**Support Services Provided**	**Does HIV Testing**
19	Metro TeenAIDS	651 Pennsylvania, Ave., SE	A, DC, Prevention	Early Intervention Services	*HIV Counseling and Testing, Care Advocacy, Drop-in Center, Peer Education*	Yes
20	Regional Addiction Prevention (RAP), Inc.	The Calvin Rolark Center, 1949 4th St, NE	A, B, HOPWA, Private	Outpatient/Ambulatory Medical Care, Medical Case Management, Medical Nutrition Therapy, Outpatient Substance Abuse Services	*Residential Substance Abuse Services (Therapeutic Community), Emergency Housing, Transitional Housing, Substance Abuse Prevention and Outreach Services*	
21	The Women's Collective	1331 Rhode Island Ave., NE	A, DC, Prevention	Medical Case Management	*HIV Prevention, Prevention with Positives, Female Condom Outreach and Education, Social services including peer-based support*	Yes
22	Unity Health Care, Inc.	Anacostia HC, 1220 12th St., SE; Brentwood HC, 1201 Brentwood Rd., NE; Columbia Road HC, 1660 Columbia Rd., NW; Congress Heights HC, 3720 MLK Jr. Ave., SE; East of the River	A, B, Prevention, federal Bureau of Primary Health Care	Outpatient/Ambulatory Medical Care, Oral Health Care, Medical Case Management *(including Medical Case Management for Peri-Incarcerated)*	Treatment Adherence Counseling	Yes

Figure 37: Ryan White Part A-Funded Providers and Services Inventory Includes Providers with Part A Regular and Minority AIDS Initiative (MAI) Funding						
	Provider Name	**Location(s)**	**Funding from RW Part(s) and Other Sources**	**Core Medical-Related Services Provided**	**Support Services Provided**	**Does HIV Testing**
		HC, 123 45th St., NE; Good Hope HC, 1638 Good Hope Rd., SE; Hunt Place HC, 4130 Hunt Pl., NE; Minnesota Avenue HC, 3924 Minnesota Ave, NE; Southwest HC, 850 Delaware Ave., SW; Stanton Road Center, 3240 Stanton Rd., SW; Upper Cardoza HC, 3020 14th St., NW; Walker-Jones HC, 40 Patterson St., NE; Ballou Student HC, 3401 4th St., SE; Eastern Student HC, 1700 E. Capitol St. NE; Unity at DC General, 1900 Massachusetts Ave., SE; plus services at 9 homeless sites				

Figure 37: Ryan White Part A-Funded Providers and Services Inventory Includes Providers with Part A Regular and Minority AIDS Initiative (MAI) Funding						
	Provider Name	**Location(s)**	**Funding from RW Part(s) and Other Sources**	**Core Medical-Related Services Provided**	**Support Services Provided**	**Does HIV Testing**
23	Us Helping Us	3636 Georgia Avenue., NW	A, B, DC, Prevention	Medical Case Management, Mental Health Services	Treatment Adherence Counseling, *Individual and group counseling, Support groups*	Yes
24	Whitman Walker Health	Elizabeth Taylor Medical Center 1701 14th St., NW Max Robinson Medical Center 2301 M L King Jr Ave, SE (Also mobile testing unit)	A, B, DC, Prevention, HOPWA, STD	Outpatient/Ambulatory Medical Care, Home & Community-Based Health Services, Medical Case Management, Mental Health Services, Medical Nutrition Therapy, Outpatient Substance Abuse Services, *Early Intervention Services*	Legal Services, Psychosocial Support, Treatment Adherence Counseling	Yes
Maryland						
25	Charles County Health Department	4545 Crain Highway, White Plains, MD	A, B, Prevention, MD State grant	Medical Case Management, Medical Nutrition Therapy, *Seropositive Clinic, Dental Care*	Non-Medical Case Management, Medical Transportation, *Emergency Financial Assistance, Psychosocial Support Services*	Yes
26	Dimensions Healthcare System (Glenridge Medical Center)	7582 Annapolis Rd., Lanham, MD	A	Outpatient/Ambulatory Medical Care, Medical Case Management		Yes
27	Children's National Medical Center	111 Michigan Avenue, NW, Washington, DC	A, B, D	Outpatient/Ambulatory Medical Care, Medical Case Management, Mental Health Services, Medical Nutrition Therapy, Outpatient Substance Abuse Services	Non-Medical Case Management, Child Care, Emergency Financial Assistance, Medical Transportation	Yes

Figure 37: Ryan White Part A-Funded Providers and Services Inventory Includes Providers with Part A Regular and Minority AIDS Initiative (MAI) Funding						
	Provider Name	**Location(s)**	**Funding from RW Part(s) and Other Sources**	**Core Medical-Related Services Provided**	**Support Services Provided**	**Does HIV Testing**
28	Food and Friends	219 Riggs Rd., NE Washington, DC	A		Food Bank/Home-Delivered Meals	
29	Frederick County Health Department	350 Montevue Lane, Frederick, MD	A, B, Prevention, MD State grant	Outpatient/Ambulatory Medical Care, AIDS Pharmaceutical Assistance (Local), Mental Health Services, Oral Health Care, Health Insurance Premium Assistance, Medical Case Management, Medical Nutrition Therapy, *Seropositive Clinic*	Non-Medical Case Management, Linguistics Services, Emergency Financial Assistance, *Medical Transportation*	Yes
30	Greater Baden Medical Services, Inc.	7450 Albert Rd., Brandywine, MD; 1458 Addison Rd. S, Capitol Heights, MD; 5001 Silver Hill Rd., 2nd Floor, Suitland, MD; 4375 Port Tobacco Rd., Nanjemoy, MD	A, C, Bureau of Primary Health Care	Outpatient/Ambulatory Medical Care, AIDS Pharmaceutical Assistance (Local), Oral Health Care, Medical Case Management, Early Intervention Services		Yes
31	Heart to Hand	1300 Mercantile Lane, Suite 142, Largo, MD	A		Non-Medical Case Management, *Psychosocial Support Services, Food Pantry*	Yes
32	Montgomery County Department of Health and Human Services – Dennis Avenue Clinic	2000 Dennis Avenue, Silver Spring, MD	A, B, Prevention, HOPWA	Outpatient/Ambulatory Medical Care, AIDS Pharmaceutical Assistance (Local), Oral Health Care, Medical Case Management, Medical Nutrition Therapy, Mental Health Services, Outpatient Substance Abuse Services	Emergency Financial Assistance, Medical Transportation, *Housing Assistance, Non-Medical Case Management*	Yes

Figure 37: Ryan White Part A-Funded Providers and Services Inventory Includes Providers with Part A Regular and Minority AIDS Initiative (MAI) Funding						
	Provider Name	**Location(s)**	**Funding from RW Part(s) and Other Sources**	**Core Medical-Related Services Provided**	**Support Services Provided**	**Does HIV Testing**
33	Prince George's County Health Department	3003 Hospital Drive, Cheverly, MD; 9314 Piscataway Rd, Clinton, MD	A, B	Outpatient/Ambulatory Medical Care, AIDS Pharmaceutical Assistance (Local), Oral Health Care, Medical Case Management, Mental Health Services, Medical Nutrition Therapy, Outpatient Substance Abuse Services	Non-Medical Case Management, Emergency Financial Assistance, *Linguistics Services, Medical Transportation*	Yes
Virginia						
34	AIDS Response Effort, Inc.	333 West Cork St., Winchester, VA	A, B, HOPWA	Outpatient/Ambulatory Medical Care, Medical Case Management	Emergency Financial Assistance, Medical Transportation, *Housing Assistance*	Yes
35	Alexandria Health Department, Casey Health Center – Subcontractor is Alexandria Neighborhood Health Services, Inc.	1200 N. Howard St., Alexandria; 2 East Glebe Rd., Alexandria; 3804 Executive Dr., Arlandria; 3802 Executive Drive, Arlandria	A, B, Prevention	Outpatient/Ambulatory Medical Care, Oral Health Care, AIDS Pharmaceutical Assistance (Local), Medical Case Management		Yes
36	Children's National Medical Center	111 Michigan Ave., NW, Washington, DC	A,D	Medical Case Management; *Inpatient and outpatient medical care for children, including specialty care for pregnant women, children, and adolescents*	Emergency Financial Assistance (food vouchers)	Yes

Figure 37: Ryan White Part A-Funded Providers and Services Inventory Includes Providers with Part A Regular and Minority AIDS Initiative (MAI) Funding						
	Provider Name	**Location(s)**	**Funding from RW Part(s) and Other Sources**	**Core Medical-Related Services Provided**	**Support Services Provided**	**Does HIV Testing**
37	CommonHealth ACTION, Institute for Public Health Innovation	1301 Connecticut Ave., NW, Washington, DC	A	Early Intervention Services		
38	Fredericksburg Area HIV/AIDS Support Service	415 Elm St., Fredericksburg	A, B, Prevention	Outpatient/Ambulatory Medical Care, Oral Health Services, Medical Case Management, Mental Health Services	Emergency Financial Assistance, Medical Transportation, *Psychosocial Support, other support services*	Yes
39	Inova Juniper Program	8001 Forbes Place, Suite 200, Springfield, VA; 5015 Lee Highway, Arlington, VA; 8350 Richmond Highway, #233, Alexandria, VA	A, B, C, D, F	Outpatient/Ambulatory Medical Care, AIDS Pharmaceutical Assistance (Local), Oral Health Care, Medical Case Management, Mental Health Services, Health Insurance Premium Assistance, Medical Nutrition Therapy, Outpatient Substance Abuse Treatment	Emergency Financial Assistance, Outreach, Linguistics Services, Medical Transportation	Yes
40	Loudoun County Health Department	102 Heritage Way, NE, Suite 101, Leesburg, VA	A, C, Prevention	Outpatient/Ambulatory Medical Care, AIDS Pharmaceutical Assistance (Local), Oral Health Services, Medical Case Management		Yes
41	Mary Washington Healthcare	1101 Sam Perry Blvd., Suite 101, Fredericksburg, VA	A, C	Outpatient/Ambulatory Medical Care; *Inpatient and specialty care*		Yes

Figure 37: Ryan White Part A-Funded Providers and Services Inventory Includes Providers with Part A Regular and Minority AIDS Initiative (MAI) Funding						
	Provider Name	**Location(s)**	**Funding from RW Part(s) and Other Sources**	**Core Medical-Related Services Provided**	**Support Services Provided**	**Does HIV Testing**
42	Northern Virginia Area Health Education Center	2 Herbert St., Alexandria, VA	A		Linguistic Services, *Support to area health care providers to help them serve a diverse, multi-cultural population*	
West Virginia						
43	Shenandoah Valley Medical Systems, Inc.	99 Tavern Road, Martinsburg, WV	A, C (through West Virginia University)	Outpatient/Ambulatory Medical Care, AIDS Pharmaceutical Services (Local), Oral Health Services, Health Insurance Premium Assistance, Medical Case Management, Mental Health Services, Outpatient Substance Abuse Services	Emergency Financial Assistance, Linguistic Services, Medical Transportation, Outreach; *HIV Outreach Testing, Testing of HIV-Positive Partners*	Yes

Figure 38: Non-Part A Provider and Services Inventory

Provider Name	Location(s) and Service Area	Funding Sources	Types of Core Medical-Related Services Provided	Type of Support Services Provided	Does HIV Testing
District of Columbia					
Anchor Mental Health [Component of Catholic Charities]	1001 Lawrence Street, NE	DMH, Faith-based, Private	Mental Health Services – including Psychiatric Services, Counseling, and Community Support Services		
Bread for the City	1525 7th St, NW and 1640 Good Hope Rd., SE	DC Alliance, Private corporations, foundations, and individuals; public grants	Medical Care, Oral Health Care [Operates clinic in NW; houses Unity Clinic in SE]	Food Bank, Legal Services, Social Services, Clothing	Yes
Building Futures	1440 Meridian Place, NW	Part B, HOPWA	Medical Case Management	Housing Assistance	
Capital Area Food Bank	645 Taylor St, NE	Private		Food Bank, other food-related programs, including Food Distribution and Emergency Food Assistance through partner agencies	
Capital Community Services, LLC	2041 Martin Luther King, Jr. Ave, SE Suite 236	DMH, Medicaid and Medicare	Mental Health Services		
Charlie's Place	1830 Connecticut Ave, NW (St. Margaret's Episcopal Church)	Private/faith-based		Free breakfasts and other services for homeless people	
Clean and Sober Streets	2 North, 425 2nd St, NW	Private		Long-term Residential Substance Abuse Services	
CMS Health Initiatives (formerly Center for Minority Studies, Inc.)	1307 ½ St., NE, Suite 302	Part B, ADAP		Treatment Adherence Counseling, Prevention Education, Pharmacy Education	

Provider Name	Location(s) and Service Area	Funding Sources	Types of Core Medical-Related Services Provided	Type of Support Services Provided	Does HIV Testing
Community Connections, Inc.	801 Pennsylvania Ave., SE	HOPWA, DMH	Mental Health Services, including Outpatient Substance Abuse Services for those with co-occurring conditions	Housing Assistance	
Community Education Group	3233 Pennsylvania Avenue, SE	Part B, Private	Early Intervention Services	HIV Education and Prevention, Condom Distribution, Training of community health workers	Yes
Community of Hope	Administrative Offices and housing services - 1717 Massachusetts Ave., NW; Covenant Health Center – 3845 S. Capitol St., SW Marie Reed Health Center – 2250 Champlain St., NW Family Health and Birth Center – 801 17th St., NE	Federal Bureau of Primary Health Care, DC Department of Housing and Community Development, Private corporations, foundations, and individuals	Primary Medical Care, Oral Health Services, Mental Health Services; Young Adult Clinic (ages 13-24); Birthing Center	Short-term Housing, Transitional Housing, and Long-term Housing	
Consortium for Child Welfare	1438 Rhode Island Ave, NE	Prevention, Private		Permanency planning to families affected by HIV disease	
Cornerstone Community	4800 Arkansas Ave., NW	HOPWA		Transitional Housing and coordination of support services for formerly homeless men working to overcome substance use	

Provider Name	Location(s) and Service Area	Funding Sources	Types of Core Medical-Related Services Provided	Type of Support Services Provided	Does HIV Testing
Deaf Reach	3521 12th St., NE	Prevention, Private including United Way	Outpatient Substance Abuse Treatment Services: Mental Health Services	Housing for mentally ill deaf adults; Referral, education, advocacy, & counseling services to maximize self-sufficiency of deaf adults	
DC Central Kitchen	425 2nd St, NW	Private – foundations, corporations, restaurants		Meal Distribution through partner agencies; Food Recycling; Culinary Job Training	
Family Matters of Greater Washington	1509 16th Street, NW	DMH, Other public agencies, Private including United Way	Mental Health Services for adults, seniors, and children		
George Washington University Hospital	2150 Pennsylvania Ave., NW, Suite 2B-417	Prevention	Medical Care – inpatient, outpatient, and emergency; Infectious Disease Outpatient Clinic		Yes
Georgetown University Medical Center	3800 Reservoir Rd., NW	Part B	Medical Care – inpatient, outpatient, and emergency; Pediatric HIV/AIDS services, HIV Clinical Program, services for HIV-positive pregnant women		Yes
Gospel Rescue Ministries: Treatment Ministries	810 5th St, NW	Private; Faith-based	Outpatient Substance Abuse Treatment Services	Residential Substance Abuse Treatment Services; Includes transitional housing, food, psychological counseling, education and life skills, job training and placement, and aftercare	

Provider Name	Location(s) and Service Area	Funding Sources	Types of Core Medical-Related Services Provided	Type of Support Services Provided	Does HIV Testing
Greater Washington Urban League	2901 14th Street, NW	HOPWA		Housing Placement, Short-term Rental, Mortgage & Utility Assistance, Tenant-based Rental Assistance	
Green Door	1221 Taylor Street, NW	DMH, Medicaid, Private	Mental Health Services – Psychiatric and Support Services	Housing Assistance and Job Training and Placement for individuals with mental illness	
HIPS	1789 Columbia RD., NW, 3rd Floor	Prevention, DOH, DC Department of Justice, Private		HIV/STD Prevention using a risk reduction model; Hotline, Support Groups, Other Services for men, women, and transgenders engaging in sex work	Yes
Homes for Hope	3005 G St, SE, Suite A	Part B, HOPWA	Medical Case Management	Transitional Housing	
Housing Counseling Services	2410 17th St., NW	HOPWA		Housing Information Services	
Latin American Youth Center	1419 Columbia Rd, NW and 3035 15th St., NW in DC; also MD locations at 1320 Fenwick Lane, Suite 600, Silver Spring; 7411 Riggs Road, Hyattsville; and 6200 Sheridan Street, Riverdale	DMH; Other government grants; Private, including corporations, foundations, and individuals	Mental Health Services and Substance Abuse Counseling for youth	Wide range of services for youth, including transitional housing, education, wellness, coordinated youth development model using *promotores,* workforce development	

Provider Name	Location(s) and Service Area	Funding Sources	Types of Core Medical-Related Services Provided	Type of Support Services Provided	Does HIV Testing
Martha's Table	2114 14th St, NW	Private		Food Bank, Meals for the homeless, Clothing, Social Services, Education, Family Support Services; Services for children	
McClendon Center	1313 New York Ave, NW	DMH, Medicaid, Private	Mental Health Services for individuals with serious and persistent mental illness; includes a Day Program		
Mental Health Services Division, Department of Mental Health	35 K Street, NE	DMH	Mental Health Services – the component of DMH that provides direct services		
Miriam's Kitchen	2401 Virginia Ave, NW	Private, including individuals, foundations, corporations, faith-based entities		Soup Kitchen; Case management, life skills classes, and other supportive services to chronically homeless; includes art therapy, support groups, and other services in Miriam's Studio	
Miriam's House [Now a part of N Street Village]	1300 Florida Ave., NW	HOPWA, Private, including foundations, corporations, and individuals		Housing and supportive services for women with HIV disease; focus on formerly homeless substance users; Hospice Care	
N Street Village	1333 N Street, NW	HOPWA; Private, including corporations, foundations, and individuals		Transitional Housing; other services for homeless and low-income women, including women with HIV/AIDS	

Provider Name	Location(s) and Service Area	Funding Sources	Types of Core Medical-Related Services Provided	Type of Support Services Provided	Does HIV Testing
Neighbors Consejo	3118 16th Street, NW	DMH, APRA, Private	Mental Health Services, Outpatient Substance Abuse Services	Residential Substance Abuse Services; Services to prevent homelessness	
Our Place DC/Jubilee House	1475 Columbia Rd, NW	HOPWA, Prevention		Transitional Housing, Legal Services, and other support services for incarcerated and recently incarcerated women	
Planned Parenthood	1108 16th St., NW 3937A Minnesota Ave, NE	STD, Title X	Women's and reproductive health care		
PSI	770 M Street, SE	DMH, Medicaid	Mental Health Services for individual and families dealing with the challenges of mental illness, developmental disabilities, abuse and neglect		
Psychiatric Institute of Washington	4228 Wisconsin Ave, NW	Medicaid, Medicare, Private Insurance	Mental Health Services (psychiatric hospital plus outpatient services)		
Safe Haven Outreach Ministry	1140 North Capitol St, NW, #924		Mental Health Services	Substance Abuse Services	
Samaritan Ministry of Greater Washington	1516 Hamilton Ave., NW	Private, Faith-based		HIV services including spiritual retreats, monthly dinners, bereavement counseling, and burial assistance; Services for the Homeless	

Provider Name	Location(s) and Service Area	Funding Sources	Types of Core Medical-Related Services Provided	Type of Support Services Provided	Does HIV Testing
Sasha Bruce Youthwork	714 8th St., SE	Prevention, government grants; Private including corporations, foundations, individuals, and United Way		HIV Education, Housing Services, other youth services	Yes
Second Genesis	1320 Harvard St, NW	APRA, Court Services & Offender Supervisory Agency (CSOSA), DC Pre-Trial Agency, Family Treatment Court, Child and Family Services Agency (CFSA).		Residential Substance Abuse Treatment Services	
So Others Might Eat	71 O Street, NW, 60 O St, NW	Private Contributions, Foundations, Corporations, United Way, Federal Grants	Primary Medical Care, Oral Health Care, Mental Health Services	Residential Substance Abuse Services, Transitional Housing, and Continuing Care Addiction Services; Food Bank, Job Training, Crisis Housing for the Homeless; Clothing; Other social services	
Spanish Catholic Center [Component of Catholic Charities]	1618 Monroe St., NW; also 12247 Georgia Ave., Silver Spring, MD	DC Alliance, Private, Faith-based	Primary Medical Care, Oral Health Services	Food Bank, other social Services, Job training, English as a Second Language classes	
Terrific, Inc.	1222 T St., NW	Part B	Medical Case Management	Transitional Housing	
Thrive, DC	1525 Newton St, NW	Private		Soup Kitchen and other services for the homeless	

Provider Name	Location(s) and Service Area	Funding Sources	Types of Core Medical-Related Services Provided	Type of Support Services Provided	Does HIV Testing
Transgender Health Empowerment	1414 North Capitol St., NW	Part B		Treatment Adherence Counseling, Transitional Housing, Emergency Housing, HIV Prevention; Health Education and Risk Reduction Services, other social services	Yes
Union Temple Baptist Church	1225 W St., SE	Part B	Medical Case Management (Project Akoma)		
Washington Hospital Center/Behavioral Health Service	216 Michigan Ave, NE	DMH, Medicaid and Medicare	Inpatient Psychiatric Services; Outpatient Mental Health Services; combined treatment services for individuals with co-occurring mental health and substance abuse issues and for older adults); Partial Hospitalization		
Maryland					
Anchor of Walden Sierra	30007 Business Center Drive, Charlotte Hall, MD		Substance Abuse Treatment	Halfway House	
Another Way	1363 Holton Lane, Takoma Park, MD		Substance Abuse Treatment		
Calvert County Health Department, Mental Health Clinic	975 Solomons Island Rd. N, Prince Frederick, MD		Mental Health		
Calvert Memorial Hospital, Behavioral Health Unit	100 Hospital Rd., Prince Frederick, MD		Mental Health		

Provider Name	Location(s) and Service Area	Funding Sources	Types of Core Medical-Related Services Provided	Type of Support Services Provided	Does HIV Testing
Capital Hospice	9200 Basil Court, Suite 200, Largo, MD			Hospice Care	
Chinese Culture and Community Service Center, Pan Asian Volunteer Health Clinic	16039 Comprint Circle, Gaithersburg, MD	Montgomery County Dept. of Health and Human Services through Primary Care Coalition of Montgomery County (Community HealthLink Clinic)	Medical Care		
Community Clinic, Inc.	15950 Crabbs Branch Way, Suite 350, Rockville, MD	Federal Bureau of Primary Health Care, Montgomery County Dept. of Health and Human Services through Primary Care Coalition of Montgomery County (Community HealthLink Clinic)	Medical Care		
Community Ministries of Rockville, Mansfield Kaseman Clinic	8 West Middle Lane, Rockville, MD	Montgomery County Dept. of Health and Human Services through Primary Care Coalition of Montgomery County (Community HealthLink Clinic)	Medical Care		
Frederick Institute	5716 C Industrial Lane, Frederick, MD		Substance Abuse Treatment		

Provider Name	Location(s) and Service Area	Funding Sources	Types of Core Medical-Related Services Provided	Type of Support Services Provided	Does HIV Testing
Gaudenzia at Landover	337 Brightseat Road, Suite 220, Landover, MD		Substance Abuse Treatment		
Holy Cross Hospital Health Centers	7987 Georgia Ave., Silver Spring, MD	Montgomery County Dept. of Health and Human Services through Primary Care Coalition of Montgomery County (Community HealthLink Clinic)	Medical Care		
Housing Authority of the City of Fredrick	209 Madison Street, Frederick, MD	HOPWA		Housing Assistance	
Identity	414 East Diamond Ave., Gaithersburg, MD; 7676 New Hampshire Ave., Takoma Park, MA	CDC, county, other government grants, private		Prevention services for youth	
Maryland Department of Health and Mental Hygiene	201 W. Preston St., Baltimore, MD		ADAP		
Mercy Health Clinic	7-1 Metropolitan Court, Gaithersburg, MD	Montgomery County Dept. of Health and Human Services through Primary Care Coalition of Montgomery County (Community HealthLink Clinic)	Medical Care		

Provider Name	Location(s) and Service Area	Funding Sources	Types of Core Medical-Related Services Provided	Type of Support Services Provided	Does HIV Testing
Mobile Medical Care, Inc.	9309 Old Georgetown Road, Bethesda, MD	Montgomery County Dept. of Health and Human Services through Primary Care Coalition of Montgomery County (Community HealthLink Clinic)	Medical Care		
MRB Counseling Services Inc	1835 University Blvd., Suite 220, Hyattsville, MD; 317 East Diamond Ave., Suite C, Gaithersburg, MD		Mental Health, Substance Abuse Treatment		
Muslim Community Center Medical Clinic	15200 New Hampshire Ave., Silver Spring, MD	Montgomery County Dept. of Health and Human Services through Primary Care Coalition of Montgomery County (Community HealthLink Clinic)	Medical Care		
Open ARMMS, Inc.	2590 Business Park Court, Waldorf, MD		Substance Abuse Treatment		
Planned Parenthood at Frederick	170 Thomas Johnson Dr., Frederick, MD	STD, Title X, Private	Women's and reproductive health care		
Planned Parenthood in Gaithersburg	19650 Clubhouse Rd, #104, Gaithersburg, MD	STD, Title X, Private	Women's and reproductive health care		

Provider Name	Location(s) and Service Area	Funding Sources	Types of Core Medical-Related Services Provided	Type of Support Services Provided	Does HIV Testing
Planned Parenthood in Silver Spring	1400 Spring St, #450 Silver Spring, MD	STD, Title X, Private			
Planned Parenthood at Waldorf	3975 St. Charles Pkwy, Waldorf, MD	STD, Title X, Private	Women's and reproductive health care		
Prince Frederick Family Planning Clinic (Calvert County Health Department)	975 Solomons Island Rd., Prince Frederick, MD	STD, other public	Women's and reproductive health care		
Prince George's County Housing Authority	9400 Peppercorn Place, Largo, MD	HOPWA		Housing Assistance	
Proyecto Salud	2424 Reedie Dr., Wheaton, MD	Montgomery County Dept. of Health and Human Services through Primary Care Coalition of Montgomery County (Community HealthLink Clinic)	Medical Care		
Psychotherapeutic Rehabilitation Services, Inc.	337 Brightseat Rd., Suite 106, Landover, MD		Mental Health		
Southern Maryland Hospital Center Behavioral Health Services	7503 Surratts Rd., Clinton, MD		Mental Health		

Provider Name	Location(s) and Service Area	Funding Sources	Types of Core Medical-Related Services Provided	Type of Support Services Provided	Does HIV Testing
Spanish Catholic Center	12247 Georgia Ave., Silver Spring, MD	Montgomery County Dept. of Health and Human Services through Primary Care Coalition of Montgomery County (Community HealthLink Clinic), Private,	Medical Care, Oral Health Care,	Employment and training, English as a Second Language classes	
The People's Community Wellness Center	3300 Briggs Chaney Road, Silver Spring, MD	Montgomery County Dept. of Health and Human Services through Primary Care Coalition of Montgomery County (Community HealthLink Clinic)	Medical Care		
Vesta, Inc. Forestville Region	3900 Forestville Rd., Forestville, MD		Mental Health		
Washington Pastoral Counseling Service Substance Abuse Services	3235 Leonardtown Rd., Waldorf, MD		Substance Abuse Treatment		
Virginia					
Arlington County Department of Human Services /VA Department of Health	2100 Washington Blvd., Arlington, VA	HOPWA		Housing Assistance	Yes

Provider Name	Location(s) and Service Area	Funding Sources	Types of Core Medical-Related Services Provided	Type of Support Services Provided	Does HIV Testing
Food and Friends	219 Riggs Rd., NE Washington, DC	HOPWA		Outreach, Food Pantry, Transportation Assistance, Psychosocial Support; HIV prevention and testing services Food Bank/Home-Delivered Meals	
Homestretch	340 South Washington St., Suite 400, Falls Church, VA	HOPWA		Support Services for occupants of 2 units of housing	
K.I. Services	25 S. Quaker Lane, Alexandria 22214	B, Prevention		Outreach, Food Pantry, Transportation Assistance, Psychosocial Support; HIV prevention and testing services	Yes
Legal Services of Northern Virginia	6066 Leesburg Pike, Suite 500, Falls Church, VA	HOPWA		Legal Services	
Northern Virginia AIDS Ministry	803 West Broad St., Suite 700, Falls Church, VA	HOPWA		Medical Transportation Prevention services for youth	Yes
Northern Virginia Family Service	10455 White Granite Dr. #100, Oakton VA	HOPWA		Housing Assistance	
Planned Parenthood	303 S. Maple Avenue Suite 300 Falls Church, VA	STD, Title X	Women's and reproductive health care		

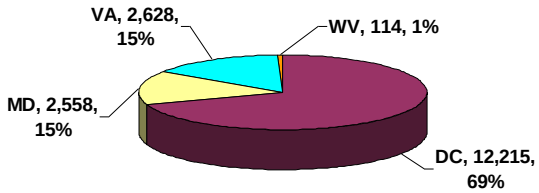
Provider Name	Location(s) and Service Area	Funding Sources	Types of Core Medical-Related Services Provided	Type of Support Services Provided	Does HIV Testing
Prince William Office of Housing and Community Development	15941 Donald Curtis Dr, Suite 112, Woodbridge, VA	HOPWA		Housing Assistance	Yes
Wesley Housing Development Corporation – Agape House	4245 Members Way, Fairfax, VA5515 Cherokee Ave Suite #200, Alexandria, VA	HOPWA		Housing Assistance, Non-medical Case Management Housing Plan Development	
Wholistic Family Agape Ministries Institute	2423 Mount Vernon Ave., Alexandria, VA	HOPWA		Housing Case Management, Housing Plan Development	
West Virginia					
Community Networks, Inc HOPE Living Center	216 East John St., Martinsburg, WV	HOPWA		Housing assistance; includes Faith House for persons living with HIV disease (women and small children) and Bethany House (32-bed homeless shelter)	
Loaves and Fishes (Berkeley County Congregational Cooperative Action Project)	336 South Queen St. Martinsburg, WV	Private		Food Pantry	
Telamon Corporation	STEPS (Families) 129 S. Queen Street, Martinsburg, WV Victory House (Male Veterans)			Transitional housing for PLWH	

Provider Name	Location(s) and Service Area	Funding Sources	Types of Core Medical-Related Services Provided	Type of Support Services Provided	Does HIV Testing
VA Medical Center	510 Butler Avenue, Martinsburg, WV	VA	Medical care for veterans: Medical Care, Medications, Medical Case Management	Support services for veterans	Yes

E. Service Utilization

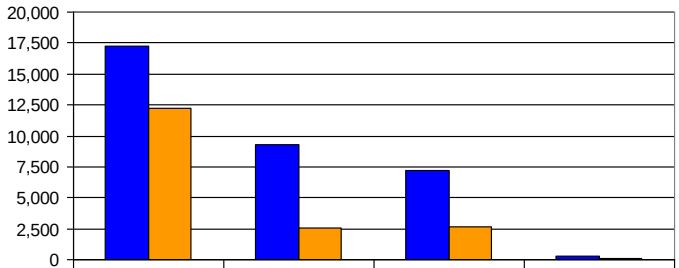
Service utilization data for the EMA are available but with limitations. The EMA is in the process of implementing a new client-based data system, but it was not operational in 2010 or 2011. In addition, partly because the EMA includes parts of four states, there are no consistent definitions of units of services. Providers also vary in the completeness of their data; for example, a minority of providers report client risk factor. In addition, there are some issues with the data; for a few service categories the reported number of clients is larger than the total number of Ryan White clients for that jurisdiction, suggesting that units of service may have been reported rather than individual clients. The utilization data provided here should be viewed with these limitations in mind. These data were provided by the Grantee and come from the Ryan White Client Services Report (RSR). They are for calendar year 2010, which is the time frame used in client and service data reports to the HIV/AIDS Bureau.

Figure 39: Ryan White Clients by Jurisdiction, 2010 [N = 17,515]



As Figure 39 shows, 17,515 clients received Ryan White services in 2010. DC accounted for more than two-thirds of Ryan White clients, Suburban Maryland and Northern Virginia about 15% each, and West Virginia 1%. Figure 40 compares the number of PLWH and the number of Ryan White clients by jurisdiction, showing that a much higher proportion of people living with HIV disease in DC are Ryan White clients than in other jurisdictions. As of 2010, about 51% of PLWH in the EMA lived in DC, yet more than two-thirds of Ryan White clients were DC residents. Suburban Maryland had 27% of PLWH and 15% of clients, Northern Virginia 21% of PLWH and 15% of clients, and the West Virginia counties 1% of the PLWH and 1% of clients.

Figure 40: Number of People Living with HIV Disease and Number of Ryan White Clients, by Jurisdiction, 2010

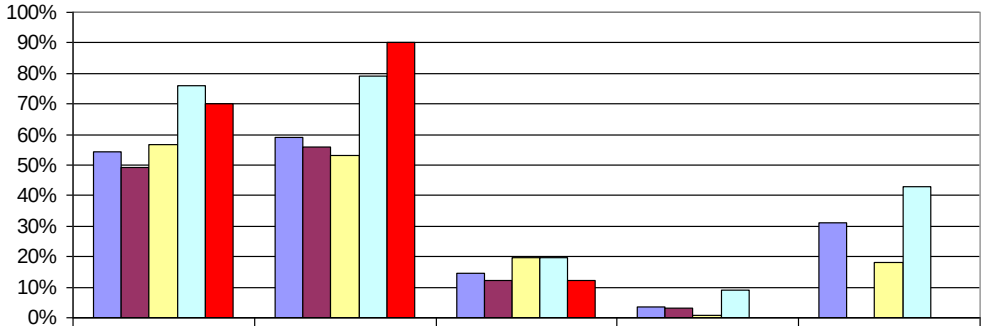


	DC	MD	VA	WV
Number of PLWH	17,272	9,268	7,224	330
Number of Clients	12,215	2,558	2,628	114

The RSR data include reports only from Ryan White-funded service providers. Services from other providers, such VA and non-Ryan White safety net clinics and community-based organizations, are not included. While some service categories are funded in all jurisdictions, others are not. For example, in 2010, Maryland did not fund food bank/home-delivered meals with Part A funds, and DC and West Virginia did not fund a local pharmacy assistance program. There are also some differences in the service categories funded in 2010 (Program Year 20) versus 2012 (Program Year 22).

Percent of Clients Using Selected Services: One way to explore service use is to determine the proportion of all Ryan White clients in the jurisdiction (individuals who received at least one Ryan White service) who used a particular service category during the program year. Figures 41 and 42 show the percent of clients in each jurisdiction who used core medical and support services in calendar year 2010, according to Ryan White Service Report (RSR) data. The service categories included are those that were funded in at least two of the three large jurisdictions and for which data did not have obvious errors. For example, mental health services were reportedly used by 10-11% of DC, Maryland, and West Virginia residents of the EMA, but these data are not included in Figure 41 because Virginia identified significant reporting errors that inflated the number of clients reported as using service category.

Figure 41: Percent of Ryan White Clients Using Selected Core Medical-related Services, by Jurisdiction, 2010



	Amb/Outp Medical Care	Medical Case Mgmt	Oral Health	Substance Abuse - Outpatient	Local Pharm. Asstnce
EMA - 17,515	54%	59%	14%	4%	31%
DC - 12,215	49%	56%	12%	3%	0%
MD - 2,558	57%	53%	20%	1%	18%
VA - 2,628	76%	79%	20%	9%	43%
WV - 114	70%	90%	12%	0%	0%

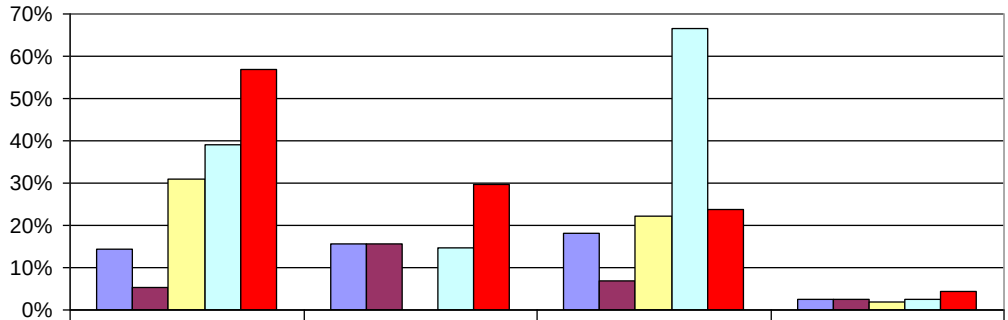
For the EMA, the percent shown is based on the number of clients for whom that service category was available. For example, 31% of Ryan White clients who had a local pharmacy assistance program available to them used that service, but this represents only 9% of all Ryan White clients, since the service was not funded and therefore not available to the 12,215 clients in DC or the 114 clients in West Virginia. Clients in all four jurisdictions received the other core services shown, except that no outpatient substance abuse treatment services were provided in West Virginia.

As Figure 41 indicates, the single most used service category in 2010 was medical case management; 59% of Ryan White clients in the EMA received this service, compared to 54% for ambulatory/outpatient medical care. The highest use of medical case management and medical care is in Virginia, where more than three-fourths of Ryan White clients used these services. Oral health and mental health services were each used by 14% of clients throughout the EMA, with

variations by jurisdiction. Oral health use ranged from a low of 12% in DC and West Virginia to a high of 20% in Suburban Maryland and Northern Virginia. Of the five core services shown, outpatient substance abuse treatment was the least frequently used – by 4% of clients overall. The local pharmacy assistance program but served 43% of Northern Virginia clients.

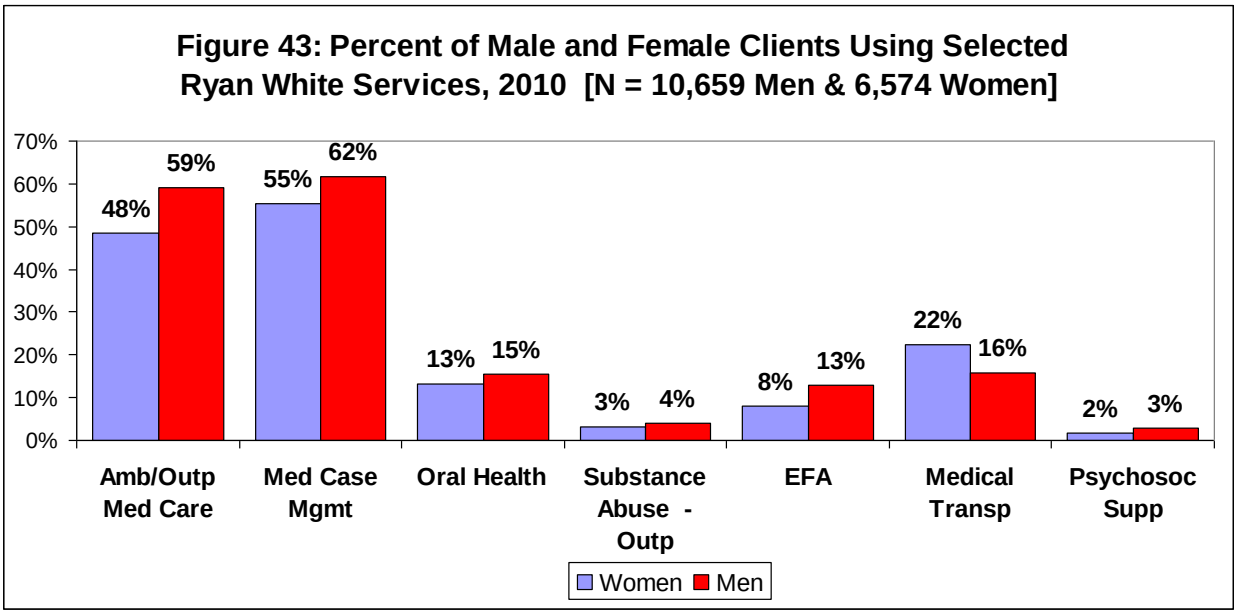
As for support services, four service categories were available and used in all or almost all jurisdictions: emergency financial assistance, food bank/home-delivered meals, medical transportation, and psychosocial support services. As Figure 42 shows, the most used support service in 2010 was medical transportation, with 18% of all clients in the EMA using this service at least once. The rate of use was much higher (67%) in Virginia than in the other jurisdictions. Food bank services were used by 16% of the clients living in the parts of the EMA with this service available; the rate of use was highest (30%) in West Virginia. Emergency financial assistance was used by 14% of all EMA clients, with the level of use ranging from 57% in West Virginia to 5% in DC. In 2010, two jurisdictions – Suburban Maryland and Northern Virginia – funded non-medical case management. It was used by 30% of Maryland Ryan White Clients; there were errors in the data for Virginia.

Figure 42: Percent of Ryan White Clients Using Selected Support Services, by Jurisdiction, 2010

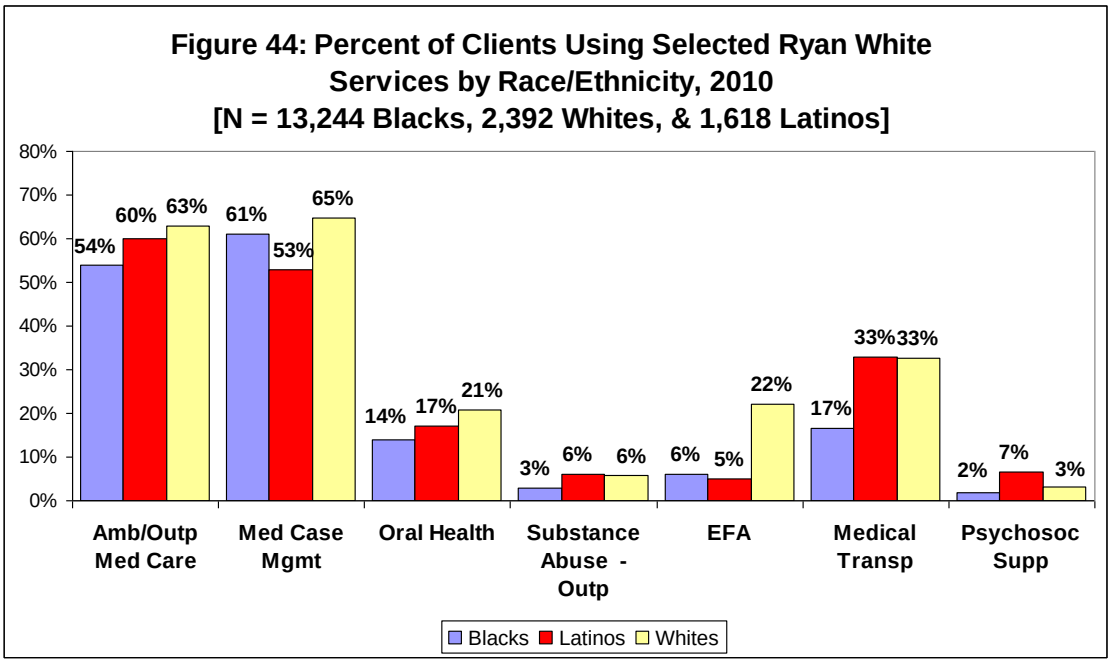


	EFA	Food Bank/H-D Meals	Medical Transportation	Psychosocial Support
EMA - 17,515	14%	16%	18%	2%
DC - 12,215	5%	16%	7%	2%
MD - 2,558	31%	0%	22%	2%
VA - 2,628	39%	15%	67%	2%
WV - 114	57%	30%	24%	4%

Gender: Figure 43, below, shows the proportion of all male Ryan White Clients and all female Ryan White clients who used selected services in 2010. Note that the gender data do not add up to 17,515 because transgenders and "unknown or unreported" groups are not included. Since transgenders were separately reported primarily in DC, there are no accurate data on their use of services throughout the EMA. As the figure indicates, male clients were more likely to use almost all services than women. The one exception was medical transportation. This may be partly because women, especially women with children, were more likely than men to be covered by Medicaid, and therefore may not have been as dependent as men on Ryan White for their services, particularly core medical services.



Race/Ethnicity: Race/ethnicity comparisons are complicated because the RSR separately asks for race (Hispanics can be of any race) and Hispanic origin, and no data are available for non-Hispanic Whites or non-Hispanic Blacks. Thus Hispanics are counted twice in these data – once in the race category and again in the question about Hispanic origin. Figure 44 shows the percent of Black, White, and Hispanic/Latino Ryan White clients that used selected services in 2010.



Numbers of other racial groups were unreliable or too small to present. Blacks made up 76% of Ryan White clients, Whites 14%, and Latinos 9%. As the bars indicate, use of most core medical services was proportionately higher among Whites than among the other two groups – 65% of all

White Ryan White clients used medical case management, 63% used ambulatory/outpatient medical care, and 21% used oral health services. Latinos generally were more likely than Whites but less likely than Blacks to use services, except for lower use of medical case management and emergency financial assistance; they were the highest users of psychosocial support services, though this service was used by only a small fraction of all three groups. Compared to their proportion in the client population, Blacks were least likely to use all the core medical services.

Age: The pie chart in Figure 45 shows Ryan White clients by age in 2010. As indicated, 11% of clients were under 25, and 19% were 55 or older. These age breakdowns are different from those used for surveillance, so comparisons cannot be made between the proportion of people living with HIV disease and the proportion obtaining services through Ryan White Part A.

Figure 45: Ryan White Clients by Age, 2010

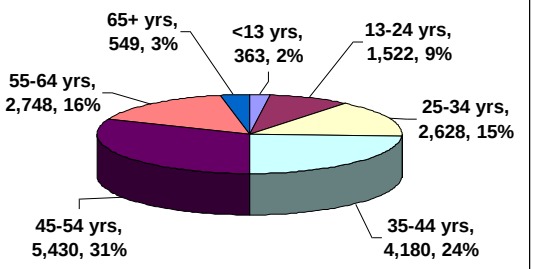
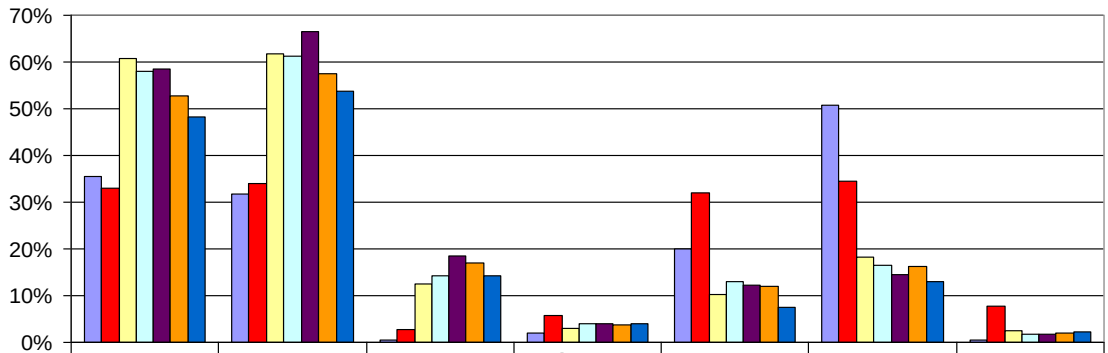


Figure 46 shows the proportion of all clients of various age groups that used selected service categories in 2010. Use by age varied considerably by service category. Only about one-third of clients under 13 and 13-24 reported use of ambulatory/outpatient medical care and medical case management, a rate considerably lower than all other age groups. For those under 18, this may reflect a higher level of eligibility for Medicaid and SCHIP. This may also help to explain low use of oral health services. Unfortunately, separate data are not available for the 19-24 age group, which nationally is especially challenging to attract to and retain in care. These two

Figure 46: Percent of Clients Using Selected Ryan White Services by Age Group, 2010 [N = 17,420]



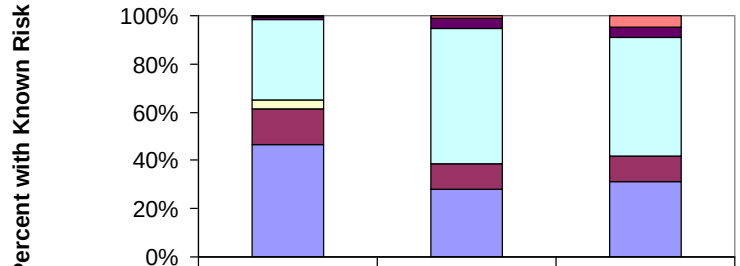
	Amb/Outp Med Care	Med Case Mgmt	Oral Health	Substance Abuse - Outp	EFA	Medical Transp	Psychosoc Supp
<13	36%	32%	1%	2%	20%	51%	1%
13-24	33%	34%	3%	6%	32%	35%	8%
25-34	61%	62%	13%	3%	10%	18%	3%
35-44	58%	61%	14%	4%	13%	16%	2%
45-54	58%	66%	19%	4%	12%	14%	2%
55-64	53%	57%	17%	4%	12%	16%	2%
65+	48%	54%	14%	4%	7%	13%	2%

groups had the highest reported use of medical transportation and emergency financial assistance; clients under 13 were the only group with a majority (51%) using medical transportation. The 13-24 age group had the highest use of psychosocial support services, though this was only 8%.

Clients aged 25-54 had high rates of use of medical care and medical case management, with those aged 25-34 most likely to receive medical care (61%) and those 45-54 most likely to receive medical case management (66%). Use of oral health services was similar for groups aged 25 and older, ranging from a low of 13% of clients hose 25-34 to a high of 19% among clients 45-54. Use of substance abuse services was relatively low among all groups, with clients 13-24 having the highest proportion (6%) enrolled. Almost half of clients 65+ reported using medical care, which raises questions regarding possible barriers to Medicare enrollment.

Risk Factor: Risk factor data are missing for about half the Ryan White clients, so the comparison in Figure 47 should be viewed as a rough estimate. Note that the combined risk factor of MSM/IDU is used in surveillance data but not in reporting risk factors for Ryan White clients. The table suggests that in 2010, PLWH with a heterosexual risk factor were more likely to be receiving one or more Ryan White services compared to their proportion of all PLWH, as were pediatric cases, while MSM and IDUs were less likely to be receiving services compared to their proportion of living PLWH in the metro area. It is not clear what role other factors – from income to barriers to care – play in levels of Ryan White participation by risk factor. Some PLWH have income levels too high to be eligible for Ryan White services; data are not available to indicate whether there is any relationship between income and risk factor.

Figure 47: Percent of PLWH/A and Ryan White Clients By Risk Factor, 2010 (Known Risk Only)



	Epi Data	Receiving RW Medical Care	Receiving RW Services
Other	0%	1%	5%
Perinatal	1%	4%	4%
Heterosexual	33%	56%	50%
MSM/IDU	4%		
IDU	15%	11%	10%
MSM	47%	28%	31%

Waiting Lists and Waiting Times: Utilization data give a sense of the demand for certain services, but do not provide direct information about the number of PLWH who needed a service but were unable to obtain it. No information was provided indicating a waiting list for any Ryan White Part A services other than Virginia As noted earlier, there is a waiting list for HOPWA and for some other housing-related services. The Planning Council sent out a provider survey to Ryan White Part A and other major service providers, and it included questions about waiting lists and waiting times. About half the funded providers completed the survey. Information from

these providers indicates that the vast majority have neither waiting lists nor waiting times of more than a week. The two nonprofit housing providers, however, indicated significant waiting lists – one, which provides short-term rental, mortgage, and utility assistance, reported a waiting list of 984 in DC and 54 in Prince George's County. The other operates housing for PLWH and other special-needs clients and has Part B as well as HOPWA funding; it has a waiting list of 96 for housing and 22 for medical case management. This provider estimated the waiting time at six years for housing and 35 months for medical case management; it refers clients to other providers where possible.

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

The EMA recognizes the critical importance of including in the continuum of care both Ryan White and non-Ryan White funded services and providing for planned interaction among these two groups of providers. Opportunities and methods of interaction vary considerably by jurisdiction, given differences in Medicaid, state and local systems and funding, and private resources and providers.

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

CHCs/FQHCs: One of the most complex aspects of funder and service interactions is how to maximize the engagement of community health centers/federally qualified health centers (CHCs/FQHCs) in providing and in some cases coordinating medical care for PLWH. In Washington, DC, three of the four CHCs/FQHCs and the one FQHC "look alike" are Part A providers; one also receives "off-the-top" MAI funds to serve limited English proficient (LEP) PLWH from all jurisdictions. In Prince George's County, Maryland, a large CHC is a Ryan White provider. In Montgomery County, which is not considered a Medically Underserved Area (MUA) although it has an estimated 90,000 uninsured individuals, there is only one CHC and it is not a Ryan White-funded provider. In Virginia, only one of three CHCs/FQHCs is a Ryan White provider, but the other two work with the Ryan White program, providing non-HIV-related primary care to PLWH. Even when a CHC/FQHC is funded for only one or two services, not including medical care, the link with Ryan White creates a valuable interaction with other

providers and increases its engagement with PLWH. This provides an important additional resource.

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

Role of Case Managers: Case managers currently serve a key role in determining the level of referrals to and service interactions with both Ryan White and non-Ryan White providers. In recent years, there has been a shift in funding from non-medical to medical case management. In the EMA, only Suburban Maryland continues to allocate Part A funds to support non-medical case management. While the focus on linking case management to medical care has been beneficial, both providers and PLWH believe that the expertise of the two types of case managers is often very different. Medical case managers often have much more clinical knowledge but much less capacity to help clients access support services, especially services not funded through Ryan White and offered by CBOs and non-medical providers. This can create challenges for PLWH who need help in identifying and accessing such services. Rather than look to their case managers for such referrals, PLWH must seek information from peers and other sources.

Written Agreements. Ryan White legislation [Section 2605(a)] requires assurances that funded entities "maintain appropriate relationships with entities in the eligible area served that constitute key points of access to the health care system for individuals with HIV/AIDS," including what the *Part A Manual* describes as "an array of substance abuse, mental health, homeless services, and other providers…to enhance access to the continuum of services." The National Monitoring Standards require "documentation that written referral relationships exist between Part A service providers and key points of entry" and inclusion of these requirements in "RFPs and contracts." [*] In the EMA, such relationships may exist on paper, but are not always operational. The Planning Council will explore with the Grantee and Administrative Agents the use of standards of care, directives, or other mechanisms to ensure that such relationships are actively implemented, and that ensuring implementation is a component of program monitoring and quality management.

G. Current Prevention and Testing Programs

A System in Transition: It is challenging to describe the current system of prevention and testing in the EMA, both because there are major differences by jurisdiction and because their focus is undergoing major change in response to the following:

- The Ryan White Treatment Extension Act of 2009, which established testing and linkage to care as shared responsibilities of CDC- and HRSA/HAB-funded programs and has led to the

[*] See Ryan White Part A Manual, Section VII, Program Guidance, Chapter 5. Coordination with Payers and Programs, at http://hab.hrsa.gov/tools2/PartA/parta/ptAsec7chap5.htm, and National Monitoring Standards, Program - Part A, Section E. Administration, at http://hab.hrsa.gov/manageyourgrant/files/programmonitoringparta.pdf.

implementation of a variety of activities related to the Early Identification of Individuals with HIV and AIDS (EIIHA)

- The National HIV/AIDS Strategy, with its focus on preventing new infections through early diagnosis and treatment
- Recent research on "treatment as prevention," which has demonstrated the value of anti-retroviral therapy (ART) as a means of reducing HIV transmission[26]
- The new CDC High Impact HIV Prevention Strategy, which calls for "combinations of scientifically proven, cost-effective, and scalable interventions targeted to the right populations in the right geographic areas" and emphasizes testing, linkage to care, early implementation of ART, access to condoms and sterile syringes, and prevention for positives
- The CDC funding guidance for 2012-2016, designed to implement the new CDC prevention strategy, which reallocates funds to focus on areas with the highest disease burden and requires that 75% of CDC core prevention funds be spent on prevention for positives; this has the effect of reducing resources and emphasis on Diffusion of Effective Behavioral Interventions (DEBIs) and other primary prevention initiatives with more limited reach
- National Enhanced Comprehensive HIV Prevention Planning (ECHPP) and implementation, targeting the 12 metro areas most affected by epidemic; these sites include DC and Baltimore, and Maryland plans to apply the principles and interventions statewide
- The newly revised PHS treatment guidelines for HIV-related medical care, which recommend early initiation of antiretroviral therapy (ART) for all HIV-positive individuals – highlighting the need for early diagnosis and prompt entry into care

Current Prevention and Testing: Community input sessions, review of prevention materials, and discussions with staff provided a sense of the current and emerging prevention and testing efforts by jurisdiction. Figure 48 summarizes the populations who are currently identified as high priority for prevention and testing efforts, and also identifies the populations identified by CDC. The jurisdictions do not necessarily list these groups in priority order. Information is not available for West Virginia, which is a low-incidence state.

Figure 48: Key Target Populations for HIV Prevention and Testing, by Jurisdiction

CDC*	DC	MD**	VA
PLWH	PLWH Priority on the following (no specific order): • Black heterosexuals of all ages • Black MSM of all ages • Latino MSM 20-39 • White MSM 20-49 • Black IDU 20-59 • Latino IDU 40-49 • White IDU 30-49	PLWH	PLWH
Gay and bisexual men of all races and ethnicities	High-risk HIV-negative individuals from the same populations as identified for PLWH above	MSM • 72% African American	MSM • Key sub-populations: Young Black (16-24), Black, White, and Hispanic
African Americans	Special Populations (no specific	Heterosexuals	High-Risk Heterosexuals

Figure 48: Key Target Populations for HIV Prevention and Testing, by Jurisdiction			
CDC*	**DC**	**MD****	**VA**
	order) • High-Risk Youth • Transgender Individuals • Individuals involved in the sex trade • The deaf and hard of hearing • Individuals 50 or older • Latino heterosexuals 20-49 • Recent immigrants • Incarcerated and recently released individuals • Individuals with physical, mental or developmental disabilities • Homeless individuals	• 83% African American or African	• Key sub-populations: Black Females, Black Males, Hispanic Females (Northern Virginia specific), and Hispanic Males (Northern Virginia specific)
Hispanics/Latinos		Injection Drug Users • 86% African American	Injection Drug Users (Needle Sharing) • Key sub-populations: Black Males, Black Females, and White Males
Injection Drug Users		Deaf and Transgender Persons	Transgender Individuals • Key sub-population: Male-to-Female
Transgender Individuals			
* CDC does not specify priorities among target populations but lists these five populations and places key emphasis on prevention for positives with regard to use of funds. ** In Maryland, African Americans are prioritized within all target populations, and high-risk persons (as defined by HIV prevalence or individual risk behaviors) are prioritized within all transmission categories.			

Following are summary descriptions of current prevention and testing programs and priorities in each jurisdiction, as well as their plans for change. As the summaries indicate, prevention efforts vary significantly by state, and within states, by county. However, core funding comes from CDC, so programs reflect CDC's strategies and program requirements.

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

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

- **Routine testing for early diagnosis** – DC has been a national leader in changing policies and providing incentives to encourage routine testing. Six DC hospital emergency departments do routine testing, and outreach has been done to private physicians as well as nonprofit clinics. DC requires insurance providers to cover the costs of HIV testing, including in emergency departments. It provides for automatic screening for every inmate entering the DC correctional system.

- **Linkage to and retention in care and treatment to improve PLWH health outcomes and reduce new transmissions** – DC is working to link prevention and care and to ensure that newly diagnosed PWLH are immediately linked to care. The Ryan White Red Carpet Entry program involves close coordination with testing sites to provide rapid linkage to care for both the newly diagnosed and other HIV-positive individuals who have been out of care. DC is now using treatment cascade measures to evaluate the success of test and linkage to care. Surveillance data indicate that DC reduced the percent of late testers from 58% of those diagnosed in 2004 to 44% of those diagnosed in 2008 (The measure is made one year after testing, since the definition of late testing is an AIDS diagnosis when tested or within one year after testing). DC also increased the proportion of newly diagnosed PLWH who were linked to care within 90 days from 48% in 2005 to 71% in 2009. Data for 2010 were not available.
- **Large and structural interventions to prevent new transmissions** – DC provides access to free or low-cost medical care to all its low-income residents through the DC Alliance; about 93% of adults and 96% of children living in DC have public or private health care coverage.[27] In 2011, DC became the second state to implement Medicaid expansion as specified under health care reform, using a waiver to include individuals up to 200% of poverty. DC makes both male and female condoms widely available in all eight wards; its female condom project was initiated as a public-private partnership with funding provided to the Washington AIDS Partnership by the MAC AIDS Fund. In 2011, more than 500,000 male and female condoms were distributed. DC uses its own money to support syringe exchange. One provider ended services in 2011, but the remaining three were able to get more than 300,000 dirty needles off the street.

Maryland: Maryland's Infectious Disease and Environmental Health Administration (IDEHA), within the Maryland Department of Health and Mental Hygiene DHMH), is responsible for both HIV prevention and care. The State works primarily through county health departments to coordinate and provide prevention services. Local health departments reach out to and in some cases fund community-based organizations. HIV prevention and testing efforts are designed to prevent new HIV infections and ensure that PLWH are aware of their status and are linked to HIV-related medical care, prevention, and support services.

Maryland's prevention programs reflect the use of available data describing the distribution of the Maryland epidemic, efficacy studies, and behavioral research. As treatment has improved and as the epidemic has spread, it has focused on ensuring that its allocation of prevention resources reflects the following:

- Use of cost-effectiveness data
- Use of proven prevention strategies
- Application of new surveillance and prevention technologies
- Translation of prevention science to community-level action
- The elimination of social barriers that impede prevention effectiveness

IDEHA supports routine HIV screening in health care settings, and provides direct implementation and support for routine HIV screening programs in high prevalence health care and correctional settings; these include emergency departments, STD clinics, substance abuse

treatment centers, correctional facilities, and perinatal settings. It also encourages routine testing by community health centers and clinics that serve the homeless. IDEA also provides education to providers and the public about CDC recommendations for routine testing and opportunities to expand such testing in health care settings, and about Maryland HIV consent and testing laws, which require written consent for HIV testing. In a health care setting, a patient's consent can be documented in the medical record; in community settings, the State's uniform HIV informed consent form must be must be completed before testing can be done. IDEHA has met with representatives of the Maryland Insurance Administration and with several health insurance providers and Medicaid Managed Care Organizations to discuss routine testing and explore possibilities for insurance reimbursement for HIV testing.

Prevention funding supports interventions for HIV-positive individuals, which are designed to help reduce unsafe sexual behavior and/or needle-sharing and support entry into and retention in care.

At the state level, IDEHA has merged its Center for HIV Prevention and Center for HIV Health Services in order to ensure close coordination and collaboration between prevention and care, and is developing a combined comprehensive plan for prevention and care that will also include the Statewide Coordinated Statement of Need (SCSN).

The Baltimore-Towson MSA is one of the 12 ECHPP sites, and Maryland is applying its ECHPP-based resource optimization modeling throughout the state, using these directions and strategies as the foundation for the State's prevention strategy and as a model for evidence-based decision making across funding sources. The approach is described as "grounded in NHAS, our local goals, and the Maryland epidemic." IDEHA is working with county health departments on local plans and strategies. Maryland has received CDC funding to improve utilization of system-level HIV surveillance data to target HIV partner notification and linkage to care efforts, trigger follow up on clients who fall out of HIV-related medical care, and to support evaluation in high-incidence counties.

The five counties within the Metropolitan Washington EMA vary considerably in their level of prevention funding. Prince George's County, which is second to Baltimore in HIV/AIDS cases, receives CDC funding from the state for routine testing in high-volume clinical settings located in high prevalence communities. Initial sites include the Prince George's County STD Clinic and Prince George's Hospital Center. Montgomery County also has a large number of HIV/AIDS cases; it differs from the other counties in its allocation of local funds to support prevention activities, including efforts targeting specific high prevalence geographic areas and disproportionately affected populations.

Virginia: Virginia's prevention program is directed by the Virginia Department of Health (VDH) Division of Disease Prevention. In Virginia, the State supports local health districts that are typically county-specific or serve several counties or a county and nearby independent cities. Most CDC funding and a small amount of State funding are awarded by VDH to the various health districts and to CBOs. In recent years, CDC funds have supported services including counseling and testing, referral and partner counseling and referral services, health education/risk reduction, public information, a toll-free hotline, capacity building, technical assistance, training, quality assurance, and evaluation. Funds provided to the health districts and CBOs are used for prevention and community-based testing programs; there are currently eight grant programs targeting priority populations such as MSM, communities of color, inmates, and HIV-positive

individuals. Several of these programs, such as AIDS Services and Education Grants, have State funding.

In most health districts, staff offer some prevention education in places like HIV/STI clinics and provide free testing, but rely largely on nonprofit organizations for community-based prevention services. In the Virginia segment of the EMA, local or regional nonprofit prevention providers provide outreach, behavioral interventions, testing, and linkage to care that target specific populations based on age, race/ethnicity, sexual orientation, and risk factors.

VDH is modifying its prevention efforts to address NHAS and new CDC guidelines. Its planning now addresses prevention and care together, as if they had been merged, and will provide for close coordination of prevention and care services. The State has consolidated its target populations to five (as shown in Figure 48), many with several subpopulations, and is placing increased emphasis on linkage to care. Both the State as a whole and the health districts that are part of the EMA are a combination of urban, suburban, and rural areas. The new CDC strategy focuses additional resources on high-prevalence areas, but Virginia recognizes the importance of HIV/AIDS awareness and stigma reduction in rural areas, and making sure testing is accessible. The State recently began the Virginia version of a national social marketing campaign, "HIV Stops with Me," that promotes HIV prevention among Virginians who are HIV-positive and is also designed to reduce stigma associated with HIV disease. It has been used in urban, suburban, and rural areas, and will soon be rolled out in the EMA.

Increasing routine testing in health care settings is a priority for Virginia. State law was changed in 2008 from "opt in" to "opt out," to facilitate such testing. The State provides funding for routine testing in hospital emergency departments; such testing is now done in three hospitals in Northern Virginia. The State convened a task force on routine testing in 2011 that provided useful guidance. There have been numerous discussions with insurance companies and brokers about definitions of "high risk" and coverage for testing. Among focus areas for the future is education of doctors and nurses about routine testing.

Virginia does yet not have consistent data on the proportion of newly diagnosed individuals who are tested late or delay entry into care. It is working with providers to document not only referrals to care but also whether the individual actually goes to the agency and requests and receives services. The State is moving to a new program monitoring and evaluation system that should be helpful in generating additional data. There is great interest in determining community viral load.

Northern Virginia has some special HIV prevention efforts initiated by a CBO or a county. For example:

- The Fairfax County Health Department initiated the development of an HIV Prevention Faith Initiative and the creation of the Northern Virginia Clergy Council for the Prevention of HIV/AIDS. The agency engaged and held numerous education meetings with faith community leaders regarding the epidemic and how faith-based groups can help address the epidemic in the African American community. The initiative has led to AIDS ministries in churches and community sessions like the Annual HIV/AIDS Prevention Summit for Teens and Adults, attended by church leaders and members from African American churches throughout Northern Virginia. The Clergy Council has helped to address stigma and engage the faith community in HIV prevention, testing, and care.

- The Northern Virginia HIV Consortium is completing the first regional HIV prevention plan, thanks to an effort led by Northern Virginia AIDS Ministry (NOVAM), a CBO engaged in youth- and young-adult based HIV prevention, testing, and assistance, and funded by the Washington AIDS Partnership. Since most planning occurs at the state level, this initiate has been important in helping providers, PLWH, and health district staff to explore shared priorities and opportunities for collaboration on HIV prevention and testing.

West Virginia: As a low-incidence state, West Virginia has limited funds for HIV prevention. It does testing at county health departments and some other medical facilities. With the new national prevention strategy, West Virginia's funding from the CDC has been cut by more than 50%, according to state officials. West Virginia does not provide state funds for HIV prevention. Nearly all funding to support testing by community-based organizations has been eliminated because the positive rate was not considered high enough to justify the expenditure. The focus now is on rapid testing through outreach. All funds supporting the use of evidence-based interventions (EBIs) have also been eliminated. The VA facility in Berkeley County has a rapid testing program.

Reduced Funding for Behavioral Interventions: States will be submitting new prevention plans to CDC in June 2012 that reflect the new guidelines and realities. Prevention programs, resources, and services will be different within the next year. As noted above, DC, Maryland, Virginia, and West Virginia all say in their prevention and ECHPP plans and proposals that much of the current funding for prevention efforts based on behavioral interventions will be redirected as they implement the new CDC strategy:

- DC is shifting core prevention funding from "limited impact behavioral interventions to larger scale approaches and targeted population activities." It is also "examining the existing service delivery network of over 90 prevention, care and treatment providers in order to maximize health outcomes and results."
- Maryland plans to decrease funding for intensive behavioral risk reduction interventions targeting HIV-negative individuals except in the highest prevalence areas, with populations that have the highest rates of HIV infection, such as African American MSM, active substance users, and heterosexuals with the greatest risk of infection. It is exploring briefer and less resource intensive interventions.
- Virginia will be ending funding for its current high-risk youth and adult grant program.

Testing Sites: Many prevention and testing providers also offer HIV-related care, and are listed in the two provider inventories in Sections C and D, above. Testing sites are separately identified below, in Figure 49.

Figure 49: State-Supported Testing Sites in the Metropolitan Washington EMA

Organization	Scope/Location	Description
District of Columbia		
Northwest		
AIDS Healthcare Foundation Blair Underwood Healthcare Center	Ward 2	Free testing 3 days a week
Andromeda Transcultural	Ward 4	Free walk-in testing five days a

Figure 49: State-Supported Testing Sites in the Metropolitan Washington EMA		
Organization	**Scope/Location**	**Description**
		week; languages include English, Spanish, French and Portuguese
Carl Vogel Center	Ward 2	Free walk-in testing 1 day a week; by appointment testing three afternoons a week
La Clinica del Pueblo	Ward 1	Free walk-in testing six days a week; all languages spoken [Clinic operates a health interpretation service]; targets all in need, particularly immigrants and Latinos
Planned Parenthood – Schumacher Clinic	Ward 2	Free testing by appointment 4 days a week; languages include English, Spanish; American Sign Language by appointment
University of the District of Columbia Health Services	Ward 3	Free walk-in testing five days a week; UDC faculty and students only
Us Helping Us, People into Living, Inc.	Ward 1	Free walk-in testing five days a week; testing by appointment on first and fourth Saturdays; targets African Americans
Whitman Walker Health – Elizabeth Taylor Medical Center	Ward 1	Free HIV testing by appointment five days a week; languages include English, Spanish, American Sign Language
Northeast		
New Samaritan Baptist Church – HIV/AIDS Ministry	Ward 5	Free testing by appointment five days a week
Planned Parenthood – Ophelia Egypt Health Center	Ward 7	Free testing five days a week; American Sign Language by appointment
Sasha Bruce	Ward 6	Free walk-in testing two days a week; by appointment three days a week
The Women's Collective	Ward 5	Free testing five days a week; languages include English and Spanish; targets women and families
Unity Health Care – Brentwood Square	Ward 5	Free testing five days a week
Southeast		
Anacostia Neighborhood Health Clinic	Ward 8	Free testing four days a week

Figure 49: State-Supported Testing Sites in the Metropolitan Washington EMA		
Organization	**Scope/Location**	**Description**
Department of Health Southeast Clinic	Ward 6	Free testing five days a week
Family and Medical Counseling Center	Ward 8	Free testing five days a week
The HOYA Clinic	Ward 6	Free testing two evenings a week
Sexual Minority Youth Assistance League	Ward 6	Free walk-in testing three late afternoons/evenings a week; other testing by appointment; targets GLBT adolescents and young adults
Whitman Walker Health – Max Robinson Clinic	Ward 8	Free walk-in testing five days a week (including Saturday); languages include English, Spanish, American Sign Language
Metro TeenAIDS	Ward 6	Free walk-in testing five days a week; languages include Spanish by appointment; targets youth and young adults aged 13-24
Unity Health Care – Anacostia Neighborhood Health Center	Ward 8	Free testing available four days a week
Southwest		
START at Westminster	Ward 6	Free testing by appointment
Unity Health Care – Southwest Clinic	Ward 8	Free testing four days a week by appointment only; walk-in testing ½ day
Hospital Emergency Departments		
Children's National Medical Center		Routine testing in hospital emergency departments – extent of testing varies
George Washington University Hospital		
Howard University Hospital		
Providence Hospital		
Washington Hospital Center		
United Medical Center		
Maryland		
African American Health Program	Colesville Center, Silver Spring; serves Montgomery County	Program established by Montgomery County Department of Health and Human Services; testing provided by a health educator; targets African Americans
Calvert County Health Department	Prince Frederick; serves Calvert County	Free testing two days a week by appointment, plus limited walk-ins

Figure 49: State-Supported Testing Sites in the Metropolitan Washington EMA		
Organization	**Scope/Location**	**Description**
Casa de Maryland	Silver Spring; serves MD residents	On-site HIV testing two days a week, in cooperation with La Clinica del Pueblo, as part of the *Salud es Vida* program
Charles County Health Department	While Plains; serves Charles County	Free testing two mornings a week by appointment
Frederick County Health Department	Frederick; serves Frederick County	Free rapid testing by appointment two days a week; walk-ins one day a week
Gapbusters	Silver Spring; serves Montgomery County	Free HIV testing by appointment; targets economically disadvantaged youth
Heart to Hand	Glenarden; serves primarily Prince George's County	HIV testing by appointment; partners with Health Department and others on community testing
Hyattsville United Methodist Church – HIV/AIDS Ministry	Hyattsville; serves primarily Prince George's County residents	HIV/AIDS Ministry; provides free rapid HIV testing the third Saturday of every month from 1-3 pm
Identity	Gaithersburg and Takoma/Langley Park; serves primarily Montgomery County residents	Free confidential walk-in testing three days a week at each location; testing by appointment at other times; focus on Latino youth
La Clinica del Pueblo	Located in Washington, DC; community health center so no residence requirements	Free walk-in testing six days a week in clinic, plus community testing in suburban MD in collaboration with Casa de Maryland and in DC with various community partners
Montgomery County Health Department	Silver Spring and Germantown; serves Montgomery County residents	Testing five days a week at Dennis Avenue Health Center and one day a week at Germantown Health Center
Prince George's County Health Department	Cheverly and Clinton health department locations, Bowie State University (Bowie), and Prince George's Community College (Largo)	Rapid and conventional testing; 3-5 days a week in health department, ½ day a week at college locations
Prince George's Hospital Center	Primarily Prince George's County but available to all, regardless of residence	Walk-in rapid testing in the Emergency Department six days a week

Figure 49: State-Supported Testing Sites in the Metropolitan Washington EMA		
Organization	**Scope/Location**	**Description**
Virginia		
Inova Juniper Program	Northern Virginia, primarily Alexandria, Fairfax County, Fairfax City, and Falls Church	Rapid testing in Emergency Departments in Inova Alexandria, Inova Mt. Vernon, and Inova Fairfax Hospitals
Virginia Department of Health	Alexandria and Arlington County	Rapid testing in Alexandria City and Arlington County Local Health Department STD clinics
Virginia Department of Health	Prince William County, Manassas, Manassas Park, Alexandria	Conventional testing in Prince William and Alexandria health district Family Planning clinics
Northern Virginia AIDS Ministry	Northern Virginia	Community HIV testing – rapid testing; targets youth and young adults
Virginia Department of Health	Health Departments within Health Districts of Lord Fairfax (Clark and Warren Counties), (Rappahanock Area (King George, Spotsylvania, and Stafford Counties and City of Fredericksburg), and Rappahanock-Rapidan (Culpeper and Fauquier Counties)	Confidential HIV testing in health departments
K.I. Services	Northern Virginia	Community HIV testing voluntary including testing of inmates – rapid testing
West Virginia		
Berkeley County Health Department	Martinsburg, Berkeley County	Conventional testing
Jefferson County Health Department	Kearneysville, Jefferson County	Conventional testing
Martinsburg VA Medical Center	23 counties in Western MD, WV, South Central PA, and Northwest VA.	Rapid testing
Shepherd University	Shepherdstown area	Conventional testing

H. State and Local Budget Cuts and Insufficiencies

The EMA has received approximately level Part A funding over the past three years. However, it faces challenges associated with increases in the number of clients, both because of the emphasis on EIIHA and unmet need and because of the economic recession. Many PLWH who were previously employed and insured have lost their jobs and their insurance and become eligible for

Ryan White services. State and local governments have been less able to provide appropriated dollars to maintain or expand services due to reduced tax revenues since 2008. Even when HIV/AIDS funds are not reduced (or where the states or localities were not providing funding for HIV/AIDS services), related budget cuts or insufficiencies affect the availability of health and human services. For example, all four jurisdictions have cut their public health budgets in recent years as a result of the recession. From 2010 to 2011, cuts totaled 19.5% in DC, 5.7% in Maryland, 5.1% in Virginia, and 2.4% in West Virginia.[28]

Mental health funding has been cut throughout the EMA. From 2009 to 2011, public appropriations for mental health services were reduced by 19% in DC, 9% in Virginia, 7% in West Virginia, and 4% in Maryland.[29]

In the spring of 2012, state budgets were still being developed as the comprehensive plan was being completed. For example:

- The **Virginia** legislature approved $250,000 in supplemental funding for ADAP, and a one-time federal supplement was expected to bring another $600,000; in 2011, the State provided $500,000 for ADAP. The Governor proposed a cut of 50% in funding (almost $6.2 million), for community health centers and free clinics, but the legislature may seek full funding for the safety net. There was also hope of fewer Medicaid cuts than proposed by the Governor, who proposed an $802 million Medicaid reduction, as well as severe cuts in indigent care provided through public hospitals. Further reductions in funding for the health care safety net would be particularly significant if some parts of health care reform were to be struck down by the Supreme Court.
- There were threats of new health care cuts in **West Virginia,** which is projecting a Medicaid shortfall of $187 million. To help address this, the State has determined that no new clients are to receive home and community-based care.
- As of early May, **Maryland** had agreed on a budget but had been unable to pass a bill authorizing the revenues needed to fund it. The State was operating under a threat of a "doomsday budget" that would cut more than $500 million in services, including $22 million in health care funds, unless a special session of the General Assembly succeeds in approving a revenue plan.
- In **Washington, DC,** the Mayor has proposed a $23 million cut in the DC HealthCare Alliance, which would eliminate hospital coverage, both in-patient and out-patient visits, for 23,000 low-income DC residents who are not eligible for Medicaid. Many are recent immigrants or refugees or undocumented immigrants; an unknown number have HIV disease. The impact of these cuts is not clear. The City says that many of these hospitals receive "disproportionate share" or DSH payments from Medicaid, so they are in a sense being paid twice. However, some hospitals with emergency rooms do not receive DSH payments. Low-income patients might still be billed for services for which they cannot afford to pay, and might be discouraged from seeking needed emergency or hospital care. The proposed DC budget also includes a cut of $8 million through reduced Medicaid reimbursement rates for hospitalization.

The most obvious example of budget insufficiencies for Ryan White is Virginia's AIDS Drug Assistance Program, with its ongoing waiting list – about 1,000 people tend to be on the waiting list, and almost one-fourth of them live in the Virginia segment of the EMA. In addition, to

reduce costs, Virginia has reduced its formulary (eliminating some mental health and Hepatitis C drugs, among others), restricted eligibility criteria, and transitioned 204 ADAP clients onto the waiting list. Enrollment is effectively closed, except to pregnant women, children, and individuals with opportunistic infections. Even with the federal supplement and $250,000 from the State of Virginia, ADAP funding remains insufficient and uncertain.

The Ryan White Part A program has responded to these cuts and insufficiencies in a variety of ways. To address the Virginia ADAP shortfall, Part B funds in Northern Virginia were redirected from support services to ADAP, Part A funds originally budgeted for Quality Management were reallocated to ADAP, and HOPWA funds were used to help fill the support services gap. Medical Case Managers maximized the use of pharmacy assistance programs as a source of medications, and the Planning Council established a special local pharmacy assistance program with off-the top funds to assist PLWH on a waiting list. The Planning Council takes into account budget cuts and changes in other funding streams in making its resource allocations, and in approving reallocations during the program year. However, overall reductions in the health care safety net do inevitably affect PLWH, since Ryan White cannot fill the gaps caused by a reduction in safety net services. It can and does focus on very high priority services – such as medical care, medications, medical case management, and oral health.

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

A. Overview

This chapter describes the service needs, gaps, and barriers for people living with HIV/AIDS in the Metropolitan Washington EMA. It summarizes needs assessment data from people living with HIV disease, providers, the Grantee and Administrative Agents, and other interested community members, as well as service utilization data. It also describes prevention needs based primarily on data gathered by the prevention units and community planning groups in each of the jurisdictions that are part of the EMA, supplemented by community town halls and consultations. Because the EMA is extremely diverse, it includes some information specific to particular jurisdictions and to populations of particular importance in addressing the regional epidemic.

Findings indicate that the most important service needs as described by PLWH are for HIV-related medical care and medications, medical case management, and oral health services, with mental health and substance abuse services also needed by many. Most needed support services include housing, emergency financial assistance, food bank/home delivered meals, and support groups (psychosocial services). In some areas, medical transportation is identified as necessary to provide access to care. In terms of service gaps, core medical-related services are available to most PLWH in the region, the important exception being the Virginia waiting list for ADAP. The most frequently mentioned service gap throughout the EMA is housing, given high housing costs, low turnover in HOPWA slots, and limited PLWH access to other housing assistance. PLWH also report a need for consistent access to "wraparound" services, both medical-related and supportive, that help people enter and stay in care, remain adherent to medications, and live healthy and productive lives. These service gaps are seen as partly related to resource limitations and partly to other factors. There is a widely perceived lack of readily available information about available services. In addition, some medical case managers are reportedly not fully aware of available wraparound, and Part A provider referral relationships with non-Ryan White funded providers are seen as limited. Specific service needs and gaps vary somewhat by jurisdiction, and more significantly by population group.

B. Care and Treatment Needs

PLWH in Washington metropolitan area, like those in most communities, need a mix of medical-related and supportive services. The EMA uses a number of approaches to determine need: needs assessment (especially periodic PLWH surveys that ask what services individuals need), review of utilization data and related provider reports (including which services meet or exceed projections and which have waiting lists), and established service priorities (set for the EMA by the Planning Council and adjusted for each jurisdiction by resident PLWH and providers).

Needs Assessment: The Planning Council learns about PLWH service needs through PLWH surveys; special studies focusing on particular populations, service categories and/or locations and typically including key informant sessions and focus groups or interviews among other data-gathering techniques; and community consultations such as town hall meetings. In preparation

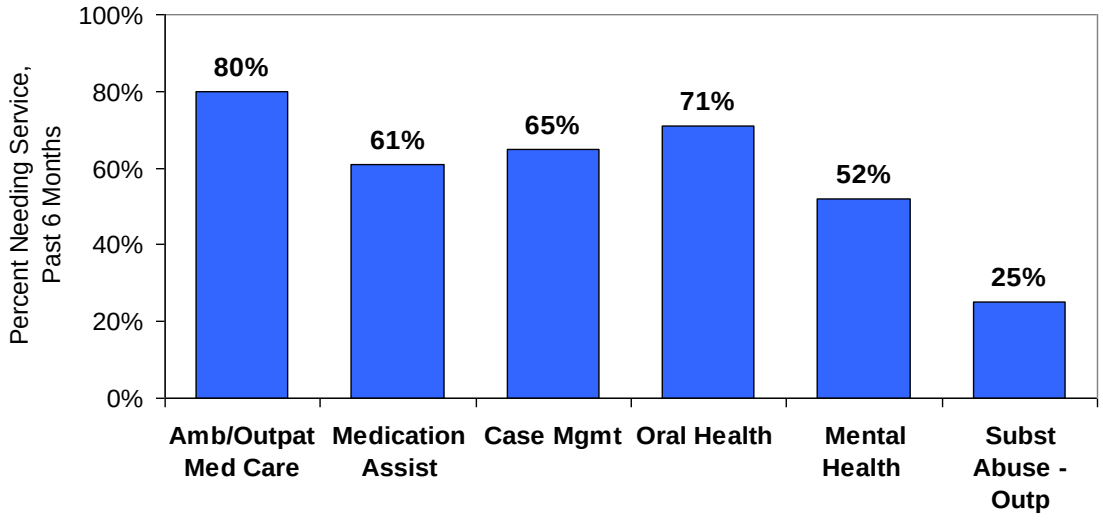
for the comprehensive plan, the Planning Council conducted consumer and provider town halls and other meetings in all four jurisdictions that together reached more than 220 people. The Planning Council conducts a PLWH survey approximately every three years.

PLWH Survey: The last PLWH survey, completed in 2009, obtained data from 1,054 PLWH, the vast majority of them in care. It asked what services PLWH need and included the most commonly used Ryan White service categories as well as some services not supported through Part A funds. In its PLWH survey in 2009, the Planning Council obtained information from more than 1,000 PLWH. The data are several years old, but they provide useful supplemental information on service gaps.

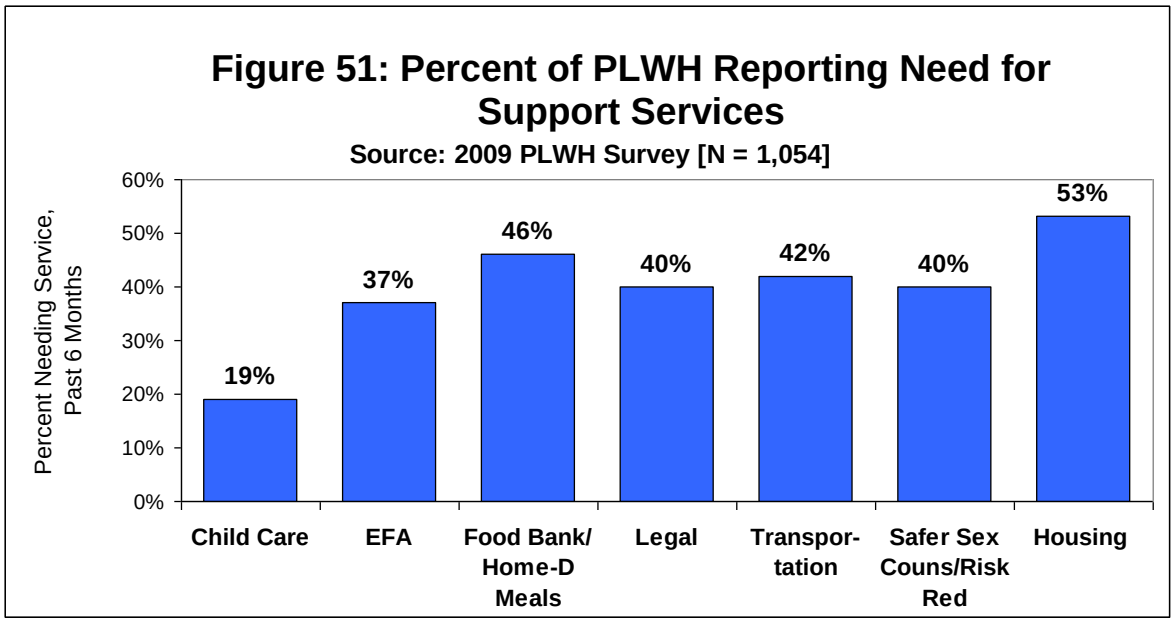
Figures 50 and 51 below show the percent of respondents indicating a need for various services during the six months prior to the survey. As indicated, the greatest identified needs were for medical care (80%), oral health services (71%), case management (65%), and AIDS drug assistance (61%). About half of responding PLWH indicated a need for mental health services, and one-quarter for outpatient substance abuse treatment.

Among support services, a majority of responding PLWH (53%) said they had needed help in

Figure 50: Percent of PLWH Reporting Need for Core Medical-Related Services
Source: 2009 PLWH Survey [N = 1,054]



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



Special Studies: Special studies carried out in 2011 identified service needs for three specific populations, as shown in Figure 52.

Figure 52: Identified Service Needs for Specific Populations

Population	Source	Core Medical-related Services	Support Services
African Immigrants	2009 PLWH Survey, 2011 Special Study	Prefer to receive services where they are unlikely to see others from their nationality/community, due to concerns about confidentiality and stigma, some prefer services outside their jurisdiction of residence	
		• Medical care – free or low-cost • Early Intervention Services – with peer support but with peers from a different country/community • Mental health services	• Emergency Financial Assistance • Food bank/groceries • Linguistic services, particularly for those who do not speak French or Amharic • Housing assistance • Health and HIV information and education – information about living with HIV/AIDS and available services • Support groups – not near their home due to confidentiality concerns
Latinas	2009 PLWH Survey, 2011 Special Study	Prefer to receive services from a Latino-focused organization, where staff are bilingual so interpreters are not needed	
		• Medical care • Access to medications • Oral health services • Mental health services • Case management – both medical and	• Child care, so they can keep appointments • Food bank/groceries • Health education and information about available services and resources

Figure 52: Identified Service Needs for Specific Populations			
Population	**Source**	**Core Medical-related Services**	**Support Services**
		general; includes care coordination and support, particularly for immigrants with few family supports	• Outreach that is women-focused • Support groups in Spanish
Older PLWH (55+)	2009 PLWH Survey, 2011 Special Study, 2012 Town Halls	Prefer to receive services from clinicians and case managers with geriatric training and from peers who are themselves older PLWH	
		• A medical home to coordinate care • Medical care for non-HIV conditions • Co-pays for those 50-64 with public or private insurance • Oral health services • Early Intervention Services with peer support • Mental health services, especially counseling from a therapist or licensed clinical social worker • Medical nutrition therapy • Case management – medical plus referrals to needed support or wraparound services	• Food bank/groceries – often needed every month due to limited incomes • Housing assistance • Support groups – senior-focused • Health education – for newly diagnosed

Service Priorities: The Planning Council ranks all 29 allowable Ryan White service categories based on their perceived importance for PLWH throughout the region, without regard to funding issues. Figure 53, below, identifies the 12 highest-priority service categories. It includes the overall EMA ranking and the slightly different rankings by jurisdiction. West Virginia was not asked to provide separate priority ratings in 2011, but is being consulted on priorities and allocations in 2012. As the table shows, there is a great deal of similarity in service priorities across jurisdictions, and the top seven priority services in all jurisdictions are medical-related. The next five are support services. Two other core services are rated in the top 12 by one or two jurisdictions. Early Intervention Services, the service category most directly related to getting people with HIV/AIDS diagnosed and into care, is rated in the top 12 by DC, which has the highest HIV/AIDS prevalence and places extremely high priority on testing and rapid entry into care, and Suburban Maryland, which includes Prince George's County, the second epicenter of the epidemic in the EMA. Maryland also ranks medical nutrition therapy as a top 12 service category.

Figure 53: Top-Rated Ryan White Service Categories, Metropolitan Washington EMA, 2011				
Service Category	**Priority Ranking, 2011 (for Program Year beginning March 1, 2012)**			
	EMA	**DC**	**Suburban MD**	**Northern VA**
Top 12 – Highest Priority Services				
Outpatient/Ambulatory (Primary & Specialty) Medical Care	1	1	1	1
AIDS Drug Assistance Program (ADAP)	2	2	2	2
Medical Case Management	3	3	4	3
Oral (Dental) Health Services	4	4	3	4
Mental Health Services	5	5	6	5
Substance Abuse Services – Outpatient	6	6	7	6
AIDS Pharmaceutical Assistance (Local)	7	7	5	7
Case Management (Non-medical)	*8*	*8*	*13*	*8*
Emergency Financial Assistance	*9*	*9*	*8*	*9*
Housing Services	*10*	*11*	*14*	*11*
Food Bank/Home Delivered Meals	*11*	*12*	*11*	*12*
Medical Transportation Services	*12*	*13*	*10*	*13*
Other Services Rated in Top 12 by at Least One Jurisdiction				
Early Intervention Services	15	10	12	16
Medical Nutrition Therapy	13	14	9	14
Key: *Italics = Support service;* regular type = Core medical-related service				

At the PLWH town hall meetings held in each jurisdiction in early 2012 in preparation for priority setting and resource allocations for GY 23, participants were asked what service categories they consider the most important – the services that most need to be continued or expanded if funds are right. The top seven service priorities in each jurisdiction are shown in Figure 54, below. As the table indicates, PLWH in all four jurisdictions rank medical care and ADAP as their top priorities. Medical case management and oral health services are in the top seven in all jurisdictions, while AIDS pharmaceutical assistance (local) and outpatient substance abuse services are in the top seven in two jurisdictions and mental health services in only one. DC and West Virginia rank housing services as their number four priority, and medical transportation in their top seven. The only other support service ranked in the top seven is emergency financial assistance, ranked #5 by PLWH at the town hall session in DC.

The PLWH rankings are similar to the GY22 overall jurisdictional priorities, but give slightly lower rankings to several core services including mental health services and include some support services in the top seven. EIS makes the top seven for PLWH in Virginia; it is ranked 10th or below in the jurisdictional priorities. Housing has a higher priority in some PLWH town hall rankings than in the jurisdictional priorities, as does medical transportation.

Figure 54: Most-Needed Services as Identified at Spring 2012 PLWH Town Hall Meetings, by Jurisdiction				
	DC	**MD**	**VA**	**WV**
1	Outpatient/Ambulatory Medical Care	Outpatient/Ambulatory Medical Care	Outpatient/Ambulatory Medical Care	Outpatient/Ambulatory Medical Care
2	AIDS Drug Assistance Program (ADAP)	AIDS Drug Assistance Program (ADAP)	AIDS Drug Assistance Program (ADAP)	AIDS Drug Assistance Program (ADAP)
3	Medical Case Management	Medical Case Management	AIDS Pharmaceutical Program (Local)	Medical Case Management
4	*Housing Services*	Oral Health Services	Oral Health Services	*Housing Services*
5	*Emergency Financial Assistance (EFA)*	Mental Health Services	Medical Case Management	*Medical Transportation*
6	Oral Health Services	Outpatient Substance Abuse Services	Health Insurance Premium and Cost-Sharing Assistance	Oral Health Services
7	*Medical Transportation*	AIDS Pharmaceutical Program (Local)	Early Intervention Services	Outpatient Substance Abuse Services
Key: *Italics = Support service;* regular type = Core medical-related service				

C. Service Gaps

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

ADAP Waiting List: The important service gap involving a waiting list is access to medications in Northern Virginia, where 219 PLWH were on a waiting list for ADAP as of April 19, down from 267 as of February 6. A large majority of these PLWH live in Fairfax County (86), Alexandria (39), Arlington County (24), and Prince William County (17). Case managers have worked very hard to obtain medications for these clients through Pharmaceutical Assistance Programs, though this is very time-consuming and often requires submitting a separate application for each medication.

Approximately $600,000 in Part A funds were reallocated from EMA Quality Management to ADAP in Virginia during the 2011 program year. For the 2012 program year the EMA initiated a local pharmacy assistance program designed to provide short-term medication assistance to PLWH waiting for access to ADAP. In addition, by mid-2012 Virginia hopes to begin enrolling PLWH into the Pre-existing Condition Insurance Program (PCIP), established under the Affordable Care Act as an interim measure until health insurance exchanges are implemented in 2014. It is not clear how long the waiting list will continue.

Other Waiting Lists or Wait Times: No information was provided indicating a waiting list for any Ryan White Part A services other than Virginia ADAP. As noted earlier, there is a waiting list for HOPWA and for some other housing-related services. The Planning Council sent out a

provider survey to Ryan White Part A and other major service providers, and it included questions about waiting lists and waiting times. About half the funded providers completed the survey. Information from these providers indicates that the vast majority have neither waiting lists nor waiting times of more than a week. The two nonprofit housing providers, however, indicated significant waiting lists – one, which provides the HOPWA-funded Tenant-Based Rental Assistance Program, reported a waiting list of approximately 1,000 in DC and 54 in Prince George's County. The other operates housing for PLWH and other special-needs clients and has Part B as well as HOPWA funding; it has a waiting list of 96 for housing and 22 for medical case management. This provider estimated the waiting time at six years for housing and 35 months for medical case management; it refers clients to other providers where possible.

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

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

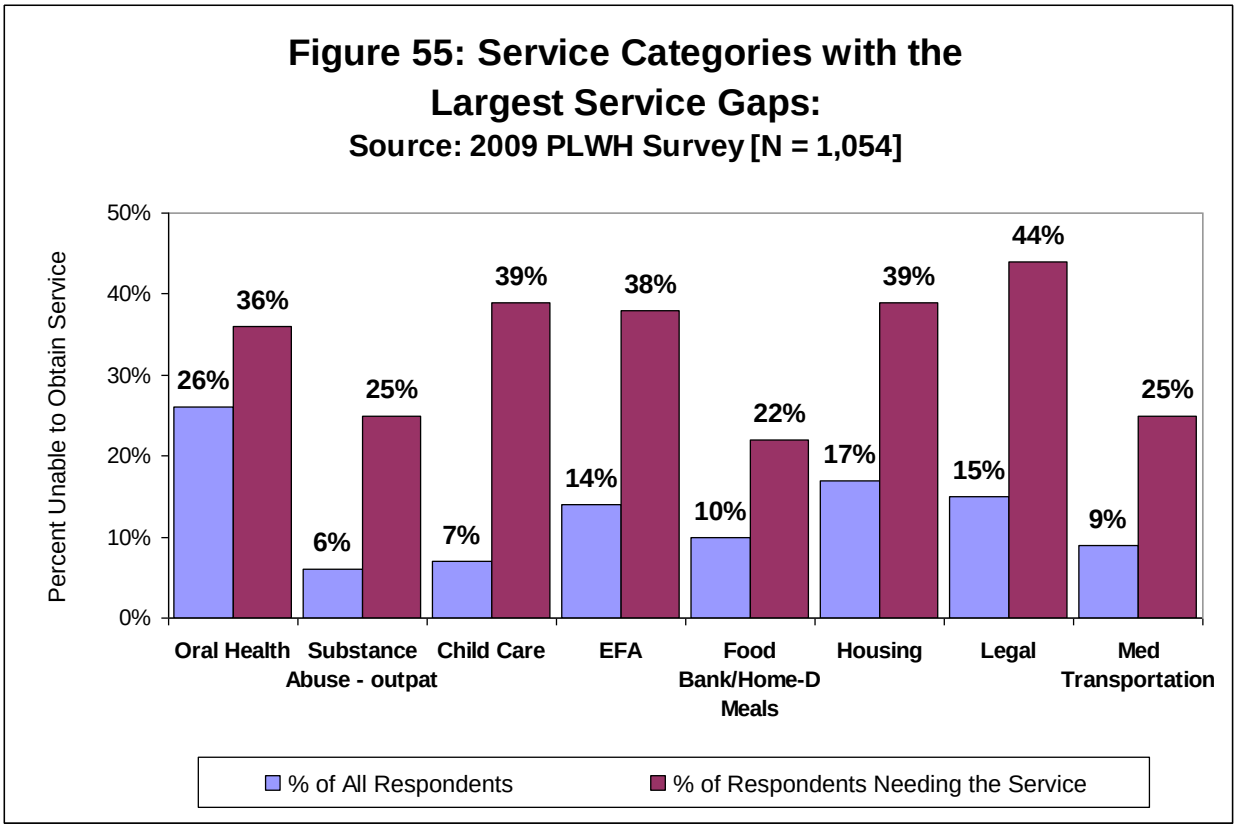


Figure 55 shows the services with the largest identified service gaps. As it indicates, some of the services needed by a small proportion of PLWH had large service gaps. For example, 9% of *all* PLWH indicated in 2009 that they needed but were unable to obtain medical transportation over the prior six months, but 25% of those who *needed* medical transportation said they were unable

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

A new PLWH survey is planned for 2012 or early 2013. The next survey will ask similar questions, to provide an updated understanding of service gaps as identified by PLWH and possible reasons for these gaps, and will be designed to reach PLWH in and out of care.

Other Reported Service Gaps: There are some service gaps with regard to services other than ambulatory/outpatient medical care, medications, and medical case management – "wraparound" services, both medical-related and supportive, that are needed to help people enter and stay in care, remain adherent to medications, and live healthy and productive lives. Recent input from PLWH indicates that it continues to be difficult for PLWH in some jurisdictions, including Washington, DC, to obtain oral health services. Additional resources have been allocated to the service category. and remaining challenges appear to be associated with factors other than funding level. Other service needs and gaps vary somewhat by jurisdiction, and more significantly by population group.

In 2011 and 2012, the Planning Council obtained structured input on service needs and gaps from more than 400 consumers, providers, and interested community members through a series of special studies and consultations. These included consumer and provider town hall meetings, input meetings with PLWH groups in all four jurisdictions and the EMA-wide Consumer Access Committee, discussions with the Northern Virginia HIV Consortium and the Maryland Regional Advisory Committee, focus groups with PLWH from specific populations and with peer community health workers, and key informant sessions.

The 2012 consultations for the comprehensive plan and the town hall meetings in preparation for Program Year 23 priority setting and resource allocations process, as well as needs assessment activities, identified a number of service gaps. The most frequently identified gaps are summarized in Figure 56. Some are in specific Ryan White-defined service categories, while others involve a broader system of prevention, testing, and care. Some gaps were identified as EMA-wide, while others are jurisdiction-specific. Most frequently gaps include a lack of easily accessible, centralized information about testing and care; insufficient Hepatitis C testing and care, particularly for PLWH who are dually diagnosed; lack of sufficient age-appropriate care for both young PLWH (18-24) and for older PLWH (age 50-plus); housing assistance, both long-term and transitional; medical transportation overall and transportation that enables women with children to get to appointments; and accessible support groups for a range of PLWH populations.

Figure 56: EMA-Wide and Jurisdiction-Specific Service Gaps	
Jurisdiction and Service Gap	**Description**
Multiple jurisdictions	
Service Gaps Identified in All Jurisdictions	
Information	Information about how to obtain HIV testing and services, including availability of services for those who cannot pay – mentioned by consumers and providers in every jurisdiction • Information on care is harder to find than information about testing sites • Lack of centralized information on available treatment services throughout the EMA rather than for one jurisdiction • Access to information varies by jurisdiction • Also need information to counter both the mistaken belief that HIV diagnosis is a death sentence and the equally unrealistic view that it is a chronic disease that can be controlled with a few pills and therefore is not a serious threat
Hepatitis C Testing and Care	Testing, medications, and co-treatment • Need more Hepatitis C testing • Not enough coordination of treatment for PLWH co[infected with Hepatitis C • Services related to Hepatitis C seen as far less accessible than HIV testing and medications • Jurisdictions vary in availability of medications – VA and WV do not have Hepatitis C medications on their ADAP formularies
Age-appropriate Services for Young Adults	Not enough providers with services that engage and meet the needs of young people aging out of pediatric programs, or other young PLWH, including African American MSM
Age-appropriate Services for Older PLWH	More services needed to meet the needs of both newly diagnosed and long-time survivors; there are few geriatric social workers or clinicians trained to address the intersection of health care issues related to HIV and aging
Support to help PLWH enter and become fully connected to care	• Not enough peer community health workers to assist newly diagnosed PLWH as well as individuals who have been out of care • Both inadequate numbers of peers and use of peers in too few service categories • Peer-led support groups seen as a largely missing mechanism to help address this need – a particularly important gap in West Virginia and in other rural areas
Housing	Lack of decent, affordable housing a problem in all four jurisdictions • Housing costs high throughout the EMA; rentals especially expensive in DC • Long waiting lists for HOPWA and other subsidized housing • Without stable housing, it is extremely difficult to get care – no way to store food bank groceries, refrigerate medications; difficulties in getting to appointments and maintaining contact with providers • Ryan White funding only for EFA rent and utility emergency assistance
Medical Transportation	• Without access to transportation, clients cannot get to appointments and remain closely connected to care • Transportation a major issue in rural and outer suburban areas with limited or no public transportation • In urban areas, bus tokens seen as insufficient for a woman with small

Figure 56: EMA-Wide and Jurisdiction-Specific Service Gaps	
Jurisdiction and Service Gap	**Description**
	children, especially where getting to care requires several transfers • Unreliable transportation (e.g., late pick-up by MetroAcess) can make clients late for appointments, which are then sometimes cancelled • Costs for medical transportation often high and seen as taking funds away from direct services • If gap cannot be closed, other means needed to make service more accessible – such as use of mobile medical vans or telemedicine
Support Groups (Psychosocial Support Services)	• Too few support groups, either broadly targeted or population-specific • Groups often run by medical providers and access is often limited to their medical clients – individual providers typically offer only a few groups, which do not meet all needs • Need for peer-led focus groups with appropriate supervision as well as professionally-led groups • Some rural areas, including West Virginia counties, have virtually no access to support groups • New EMA-wide support groups funded for 2012 not yet implemented; should help to fill gap
Other Data Gaps Identified by Multiple Jurisdictions	
Non-HIV-related Medical Specialty Care	Care not covered by Ryan White funds is very difficult to obtain, particularly for specialists not available at safety net clinics such as CHCs/FQHCs
Mental Health/ Psychiatric Services	Shortage of resources for mental health services, particularly for psychiatrists – often too expensive to hire and limited referrals available
Training for PLWH in Self-advocacy	Individual or group sessions needed so that consumers not only know what services are available but know how to work with providers to obtain the assistance they need and to take responsibility for managing their disease
Long-term Substance Abuse Treatment	Combination of residential and out-patient services to address the needs of some long-time addicts, for whom most programs are too limited or short-term – intensive programs funded by other public and private sources are hard to access
Services in Rural Areas	Medical provider is generally available within one hour of travel, but other needed services, especially support services, are difficult to obtain and may not exist in the PLWH's county of residence
District of Columbia	
Oral Health Care	• Still reported as hard to obtain for some PLWH • Concern that there are not enough providers available throughout the year • Some providers said to charge high up-front co-pays
Prevention education and outreach	• Testing available, but more outreach needed • Need outreach targeting specific populations, especially women
Suburban Maryland	
Community-based Clinics Providing Primary Medical Care	Limited community health safety net; some counties have very few safety net providers, whether CHCs/FQHCs or free clinics, which means that affordable non-HIV-related medical care is difficult to obtain
Syringe Exchange Programs	Lack of access to clean needles • Although syringe exchange programs are legal, state has only one, in Baltimore • Provider staff say many Maryland residents come into DC for needle

Figure 56: EMA-Wide and Jurisdiction-Specific Service Gaps	
Jurisdiction and Service Gap	**Description**
	exchange
Mental Health Services for Immigrants	• Sometimes a long wait for services • Few multilingual clinicians, and this is a difficult service to receive through an interpreter
Transitional Housing	• Almost no transitional housing specifically for PLWH • Needed for PLWH coming out of the hospital, ex-inmates, others with short-term needs
Northern Virginia	
HIV-related Medications	Gaps in access due to the ADAP waiting list, as well as co-pays for individuals who have insurance with limited drug coverage
Syringe Exchange Programs	Lack of access to clean needles – syringe exchange programs are illegal in Virginia
Services for transgenders	• Stigma makes it particularly difficult for transgender PLWH to get needed services • Hard to find doctors who are willing and have skills to serve this population
Outreach to immigrants	• Need outreach directed at growing African immigrant population and at Latinos, to get them tested and into care early • Stigma means that outreach is best done by individuals not from the same country • Outreach particularly challenging for those who do not speak Spanish or French
Legal Services	Limited access to both HIV-related and immigration-related legal services, which are not Ryan White eligible. No Part A funds allocated for legal services, and PLWH sometimes have difficulty accessing legal assistance supported through other funding streams
West Virginia	
HIV-related Medical Care	• Clients have access to infectious disease specialists, but face to face contact is challenging • Part A provider has access to infectious disease doctor located in Morgantown several hours a week, but client contact typically largely with local clinicians rather than directly with doctor • Some clients needing direct contact with the specialist are given transportation to Morgantown; telemedicine being considered • Veterans receive transportation into DC or Baltimore for care at VA facilities that have infectious disease specialists
Housing Services	• Very limited housing assistance available • Perceived differences in access by county; some PLWH reportedly have moved to Jefferson County because more HOPWA-funded assistance is available in that county than in Berkeley County
Mental Health Services	Mental health services limited
Peer Support	• Strong need identified for use of peer PLWH groups and peer support, formal and informal • Would like to be part of the peer EIS demonstration that will begin in 2012 • Gap created several years ago, after closure of community-based AIDS service organization in Martinsburg, which provided both Ryan White

Figure 56: EMA-Wide and Jurisdiction-Specific Service Gaps	
Jurisdiction and Service Gap	**Description**
	services and a gathering place for PLWH • No regular source of shared information about new drugs or other HIV news • Limited contact with Planning Council, which is seen as able to provide such information – application pending for at least one WV PLWH to join the Planning Council
Support Services	• Some services not available within the two counties • Services sometimes available in Hagerstown, MD, or Winchester, VA (short distances from the WV counties), but both are in different states and not part of the EMA, so obtaining services can be difficult • Particular concern is lack of support groups
Multilingual/ Multicultural Outreach and Care	• Lack of staff diversity complicates care for communities of color and immigrants • No bilingual staff – makes it very hard to reach out to farmworker population or other Spanish-dominant Latinos • Very limited funds for outreach creates further challenges
Food Bank	Difficult to obtain groceries

D. Barriers to Testing and Care

Special studies and community consultations identified a number of barriers to testing and to entry to and retention in care. Most apply throughout the EMA, but some are specific to particular jurisdictions or populations, as summarized in Figure 57, below. As the list indicates, some barriers are primarily client-based, others provider-based. Some can be minimized with increased awareness and training; others require system refinements.

Figure 57: Identified Barriers to Testing and Care	
Barrier	**Description**
Barriers to Testing	
Insufficient Routine Testing	• True in all jurisdictions, though more progress in DC • Hospitals test only when prevention funds are made available • Clinicians in hospitals concerned about the time frame and the ability to give test results • Some concern that patients will be billed for tests and be less likely to come for health care as a result • Private physicians often concerned about costs and about providing results • In some relatively low prevalence areas, low positivity rates may not justify the expense
Who Pays for Testing	• Lack of clarity about who pays for a routine test in a hospital emergency department; only DC has legislation that requires insurance companies to pay • Different insurer definitions of who is "high risk" and when a test is "necessary" • Requirement that client pay for test or confirmatory test can delay or prevent routine testing or entry into care (in DC, confirmatory test is now done as part

Figure 57: Identified Barriers to Testing and Care	
Barrier	**Description**
	of first medical visit)
Insufficient Marketing and Outreach	• Many people won't go to health departments for testing, but not enough testing is done in the community • Too few targeted marketing campaigns to encourage testing and to announce where testing is done • Information on testing sites available on-line but websites vary in ease of use
Language and Cultural Issues	• While interpretation can be used to serve clients, outreach for testing requires bilingual personnel; for example, in WV, lack of bilingual staff makes outreach to farmworker population and other Latinos very difficult
Access	• Some health departments have limited testing days and hours • Requiring appointments can discourage testing • Transportation a problem in rural areas – especially if people come a long way to a testing site and is then turned away because no one is available (reportedly not uncommon in health departments with small staff who have multiple responsibilities)
Stigma and Confidentiality	• Among certain populations and in rural areas, people do not want anyone to know they are being tested, and may be unwilling to come to an office with an HIV testing sign • A community health center or other clinic may create less concern about confidentiality, unless front desk personnel or other staff do not follow HIPAA and other confidentiality rules – a problem reported in multiple jurisdictions
Barriers to Care	
Lack of PLWH Knowledge about Available Services or How to Access Them	• Many people still unaware of the existence of Ryan White services • No single central source of information about available services • Many people are unaware of the availability of free or low-cost services or unclear about eligibility requirements • Private physicians often do not know where to refer people who test positive
Weak Linkage to Care after Testing	• Some testing sites such as hospital emergency departments or private physicians' offices may lack personnel responsible for linkage to care • Insufficient use of peer CHWs • Some PLWH still get only a telephone number or a brochure rather than hands-on assistance in making and keeping an appointment
Stigma	Still a major barrier, especially in rural areas and for certain populations such as African immigrants
Intake Barriers	• Documents required can be challenging to provide, especially for homeless, individuals in shared or unstable housing, and immigrants • Some documents, such as those on residency, must be notarized • Intake done at each provider, so PLWH must carry documentation with him/her
Delays in Getting First Appointment	Medical providers may be over capacity Sometimes newly diagnosed or out of care may have to wait weeks or even months for a first medical appointment
Language and Cultural Barriers	• Not enough culturally competent providers and staff to serve communities of color, immigrants, transgenders, other special populations • Ryan White funds interpretation services, but some providers don't seem

Figure 57: Identified Barriers to Testing and Care	
Barrier	**Description**
	aware of them and rarely use them; this includes sign language interpretation • Private physicians (including those with Medicaid MCO linkages) sometimes do not use interpreters because of cost
Limited Engagement of Community-Based Organizations (CBOs)	• Some PLWH would be more likely to seek and remain in care if they could get services from a community provider they know and trust • Only a few CBOs in Maryland and Virginia have HIV-related prevention or care funds • Sometimes only 1-2 providers in a county
Housing Instability	It is almost impossible for PLWH to stay on medications, eat properly, and get to service appointments on time if they are homeless
Bad Initial Provider Experience	PLWH who have a bad experience with a provider soon after diagnosis may delay entry into care. Examples include: • Front desk personnel who do not maintain confidentiality or are not helpful or culturally competent • Clinician or provider that is a "bad fit" • Provider that requires significant pre-payment for initial visit or lab tests at first visit
Problems Navigating the System of Care	• A particular problem for newly diagnosed, PLWH who have had limited access to the health care system prior to diagnosis, and immigrants • PLWH may access medical care and case management but not other needed services • Common problem in the absence of a peer CHW • Case managers sometimes so busy that they provide limited information or support and do not ensure that a referral is successful
Lack of Experience with Insurance	• Challenges for PLWH who become eligible for Medicaid, Medicare, PCIP, or local/state insurance-type programs in obtaining services other than medical care; • Most insurance does not pay for Ryan White-level medical case management, which may mean no service coordination unless the individual receives such services through Ryan White
Insufficient Follow Up after Initial Link to Care	Insufficient follow up and assistance after intake or first appointment, for many reasons: • Particular problem for those diagnosed through routine testing or at sites without peer community health workers or other specifically assigned personnel – no one responsible for follow up • Where "linkage to care" means a referral or one visit, PLWH may not get needed additional support • Many providers with very limited capacity to provide follow up on clients who miss appointments • Follow up that is not culturally competent • Insufficient use of peer CHWs with cultural competence and time to do community follow up
Difficulties related to Appointments	Few providers allow clients to get care unless they have an appointment, and some are very inflexible if the client is late – even though this may be due to a MetroAccess or other public transportation delay
Multiple Sites and Appointments	Clients who must make multiple trips to varied locations to get services sometimes begin to miss appointments, not receive all needed services, and not

Figure 57: Identified Barriers to Testing and Care	
Barrier	**Description**
	remain fully linked to care
Facility Access Issues	Access to provider may be difficult due to such factors as: • No evening or weekend hours • Facility that is hard to reach via public transportation • Location that is not considered "safe" by some PLWH groups • Physically inaccessible facilities (e.g., no elevator)
Distance and Transportation	• In rural areas, PLWH have to drive a considerable distance to reach a provider • Transportation assistance may be insufficient – e.g., a woman with several children may not keep appointments if given bus tokens and expected to make several transfers
Limited Referrals	Medical case managers vary in their awareness of non-medical and non-Ryan White providers and services

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

E. Population-Specific Service Needs, Gaps, and Barriers

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

Adolescents: Youth 13-19 make up 3% of living PLWH in the EMA, and almost 4% of the HIV/non-AIDS cases. While their numbers are relatively small – 428 individuals throughout the EMA who know their status – adolescents represent important challenges in prevention, testing, and care.

Providers and consumers, including relatives of HIV-positive adolescents, express concern that prevention messages including realistic warnings about HIV are not sufficiently targeting or reaching this population. A recent national Kaiser Health Foundation survey found that while in 1987, two-thirds of Americans viewed HIV/AIDS as the nation's most urgent health problem, only 7% nationally held that view in 2011 – compared to one-third of DC residents. In addition, only four in ten people reported seeing, hearing, or reading about the epidemic in the past year, compared to seven in ten in 1987.[30] Young people were not around when HIV/AIDS was a top news item, and suburban youth are less likely to hear such messages now.

Several adolescent-focused prevention and testing providers target African American and Latino youth. They operate in DC, Northern Virginia, and Suburban Maryland. However, with

reductions in resources for targeted prevention programs and the new CDC prevention strategy, some of these targeted programs may be lost. This may make it harder to reach adolescents. The jurisdictions vary in their openness to HIV education in the schools, and many do not permit discussion of condoms.

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

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

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

Only one children's hospital with an HIV/AIDS adolescent specialization (and Part D as well as Part A funding) is located within the EMA, though some adolescents receive services at facilities outside the EMA. DC, MD, and VA Part A programs all contract with the hospital. Some adult-focused organizations face challenges in providing age-appropriate care for this population. There are only a few adolescent-focused community-based providers in the region, most of them primarily engaged in prevention and testing, and only one – located in DC – has Part A funding.

Adolescents and Young Adults Transitioning out of Adolescent Care: Young people who were perinatally infected represent a growing and particularly challenging subgroup of adolescents and young adults. While very few new cases are occurring today (none of the jurisdictions reported perinatal cases in 2011), epi data indicate that there are 433 PLWH in the EMA aged under 20 (134 aged under 13 and 299 aged 13-19), but 1,401 PLWH in the EMA were diagnosed before their 20th birthday (428 under 13 and 973 13-19). This means a growing number of young people aged 20-29 have been HIV-positive all their lives or since adolescence. With improvements in medications, "AIDS babies" are growing to adulthood – and aging out of pediatric and adolescent services. It also appears that young people are likely to be late testers; Virginia data from 2006-2010 indicate that 75% of 13-19 year-olds diagnosed with HIV disease had AIDS at diagnosis or within one year after diagnosis, compared to 62% of all PLWH.

At least one provider sometimes extends care until these young adults are in their early 20s, but both providers and caregivers report difficulties in transitioning such young people to adult care. These young adults need to learn disease self-management and how to navigate the adult system of care. There is concern about a lack of preparation and transitional support as they move to adult services and about a dearth of providers with special expertise in serving older adolescents and young adults. Areas of particular importance include retention in care, treatment adherence,

and advice and support around issues such as forming families of their own and perhaps having children.

Some of these PLWH may need continuing intensive services, while others need short-term help in transitioning to adult services. There is a perceived need for more provider expertise in assessing and addressing the needs of this very special population.

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

Nationally, the CDC reports that African American MSM represented about 73% of new infections among African American men and 37% of infections among MSM in 2009. The age and racial group with the largest number of new HIV infections was young African American MSM aged 13-29, and the number of new HIV infections among this population increased by 48% from 2006-2009.[31]

Out of all new AIDS cases reported in the EMA in 2010, nearly one-fourth (23%) were young adults aged 20-29, 65% were men, nearly 77% were African American, and at least 29% were MSM of all ages (33% had no risk reported). A behavioral risk study in DC found that older MSM were more likely than young MSM to be HIV-positive, but nearly all the young (18-29) MSM who were positive were people of color.[32]

Once diagnosed, these young men tend not to immediately enter, or if they enter, not to remain in care – though rapid entry and committed follow up can be effective. A recent SPNS study of outreach, linkage, and retention in care for young MSM of color found that early entry into care was facilitated when the person providing the HIV test result made an immediate referral to care and called the provider for an appointment. The study also found that while 87% of young MSM of color in the study were linked to care within 90 days, retention in care was lower for African Americans (80%) than for Latinos (96%). The study concluded that: "While unique challenges exist in the care of adolescents infected with HIV from identification to engagement and retention in clinical care, programs that are responsive and dedicated to the needs of these youth can be successful in retaining them in care."[33]

As with the other groups of adolescents and young adults, ensuring culturally appropriate care is challenging. Often, these young men have limited experience with the health care system, and need help in learning to navigate the system and obtain needed services. In other locations, peers have proven effective with this population.[34]

Homeless: Homelessness makes it difficult for PLWH to enter or remain in treatment. It is almost impossible for PLWH to get to service appointments on time, store and stay on medications, or maintain good nutrition if they are homeless. Lack of decent, affordable housing for PLWH is a serious problem in DC, MD, and VA. Particularly in DC and the inner suburbs, housing is expensive, and there are few affordable rental units.

A summit on HIV/AIDS and housing convened by the National AIDS Housing Alliance in 2005 found that anywhere from 17% to 60% of PLWH had experienced homeless or unstable housing at some point; the proportion of currently homeless PLWH ranged from 1% to 16%, with the

highest rates in large cities.[35] In addition, while individuals tend to be homeless for periods of about six months, the *rate* of homelessness tends to remain constant over time.[36] The situation does not appear to have improved, with Housing Opportunities for Persons with AIDS (HOPWA) funds being reduced and budget-strapped state and local governments cutting housing assistance budgets. Some homeless shelters have been closed.

In DC, an estimated 371 people living with HIV/AIDS were homeless when diagnosed. More often, PLWH become homeless after diagnosis.

HIV-specific housing was originally designed to be short term. Today, PLWH stay in such housing for many years, as waiting lists continue to grow. Those fortunate enough to obtain housing often have access to a variety of housing-based support services. The challenge is finding decent and affordable housing for more PLWH.

This EMA does not allocate Part A funds to housing, except Emergency Financial Assistance for rent and utilities. It depends on HOPWA and other assisted housing to provide housing opportunities, most often rental assistance. In all jurisdictions, consumers consistently rate housing as a high-priority service need that is very difficult to meet.

Immigrants: The Washington metropolitan area ranks 14th nationally in percent of foreign-born residents; as of 2010, more than 1.2 million – nearly 22% of residents – are immigrants. This represents an increase of nearly 48% from 2000. A large majority – 86% – live in the suburbs.[37]

The foreign-born population is extremely varied, as is the population of immigrants with HIV disease. Linguistic services providing interpretation and translation are funded in all jurisdictions. There is great concern about reaching and serving immigrants, but a recognition of considerable barriers.

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

African immigrants: There are about 3.5 million African immigrants in the U.S. (based on 2009 data). Almost half have arrived since 2000, and about 860,000 received legal resident status from 2001-2009, many as refugees or asylum seekers fleeing persecution in their home countries. More than 147,000 live in the Washington metro area, most of them in Maryland (which has over 117,000 African immigrant residents statewide) and Virginia (which has 60,000).[38] They come from many different countries and speak many languages. However, unlike most other immigrant groups, most speak English. More than 70% are native English speakers or speak English "very well," according to Census data. Other common languages include Amharic and French. Africans are a large and important component of the PLWH population in the EMA, though it is difficult to obtain accurate information about the size of the African immigrant PLWH population because this group is not considered a separate population for surveillance purposes or in client utilization data, except for a small number of providers that keep track of immigrant status and country of origin. Epi data for DC identify 303 African immigrants living with HIV and AIDS; two-thirds have a risk factor of heterosexual contact.

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

Many Africans reportedly delay testing because they believe they cannot afford care; when made aware of Ryan White services, they are more likely to take action to learn their status.

African immigrants account for about half the HIV/AIDS clients in at least two Ryan White-funded clinics in Suburban Maryland. These clinics have on staff individuals who speak French and Amharic. The Planning Council allocates off-the-top MAI funding to permit EMA-wide access to medical and related services for a limited number of limited-English-proficient (LEP) PLWH, which is very helpful for those who speak languages that are less commonly used and may require interpreters, and for those who do not wish to receive services in their own communities due to confidentiality concerns.

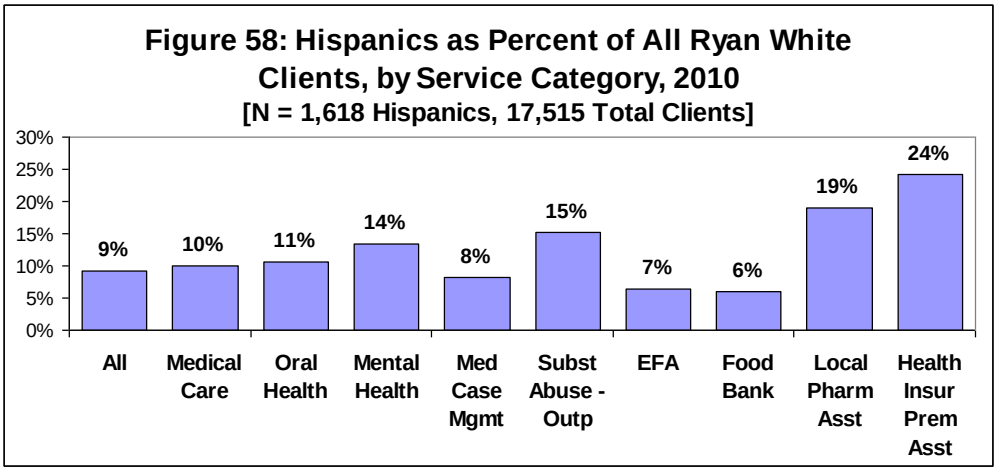
Hispanics/Latinos: The Hispanic population in the metro area grew by more than 340,000 from 2000 to 2010. The area has a very large Central American population; one-third of Latinos are Salvadoran. There are also large groups of Mexican, Puerto Rican, and Guatemalan origin.[39]

Nationally, Latinos are overrepresented among PLWH. In this metro area, they account for nearly 14% of the residents of the Washington metropolitan area and not quite 8% of PLWH. It is not clear whether this represents a lower HIV/AIDS rate or a high rate of HIV-positive unaware individuals. Northern Virginia data from 2006-2010 indicate that Latinos are the racial/ethnic group most likely to be late tested; 79% had AIDS when first diagnosed or within one year after diagnosis, compared to 60% of White non-Hispanics and 55% of African Americans.

According to service utilization data, about 9% of the EMA's Ryan White clients (1,618) are Hispanic. Numerically, they are most likely to use ambulatory/ outpatient medical care (964 Hispanics used that service in 2010) and medical case management (862 Hispanics). However, as Figure 58, below, shows, they are a much higher proportion of all clients in some service categories than others. Hispanics represent 9% of Ryan White clients. They are only 6% of clients receiving food bank/home-delivered meals but 24% of clients receiving health insurance premium and cost-sharing assistance, 19% of clients in local pharmacy assistant programs, and 15.2% of clients in outpatient Substance Abuse Treatment.

Like Africans, some Latinos benefit from "off-the-top" funding, currently under MAI, that allows limited English-proficient PLWH to come to a central multicultural facility for medical care.

The Planning Council's special study of Latinas found considerable concern about stigma and confidentiality; some Latinas indicated that their families do not know their status. They identified a number of service gaps, including mental health services, which can be difficult to access. Several mental health providers have bilingual staff, but many do not, and it can be difficult to participate in counseling and other mental health services through an interpreter.



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

Injection Drug Users (IDUs): The number of PLWH whose risk factor is injection drug use (alone or along with MSM) is decreasing in the EMA, but this population represented more than 14% of people living with HIV and AIDS and 10% of people living with AIDS as of the end of 2010. At that time, there were nearly 5,000 such individuals (4,941) in the EMA, and 61% lived in DC. In 2009 and again in 2010, 79 people new IDU-related AIDS cases were diagnosed, representing about 9% of new AIDS cases in the EMA.

Providers and consumers indicated that availability of clean syringes is an important means of preventing HIV infection among IDUs. This view is supported by national research, including a study in 2007 in Wisconsin (where the percentage of AIDS cases among IDUs was comparable to Virginia's (in 2007, 14.8% and 16.4% respectively). It found that between 1994 (when Wisconsin's needle exchange program began) and 2007, the state saw a 66% decrease in HIV infection among IDUs.[40]

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

Within the EMA, only DC has syringe exchange programs. The DC Department of Health funds three syringe-exchange programs through local tax dollars. Currently, 33 states plus the District have syringe exchange programs; 17, including Virginia and West Virginia, do not. Such programs are legal in Maryland; however, the only current program is in Baltimore. Virginia does not permit such programs, although some people obtain clean needles informally. In rural parts of the EMA, individuals can reportedly purchase needles available for use with livestock.

Treatment cascade data for DC over the past five years indicate that 536 IDUs were diagnosed with HIV/AIDS, 86% of them were linked to care at some point in the past five years, a little less than 27% were in care as of December 31, 2010, and 74% of those in care were virally

suppressed. Retention in care is clearly a key concern. A total of 1,660 PLWH in DC died over the past five years; 526 or almost 32% were IDUs, at a time when IDUs made up about 15% of the total HIV/AIDS population. Thus their death rate is double their proportion in the infected population.

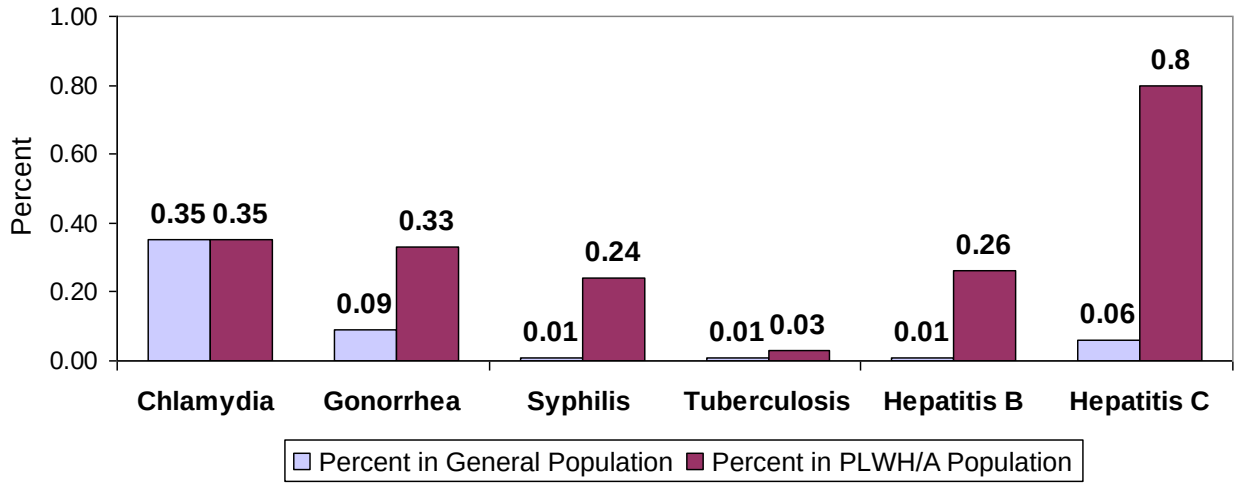
Several service providers focus on serving PLWH with a history of substance use including IDU, and individuals reportedly can locate service providers who have expertise serving this population. However, providers report challenges in serving active IDUs, particularly with regard to retention in care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

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

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

EMA data for 2010 indicate that PLWH overall have about the same level of chlamydia as the general population, but are much more likely to be diagnosed with Hepatitis B and C and with syphilis and gonorrhea (see Figure 59). They also have three times the rate of tuberculosis, though the percentages are very low for both populations.

Figure 59: Percent of General Population and Population with HIV/AIDS Diagnosed with STDs and TB, Metropolitan Washington EMA, 2010



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

Testing and treatment for Hepatitis C were identified through provider and consumer consultations as a particular concern in the EMA. According to new data released by the CDC in February 2012, more people in the U.S. now die each year from Hepatitis C than from AIDS. Between 1999 and 2007, recorded deaths from Hepatitis C increased to 15,106, while deaths from HIV/AIDS decreased to 12,734 annually. The study identified HIV co-infection and minority status as among the factors associated with such deaths, along with chronic liver disease, Hepatitis B co-infection, and alcohol-related conditions.[41] The EMA plans to explore in more detail the number of PLWH in the EMA who are dually diagnosed with HIV and Hepatitis C, and how testing and care might be made more available and better coordinated with HIV/AIDS services.

Getting tested for Hepatitis C is more difficult than obtaining an HIV test, and obtaining treatment can be challenging. While Ryan White pays for Hepatitis C testing, there does not appear to be much joint HIV and Hepatitis C testing in the community. Some of the newest (and very expensive) Hepatitis C drugs are not considered safe and effective for PLWH on anti-retroviral therapy. Some current Hepatitis C drugs have been removed from the ADAP formulary in some states, including Virginia, due to budget issues.

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

In the Metropolitan Washington EMA, 2010 epi data indicate that 26% of people living with HIV and AIDS are 50-59 and another 10% are 60 and older. While only 12% of all PLWH were diagnosed when over 50, the rate is increasing; 19% of new AIDS cases in 2009-2010 were 50 or older when diagnosed. Unfortunately, the age ranges used for the Ryan White Service Report (RSR) are inconsistent with the epi breakdowns, using 45-54, 44-64, and 65+, so it not possible to compare epi and client utilization data. The RSR data indicate that about one-fifth (19%) of Ryan White clients as of 2010 were 55 and older. The number and proportion of older PLWH needing care will continue to grow.

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

Recently diagnosed: There are indications in some parts of the EMA that older people with HIV are being diagnosed late – they are more likely than younger PLWH to have AIDS when they are diagnosed or within a year after diagnosis. One Duke University study found that older PLWH are "twice as likely as younger patients to have already developed AIDS by the time they are diagnosed with HIV infection," which means they often do not benefit as much from anti-retroviral therapy.[43] Virginia late testing data indicate that during the period 2006-2010, individuals aged 60 and over were more likely to test late (67%) than the overall PLWH population (62%). This highlights the need for increased education and testing targeting older residents and their physicians. Many older people are poorly informed about HIV/AIDS. Often they had a single sex partner for many years and are not accustomed to condom use. Many do not see themselves as at risk, even though they may engage in unprotected sex. Physicians serving older Americans are often uncomfortable talking to them about sex and do not see their patients as being at risk. They may fail to identify symptoms of HIV disease. In addition, few

public campaigns on testing target older Americans. DC has expanded the CDC routine opt-out testing age range from 18-64 to 18-82, due to the high rate of HIV/AIDS in the District. This may not be practical in lower-prevalence areas, but sexually active older people need to be educated and to have easy access to HIV testing.

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

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

The new PHS Guidelines for medical care address the special considerations for caring for older PLWH. They call for antiretroviral therapy (ART) regardless of CD4 count, while warning that ART-associated adverse events may be more frequent in older patients so close monitoring is required. They warn of the increased risk of drug interactions between ART and other medications, urge that HIV and primary care providers work together to optimize medical care, and recommend counseling to prevent secondary transmission.[45]

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

The Planning Council's Special Study on Older PLWH found that recently diagnosed older people find it particularly helpful to be linked to peers – PLWH of similar age – who can help them learn how to live with the disease and navigate the care system. Many want to stay with their primary care physician, who may have little expertise in HIV/AIDS. They are likely to be treatment-adherent; many are accustomed to taking medications. While those over 65 (except for recent immigrants and the undocumented) usually are on Medicare, they often have very limited resources, and find it difficult to afford co-pays or obtain wraparound services. A particular identified need was mental health counseling, of the type provided by licensed therapists or clinical social workers. Transportation is a challenge, especially given the varied rates and reliability challenges of MetroAccess. Unless they are able to obtain senior or other subsidized housing, older PLWH often struggle to make housing payments and have enough money left for other necessities. Some described going to multiple food banks every month. Many would like to participate in support groups, but find appropriate groups unavailable; groups are often operated by medical providers and open only to their medical clients. The Planning Council allocated funds for EMA-wide support groups starting in 2012 to help address this problem. Older PLWH would like to see coordination between senior citizen and HIV/AIDS service providers. They

find "one-stop shops" particularly helpful, because they minimize the number of separate visits requiring transportation arrangements.

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

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

A 2010 study in Rhode Island found that testing in jails can lead to identification of a significant number of HIV-positive unaware people. It concluded that to be maximally effective, jail testing should occur very soon after incarceration, since many people remain in jail only a short time. Even a delay beyond 48 hours would have meant 29% of detainees with HIV would not have been identified.[47] Rapid tests are needed for jail testing to ensure that individuals found to be HIV-positive receive their results before discharge and are not lost to follow up. HRSA supports universal opt-out testing in prisons and jails.[48]

Jurisdictions within the EMA support several initiatives to support testing within the criminal justice system and pre-release planning for inmates. For example, since 2009, Virginia has used CDC funding to support a program called CHARLI (Comprehensive HIV/AIDS Resources and Linkages for Inmates), through which community-based organizations to do testing and provide HIV-related care for inmates due for release within 60 days. DC has a testing program in its jail, which is supposed to provide for testing within 72 hours after entry, but many people opt out or are not tested. Surveillance data indicate that 538 PLWH in DC were diagnosed while incarcerated. DC uses Ryan White Part B funds to support pre-release planning by case managers.

Some individuals are linked to care immediately upon release, and a number of agencies work to accomplish this. There is, for example, one DC-based community-based organization exists to serve formerly incarcerated women and has an HIV program. In some jurisdictions, individuals are released with only a prescription or a very small supply of medications (as little as seven

days), and without a specific link to a provider. Those who have been incarcerated for a long period may be largely unaware of available services. Sometimes parole officers help provide and encourage follow up on service referrals. Consumers at a town hall that provided input for the comprehensive plan indicated that formerly incarcerated with special need for outreach include those who served their entire sentence and therefore have no parole officer and non one responsible for assisting with their transition or linking them to care.

Transgenders: The metropolitan area has a significant transgender population, but they are not differentiated in the Census and are not consistently counted by HIV testing sites or service providers. The National Center for Transgender Equality estimates that "transsexual" individuals are between ¼ and 1% of the U.S. population.[49] That would mean between 14,000 and 57,000 transgenders living in the EMA. Populations of transgenders tend to be higher in larger cities and in places were appropriate medical care is available and there is somewhat less stigma and discrimination.

Transgenders have a high rate of HIV infection, but there is no recent data for the EMA. A 2000 survey of transgenders in Washington, DC found that 25% of 562 transgenders surveyed were HIV-positive;[50] this is consistent with national studies estimating a 28% positive rate.[51] A Virginia study released in 2007 interviewed 350 transgenders statewide; almost 11% said they were HIV-positive – 16% of the male to female transgenders and none of the female to male transgenders. About three-fourths (73%) of those interviewed had health insurance, and a large majority (79%) of Virginia transgenders with HIV disease were taking HIV-related medications, and they reported relatively few barriers to HIV care.[52] DC, Suburban Maryland, and Northern Virginia attempt to identify transgenders, but they are not separately reported for the RSR or other federal systems.

Transgenders continue to face discrimination in employment, housing, and services. There have been recent hate crimes against transgenders in both DC and the suburbs. In the Virginia study, 20% transgenders said they had been refused a job due to their sexual identity and more than one-fourth (27%) had been forced to engage in unwanted sexual activity. Thirteen states and DC have anti-discrimination laws that include protection based on gender identity, as do some municipalities including Montgomery County. The Maryland legislature held hearings on similar legislation in 2012.

Discrimination and stigma are major concerns for HIV-positive transgenders, and obtaining culturally appropriate and expert medical care is challenging. Many physicians are not expert at serving this population, and transgenders often want a medical home where they can obtain needed hormones as well as AIDS medications. Virginia has compiled a "Virginia Transgender Resource and Referral List" that identifies health and human service providers, categorized by region; it was updated in 2012.[53]

Several Ryan White and non-Ryan White providers have projects that target and serve transgenders. There is one transgender-focused community-based organization in DC, and several others have projects that target and assist transgenders. Such groups are much less common in the suburbs, and no suburban programs have Ryan White funding to target this population. There is continuing concern about how best to ensure that this population has full access to culturally appropriate services.

Rural Residents: Ensuring equity in access to care for residents of rural parts of the EMA remains challenging for this very large EMA. Suburban Maryland, Northern Virginia, and the West Virginia counties all have rural communities. Stigma and confidentiality are critical issues in these rural areas. Some PLWH have indicated that they will not enter a care facility if it is identified as providing only HIV/AIDS services. They said they are much more comfortable entering CHCs/FQHCs, local clinics that serve everyone.

The EMA has worked hard to ensure that every PLWH is within a one-hour drive of an ambulatory/outpatient primary medical care provider. It provides a flexible mix of services to a community health center in rural West Virginia so that it can arrange for the specific services clients need. However, residents of the most rural parts of the EMA may have to travel a considerable distance to obtain some services, sometimes across state lines. There are generally fewer health and human services available, regardless of funding source. Public transportation may be limited or non-existent, and the high price of gas is reportedly a barrier to care.

The Planning Council continues to work with the Grantee and Administrative Agents to enhance services for rural residents. Since transportation to facilities in other counties or states is costly, strategies are being explored that would bring the services to the PLWH rather than always transporting the client to the provider. Creating a comprehensive care center or medical home model is particularly challenging but desirable in such communities.

Insured or Formerly Insured PLWH (New to Ryan White): In the past several years, particularly since the economic downturn, an increasing number of PLWH who previously had employer-based insurance are losing their jobs and insurance for economic or health reasons. Providers and consumers note that these individuals are familiar with health insurance and their responsibilities for coordinating their own care, but they have almost no knowledge of the health care or HIV safety net. They need peer or other support to learn about Ryan White services and to be able to navigate the system of care.

F. Prevention Needs, Gaps, and Barriers

Prevention needs and gaps vary somewhat by jurisdiction, but there are many similarities across the EMA. Common needs and gaps identified by PLWH and providers in multiple locations are summarized in Figure 60, below. They include a number of specific prevention and testing components and strategies, as well as planning and coordination needs. Funding reductions for prevention, along with changing strategies and priorities, mean that it is difficult to project the extent to which the identified needs and gaps will become greater or smaller over the next several years.

Figure 60: EMA-wide Prevention Needs and Gaps	
Need/Gap	**Description/Explanation**
Intensive prevention interventions	• Less and less availability of intensive prevention interventions that target specific populations • Plans for defunding of many DEBIs by end of 2012, including those that have proven effective in the EMA with particular populations • Becoming less available following years of funding cuts and recent changes in CDC strategies that emphasize scalable, high-reach, lower-cost interventions • Some individuals need personal, intensive contacts
Outreach	• Not enough personal outreach to high prevalence populations and communities by culturally and linguistically appropriate people • Not enough media campaigns to address need for testing and stigma and inform people about available services • Too little use of social media to encourage people to get tested
Peer support	• Needed during or immediately after testing, to help newly diagnosed PLWH deal with their diagnosis and get linked to care • Also needed over time, to provide navigation, support, and advice • Peers need to matched to the PLWH they work with; this usually but not always means matching based on age, race/ethnicity, sexual orientation, and gender
Support for linkage to care	• Appears to be improving in some jurisdictions • Still many testing sites in which "linkage to care" means receiving a brochure or a phone number, even when the newly diagnosed individual clearly needs more
Information about testing	• Need easy to find, user-friendly, updated information about testing site locations and access • Should include location, accessibility by public transportation, language spoken, days of the week and hours when testing is available, and whether appointments are required • Testing data available for DC on the HAHSTA website; information in other jurisdictions seen as less detailed or less accessible • Some populations such as African immigrants also need information about free or low-cost treatment prior to testing, because without it they see little benefit in learning their status
School-based education and prevention services	• Concern that less HIV education is being provided in schools now, perhaps due to CDC budget cuts • May reflect public belief that the epidemic is no longer such a serious threat • Youth lack accurate information about HIV, including its severity (not something for which you just take a bill every day) • Condoms not readily available to sexually active youth, but most schools do not allow distribution in schools – or even demonstrations as part of the prevention curriculum
Testing choices	• People have different needs and concerns around testing, so testing choices need to be available • Some people not comfortable getting tested at a health department – often

Figure 60: EMA-wide Prevention Needs and Gaps	
Need/Gap	**Description/Explanation**
	because of fears about confidentiality or immigration status • Some people need counseling and support that may not be available in venues such as emergency departments or health fairs • Some people need to come to a CBO with deep ties to their community • Belief that the less choice available, the harder it will be to get people tested
Targeting of specific populations	• Concern that focus on prevention for positives (PFP) will leave little funding to focus on high-prevalence populations • Challenges in developing scalable, high-impact interventions that lead to testing and linkage to care
Community-based organization involvement	• Reduced role of CBOs feared • Over past decade, number of CBOs engaged in HIV/AIDS services in Northern Virginia has declined significantly – need more such groups as prevention grantees • CBOs seen as having special capacity to reach particular populations, to get them tested and get/keep them engaged in care • Concern that some will lose prevention funding and stop providing HIV/AIDS services – and PLWH would lose a source of community support • May make it harder to reach and serve some target populations
PLWH involvement in planning	• Concern about a probable decreased role for prevention planning groups – new guidance due from CDC on what are now Prevention Planning Groups (PPGs) rather than Community Planning Groups (CPGs) • PPGs will not be responsible for prioritizing target population • New guidelines could further reduce PLWH and community input • Concern that this will lead to models and strategies that are less appropriate and effective • May also close off a leadership development opportunity and reduce informal community outreach, peer support, and peer advocacy
Linked prevention and care planning	• Linked planning most feasible in a single jurisdiction • Collaboration across counties or health regions also important and not automatic; most often happens at the state rather than sub-state level • Collaborative planning much more difficult for DC EMA with its four jurisdictions • Need to provide for coordinated prevention and care planning that involves the Part A jurisdictions – but this will require resources
Coordination of services provided by both prevention and care	• Testing, linkage to care, risk reduction for HIV-positive individuals, and retention in care all now shared responsibilities of prevention and care • Some overlap probably useful • Do need to coordinate to optimize results • Will require common definition of terms and outcome measures • New linkages needed across funding streams

Each of the jurisdictions has identified some prevention-related needs. They are summarized in Figure 61, below.

Figure 61: Identified Prevention Needs and Gaps by Jurisdiction

Jurisdiction and Prevention Needs and Gaps	Description/Explanation
District of Columbia	
Scalability and financing	• Lack of resources to fund prevention programs for several prioritized populations (HIV-negative Black heterosexual men, HIV-positive Latino MSM, transgender women, high- risk youth) • Need to leverage the health care system, under which about 93% of DC adults have health insurance coverage, to help deliver prevention services • Need to increase share of testing funds that come through third party reimbursements such as insurance company payments
Coordination of services	• Need systematic screening for multiple morbidities (e.g., HIV and syphilis, Hepatitis B, Hepatitis C, TB) • Should coordinate HIV with mental health and substance abuse services • Need third party reimbursements to cover coordinated services • Must arrange for evaluation of effectiveness of coordinated service strategies, using outcome measures that consider both HIV and the co-morbidities
Shifting priorities	• Shift of prevention strategies requires focus on scope and scale • Must evaluate existing prevention service network and determine whether services need to continue, modified, or replaced, based on program results • Need to ensure that transition leads to more impactful prevention and testing and that outcomes are improved for key populations and communities
Prevention with Positives	• Need to increase coordination of prevention for positives services funded under Prevention with Early Intervention Services and other services funded under Ryan White • Must determine how to include risk reduction strategies within other service categories such as Mental Health and Outpatient Substance Abuse Services
Suburban Maryland	
Increased HIV testing	Increase routine testing as part of ongoing medical care Increase testing in emergency departments located in high-prevalence communities Increase testing of populations at highest risk for HIV infection • Increase targeted testing in non-clinical settings
Scaled-up partner services	• Increase the number of partner services field staff in health departments in high morbidity jurisdictions • Target both sex and needle-sharing partners • Use partner services to identify high-risk women and connect pregnant women to pre-natal care

Figure 61: Identified Prevention Needs and Gaps by Jurisdiction	
Jurisdiction and Prevention Needs and Gaps	**Description/Explanation**
	• Use system-level data to enable staff to target highest priority cases • Educate private providers including Medicaid MCOs • Reduce barriers to use of partner services with newly diagnosed who were not tested with IDEHA resources
Focused behavioral risk reduction interventions	Two focuses for such interventions: HIV-positive individuals HIV-negative individuals at highest risk for HIV transmission of infection
Improved linkage to care	• Increase availability of Ryan White-funded linkage to care and case management services • Enhance coordination between HIV testing, HIV/STI partner services, linkage to care programs, and HIV care providers • Revise linkage to care protocols for IDEHA-supported testing programs • Improve outcomes related to the "treatment cascade," including linkage to care, retention in care, and adherence to antiretroviral treatment
Northern Virginia	
Maintain activities targeting key populations	• Ensure ability to continue reaching target populations and finding people most at risk
Increase sustainable routine testing	• Determine a financially sustainable model for testing in hospital emergency departments – not dependent on continued VDH funding • Continue exploring opportunities for third-party reimbursements from insurance companies • Determine when routine testing in emergency departments is cost-effective based on positivity rates
Reduce duplication of effort between programs and funding streams	• Implement a collaborative information campaign to raise awareness about HIV/IDS testing and linkages • Analyze new CDC directives and their potential impact on care services
Increase linkage to care	• Increase the percentage of newly diagnosed who enter care within three months
Improve data sharing and data quality	• Increase data sharing across prevention, surveillance, and care units • Revise Counseling, Testing, and Referral (CTR) form to include more data on linkage to services for both HIV-positive and HIV-negative persons • Hold annual webinars with program staff to document and improve data quality
Engage PLWH in outreach and planning	• Identify key PLWH to assist with recruiting/accessing PLWH and affected individuals for social networking activities • Engage key PLWH on community planning groups

Figure 61: Identified Prevention Needs and Gaps by Jurisdiction	
Jurisdiction and Prevention Needs and Gaps	**Description/Explanation**
West Virginia Counties	
Keep CBOs engaged in testing	• No longer federal funding to support testing by community groups
Address special needs of two counties in EMA	• Higher rate of IDU than most other counties; population growth of area as Washington suburb means new residents with different characteristics and needs than long-term population

G. Capacity Development Needs

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

- **Assistance in preparing for health care reform:** Specific needs identified include information, training, and/or technical assistance related to the following:
  - Navigating health care reform – an overview and specific requirements and expectations for HIV service providers
  - Forecasting of changing operational environments for nonprofits, their practical implications, and how to address them as individual providers and as a care network
  - Available resources including funding opportunities and in-kind assistance
  - Selection, implementation, and "meaningful use" of electronic medical records systems
  - Third party billing, particularly for Medicaid including Medicaid Managed Care Organizations
- **Training and support in installing and fully using the new Maven system**
- **Clinician training,** including the following focus areas:
  - Regular adherence training sessions for nurses and other staff
  - Training in providing HIV care for primary care physicians, particularly in rural areas
  - Training and technical assistance in working with older PLWH, with a special focus on social workers and clinicians
- **Cultural competence:** includes:
  - Training in working with diverse and changing populations, including all communities of color, the GLBTQ community, and the disability community; particular focus on groups such as African immigrants, Latinos, transgenders, deaf, and disabled, recognizing that different providers and jurisdictions have different needs based on their level of HIV/AIDS experience, community environment, and client populations
  - More knowledge of both the federal Limited English Proficiency (LEP) Guidelines that apply to all federally funded providers and the resources available to providers to meet these guidelines

  - Introduction to the CLAS (Culturally and Linguistically Appropriate Services) Standards and their use
- **Capacity to provide services in more than one location:** includes ways to co-locate services and where necessary house staff in central service locations
- **Capacity for collaboration between medical facilities and CBOs:** includes Grantees/Administrative Agent assistance clarifying expectations for such linkages and building an infrastructure for collaboration
- **Expectations and methods for linking prevention and care:** what is expected of Part A providers and how these expectations can be met in operational ways that improve entry into and retention in care
- **Models and best practices in care coordination between medical and support service providers:** training that asks providers to share effective approaches and serve as peer consultants where appropriate

Providers noted that some of these capacity development needs can be met through the AIDS Education and Training Centers. It was suggested that AETC collaboration across jurisdictions could ensure that priority training sessions are made available throughout the EMA.

Chapter 5: Description of Priorities for the Allocation of Funds

A. Overview

The priority setting and resource allocations (PSRA) process in the Metropolitan Washington EMA is very complex because the EMA includes segments of four states and because – as described in Chapter 3 – it allocates more than 96% of service dollars to the jurisdictions based on their proportion of living HIV and AIDS cases, rather than doing a single set of EMA-wide allocations. While EMA-wide priorities are established, the jurisdictions each have the opportunity to refine those priorities and to develop allocations specific to their jurisdiction. The Planning Council makes some EMA-wide allocations for particular service categories and program models important to the entire EMA. The remaining service funds are allocated among DC, MD, VA, and WV. PLWH, providers, and other interested community members have opportunities for extensive input to the priorities and allocations for their jurisdiction at one PLWH town hall meeting and two work sessions each (except in West Virginia, which has one town hall meeting and one work session). The Planning Council members from each jurisdiction must approve the allocations, and the entire package of allocations comes back to the Planning Council for final review, refinement as needed, and approval. These EMA-wide and jurisdiction-specific data presentations and work sessions require extensive preparations and a great deal of volunteer and staff time. The process occurs between March and August of each year, with final allocations approved by the end of August for use in the Grantee's Part A application, generally due to HRSA/HAB sometime in the fall.

B. Priority Setting and Resource Allocations Process

Intent of the PSRA Process: The Planning Council adopted a refined priority setting and resource allocations process in April 2011 that is data based, structured, and inclusive. It involves the entire Planning Council and makes it the ultimate decision maker about priorities and allocations, since PSRA is a legislative responsibility of the Planning Council. The process ensures strong PLWH involvement at both jurisdictional and EMA-wide levels, as well as input from other stakeholders.

Responsibilities and Steps: The Planning Council and its technical and logistical support personnel are engaged in tasks related to PSRA at the EMA level and in the jurisdictions for almost half the program year, from March through August, ensuring that the Grantee has the information needed for submission of the Part A application in the fall of each year. The Planning Council guides the process, with information, advice, and support from the Grantee and the Administrative Agents in Suburban Maryland and Northern Virginia.

- **At the EMA level,** the Planning Council is responsible for:
  - Participating in an annual orientation to the PSRA process, which provides updates and familiarizes new members with the process and expectations for individual members.

  - Holding a cross-jurisdictional PLWH town hall led by the Consumer Access Committee, the committee responsible for linking the Planning Council to the infected and affected community in all jurisdictions.
  - Participating in an extended Planning Council meeting that includes (a) a Data Presentation, including epi, needs assessment, client utilization, and cost data for the EMA as a whole, and (b) setting of priorities for the EMA as a whole.
  - Holding an extended Planning Council meeting to discuss and vote on the amount and service categories for off-the-top allocations.
  - Spending significant time at two Planning Council meetings to discuss suggested directives and then to review and vote on directives for the EMA; these directives are based on recommendations from the Consumer Access Committee, PLWH input sessions, and other committees, especially Care Strategy, Coordination, and Standards (CSCS); a task force explores, refines, and recommends directives based on these inputs and brings them to the Council for final action.
  - Meeting to review jurisdictional resource allocation recommendations, refine them as needed, and adopt them – then forward them to the grantee for inclusion in the Part A grant application.

- **At the jurisdictional level,** the Planning Council is responsible for:
  - Providing an orientation to the process in each jurisdiction and specific training at Consumer Access Committee and PLWH group meetings in all four jurisdictions.
  - Holding a structured town hall meeting for PLWH in each jurisdiction, so they can provide specific input to the PSRA process, identifying key service priorities, needs, and gaps.
  - Arranging two jurisdiction-specific work sessions in DC, Maryland, and Virginia, and at least one in West Virginia. The first of these includes (a) a Data Presentation including PLWH town hall meeting findings from that jurisdiction and (b) development of jurisdiction-specific changes in the service priorities. The second includes community participation with Planning Council members from that jurisdiction in developing resource allocations. This means a total of at least seven jurisdictional PSRA sessions.

- **Based on the input from jurisdictions,** Planning Council members bring recommended resource allocations to the Financial Oversight and Allocations Committee (FOAC), which reviews them and makes recommendations to the Executive Committee and then to the Planning Council as final decision maker on priorities and allocations.

C. Responsiveness to Size and Demographics of the HIV/AIDS Population

The PSRA process was designed specifically to ensure that priorities and allocations consider the size and demographics of the epidemic in each jurisdiction and the EMA as a whole. This means balancing EMA-wide and jurisdiction-specific concerns and ensuring that allocations are equitable.

Priorities: The Planning Council's two-part priority-setting process helps ensure some consistency in the service systems throughout the EMA and gives proportional weight to the needs of PLWH based on the size of the HIV/AIDS population in each jurisdiction. The Planning Council's membership is designed to equitably represent the various jurisdictions, with the

District of Columbia having the largest representation because it has the largest share of PLWH. The Planning Council sets EMA-wide service priorities. Recognizing demographic differences in the HIV/AIDS population by jurisdiction, the Council then allows jurisdictions to adjust the priorities to fit their needs – so one jurisdiction may give higher priority to Early Intervention Services or Medical Transportation, based on differences in unmet need and the distances PLWH must travel to obtain HIV/AIDS services in rural areas.

Allocations: The allocations process is designed to ensure the available of certain services across jurisdictions, while dividing most service dollars among jurisdictions based on the number and proportion of people living with HIV and AIDS in that jurisdiction:

- **Off-the-top allocations:** Each year the Planning Council identifies EMA-wide needs and addresses these through "off-the-top" allocations, which are determined before remaining service funds are allocated to the four jurisdictions. In planning for the 2012 program year, for example, based on needs assessment findings and consumer input, the Planning Council developed a directive and then allocated off-the-top funds to initiate a pilot EMA-wide peer-based Early Intervention Services (EIS) program to help PLWH enter or re-enter and remain closely linked to care, support psychosocial support groups that are open to PLWH from all jurisdictions, and establish a local pharmacy assistance program that can provide short-term medications when there is an ADAP waiting list or other situation that might otherwise cause eligible PLWH to be without needed HIV-related medications.

- **Jurisdictional allocations:** Once off-the-top allocations have been determined, remaining service funds are allocated to the four major jurisdictions based on the percent of all persons living with HIV and AIDS in the EMA who reside in each jurisdiction. The West Virginia counties receive an allocation of at least 1% of service dollars.

Data-based decision making: The Planning Council's PSRA decision making based on careful analysis and use of available data, and a major focus is ensuring that epi, needs assessment, and client utilization data are used to describe the needs of diverse PLWH populations and the extent to which they are being met. The Needs Assessment and Comprehensive Planning Committee oversees this process. In 2011, the Planning Council commissioned three special studies as part of its needs assessment, to determine the service needs, gaps, and challenges for Latinas, African immigrants, and older PLWH. In 2012, the Planning Council is conducting a provider capability and capacity survey of both Ryan White-funded and non-funded providers. A PLWH survey will be conducted as soon as resources are available. All participants in the PSRA process – Planning Council members and other PLWH and providers who are part of the jurisdictional sessions as well as staff – receive a detailed matrix summarizing data from various needs assessment sources, utilization data, and PLWH town hall input. PowerPoint presentations and other carefully selected summary data and charts are provided, with materials designed to be user-friendly and focused, based on analysis of the data, rather than all-inclusive and potentially overwhelming. Like most EMAs, there are some important data gaps, which the Planning Council and Grantee are working to fill.

D. Responsiveness to Identified Needs of PLWH

Commitment to PLWH-focused Decision Making: In all its decision making, the Planning Council focuses on hearing from people living with HIV disease and responding to their identified needs. It does this through its needs assessment process and through the intensive and deliberate involvement of PLWH from the various jurisdictions, as well as those who are Planning Council members, in each stage of the PSRA process. This includes holding jurisdictional and EMA PLWH town hall meetings (described below) to obtain input for PSRA and by ensuring that PLWH receive orientation to each segment of the priority setting and resource allocations process. Jurisdictional decision-making sessions are scheduled around the PLWH group meeting times, and centered on PLWH groups and regional entities like the Northern Virginia HIV Consortium, which includes PLWH from multiple counties and cities. In 2012, the Planning Council initiated a series of orientations for jurisdictional PLWH groups that are designed to prepare them for active engagement in data presentations, jurisdictional priority setting, and resource allocations, as well as the development of directives. The intent of all these efforts is to ensure that PLWH have multiple opportunities to identify service needs and that priorities and allocations are responsive to these identified needs.

PLWH Town Hall Meetings: Each jurisdictional PLWH subcommittee hosts a structured town hall meeting each spring to provide PLWH input regarding service priorities and resource allocations. (A meeting is also arranged to obtain PLWH input in West Virginia, which does not yet have an established PLWH group.) The town hall meeting is held at the PLWH group's regular meeting time and location, but the meeting receives special announcements to encourage maximum PLWH attendance. PLWH attending the town hall meetings are asked to:

- Review and comment on data from needs assessments and prior PLWH input sessions
- Identify barriers to care and service gaps for PLWH in that jurisdiction
- Recommend ways to get people tested and into care and keep them in care
- Given difficult economic times, identify the services that are most important to PLWH and need to be continued or expanded
- Provide other PLWH input to guide decisions about service priorities and allocation of Part A funds

Special questions are included as needed in a given year. For example, PLWH might be asked if they would like the option of obtaining some services outside the jurisdiction where they live, or whether they would like to see a particular service model tested in their jurisdiction.

The EMA-wide Consumer Access Committee also holds a structured Town Hall meeting. It hears quick summaries of findings from the other jurisdictions, and then discusses and adds to those issues to provide an EMA-wide PLWH perspective on service barriers, gaps, most important services, and other issues that should be considered in the PSRA process. Discussion from this Town Hall meeting is summarized and provided to the Planning Council.

In 2011, a large majority of the directives – which provide guidance to the grantee on how best to meet identified priorities – approved by the Planning Council originated in issues raised and recommendations made at the various PLWH town hall meetings.

Principles for PSRA Decision Making: The Planning Council has adopted and implemented a set of principles to guide PSRA decision making, many of them designed to ensure that the process is responsive to the identified needs of people living with HIV disease throughout the EMA. For example:

- **Priorities and allocations are data-based.** Decisions are based on the data, not on personal preferences or individual experiences. Planning Council members are required to participate in the Data Presentation in order to participate in PSRA sessions. Data used for decision making include epi data, other needs assessment data (such as results of special studies, PLWH town hall meetings, PLWH surveys, and provider capacity and capability data) as well as Grantee client utilization data and cost data from both the last full year and the current year. The data are summarized in a written Data Matrix that is disseminated before and during the Data Presentation and presented through Power Points and intensive discussions. The data are also briefly summarized at the beginning of each work session and summary data (such as the Matrix) are provided in work session information packets for reference.
- **In the review of data, information from different sources is "weighted."** The more reliable the data source and the larger the number of PLWH perspectives involved, the greater weight given to that data in setting priorities and allocating resources. Anecdotal data and "impassioned pleas" presented in discussions, Town Hall meetings, focus groups, and/or surveys are considered. But they are given less weight than a survey of 1,000 PLWH or other more formal needs assessment data sources.
- **Conflicts of interest are stated and managed, to avoid inappropriate domination by individuals representing funded providers.** At the beginning of each work session, all Planning Council members and community participants disclose verbally any service categories in which they have a conflict of interest (e.g., they are employed by or on the Board of a provider funded under Part A to deliver this service). An individual with a conflict of interest may neither initiate discussion nor vote on individual priorities or allocations for those service categories. Individuals representing providers are permitted to answer factual questions about the service category (not about their individual agency), and are not permitted to vote on priorities or allocations that involve the service categories for which they have a conflict of interest, except when voting is for an entire list or "slate."
- **Service needs and gaps for specific populations and geographic areas are an integral part of the discussion and decision making,** and are highlighted in the Data Presentations. Results of special studies (e.g., key informant sessions, focus groups, and client utilization data) are carefully reviewed.
- **The Planning Council uses its decision making to help achieve parity in access to services** for all Ryan White-eligible PLWH, regardless of their characteristics or where they live in the EMA.
- **There is a continuing focus on reducing unmet need** by getting people who know their status into HIV-related primary medical care and keeping them there**.** This means ensuring funds for service categories to help individuals enter care. It also means using needs assessment and client utilization data to estimate the mix of services such individuals are likely to need from Part A, and allocating funds sufficient to meet increased demand for those services. Where a choice must be made between providing a

wider range of services and getting additional people into care, the Planning Council gives priority to making critical services available for additional PLWH (such as HIV-related medical care and medications). For example, in 2011, funds were redirected to help support the Virginia's ADAP program, to reduce the waiting list for Northern Virginia clients.

- **Emphasis is placed on Early Identification of Individuals with HIV/AIDS (EIIHA),** with support for efforts to maximize testing and prompt linkage to care for the newly diagnosed. For example, in 2011 the jurisdictions and Planning Council increased emphasis on and funding for EIS, favoring it over outreach as a service category that is more closely linked to testing and more able to ensure that PLWH are not just referred to a medical provider but also helped to become fully connected to care. The Planning Council provided off-the-top funding to test a peer-based EIS program in all parts of the EMA.

In addition to regular needs assessment, the comprehensive planning process has involved extensive information gathering from consumers of Ryan White services and other PLWH – through jurisdictional PLWH groups, an EMA-wide town hall meeting, sessions with planning bodies and advisory groups in each jurisdiction, and meetings with groups like peer community health workers to obtain their special perspective. The findings from these efforts have been aggregated, summarized, and used in preparing this plan – and will also serve as PLWH input to the 2012 PSRA process.

Chapter 6: Evaluation of the 2009-2011 Comprehensive Plan

A. Overview

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

B. Progress, Challenges, and Lessons Learned

Figure 62, below, provides the goals and objectives from the previous comprehensive plan, along with planned deliverables, timeline, progress made, challenges encountered, and lessons learned.

Progress: As the chart indicates, the Planning Council has made progress in many aspects of its operations, from formalizing a multi-year needs assessment process to adopting updated standards of care for all funded core medical-related service categories. HRSA/HAB technical assistance to the Planning Council was in process when the 2009 plan was developed. It was successfully completed, leading to a Memorandum of Understanding (MOU) between the Grantee and Planning Council, a refined Planning Council committee structure, revised Bylaws, and a set of updated policies and procedures to guide the Council. In 2011, the Planning Council restructured its priority setting and reallocations process to make it more efficient and to ensure structured PLWH input at all stages. As of the end of 2011, the MOU, Bylaws, and policies and procedures were in the process of being reviewed and updated to reflect experience and changes in the program, and a new MOU was being negotiated. The revised MOU was signed by the Planning Council and Grantee just as the new program year began in March.

A new mayoral administration took office in the District of Columbia in January 2011, which meant staffing changes but a continued high Grantee priority on addressing the HIV/AIDS epidemic through testing, early entry into care, and "treatment on demand."

The Planning Council recommended a full slate of members to the DC Office of Boards and Commissions in November 2011, after a targeted recruitment effort that brought 30 new applicants and 18-20 members requesting renomination, and a thorough vetting process. In early May, the Mayor swore in a new Planning Council that includes 19 new and 16 returning members.

The Grantee also reported success with most of its objectives. Perhaps its greatest accomplishments involve making the transition to outcome-based measurement of program success, including increasing use of viral load measures. There has been considerable success in increasing routine testing, due to the combined efforts of Prevention and Ryan White programs, and in helping newly diagnosed PLWH enter care within 90 days. The Grantee has also refined its three-tiered contract monitoring process to meet the National Monitoring Standards requirements, worked with subgrantees to ensure full understanding and consistent

implementation of sliding fee scale and cap requirements. The Grantee and Administrative Agents have also carried out numerous capacity-building sessions for subgrantees.

Challenges: There were some important challenges. Some planned efforts related to systems change based on analysis of client and program data were not feasible because of delayed implementation of the planned Maven client-level data system; once the system is fully implemented, these tasks will be implemented. The lack of a reliable client-based data system continues to limit the availability and quality of service utilization data, needed by both the Grantee and Administrative Agents and the Planning Council for optimal data-based decision making. With the change in Department of Health leadership, the MOU between the Grantee and Planning Council was not used in 2011, although it was under reviewed, revised, and adopted early in 2012. Some planned needs assessment activities were disrupted in 2011 because the final grant award from the federal government was delayed and this led to limitations on Planning Council support activities for most of the second half of the calendar year, but full activities were resumed in December 2011. The economic situation – which affected the entire EMA although it hit some jurisdictions harder then others – led to an increase in the number of PLWH needing Ryan White services – and contributed to Virginia's ADAP waiting list.

Lessons Learned: The importance of external factors was clearly demonstrated during the 2009-2011 period. The 2009 Ryan White legislation brought new requirements for the Ryan White program in addressing HIV-positive/unaware individuals, and the National HIV/AIDS Strategy provided a new focus and is bringing significant changes in strategies and priorities for HIV prevention, testing, and care. The passage of health care reform legislation has led to some short-term changes in health care systems and intensive planning for a significantly changed health care safety net – with implications for Ryan White and for HIV services unlikely to become clear until after the Supreme Court's decision is announced. The great importance of a close working relationship between the Grantee, Administrative Agents, and Planning Council was evident, as well as the necessity for enhancing collaboration between prevention and care. The complexities of the four-jurisdiction EMA; the necessity of involving four state health departments as well as regional entities were evident with regard to collaborative prevention planning and planning for health care reform. The proposed work plan for the 2012-2014 comprehensive plan attempts to take these lessons into account.

Figure 62: 2009-2011 Comprehensive Plan Goals and Objectives: Progress, Challenges, and Lessons Learned

Objective	Responsibility and Deliverable	Time Line	Progress and Challenges	Lessons Learned
Goal 1.*Ensure HIV-positive persons learn their HIV status, enter care early through the promotion of effective strategies that enable individuals to access care and remain connected.*				
Objective 1.1 Develop a comprehensive needs assessment strategy for the three year planning period, covering an assessment of service gaps, examining out-of-care populations, emerging populations, provider inventory and provider capacity.	Needs Assessment Plan outlining specific activities	Annually-2009, 2010 and 2011	Strategy and timeline developed that include a PLWH survey every 3 years and other activities during the other years, to include all HRSA-recommended needs assessment components and focus on key populations. Progress includes: • Provider Survey in 2009 • Special studies including focus groups and key informant groups plus re-analysis of provider survey data on three key/emerging populations in 2011 (Latinas, African immigrants, and Older PLWH) • Provider inventory funded in 2010-2011, delayed, but completed at the end of 2011 • Survey of provider capacity in progress in early 2012 • PLWH town halls implemented in 2011 and improved working relationship with the consumer community in the District, VA and MD	• Needs assessment activities must be scheduled over a 3-year period both due to limits in Planning Council funds and because of the demands of other legislative tasks, such as comprehensive plan development • Strong collaboration with the Consumer Access Committee, PLWH groups in DC, MD, and VA, and engagement with Northern Virginia HIV Consortium very helpful in obtaining consumer input • Provider subcontracts do not currently require cooperation with Planning Council needs assessment efforts, which has caused challenges in getting

Objective	Responsibility and Deliverable	Time Line	Progress and Challenges	Lessons Learned
			• PLWH and provider town halls implemented in early 2012 as part of comprehensive planning process, generating extensive needs assessment data Support staff changes in 2009 and federal funding delays in 2011 and delayed implementation of some needs assessment components.	provider assistance with PLWH surveys and provider surveys
Objective 1.2 Perform more detailed analysis of data and better inform the Planning Council around retention in care, lost-to-care and special populations	Grantee – Report	Priority Setting 2009	The Grantee coordinates syntheses of data across the EMA and presents on epidemiologic and service utilization data during the priority setting and resource allocation (PSRA) process to the Planning Council and throughout the year to Planning Council subcommittees. During PSRA processes for the years of the 2009-2011 Comprehensive Care Plan, the Grantee data analysis and presentation included: • Epidemiology • Trends and key issues for consideration in the EMA • Service utilization and expenditure • Estimates of unmet need and entry into care • Special population assessments, which varied among years As the system of care continues to evolve, so too does the need to implement new methods of tracking and programs around retention in care and special populations. The Grantee continues to improve its strategies for collecting, analyzing, and managing the complex data, as well as sharing of this information, as indicated.	

Objective	Responsibility and Deliverable	Time Line	Progress and Challenges	Lessons Learned
Objective 1.3 Monitor trends on high-risk populations and other issues including increases in male-to-female transmission rates, late testers, concurrent diagnoses, hepatitis C, partner concurrency, comorbidity, methamphetamine, substance abuse, homelessness	Grantee – Scheduled presentations to Planning Council committees and Priority Setting	Ongoing	In order facilitate data-driven decision making by the Planning Council, the Grantee provides on an ongoing basis the following data for consideration during the priority-setting process: • Newly diagnosed cases by mode of transmission • Estimates of late-testers • Emerging populations with special needs • Trends in health care financing and delivery • Co-morbidities for HIV cases within the District This data assists in understanding the increased demand for services for high-risk populations and affords the EMA the opportunity to respond by allocating additional funding for those services targeting individuals unaware of their HIV status and disproportionately impacted populations.	
Objective 1.4 Strengthen the service delivery system EMA-wide through targeted capacity building activities and coordination with non-Ryan White funding sources that will improve the organizational capacity of providers to reach historically underserved populations	Grantee – Planned capacity-building initiative for providers	Ongoing	HAHSTA aims to decrease disparities through strategic initiatives designed to build the capacity of organizations that target populations in the EMA, 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 Grantee and Administrative Agents provided capacity building and technical assistance on a regular basis. In FY 2011, 21 Part A subgrantees (88%) received technical assistance in the District of Columbia; eight (89%) in Northern Virginia, and six (67%) in Suburban Maryland. Technical assistance was provided in the form of formalized programmatic 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. In March 2010, the Grantee launched a series of specialized trainings on Medical Case Management to inform subgrantees of purposeful integration of HIV case management and HIV treatment adherence programs with HIV medical care, mental health, substance abuse, supportive services, entitlements information, and successful treatment outcomes. Throughout the years of this Comprehensive Care Plan, quarterly training was conducted for medical case management staff, and participation is required by organizations	

Objective	Responsibility and Deliverable	Time Line	Progress and Challenges	Lessons Learned
			funded for medical case management in the District of Columbia. In addition, the Grantee also offers monthly Brown Bag presentations, made by subject matter experts and community members to share best practices, recent research findings, and evidence-based approaches to reaching target populations.	
Goal 2. *Ensure improved health outcomes through access to comprehensive, high quality, culturally competent medical and support services.*				
Objective 2.1 Evaluate the overall health care delivery continuum of care by reviewing, revising, and implementing evaluation mechanisms	Planning Council – Evaluation measures and ongoing evaluation reports	Annually	• Planning Council obtains outcomes data primarily service category data from HAHSTA's quality management (QM) contractor, when QM reports are made available. • CSCS Committee has requested regular QM reports by service category. • Changes in the client-level data system have delayed availability of some outcomes data. • In late 2011, EMA Cross-Part Collaborative began generating client outcomes data using a variety of measures; includes measures such as viral suppression from outpatient/ ambulatory care providers. • EMA is now moving to a "treatment cascade" focused	• HRSA core clinical performance measures, EEIIHA requirements, and HIV Prevention measurable outcomes all support use of outcome measures; some form of "treatment cascade" measures appears to be particularly appropriate for Ryan White outcome measurement. • Once new Maven data system is fully implemented, it will be easier to assess client outcomes and connect those outcomes to the mix of services provided. • CSCS has begun reviewing QM data, advocating for use of peers in QM, and holding roundtables to explore

Objective	Responsibility and Deliverable	Time Line	Progress and Challenges	Lessons Learned
			approach to assessing client outcomes, using measures such as number tested, number diagnosed with HIV/AIDS, percent late tested, percent entering care within 90 days, percent retained in care, treatment adherence, and viral suppression.	issues of service quality and effectiveness, and refining standards of care. • Planning Council is using evaluation results to develop directives and refine program models – for example, it has designed and allocated funds for a pilot peer community health worker-based Early Intervention Services (EIS) program and has issued a directive for a 3% set-aside for a provider for senior citizens because of the documented need for more services targeting older PLWH.
Objective 2.2 Improve monitoring systems by reviewing and revising health outcome measures for service categories and overall evaluation mechanisms	Grantee – Health Outcome measures by service category and monitoring reports	Annually	The Grantee, with coordinated efforts of the Administrative Agents, implemented activities to assess the quality of services provided by sub-grantees. Activities such as monthly and quarterly reporting of provider- and system-level indicators, and quality assurance and programmatic site visits and follow-up improved provider operations and services delivered to clients. Evidence of improvements, relative to the emphasis on health outcomes, include the following: • Further alignment of measures with HRSA HIV/AIDS Bureau (HAB) Performance Measures	

Objective	Responsibility and Deliverable	Time Line	Progress and Challenges	Lessons Learned
			• Participation and leadership in the DC EMA Cross-Part Quality Improvement Collaborative • Standardized collection and reporting of health outcome data • Administrative Agent and subgrantee measures and reporting template review and input sessions • Substantial revision and implementation of clinical quality care for providers of ambulatory outpatient medical care throughout the EMA Re-solicitation of the contract to support these activities will be conducted by mid-year in calendar 2012. An emerging component of understanding HIV health outcomes 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.	
Objective 2.3 Evaluate the cost effectiveness of service delivery.	Grantee and Planning Council – Reports at Priority Setting and Resource Allocation Meetings	Ongoing	This objective has not been addressed. The EMA does not currently have consistently defined units of service or reliable data on costs per client.	It is very difficult to do meaningful cost effectiveness measurement without both consistent definitions for and reporting of unit costs, as well as reliable data on service costs per client.

Objective	Responsibility and Deliverable	Time Line	Progress and Challenges	Lessons Learned
Objective 2.4 Improve the data collection system of the EMA in order to meet new HRSA requirements and for use in service analysis needs	Grantee – Implementation of a new data collection system and special reports	Ongoing	In 2009, HAHSTA began shifting its focus to measuring health outcomes for HIV-infected clients as a method of enhancing quality improvement efforts throughout the EMA. Simultaneously, HAHSTA expanded its assessment of quality care to include all HIV care services in the EMA, regardless of payer source. This renewed approach in evaluating programs and quality of services was a driving force behind the decision to develop and implement a new, comprehensive HIV/AIDS monitoring and evaluation 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 • Evaluate cost and cost-effectiveness of programs and services • Increase compliance of sub-grantees in reporting requirements by simplifying data entry procedures • Adapt more quickly to future requests and/or changes in federal requirements HAHSTA is at the end of the second phase of a three-phase MIS development and roll-out strategy. Once implemented, Maven will support HAHSTA's overall strategic vision for program activities and planning which focuses on data collection, data quality, and data use. Being that provider and laboratory data are critical components that inform the quality program, Maven will enhance real-time electronic reporting mechanisms for the EMA, such as electronic laboratory reporting (to allow for clinical indicator, CD4 and VL, monitoring), and availability of core medical, support service, and housing utilization information. Access to this information will not only provide a more holistic view of the client by connecting the routine program data to the outcome and laboratory data, this richer data set will allow HAHSTA to improve	

Objective	Responsibility and Deliverable	Time Line	Progress and Challenges	Lessons Learned
			and expand coordination of services among our subgrantees, and monitor the spectrum of HIV-related illnesses and trends in the local epidemic.	
Objective 2.5 Review and revise monitoring tools to ensure that they provide aggregate and accurate information on service utilization, expenditures and quality of care	Grantee – Monitoring Tools	Ongoing	Monthly, quarterly, and annual reporting templates and monitoring tools are reviewed and revised for feasibility, uniformity, and appropriateness on an ongoing basis with internal program and grant staff, as well as with external Administrative Agents and subgrantees. The Grantee is developing a comprehensive monitoring tool for the HRSA Program and Fiscal Monitoring Standards for Ryan White 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 to ensure capacity and validation, and internally tested by program and grant monitors. After internal testing, the tool will be piloted for ease of implementation with external stakeholders during site visits.	
Objective 2.6 Delineate roles and functions of Quality Management, Planning, Monitoring, and Evaluation at the Grantee, Administrative Agent and provider level to reduce redundancy in efforts and establish uniformity in operations	Grantee – Jurisdictional Agencies Develop appropriate level protocols and policies based on HRSA guidelines	2010	The Grantee has an established Quality Management Program (QMP) that, in accordance with the Ryan White Treatment Modernization Act, is responsible for the oversight and management of quality activities throughout the multi-jurisdictional area. HAHSTA's leadership has dedicated both personnel and resources to support its commitment to monitoring performance and developing strategies for improvement in the provision of care that will lead to sustained improvement in the quality of services provided to and the health outcomes of individuals with HIV/AIDS. The Care, Housing, and Support Services Quality Team was established within HAHSTA to assist in the quality management	

Objective	Responsibility and Deliverable	Time Line	Progress and Challenges	Lessons Learned
			and improvement activities. The multi-disciplinary team consists of key staff who work with various internal and external partners to ensure that quality management and performance improvement is a component of all activities throughout the EMA. The responsibilities and functions of the team members and stakeholders are outlined in the Quality Management Plan that is shared with the Care Strategy, Coordination, and Standards Committee of the Planning Council.	
Goal 3. *Maximize resources throughout the EMA through increased linkages and coordination among Ryan White programs and non-Ryan White programs (such as Medicaid, Medicare, Veterans Affairs, and other programs of the District of Columbia, Virginia, Maryland, and West Virginia)*				
Objective 3.1 Increase collaboration with Part B, Medicaid and other funding sources across the four jurisdictions to identify best practices for improved linkages and strengthened partnerships	Grantee – Regular meetings and set of recommendations	2009	In 2010, the Department worked closely with the DC Department of Health Care Finance to support more than 1,000 persons living with HIV to enroll in the Health Care Reform expansion of Medicaid. The District launched a rapid entry into care program guaranteeing a HIV medical appointment within 72 hours of a person's diagnosis. The Part 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 counseling, testing, and referral (CTR) in a wide variety of settings including hospitals, clinical settings, specialized, non-medical, community based organizations, and upon entry into the DC Jail. The Planning Council increased its allocation of funds for Early Intervention Services to expand support for this coordinated effort. In addition, the Grantee continues to work with managed care	

Objective	Responsibility and Deliverable	Time Line	Progress and Challenges	Lessons Learned
			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 across the EMA.	
Objective 3.2 Determine the level of compliance of providers with regard to third party reimbursement, sliding fee and cap requirements	Grantee – Report	2010	Nearly 95% of clients receiving Part A-funded services in the Washington, DC EMA are documented as having been 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 Ryan White subgrant. All subgrantees are required to bill, collect, and report all revenue from third-party payer sources, and to return the revenue as program income to benefit 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	

Objective	Responsibility and Deliverable	Time Line	Progress and Challenges	Lessons Learned
			apply for Ryan White 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 payer 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 Ryan White services received during the 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 Ryan White funds, then subgrantees are required to bill, collect, and report those funds as program income. The process used to assess compliance is a quarterly report of third-party revenue by funding source, and a review of client files to test documentation of screening. This information is reviewed by program officers during the site visit. The EMA uses a multi-step process to ensure that all Ryan White 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 Council 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 utilizes contractual provisions that require any agency that does business with the Grantee to ensure that Ryan White remains the payer of last resort.	

Objective	Responsibility and Deliverable	Time Line	Progress and Challenges	Lessons Learned
Objective 3.3 Identify technical assistance needs of the provider system to maximize third party reimbursement and implement sliding fee and cap guidelines	Grantee -- Recommendations	2011	HAHSTA has had intensive interactions with the federal Health Resources and Services Administration (HRSA) regarding the implementation of sliding fee scale and cap requirements. During the period under review, HAHSTA has • Developed and circulated draft policies and procedures on sliding fee scale requirements. Drafts of the policy and presentation of the policy were reviewed by HRSA. • Convened two technical assistance sessions – one of which included HRSA participation – for all subgrantees. The technical assistance sessions included specific discussion and guidance on the implementation of sliding fee scale and cap requirements. • Ryan White Part A and (in the District of Columbia) Part B service agreements for Grant Year 22 include requirements on the preparation, adoption, posting, and circulation to clients of the policy used by each organization. Compliance will be included as part of the review of client charts and organizational operation.	
Objective 3.4 Assess provider current capacities for core medical and support services within each jurisdiction of the EMA	Grantee – Report	2010	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 subgrantee 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 subgrantee capacity and progress toward achieving programmatic and fiscal targets, and to identify barriers that may impede ability to deliver planned services or achieve proposed client targets and timely expenditure of funds. All subgrantees receive a comprehensive site visit, at least annually. • Tier II. On the Administrative Agency level, subgrantee site visits are conducted annually by the Grantee with a focus on deliverables of funding mechanisms known as Inter-	

Objective	Responsibility and Deliverable	Time Line	Progress and Challenges	Lessons Learned
			Governmental Agreements (IGAs) 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 subgrantees. • Tier III. The Quality Assurance (QA) program conducts Comprehensive Quality Assurance (QA) Site Visits, designed to assess clinical standards, with a focus on assessing the current HRSA-identified legislative and programmatic requirements of core clinical health services. The main objective is to assess current clinical practices to ensure quality of HIV treatment and care, and then to make recommendations for improvement of practices to obtain optimal results according to the most restrictive legislative and federal expectations and requirements (as well as best practices) while assuring congruence with respective state standards.	
Objective 3.5 Assess future capacity needs based on reviewing and revising current needs assessment tools and implementing an improved and ongoing comprehensive needs assessment protocol	Planning Council – Report	2010 and ongoing	• Some needs assessment activities planned for 2009 and 2010 were delayed due to changes in Planning Council logistical and technical support staffing. Special studies conducted in 2011 focused on three special populations (Older PLWH, Latinas, and African	• Comprehensive needs assessment requires full cooperation not only by the grantee and administrative agents, but also by all funded providers. This is likely to occur only if provider subcontracts require providers to complete surveys, inform

Objective	Responsibility and Deliverable	Time Line	Progress and Challenges	Lessons Learned
			immigrants); they included key informant sessions and focus groups as well as a review of relevant 2009 PLWH survey data and addressed issues of provider capacity. • A survey of provider capability and capacity was initiated in March 2011; it includes questions about provider capacity and coordination. In addition, an EMA-wide provider town hall held in March 2012 addressed those issues. • Some funded providers do not assist with needs assessment efforts, and there is no way to enforce participation in data requests or needs assessment surveys or sessions, since provider subcontracts do not require it. • The Needs Assessment and Comprehensive Planning Committee has revised its approach to include a three-year schedule that includes	clients about opportunities to participate in surveys, focus groups, and other needs assessment activity, and provide other data needed for assessing the system of care and provider capacity. Active engagement and support from the grantee and administrative agents is also very important.

Objective	Responsibility and Deliverable	Time Line	Progress and Challenges	Lessons Learned
			attention to provide capacity.	
Goal 4. *Improve the effectiveness of the Planning Council to ensure that the system of care in the Washington D.C. EMA addresses the needs of communities affected by the disease and fulfill the legislative requirements.*				
Objective 4.1 Increase collaboration and coordination with other funding sources by filling mandated slots on the Planning Council	Planning Council – Filled mandated slots	2009	The Planning Council has made significant progress in this area, with some limitations that are outside its control. • The Planning Council's Membership Committee works hard each year to recommend a full slate of candidates to DC's Office of Boards and Commissions. For example, the slate recommended in the fall of 2011 filled all required slots after reviewing 30 new applicants and 18-20 re-applications from current members. • Getting representation from far-out suburbs is difficult given the size of the EMA.	• Applications for the Planning Council have increased over the past several years in response to the improved structure, policies and procedures, and operations of the Planning Council. • In order to reduce vacancies and ensure that mandated slots are filled, it would be helpful to move back to staggered terms. • If there were a way to expedite the vetting process that must be carried out by the Office of Boards and Commissions so that applicants could be vetted year-round and the

Objective	Responsibility and Deliverable	Time Line	Progress and Challenges	Lessons Learned
			The Planning Council is trying t use technology (such as Skype) to overcome the distance barriers, particularly to get representation from individuals in West Virginia. • The former DC Mayor changed the terms of the Planning Council so that now ALL member terms end at the same time. • There have been lengthy delays in the Boards and Commissions review process, with the result that a growing number of vacancies occur, and some nominees drop out before the appointments are made. Terms are supposed to end in December, but as of mid-March 2012, new candidates for 1012-2013 had not yet been appointed. • The Planning Council uses a year-round application process in order to fill vacancies as they arise.	annual applications could be acted on within 3 months, this problem could be resolved.
Objective 4.2 Work closely with HRSA-	Grantee and Planning Council	2009	This objective was met in 2009 and work continued to ensure	• Having an EMA that includes both the District of

Objective	Responsibility and Deliverable	Time Line	Progress and Challenges	Lessons Learned
funded technical assistance to ensure that all Planning Council activities operate according to federal requirements	– Assessment and request for continued technical assistance		continued compliance with federal requirements through 2010 and 2011. The Planning Council received extensive consultant assistance in 2008 and early 2009 through the Ryan White Technical Assistance Contract. HRSA-funded technical assistance was in place at the beginning of the period of the Comprehensive Care Plan, but HRSA support ended in 2009. The Planning Council has, through its use of a logistical support contractor, secured additional support for its activities. • During the TAC TA period, the Council reviewed and refined operations and restructured committees to ensure that all federal mandates would be met. • The Planning Council Chair was added to monthly conference calls between HRSA/HAB and HAHSTA, which greatly enhanced communications and access to advice and best practices.	Columbia and parts of three states complicates the role of the Planning Council, particularly with regard to needs assessment and PSRA. The Planning Council is committed to engaging consumers, providers, and other stakeholders in all jurisdictions in carrying out its federally required activities – and this often means a series of regional meetings or consultations in each of the four jurisdictions. • To complete its work, the Planning Council requires competent, committed staff as well as technical and logistical consultants. There have been changes in the structuring of the logistics and technical support contract to help ensure needed services to support the Planning Council's work.

Objective	Responsibility and Deliverable	Time Line	Progress and Challenges	Lessons Learned
			• The Planning Council Chair maintains regular communication with HRSA and the grantee. • The Project Officer/Branch Chief in 2009-2010 reviewed and approved the revised Bylaws, committee structure, and revised policies and procedures. In 2011, the new Project Officer/Branch Chief attended several meetings and reviewed proposed changes in policies such as Priority Setting and Resource Allocations (PSRA).	
Objective 4.3 Develop standard operating procedures and expectations for the redefined Planning Council committees and newly filled mandated slots on the Planning Council	Planning Council – Annual work plan with defined deliverables and delineation of responsibilities and activities for each committee and mandated slot representative	2009	• The Planning Council completed a full review, updating, and development of additional policies and procedures in 2009. • Annual work plans were implemented for Planning Council committees in 2009. • A refined priority setting and resource allocations process was adopted and implemented in 2011, including specific roles for	• Effective committees are key to carrying out Planning Council mandates. Standard operating procedures, annual work plans, and assigned Planning Council support and grantee staff are all needed to make committees effective. • Developing clear expectations for Planning Council members is

Objective	Responsibility and Deliverable	Time Line	Progress and Challenges	Lessons Learned
			most committees • Regular reviews and updates of policies continued in 2010 and 2011. • In 2011, the Planning Council made significant changes in the PSRA process, managed by the Financial Oversight and Allocations Committee (FOAC) to provide for a data-based system that ensures more structured PLWH input and provides for jurisdiction-specific resource allocations to be led by the Planning Council members from each jurisdiction. The new system was successfully piloted in 2011 and refined slightly in preparation for 2012. • The Planning Council began in late 2011 to develop a committee-based budget, based on planned committee tasks and products, for the program year beginning in March 2012. • Additional Bylaws revisions were adopted early in 2012.	important, but this is related more to the overall responsibilities of members and the specific roles of committees than to the specific mandated slots filled by the individual members.

Objective	Responsibility and Deliverable	Time Line	Progress and Challenges	Lessons Learned
			• Progress has been made in clarifying the expectations of Planning Council members generally and the particular expectations based on slots, but separate position descriptions based on mandated slots are not considered desirable, since all members have common purposes. It is, however, considered important that members understand the expectations for expertise and information sharing specific to their slots.	
Objective 4.4 Establish and implement an MOU between the Grantee and Planning Council outlining responsibilities and activities.	Grantee and Planning Council – MOU	2009	• An MOU was developed and signed by the grantee and Planning Council at the end of February 2009 and approved by the Project Officer as well. However, with changes in Department of Health and Planning Council leadership and support staff, MOU was used less and less in 2010 and 2011. • A revised memorandum of understanding was proposed	• An MOU is very useful in structuring and guiding the relationship between the grantee and Planning Council, particularly when changes occur in staffing or membership. However, the MOU is useful only if it is actively used by both parties and reviewed regularly.

Objective	Responsibility and Deliverable	Time Line	Progress and Challenges	Lessons Learned
			by the Planning Council in October, 2011, under the leadership of the Bylaws and Policies and Procedures Committee, and was reviewed and ultimately adopted by the Planning Council and HAHSTA and signed on February 29, 2012.It is in place for the 2012 program year.	

Section 2: Where Do We Need to Go?

Chapter 7: Description of an Ideal System of Care for the EMA

A. Overview

This chapter describes an "ideal" system of care for the Metropolitan Washington EMA. It identifies characteristics and components of a refined system of care, defined by the Planning Council and Grantee, with input from more than 200 PLWH and the Administrative Agents.

The EMA recognizes that the health care system is changing, and HIV/AIDS services will be a part of that change. Despite uncertainty about implementation of the health care reform legislation, it is clear that third party reimbursements will be a growing part of the funding for HIV/AIDS care, and that medical and support services for many if not most clients will be paid for by multiple sources. This makes it particularly important that a coordinated, HIV-centered but comprehensive system of care be developed – using a medical home/health home or similar model. Because the EMA includes municipalities with four different Medicaid programs and very different public health systems, the model must be flexible enough to work in all of them.

Given the shared responsibilities for HIV testing, linkage to care, and retention in care, the EMA has also envisioned a system that integrates prevention and testing with care and treatment. Such system integration is also necessary so that the EMA fully addresses the goals and priorities of the National HIV/AIDS Strategy – from testing and early entry into care to effective treatment leading to positive clinical outcomes and elimination of health disparities.

B. Guiding Principles and Values

The Metropolitan Washington Regional Ryan White Part A Program is large, complex, and diverse, with a high rate of unmet need and probably a considerably higher percentage of HIV-positive undiagnosed individuals than most jurisdictions. African Americans and other communities of color (including African immigrants and Latinos) are severely affected by the epidemic, and continue to suffer from health disparities. Part A funding has been flat for the past three program years, while states and localities – even the District of Columbia, which has the highest per capita public health expenditures in the nation – have reduced public health and human service expenditures as a way of addressing revenue shortfalls. Yet the EMA places great value on increasing testing and providing for prompt linkage to care – which in turn require increased capacity to provide medical care, case management, medications, and the wraparound services necessary to keep PLWH in care and adherent to treatment.

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

1. **Coordinated care,** regardless of funding streams. As the health care system changes and – if health care reform moves forward – many PLWH become Medicaid eligible or enroll in insurance provided through the state exchanges, the need for case management and care coordination will be even greater. While the EMA cannot select a specific model until decisions have been made about health care reform and its implementation in the four

different jurisdictions, some form of medical or health home or comprehensive care center model needs to be developed and tested. It should engaged diverse providers, including community-based organizations with special capacity to reach and serve high-priority populations who may face significant health disparities – from transgenders to young African American MSM, immigrants, and the multiply-diagnosed. And it should engage providers regardless of their funding sources.

2. **Access to information.** The EMA must increase awareness and understanding of HIV disease and of prevention, testing, and care resources – so residents better understand the disease and so that PLWH can easily learn where to get tested and how to obtain care, especially if they require free or low-cost services.
3. **Maximum PLWH participation.** Efficient use of resources and effective treatment are best ensured by extensive and varied engagement of PLWH – as peer community health workers (CHWs) in multiple service categories, staff at all levels within provider organizations, Planning Council members, volunteers who link the Ryan White program with the community, and sources of input to planning and decision making.
4. **Communication and collaboration at all levels** – among prevention, testing, and care; between Ryan White and non-Ryan White providers; across jurisdictional lines; between HIV/AIDS specialists and the general health care safety net; and across jurisdictional boundaries.
5. **Improved data access, sharing, reporting, and use** – for evaluation of client outcomes and assessment of the system of care and for coordinating client care, with data collected through the planned Maven data system/warehouse analyzed, and used by the Planning Council and providers as well as by the Grantee and Administrative Agents, so that decisions at all levels can be truly data-based.

C. Components and Characteristics of an Ideal System of Care

An "ideal" system of care for the Metropolitan Washington EMA – a system maximizing capacity to address the NHAS goals and to meet the needs of a complex EMA – should have the following components and characteristics:

1. **Integration of prevention, testing, and care** into a seamless system that begins with prevention education and continues through testing, health and HIV literacy, referral and linkage to care, navigation within the system, treatment adherence, retention in care, and achievement of positive clinical outcomes including viral suppression. This system will have common definitions for service outcomes, clear delineation of roles, communications and data sharing, recognition of the importance of treatment as prevention, as well as coordination of prevention and care planning to the extent feasible given multiple jurisdictions. Such integration will help maximize both routine and community testing and as well as early entry into care, retention in care, and positive clinical outcomes.
2. **Some form of "medical home" or other coordinated service model**, so an individual with HIV disease obtains comprehensive services through an organized system of direct services and referrals that provides access to HIV-related medical care, primary medical care, medications, medical case management, specialty care, and other "wraparound" services necessary to achieve viral suppression and ongoing good health. If a PLWH obtains services through more than one payer – e.g., Medicaid, Medicare, private insurance, Ryan White, and

perhaps other public programs – these services will be coordinated and managed through a single entity – the "medical home" or comprehensive care center, physical or virtual. There will generally be multiple providers, and community-based organizations will be an integral part of the model because of their special expertise with specific population groups.

3. **Employment of peer community health workers (CHWs) and other HIV-positive individuals throughout the system,** in many service categories. This includes involvement of peer CHWs to help people get tested, learn about living with HIV disease, enter care, learn to navigate the system, adhere to treatments, and remain closely linked to care. It also includes support for the employment of HIV-positive individuals in all kinds of positions. The EMA will have standards of care and directives that incentivize hiring of peers and other PLWH and will ensure that they receive appropriate training and career training opportunities.
4. **A centralized and well publicized source of information about HIV testing, and care throughout the EMA,** which provides up-to-date service information across jurisdictions and is available to both consumers and providers, including private physicians. The system should be accessible online and in other ways.
5. **Expanded testing,** especially routine testing and testing in non-traditional locations, to increase early diagnosis and reduce transmission. This requires engagement of and collaboration among community-based organizations, safety-net clinics, hospitals, private physicians, and public agencies, as well as public and private insurance providers.
6. **Rapid access to medical care** with minimal waiting time for both newly diagnosed individuals and PLWH who have never been in care or dropped out of care. This requires strengthening the Red Carpet Entry model used in DC and ensuring similar immediate-access processes in other jurisdictions, adopting other changes to minimize waiting time for first appointments for PLWH who are newly diagnosed or re-entering care, encouraging or requiring medical providers to save some time slots for same-day access to care without an appointment for current clients, and perhaps other strategies.
7. **Increased choice, portability, and parity in access to care** throughout the EMA for all PLWH, regardless of their characteristics or their place of residence. This should enable a person with HIV disease to obtain culturally and linguistically appropriate services within his/her jurisdiction of residence where possible, and in another jurisdiction where necessary due to stigma or specific needs. A PLWH should not automatically have to change providers if s/he moves to another jurisdiction or if s/he becomes eligible for a different payer, public or private, under health care reform.
8. **Bridge programs that enable special populations to make necessary transitions into and across care services.** Some people with HIV disease – such as formerly incarcerated PLWH returning to the community and young adults aging out of pediatric care – are forced to change providers, but need skilled support to become fully linked to appropriate services. This requires ensuring providers and personnel with appropriate responsibilities and competence.
9. **Services and providers with expertise to provide culturally competent and expert care that maximizes retention.** This requires the capacity to meet the needs of diverse clients, among them transgenders, MSM, IDUs, African and Latino immigrants, adolescents, older PLWH, and women. This requires funding of providers with specific expertise, including CBOs, and increased flexibility to allow PLWH to access services from appropriate

providers. It also requires supports to providers including access to training for clinicians, case managers, peer CHWs, front desk personnel, and other staff to develop the cultural competence and skills to effectively serve individual clients from various PLWH populations.

10. **Institutional systems and procedures to maximize retention,** such as referral and collaboration procedures that provide prompt access to needed medical-related and support services and lead to treatment adherence and positive clinical outcomes**.** This includes both Ryan White-defined core services such as mental health and substance abuse treatment and support services like transportation, housing assistance, and food, whether provided through Ryan White or other funding streams. It also includes referrals to vocational rehabilitation and employment and training services for PLWH who want to return to work. Such procedures must be based on access to information about available services both online and from knowledgeable case managers and other personnel, and improved coordination and collaboration between Ryan White and non-Ryan White service providers.
11. **Services specifically designed to help PLWH adapt to the changing health care system and make the transition to managed care.** This includes benefits counseling and navigation services – associated with EIS, medical case management, and other service categories – to help PLWH transition to new payers and providers as a result of PCIP and health reform-related Medicaid expansion and health insurance exchanges (depending on the Supreme Court decision). These services will help PLWH make the transition without changing providers where possible, and will enable them to make sound choices if they become eligible for insurance through an exchange.
12. **Active consumer involvement and input,** not only as staff, but also as program and outreach volunteers, Planning Council and committee members, and regular members of quality management teams. This requires a variety of training opportunities, structured initiatives, and appropriate payment of expenses.
13. **Data sharing to improve care,** through full implementation of the Maven client-level data system throughout the EMA, adoption and full implementation of electronic medical records (EMR) by service providers, and support to ensure "meaningful use" of health information technology by HIV/AIDS service providers, This will include sharing of medical data among providers and with hospitals, with appropriate confidentiality protections, to improve care and avoid service delays or repeating of medical tests. It also includes use of EMA client and program data to determine treatment outcomes, assess system effectiveness, and refine services.

D. Exploration of an HIV-focused Medical Home Model

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

- A single, system-wide intake and recertification process, so PLWH/A can establish eligibility for services once and don't have to provide the same documentation to every provider
- Use of comprehensive care centers ("one-stop shops"), physical or virtual, where Ryan White and non-Ryan White services are available in or near a central location or through use of

technology such as telemedicine, and multiple providers (including community-based organizations) are welcomed
- Coordination of care that enables PLWH to obtain both HIV-related and general medical care and the "wraparound" services needed to help them stay in care and adherent to treatment – this includes both other core medical-related services such as mental health and substance abuse treatment and support services like transportation, housing assistance, and groceries, whether provided through Ryan White or other funding streams
- Coordination that is available to PLWH who are enrolled in Medicaid, Medicare, or private insurance within a health insurance exchange, as well as those who receive all their HIV-related care through Ryan White
- A network of providers that together ensure multicultural competence (the ability to provide culturally and linguistically appropriate services to various PLWH/A populations), which is achieved partly by involving community-based organizations expert in serving particular populations as partners in the service system
- Close, formal links with prevention and testing, including major points of entry to care
- Joint funding or collaborative agreements that ensure real coordination and cross-referrals with entities that are not Ryan White-funded
- Meaningful engagement of PLWH as staff and volunteers
- Documentation of treatment outcomes and evaluation of the quality of care

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

The chart that follows (Figure 63) outlines some key characteristics of such a model, with the understanding that it might be organized differently in each jurisdiction, due to differences in Medicaid programs, health insurance exchange structures and options, availability of community health centers and other federally qualified health centers (CHCs/FQHCs), and other components of the health care safety net. In each jurisdiction, however, the operating model must provide for coordination of HIV-related and other medical care and various wraparound services for individual PLWH. The level and quality of services must be available in all jurisdictions; it is not acceptable to have several different levels of care for PLWH/A based on where they live or who they are.

Figure 63: Medical Homes Model as a Strategy for HIV Care	
Three-Year Goal	Establish and maintain a coordinated, integrated continuum of prevention, testing, and care that provides coordinated services for individual PLWH/A and results in viral suppression
Objective	Create and begin to implement an accessible, comprehensive, longitudinal, coordinated, multiculturally competent system of care for PLWH/A in the DC EMA
Background/ Context	• Extensive literature on the added value of medical homes in primary care, including medical homes for high-need vulnerable clients and individuals with chronic care
	• "Best practices" implementation of medical homes in region
	• Use of support services to achieve medical outcomes: Ryan White Treatment Modernization Act (CARE Act Amendments) of 2006, Section 2604(d),defines support services as those "needed for individuals with HIV/AIDS to achieve their medical outcomes… those outcomes affecting the HIV-related clinical status of the person with HIV/AIDS"
Methodology	Create a "medical home" that: • Provides a core set of primary care and closely related clinical services • Has an established, documented ability to provide a set of supportive services through either internal or external partners • Ensures specialized supports and services to individuals, populations and sub-populations most vulnerable to interruption of care, through either internal or external partners • Ensures culturally competent services and links to the community • Is adjusted as needed so that it can be implemented in each EMA jurisdiction, given differences in Medicaid and the health care safety net
Components to Address	In planning the service system and procuring service providers, particular care should be given to ensuring the capacity to accommodate: • Social vulnerabilities and potential barriers to care • Chronic/acute health conditions associated with HIV disease • Health conditions unrelated to HIV disease (by referral) • Effective patient environment, including availability of clinical staff, reasonable wait times for services, responsiveness to need for urgent care • Maximum opportunity and ability of the client to be an active participant in organizing his/her care • A customer service approach that is high quality and consistent with the cultural experiences of clients served • Use of peers as staff, volunteers, and advisory board members
Requirements	Care team that can expertly provide coordinated care and assume responsibility for ongoing coordination of a particular patients care
Outcome	High-value care, and improved health status including viral load suppression
Monitoring and Evaluation	Demonstrated integration and service provision mechanisms as evidenced by: • **Process** – Client interviews, focus groups, and other means to assess service gaps, satisfaction with services – Clinical inspection visits • **Output** – Percentage continuously in care – Percentage with support service needs met
	• **Outcome** – Client viral load – Longevity and continuity in care – Quality of life

E. Meeting the Challenges from the 2009-2011 Plan

Many of the challenges of the 2009-2011 comprehensive plan were caused by external factors, including a deep recession whose impact is still being felt in reduced local, state, and federal revenues, as well as significant changes in senior HAHSTA staff and in Planning Council staff and contractors. In addition, the delays in implementation of a new data system able to provide client-level data complicated efforts to obtain reliable, complete data for decision making.

During the prior comprehensive plan period, the Planning Council worked hard to revise its committee structure, approach to needs assessment, and policies and procedures for carrying out key legislative responsibilities such as priority setting and resource allocations. With that process nearly complete by the end of 2011, and with the new PSRA process tested and refined, the Planning Council expects to move forward with a sound policy and procedural foundation for its work. It expects to continue and build upon its successful efforts to increase substantive PLWH input and engagement, carry out a multi-year needs assessment plan, use directives and standards of care to strengthen specific services and ensure that the needs of specific PLWH populations are met, and use the newly updated MOU to improve collaboration with the Grantee.

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

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

F. Addressing Multi-Jurisdiction and Parity Challenges

One of the greatest continuing challenges for the EMA is providing accessible, high quality care given the EMA's geographical and jurisdictional diversity. Only this EMA includes municipalities with four different Medicaid programs, four different ADAP programs, and four different public health systems. There are also considerable differences in population, income level, urban-suburban-rural mix, and nearly every other socio-demographic variable.

The Planning Council currently allocates the vast majority of service funds to the jurisdictions based on living HIV and AIDS cases, without consideration of other factors such as poverty, health status and disparities, or the level of public investment in HIV or other public health services. Currently, most PLWH are required to obtain services within their jurisdiction of residence, even if another jurisdiction has services more targeted to their specific needs or if a provider in another jurisdiction is closer or more convenient to their home or work. Exceptions are made for limited-English-proficient PLWH, and for participation in support groups.

The Planning Council has been exploring ways to address these challenges and increase parity in access to services, and has made this a key priority through Goal 4 of this comprehensive plan: *Work towards full access, parity, and portability of care for PLWH throughout the EMA.* Implementation of Objective 4.1 – *Explore and adopt policies and procedures to improve choice, portability, and parity in access to care for clients throughout the EMA* – will involve a number of specific initiatives tasks designed to improve parity in access to care and reduce health disparities. Objective 4.2 – *Facilitate access to care for consumers living in rural parts of the*

EMA or facing other access challenges – also calls for specific action to address multi-jurisdictional and parity challenges. For example, the Planning Council will:

- Review and consider revision of the allocation approach and formula used to determine the proportion of funds for each jurisdiction.
- Assess access and quality of care issues for specific populations most likely to suffer from disparities in HIV-related care and take appropriate action to address these disparities, through allocating off-the-top funds, permitting access to care across jurisdictions, or making other changes in the system of care in collaboration with the Grantee and Administrative Agents, through directives, service models, and allocations.
- Use improved client and program data, once available, to better understand service and outcome disparities, as a basis for appropriate action.

G. Reducing Unmet Need

The EMA places great priority on helping PLWH enter and remain in care. It has adopted several service models designed to prevent unmet need and to assist individuals who are out of care – including both PLWH who never became connected to care after diagnosis and those who dropped out of care. Reducing unmet need is a key component of Goal 3 in this comprehensive plan: *Improve – and consistently measure – service linkage, retention, quality, and outcomes.* Among the most important are the following, which are reflected in the "ideal" system of care and the objectives and work plan:

- Plans for increasing access to information about available services, so a PLWH who wants to enter or re-enter care and easily identify an appropriate service provider.
- The DC Red Carpet Entry model and "treatment on demand" initiatives, which are designed to provide rapid access to care; other jurisdictions are exploring and adopting similar approaches. This includes exploring ways to ensure that medical providers ensure some access to medical care for PLWH without an appointment.
- Increased funding for Early Intervention Services, specifically designed to include both recently diagnosed and out of care populations; this includes adoption of a peer-based EIS model in Virginia and as an EMA-wide program, since peers are particularly important in bringing PLWH into care and keeping them connected to care.
- Proposed increased training and engagement of peers who are members of the Planning Council, Consumer Access Committee, and jurisdictional PLWH groups, as volunteer community ambassadors and outreach personnel; one of their roles will be to identify PLWH who are not in care and help bring them into care.
- Recommendations for expanded hiring of peer community health workers and other PLWH at all levels, based on their demonstrated capacity – in numerous chronic care environments – to help people enter and remain in care.

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

H. Making Individuals Aware of their Status

Helping to diagnose HIV-positive unaware individuals and linking them to care became a clear responsibility for Ryan White programs in the 2009 reauthorization. The Planning Council and Grantee worked together to develop strategies for the Early Identification of Individuals with HIV and AIDS (EIIHA). This legislative requirement, along with NHAS and the new CDC prevention strategy, make close collaboration between prevention and care a necessity. Goal 2: *Establish and maintain a coordinated, integrated continuum of prevention, testing, and care that provides for coordination of services for individual PLWH and results in viral suppression* focuses on linkages and collaboration between testing and care. Within Goal 3: *Improve – and consistently measure – service linkage, retention, quality, and outcomes* is Objective 3.3: *Take action to reduce known barriers to testing, entry into, and retention to care.* Over the next three years, the EMA plans a number of actions to meet EIIHA. For example, to meet these goals and objectives, the EMA will accomplish the following:

- Linkages between prevention and care planning bodies; in some jurisdictions, such bodies can be combined, but because the EMA includes four jurisdictions with four prevention and testing programs, collaboration will require meetings and cross-membership among prevention and care planning bodies within and across jurisdictions. Maryland will prepare a combined prevention and care comprehensive plan in 2012.
- Development of common terminology and definitions and sharing of data between prevention and care.
- Coordination in DC between the ECHPP program and the Ryan White Part A program – and throughout the EMA between prevention and care personnel—that includes communications around testing, linkage to care, prevention for positives/risk reduction efforts, and retention in care, and treatment outcomes. In addition, ECHPP principles are being applied statewide in Maryland, and linkages with Part A and Part B programs will be a priority.
- Assisting and complementing testing in all jurisdictions, particularly through EIS. While prevention programs will retain primary responsibility for routine and community testing and will be implementing new CDC strategies, care planning bodies, administrative personnel, and providers will support and assist with testing – and EIS programs will be particularly closely involved since funding of or coordination with testing is a service category requirement.

I. Closing Gaps in Care

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

The various work plan initiatives designed to address unmet need, eliminate HIV-related health disparities, and improve coordination among providers will all help close gaps in care and use resources efficiently. Use of telemedicine can help fill service gaps in rural areas, and technology can be used to make specialized consultants available to providers who do not have such expertise available in the immediate area – for example, a geriatric consultant or a specialist in transgender care.

The EMA recognizes that some gaps in care – such as the Virginia ADAP waiting list – reflect budget cuts or funding insufficiencies. Refining the funding allocation formula can help to reduce some critical service gaps, as can improved coordination and collaboration with service providers funded through sources other than Ryan White. However, probably the greatest hope for closing gaps in care is the implementation of health care reform, so that more PLWH become insured. Ryan White funding must be continued and used to fill gaps related to non-covered services and individuals who are either ineligible for health care reform or unlikely to benefit due to homelessness or other factors.

J. Addressing Overlaps/Duplication in Care

Given the recession and extensive cuts in health and human services budgets at the federal, state, and local levels, overlaps and duplication in care have been reduced over the past several years. However, they may still occur, often due to lack of coordination and the failure of some funded providers to maximize potential contributions by other funding sources such as Medicaid.

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

The focus on collaboration in the new plan should help to reduce undesirable service overlaps or duplication. This is most directly addressed through all three objectives of Goal 2: *Establish and maintain a coordinated, integrated continuum of prevention, testing, and care that provides for coordination of services for individual PLWH and results in viral suppression.* It will be the focus of Objective 2.2 – *Establish operating models in each jurisdiction that provide for coordination of care for individual PLWH, through the use of medical homes, comprehensive care centers ("one-stop shops"), and/or other mechanisms*. Duplication and overlap will also be addressed through increasing Part A awareness of and linkages to other services, as required for meeting Objective 2.3: *Increase regular communication, coordination, and collaboration between Part A and other service providers.* Among the focus areas:

- Strengthen, operationalize, and monitor required linkage agreements between Part A providers and other entities.
- Explore ways to ensure that case managers have the knowledge and time to provide referrals for support as well as core medical-related services; this may involve renewed use of non-medical case managers as well as a planned case manager assistant model.
- Provide for close coordination between Part A and ECHPP in DC and Part A and prevention programs in all jurisdictions, particularly with regard to areas of shared responsibility such as testing, linkage to and retention in care, and prevention for positives.

In addition, the Grantee will continue to monitor requirements that Part A providers obtain Medicaid certification and maximize use of other funding streams so that Ryan White is in fact the payer of last resort.

K. Preparing for Health Care Reform

As noted previously, preparations for health care reform are greatly complicated and to some extent delayed by the uncertain outcome of the Supreme Court case. Jurisdictions vary in the extent to which they are taking action to prepare for health care reform. DC has already expanded its Medicaid program. Both Maryland and DC have established health insurance exchange entities. Maryland is a leader in health information technology (HIT) activities related to health care reform and has had a medical homes program since 2010; it is also exploring the impact of health care reform on the health safety net and ways to assist safety-net organizations to prepare and to maintain sustainability. West Virginia had a grant to explore health care exchange models before federal health care reform was enacted. Virginia has done considerable planning, but recommendations have not been made public; the State supports the court challenge to the legislation.

Understanding the uncertainties, the Planning Council, Grantee, and Administrative Agents have explored issues related to implementation, and the proposed work plan calls for informing and educating the Planning Council, PLWH, and providers about health care reform and its implications for HIV/AIDS services, through regular briefings and training. It also calls for capacity-building assistance to providers to prepare them for third-party billing and other health care reform requirements. In addition, several jurisdictions are exploring temporary use of Pre-existing Condition Insurance Plans (scheduled to continue only until 2014) to provide services to ADAP clients. There are plans to use the experience of PCIP to better understand the challenges and opportunities of a transition from Ryan White to insurance-based funding and to prepare consumers for that transition.

Goal 1 of the comprehensive plan focuses on health care reform: *Prepare the EMA for changes in the health care system so that people living with HIV and AIDS make a seamless transition to new funding and service systems such as Medicaid and private insurance.* The comprehensive plan calls for information and education about health care reform in Objective 1.1: *Provide ongoing information and updates about health care reform to the Planning Council, providers, and consumers.* It also calls for ensuring readiness for implementation in Objective 1.2: *Prepare Ryan White funded providers for regional insurance-based care under health care reform.* This is likely to include such actions as the following:

- Providing capacity-building services to providers around health care reform challenges and requirements, such as expanded third-party billing and full use of electronic medical records systems.
- Encouraging providers to become Medicaid-certified in multiple states and to contract with Medicaid MCOs, so that they can continue to serve their clients without interruption after health care reform implementation.
- Exploring mechanisms to enable community-based organizations to partner with medical providers or obtain some other source of assistance in obtaining and implementing EMR systems.
- Developing a case management assistant model and engaging navigators/benefit specialists to help providers and consumers with the transitions required under health care reform.

L. Summary of Goals and Solutions

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

- **Health care reform:** Ensuring a seamless transition for PLWH to new funding and service systems such as Medicaid and private insurance, through preparing providers, consumers, and the Planning Council and PLWH groups for playing informed and active roles in the process. This includes education, training, and technical assistance as well as joint planning and decision making that recognizes similarities and differences across jurisdictions.
- **A coordinated, integrated continuum of prevention, testing, and care:** Refining the current system of care so that it encompasses prevention and testing as well, provides for a high level of communication and collaboration, and better provides comprehensive and coordinated care to PLWH. This includes exploration and hopefully adoption of one or more medical home/comprehensive care center models that are HIV-centered and practical for implementation in each jurisdiction.
- **Service linkage, retention, quality, and outcomes:** Implementing a variety of service models that maximize testing, ensure support for PLWH including those with the greatest barriers to testing and care, and help PLWH enter care promptly, remain in care, adhere to treatments, and reach viral suppression. This includes adopting a set of outcome measures and using them to assess success in testing, linkage to care, retention in care, and clinical outcomes.
- **Parity in access to care:** Exploring and implementing strategies that will improve choice, portability and parity in access to care for PLWH regardless of where they live in the EMA, with particular emphasis on populations that are traditionally underserved and suffer from HIV-related health disparities. This includes addressing cross-jurisdictional as well as population-specific issues, as well as the special challenges of serving rural populations.
- **Effective planning and decision making:** Working to implement the MOU between the Grantee and Planning Council; strengthen information sharing and collaboration between Part A entities including the Planning Council, Grantee, Administrative Agents, and providers; continue strengthening Planning Council operations; and doing collaborative planning between prevention and care across jurisdictions. Doing this successfully requires maximizing consumer engagement at all levels, with increased information sharing and training for PLWH groups.

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

Chapter 8: Coordination Efforts

A. Overview

Creating the "ideal" system of care described in the previous chapter requires an intensified focus on coordination and collaboration at many levels: among Part A providers, between Part A and other Ryan White and non-Ryan White funded entities, and between prevention and care. Understanding of other funding streams has always been important for Ryan White programs because Ryan White is by law the payer of last resort. With health care reform and the increased use of third-party reimbursements for funding health care and other services, increased coordination with public and private insurance providers is necessary. Moreover, this coordination is not limited to billing. There is a need for coordinated planning as well as informal and formal collaboration in the delivery of services, and a medical home model will require codified relationships among providers.

This chapter describes the kinds of coordination and collaboration the EMA has in place and proposed efforts to be implemented as part of the work plan, to move the EMA towards its ideal system of care.

B. Coordination with Other Care Providers

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

- **Other Part A providers,** within the same jurisdiction or with EMA-wide funding.
- **Providers funded under other Ryan White "parts,"** including Parts B, C, and D, and Part F – Dental programs.
- **Providers that have no Ryan White funding.** This includes providers that receive other federal funds, sometimes including Minority AIDS Initiative funds, such as substance abuse and mental health providers and community health centers and other federally qualified health centers, which often provide medical-related services needed by PLWH. Also included are free clinics and other safety net clinics. In addition, there are smaller, often community-based, providers that offer needed services**,** often support services, and may have state or local public funds or be privately funded, such as food pantries. In the DC area, there are also two counties with county-supported health care for uninsured and underinsured low-income residents:
  - In Montgomery County, county funding from the Department of Health and Human Services supports a network of 11 Community HealthLink Clinics that provide primary medical care to nearly 30,000 people. Some are independent nonprofits, others hospital-related. While few of these clinics provide HIV-related medical care, two are CHCs/FQHCs, and some provide mental health services, dental care, and/or HIV testing.
  - In Fairfax County, county funding supports the Community Health Care Network (CHCN), which provides free or low-cost care to uninsured residents with incomes below 200% of poverty. While HIV care is not offered, PLWH may be able to receive primary care services through CHCN, and it provides HIV testing based on CDC guidelines. At the time this comprehensive plan was written, there was a waiting list for services.

Current coordination and collaboration are summarized below, by type of provider.

All Providers: The EMA requires funded Part A providers to collaborate with each other, and to establish written agreements with points of entry to care and other funded and non-funded providers. The typical focus is cross-referrals, but sometimes providers closely coordinate care for particular populations or individuals. Part A medical providers and medical case managers work closely with state ADAP staff, and case managers may refer clients to Part B, C, and D providers, and to Part F dental programs, based on needs. Part B funding within the EMA is typically coordinated with Part A funding, to fill gaps and avoid duplication of effort. Many Part B and C providers also receive Part A funding, so the provider decides which "part" will pay for services to a particular client. In a number of EMA counties, there is only one Part A provider – the local health department clinic, a community health center, or a hospital-based clinic.

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

Other Part A Providers: Some Part A providers work together very closely. This is of course most common among provides within a specific jurisdiction or even a specific county, since they are likely to make frequent referrals. In some counties, there are only one or two Part A providers. A small number of Part A providers are represented on the Planning Council, and others participate in regional prevention and care planning bodies such as the HIV Consortium of Northern Virginia and the Maryland Regional Advisory Committees. The Grantee and Administrative Agents provide meetings and training for funded providers in each jurisdiction. There is an annual EMA-wide provider meeting, but other gatherings are infrequent, given distances and costs associated with such meetings. Through the Case Managers Operating Committee (CSOC), a quasi-regional body, case managers participate in quarterly training that is mandatory for DC subgrantees with case management funding and voluntary for case management providers in other jurisdictions. The relevance and quality of the training mean that training sessions are often oversubscribed. CSOC also holds monthly meetings, but participation is voluntary, and some case managers never attend. When the Planning Council held a provider meeting to obtain input to this comprehensive plan, about one-third of funded providers participated. Maryland and Virginia providers typically participate in their Data Presentation and Priority Setting jurisdictional meeting, but only a few DC providers participate in the meeting in Washington, DC.

The new plan calls for at least two meetings a year of all funded providers, with use of technology (such as teleconferencing or Skype) if feasible. In addition, capacity-building sessions are expected to help providers prepare for health care reform, which will increase interaction among Part A providers.

Cross-Part Collaboration: Ryan White Part B programs are administered by state health departments, which often subcontract to local health departments. The Northern Virginia Regional Commission administers both Part A funding in the Virginia segment of the EMA and Part B funding for Northern and Northwestern Virginia. As Figure 64 shows, there are ten Part C providers in the EMA, two Part D programs, two Part F dental providers (although the Washington Hospital Center reimbursement grant is very small), and one Part F Special Projects of National Significance (SPNS) grant. The SPNS grantee has evaluated and provided technical assistance to eight demonstration projects designed to get young MSM of color into care, but none of the pilot projects was in the EMA.

Figure 64: Ryan White Part C, D, and F Providers and Support Entities in the EMA

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

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

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

A Response Team of grantees, subgrantees, and client representative from the EMA was assembled to coordinate and guide Collaborative activities. The Response Team selected HAHSTA as Data Lead for this initiative. HAHSTA is responsible for analyzing the data from the participating sites (which include both medical and case management providers), reporting aggregate data to the Response Team, Collaborative faculty (HAB and NQC staff), and consumers, as well as communicating with individual providers regarding their performance and quality improvement project progress.

Participating sites have been submitting data every two months since May 2011, using 15 HAB Performance Measures. The Collaborative Response Team uses performance measurement data to identify and prioritize quality improvement projects, routinely monitor the quality of care provided to clients, and evaluate the impact of changes made to improve the quality and systems of HIV care. The Planning Council has asked that the Collaborative's aggregate data be included in the QM reports it receives from the Grantee.

The Collaborative is helping to strengthen quality improvement activities across the EMA. This is not a punitive process, and as such there are no associated penalties with the level of performance, regardless of the values reported. On the contrary, providers are supported with a myriad of opportunities to enhance their ability to report data and the overall quality of the services provided in the form of quarterly in-person meetings, quality improvement training, and technical assistance calls/webinars. An important benefit of the Collaborative is the interaction among providers across jurisdictions and Parts, which has contributed to information sharing and collaboration on other issues. There is strong interest in continuing the Collaborative beyond the two years of support HRSA/HAB will provide; it is not yet clear how that can be accomplished, +but exploring possibilities will be a part of the new comprehensive plan.

AETCs: The AETCs work closely with providers and with the Grantee and Administrative Agents; one AETC representative serves on the Planning Council and two are active members of Northern Virginia's HIV Consortium. AETCs have consistently offered their assistance for needed training, and the Planning Council's directives around training needs often ask that the Grantee and Administrative Agents work with the appropriate AETC. AETC representatives provide valuable input to Planning Council discussions around standards of care and clinical issues.

Non-Ryan White Providers: The Part A program depends heavily on non-Ryan White funded programs for some types of services. Sometimes Ryan White funds to support these efforts are insufficient, sometimes other funding streams have traditionally been tapped to provide services instead of or in addition to Part A. In addition, there is a continuing need to coordinate HIV-related medical care with non-HIV-related primary and specialty care, which is not paid for by Ryan White. Such care is often provided by CHCs/FQHCs – many of which are not Ryan White providers but do receive other federal funding – or by other safety net clinics including free clinics and other population- or service-focused clinics, which may or may not have federal funding and vary in their resources and capacity. A few services and issues of particular importance are summarized below.

Substance Abuse and Mental Health Services: Of particular importance are outpatient substance abuse treatment and mental health services. These are services frequently needed by Ryan White clients. In most jurisdictions they are funded partly through other funding sources and partly through Part A. The substance abuse and mental health services in Virginia are managed by legislatively established local public agencies called Community Services Boards described as the "single point of entry" for publicly funded care. In DC, both other federal and District funds support substance abuse treatment through the Addiction Prevention and Recovery Administration (APRA), which certifies substance abuse treatment centers and funds about 30 treatment programs that include outpatient treatment, as well as some detoxification and residential care. The Department of Mental Health used to employ mental health clinicians, but now primarily contracts with community-based providers. County HIV clinics in Maryland may have mental health professionals, but it is often challenging to hire and retain them. Thus relationships with external providers are very important. In West Virginia, HIV-trained providers sometimes are not available. A continuing challenge is how to arrange appropriate services for PLWH when the substance abuse or mental health provider is not Ryan White funded and clinicians have limited experience with this population. Coordination and collaboration includes encouraging training of such clinicians, by the AETCs or other sources, to provide services to individuals who are multiply diagnosed.

Assisted Care: Input from PLWH and some providers indicates a growing number of people with HIV disease who need some form of assisted care in their homes. As the PLWH population ages, this need is expected to increase. Ryan White Part A in this EMA does not currently fund the service categories of Home Health Care or Hospice Services. DC is the only jurisdiction that funds Home and Community-based Health Services, and only for non-medical day programs; there is no funding for home health aide services. Some Part A services can be provided in housing facilities, but most assisted care is neither HIV-specific nor Ryan White funded. Collaboration with other providers and payers is required in order to arrange such services. Sources vary by jurisdiction but may include assisted housing programs, Medicaid and Medicare, Area Agencies on Aging, Veterans' Affairs, Social Services block grant recipients, and various social service organizations with public and private funding, including United Way support. HOPWA provides some support services for its clients. The federal Shelter Plus Care program includes a small set-aside for people with HIV disease; it provides rental assistance for hard-to-serve homeless persons with disabilities and includes supportive services that are funded through sources outside the program. PLWH on disability who are Medicare recipients may receive home-based services. Medicaid provides some Home and Community-based Services under waiver programs and may provide Home Health Services, but resources are generally limited and sometimes services are not available; home-based services may be available only to people

receiving disability income or other federal income assistance. Hospice care is an optional Medicaid benefit covered in most states; the EMA also has a number of privately funded hospice programs. It is often difficult for small community-based organizations providing assisted housing, hospice services, or home-based care to qualify for Medicaid or Medicare certification. Finding ways to establish ongoing organizational relationships and improve referrals that meet the needs of PLWH is expected to be a growing priority and a continuing challenge within the EMA.

Coordination with Other Testing Facilities: In addition to HIV testing sites, Ryan White programs need to coordinate the sources of other kind of testing, particularly STI clinics, to ensure that PLWH have access to needed testing – for example, for Hepatitis C, HPV (genital warts), Hepatitis B and C, syphilis, and gonorrhea. This may involve coordination with county testing sites as well as hospitals and other clinical providers; the EMA is committed to having systems in place to ensure that appropriate testing is regularly available to clients.

Coordination with VA: In some parts of the EMA, most notably the two West Virginia counties, a significant number of Ryan White clients get much of their care through Veterans Affairs facilities. Coordination with VA has always been important. Some VA services are available to all veterans, while others depend on the extent to which their medical condition is service-related. In addition, some VA facilities are seriously overbooked due to the needs of Iraq and Afghanistan veterans, so coordination is particularly important in ensuring that PLWH who are veterans are able to access services through VA promptly, and that other needed services are made available through Ryan White. In West Virginia, the Ryan White medical case manager asks about veteran status and coordinates with the VA case manager. The EMA will work to ensure awareness of VA resources and capacity issues and appropriate coordination of care in all jurisdictions.

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

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

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

Enhancing Coordination and Collaboration: The comprehensive plan calls for enhancing Part A coordination with all types of providers regardless of their funding streams. Goal 2 of the comprehensive plan is *establishment of a coordinated, integrated continuum of prevention, testing, and care that provides for coordination of services for individual PLWH and results in viral suppression.* Coordination between Ryan White and non-Ryan White providers to arrange medical-related and support services needed by PLWH will be an integral component of any medical home/comprehensive care center models that is developed. A medical home model will codify relationships among providers and provide opportunities for non-Ryan White providers to demonstrate the value of their services in contributing to positive clinical outcomes. The work plan calls for increasing regular communication, coordination, and collaboration between Part A and a wide range of other service providers.

C. Coordination with Prevention and Testing, including ECHPP

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

Priorities for Coordination and Collaboration, Including ECHPP: Initial EMA priorities for coordination include the areas with shared responsibility, such as testing, linkage to care for newly diagnosed PLWH, and prevention for positives, particularly (as with ECHPP) where that encompasses not only risk reduction but also treatment adherence and retention in care strategies. This means coordination among personnel – for example, Partner Notification and Early Intervention Services personnel, Part A providers engaged in risk reduction and in retention in care and Prevention-funded personnel of prevention for positives initiatives. It is not yet clear to

what extent actual overlapping services – funded by both prevention and care – are projected in the future, versus shared planning and an agreement on which body will fund which services – more information will be available when the new state prevention plans are completed in June 2012. Maryland has already indicated plans to refine the use of partner notification personnel, with increased targeting, more field staff, and enhanced linkage to prevention, care, and support services. If funding coordination involving shared support of particular services is determined desirable, this will require agreement and action by the Planning Council, since it allocates Part A funds. The comprehensive plan goals and work plan call for collaboration in both planning and program implementation to address these issues.

Coordination with ECHPP is a key requirement for DC. Some of the models proposed for ECHPP are still in development, and there are opportunities for joint development and implementation of linkage/retention models, such as peer-based models that are a priority for the Planning Council. It appears that prevention for positives programs being planned under ECHPP may be similar in scope to the peer EIS model that will be tested by Part A starting in June 2012. Another priority that affects planning and services is agreement on some common language and development of shared definitions for terms that prevention and care have traditionally defined differently, such as what constitutes entry into care or retention in care. This is a necessary part of coordination with ECHPP, to ensure some common outcome measures for ECHPP and Part A. The Planning Council also expects to facilitate shared outcome measures by recommending that Part A adopt "treatment cascade" measures using CDC outcome measures. These efforts are all a part of the proposed work plan, under Goal 2, and relate to establishing an integrated continuum of prevention, testing, and care.

Coordination Challenges: Coordination in planning must begin with regular communication and information exchange. This is easier to achieve within a single jurisdiction than across jurisdictions. Prevention is funded and prevention planning occurs separately in each jurisdiction, while Part A planning occurs at a metropolitan level. Prevention services are typically funded through local health departments rather than through a small number of Administrative Agents, as with the EMA's Part A services.

Coordination of prevention/testing and care planning and services is occurring within states. Maryland is developing a joint prevention and care plan and has merged HIV prevention and treatment units within the DMHH Infectious Disease and Environmental Health Administration (IDEHA). It has five Regional Advisory Committees (RACs) that provide advice to both prevention and care planning. Virginia does centralized HIV prevention planning but subcontracts Part B funds to the Northern Virginia Regional Consortium, which has for some years provided input to Part A planning and decision making. It also has an active Prevention subcommittee that as of early 2012 was completing the first Northern Virginia regional prevention plan. DC has an HIV Prevention Community Planning Group (CPG) but not an active Part B planning body – and a much larger number of HIV care services other than ADAP are funded through Part A than through Part B.

Geographic differences in planning and service areas greatly complicate efforts to coordinate HIV prevention and care planning and services (See Figure 65). Coordination of services, once funded and operational can be managed by state and regional officials responsible for prevention and care services and can involve the appropriate subset of local health departments and other funded providers.

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

Figure 65: EMA Jurisdictions and State Health Regions/Districts

Health Region or District	EMA Jurisdictions Included	Non-EMA Jurisdictions Included
Maryland		
Suburban Washington Region	Montgomery and Prince George's Counties	None
Western Region	Frederick County	Allegany, Garrett, and Washington Counties
Southern Region	Calvert and Charles Counties	St. Mary's County
Virginia		
Northern Region	Arlington, Fairfax, Loudoun, and Prince William Counties; Cities of Alexandria, Fairfax, Falls Church, Manassas, and Manassas Park	None
Northwest Region	Clarke, Culpeper, Fauquier, King George, Spotsylvania, Stafford, and Warren Counties, and City of Fredericksburg	Caroline, Fluvanna, Greene, Louisa, Nelson, Orange, Page, Rappahannock, and Shenandoah Counties
West Virginia		
District 8	Berkeley and Jefferson Counties	Grant, Hampshire, Hardy, Mineral, Morgan, and Pendleton Counties

Coordination with regional planning bodies in Maryland is complicated by the fact that the five Maryland counties that are part of the EMA are located in three different Maryland health regions and participate in three different RACs; the Planning Council has tended to work most closely with the Suburban Washington RAC, which includes the two largest Maryland counties that are part of the EMA. To the extent that Virginia does regional planning, it works through regional consortia. As the table shows, all of Virginia's Northern Region is part of the EMA, but the Northwest Region includes a mix of EMA and non-EMA counties. The two West Virginia counties are both in the state's District 8, but so are seven counties that are not part of the EMA. These inconsistencies in regional affiliations make even regular communications challenging, since so many different parties must be involved.

However, coordination of HIV prevention and care planning at a metropolitan area level was identified as a need at a Regional HIV/AIDS Forum held in December 2011 and coordinated by the Metropolitan Washington Council of Governments (COG). The Director of the DC Department of Health has also made cross-jurisdictional HIV prevention and care planning a

priority. Follow up on the COG Forum recommendation is continuing, through the COG Medical Directors Committee. An HIV/AIDS Subcommittee may be established.

Appropriate collaborative planning strategies across jurisdictions should become clearer once CDC releases the expected new guidance describing the changed role for its prevention planning groups.

The comprehensive plan calls for several specific strategies for ensuring a new, higher level of collaboration between prevention and care, under both Goal 2 – since such cooperation is part of establishing a seamless system of prevention, testing, and care services – and Goal .

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

Coordination with other payers is always a priority for the EMA at both the Grantee and provider level. With health care reform, it has become a key consideration.

Coordination with other payers involves Grantee policies and monitoring as well as provider capacity and action. Like all Ryan White Part A programs, the Metropolitan Washington program must ensure that Ryan White is the payer of last resort. Given four separate public health systems, Medicaid programs, and state and local programs, this can be a complex process. Providers are required to obtain Medicaid certification where possible, in the jurisdiction where they are headquartered and in other jurisdictions where they have Part A funding for Medicaid-reimbursable services. Another continuing Grantee and provider responsibility involves ensuring that Ryan White dollars are not used to pay for services that can be supported through other funding streams. The EMA will maintain and enforce clear requirements for the obtaining and use of program income.

Ensuring that other payers are used to the maximum possible extent to cover service costs will require increased planning, capacity-building assistance, and policy guidance from the Grantee in the next three years, as the health care funding model changes. Payers of importance to the EMA that will require specific attention over the next three years include the following:

- **Medicare:** Medicare eligibility is increasingly important for providers serving PLWH with disability, as a growing number are eligible for Medicare. In addition, as the PLWH population ages, a growing number are becoming eligible for Medicare. Within the EMA, numbers of PLWH 65 and over are growing fastest in DC. Medicare, of course, requires national certification, but no state by state efforts.
- **Medicaid:** In addition to being Medicaid-certified, providers need to enter into contracts with Medicaid managed care organizations. In DC, the majority of PLWH on Medicaid are still served through Medicaid fee-for-service, but some are being assigned to MCOs. It appears that MCOs will be the primary or sole mechanism for Medicaid coverage under the health care reform expansion. Providers will need assistance in understanding their potential roles in MCOs and seeking contracts with one or more MCOs in their states.
- **State Children's Health Insurance Programs**, which, like Medicaid, vary by state in their coverage. SCHIP is a source of funding for services to children and adolescents and pregnant women with HIV disease who are not eligible for regular Medicaid. In some states, SCHIP also covers the parents of eligible children. DC and Maryland run their SCHIP programs as an expansion of Medicaid, so providers who are Medicaid-certified can obtain reimbursement for covered services to such individuals. Both DC and Maryland cover

children under 19 with family incomes below 300% of the federal poverty line. DC covers pregnant women up to 300% of poverty, and Maryland covers them up to 250% of poverty. DC's program also covers parents of eligible children with incomes below 300% of poverty; Maryland covers parents with incomes under 116% of poverty. West Virginia's SCHIP is operated separately from Medicaid, and has a 300% of poverty eligibility limit for children and 150% for pregnant women. The Virginia program covers children with family incomes up to 200% of poverty and pregnant women up to 150% of poverty. Coverage for parents is extremely limited in Virginia and West Virginia. The Grantee expects its providers to be familiar with SCHIP programs and eligibility, ensure that eligible clients are enrolled, and appropriately bill the programs. This will continue to be a priority for providers serving women, children, and adolescents with HIV disease. The role of SCHIP is expected to change under health care reform, and the Grantee and Administrative Agents will ensure that providers are informed of such changes and their implications.

- **The DC Alliance,** which pays for HIV-related medical care, medications, other medical care, and some other Ryan White-eligible services for DC residents with incomes below 200% of the federal poverty line. When DC implemented expanded Medicaid (up to 200% of poverty) in 2011, many DC Alliance clients were transitioned to Medicaid. The Alliance continues to serve individuals not eligible for Medicaid – including recent immigrants and refugees – as well as individuals who have been unable to provide the documentation required for Medicaid eligibility.
- **Other Public Insurance Programs,** including PCIP, Maryland's Health Insurance Plan (MHIP), and Virginia's State Pharmaceutical Assistance Program (SPAP). MHIP is Maryland's high-risk pool insurance program. PLWH eligible for Ryan White may be eligible for PCIP, and – since Ryan White eligibility covers individuals well above 200% of poverty, some individuals may obtain some of their services from Ryan White and others through PCIP. It appears that only a limited number of Ryan White providers are currently providers under the federal PCIP (which is the program used in Virginia, West Virginia, and DC). However, some providers do have access to PCIP reimbursements. If PCIP becomes an alternative payer option for ADAP in some or all EMA jurisdictions, priority will be placed on encouraging Part A providers to become approved PCIP providers and to ensure appropriate billing. The Virginia SPAP has few new slots, but through Part B, PLWH receiving SPAP who are on ADAP get their Medicare Part D monthly premiums paid. Some also receive help with medication copays and deductibles, as well as with the gap in medication coverage known as the "donut hole."
- **Private insurance.** Some Ryan White medical, mental health, and substance abuse providers, including CHCs/FQHCs, accept private insurance. Some Ryan White clients have private insurance, and sometimes Ryan White pays their premiums or copayments. Many providers do not accept private insurance. If health insurance exchanges are established as planned under health care reform, more providers will need to develop agreements with insurance providers in the exchanges and establish necessary billing and record-keeping capacity. The Grantee expects to arrange for capacity-building assistance to providers in this effort.

Goal 1 of the work plan for this comprehensive plan specifies several Grantee-led objectives and strategies for ensuring that Part A providers have the knowledge, systems, billing capacity, and relationships required to receive reimbursements from multiple third party payers, public and private. Objective 1.2 focuses specifically on preparing Part A providers for reimbursement-based care under health care reform.

Section 3: How Will We Get There?

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

A. Overview

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

The work plan includes specific tasks/activities required to work toward the EMA's ideal system of HIV/AIDS services, address identified EMA needs, and meet comprehensive plan requirements. The chapter provides additional explanation regarding how the plan addresses requirements such as coordinating efforts, Healthy People 2020 Objectives, NHAS goals, and implementation of health care reform. It also relates the plan to the existing statewide coordinated statements of need in the four relevant jurisdictions, and discusses how the EMA will address the implications of any additional or unexpected budget cuts on the system of care.

The Planning Council recognizes that the work plan is ambitious, and that some specific strategies, once explored, may not prove feasible. This is particularly true with regard to strategies to plan for implementation of the Affordable Care Act, given current uncertainties with regard to both the national program and the still-emerging state plans for implementation. In such instances, strategies and tasks will be refined, with Grantee and Administrative Agent input.

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

Figure 66, attached, provides the EMA work plan. It includes five major goals, 17 related objectives, and a set of specific strategies and tasks/activities required to reach these objectives and goals. In addition, it specifies what entity has primary responsibility for each strategy/task/activity, the timeline for completion, and expected outcomes. These outcomes reflect the EMA's commitment to assessing progress and success based not simply on completion of activities, but also on system changes and client outcomes.

The Planning Council has deliberately developed a comprehensive and challenging work plan to address expected changes in the epidemic, systems of care, and the broader health care delivery system in the EMA and the nation. Some of these changes, particularly those related to health care reform, remain less than fully defined. Appropriate committees will explore the feasibility of proposed strategies and tasks. If some hoped-for approaches are found to lack operational feasibility, including cost considerations, they will be revised or eliminated.

Figure 66: Work Plan for the Comprehensive Plan				
Goals, Objectives, and Strategies/Tasks	**Lead Responsibility**	**Deliverable**	**Timeline**	**Expected Outcome**
Goal 1: Prepare the EMA for changes in the health care system so that people living with HIV and AIDS make a seamless transition to new funding and service systems such as Medicaid and private insurance. ***Note:*** *EMA actions to plan for health care reform cannot be fully developed until after the Supreme Court decision. The Work Plan includes the EMA's effort to lay out processes and plans using the information available as of May 2012. Some proposed strategies or tasks may need to be refined or eliminated based on federal and state actions and/or the results of feasibility analysis.*				
Objective 1.1 - Provide ongoing information and updates about health care reform to the Planning Council, providers, and consumers. **Strategies/Tasks/Activities:**				Planning Council (PC) able to make informed decisions re preparation for and implementation of health care reform
a. The Planning Council will receive regular updates from the Grantee and Administrative Agents and appropriate experts regarding health care reform planning in each jurisdiction and its implications for HIV/AIDS services	Grantee	Quarterly briefings	Beginning June 2012 and continuing through 2014	
b. The Grantee and Planning Council support personnel will work with the Care Strategy, Coordination, and Standards (CSCS) Committee to keep it informed about the implications for the EMA of the Supreme Court decision and federal actions related to health care reform so that care can be aligned with federal system changes	Grantee and PC Support	Regular discussions at all CSCS meetings; reports and recommendations to full PC as needed		
Objective 1.2 - Prepare Ryan White funded providers for regional insurance-based care under health care reform. **Strategies/Tasks/Activities:**				• Ryan White providers are informed about health care reform opportunities and challenges and have built capacity that ensures that they are prepared for health care reform, able to continue providing services to clients after funding sources change, and
a. Where feasible, all Part A-funded primary care providers and other providers of Medicaid-eligible services in the three major jurisdictions will be expected to obtain Medicaid certification in DC, MD, and VA (unless their services are limited to individuals from fewer jurisdictions) before full implementation of expected Medicaid expansion in 2014, or to submit written evidence of unsuccessful efforts to obtain Medicaid provider certification status.	Consumer Access Committee (CAC) of Planning Council – exploration and directive; Grantee – implementation	Directive; expectations/ guidance to funded providers	Directive, 2012; Implementation 2013	

Figure 66: Work Plan for the Comprehensive Plan				
Goals, Objectives, and Strategies/Tasks	**Lead Responsibility**	**Deliverable**	**Timeline**	**Expected Outcome**
b. Providers will be encouraged to develop relationships with Medicaid managed care organizations (MCOs) and private insurance providers that become part of the insurance exchanges in each of the three jurisdictions.	Grantee	Provider meeting/ Communication s	2012	have agreements that enable them to obtain reimbursements for services from Medicaid including MCOs and insurance companies that are part of the exchanges in the EMA jurisdictions • Ryan White clients have the option of continuing to receive services from current service providers regardless of changes in funding source
c. The EMA will explore and where feasible apply for non-Ryan White funding to expand navigation/benefit consultation services to assist clients making the transition to insurance-based care.	Grantee	Special funding for navigation services	2013	
d. The EMA will provide or arrange training for providers to help them prepare for system changes under health care reform.	Grantee	Training sessions	2012-2014	
e. The EMA will provide capacity-building assistance to providers to assist them with Medicaid certification and with processes for contracting with other public or private insurance plans, through a technical assistance request to the HIV/AIDS Bureau (HAB) or other means.	Grantee	Technical assistance services to providers based on requests and identified needs	2012-2014	
f. The EMA will explore models through which providers of core medical-related services without electronic medical records (EMR) can partner with medical providers or obtain some other source of assistance in obtaining and implementing EMR.	Grantee	Documented models; presentation to providers	2013-2014	
g. The Planning Council will work with the Grantee and Administrative Agents to ensure that lessons learned from use of the Pre-existing Condition Insurance Plan (PCIP), assuming that ADAP funds are used for PCIP in Virginia (and possibly in other jurisdictions), to facilitate consumer transition from Ryan White to insurance-supported medical care and other medical-related services.	Planning Council	Analysis of PCIP experience based on data from Grantee/ Administrative Agents	2013-2014	
Objective 1.3 - Assist Ryan White Part A consumers to transition to Medicaid and/or health insurance exchanges through information and increased case management and navigation services. **Strategies/Tasks/Activities:**				Clients make the transition to Medicaid or health insurance through an exchange without delays in care or loss of medical care

Figure 66: Work Plan for the Comprehensive Plan				
Goals, Objectives, and Strategies/Tasks	**Lead Responsibility**	**Deliverable**	**Timeline**	**Expected Outcome**
a. The Planning Council will work through its Consumer Access Committee and PLWH groups and with providers to inform and educate consumers about health care reform and how it will affect them.	Consumer Access Committee (CAC) of Planning Council	Presentations at CAC and PLWH jurisdictional meetings at least twice a year; at least two EMA-wide leadership training sessions for PLWH annually; Peer Volunteer Groups	Presentations beginning fall 2012; training beginning March 2013; peer volunteers in place by fall 2013	or medications
b. The Planning Council will develop and allocate funding for a medical case management model that includes peer community health workers (CHWs) as case management assistants and navigators, to facilitate client transition to insurance-based care, access to all needed services, and coordination of services.	Care Strategy, Coordination, and Standards (CSC) Committee of Planning Council	Directive, Allocations, Model Development, and Implementation of Model	Planning – 2012 Implementation – 2013 (GY 23)	
c. The Planning Council will explore how best to ensure the availability of eligibility and public benefit specialists throughout the system to support case managers in determining consumer eligibility for expanded Medicaid, subsidized insurance under a health insurance exchange, or other public benefits.	CSCS Committee of Planning Council	Plan, Directive, Allocations, Case Manager Training, and Guidance for Implementation	Planning – 2012 Implementation – 2013-2014 (GY 23-24)	
Goal 2: Establish and maintain a coordinated, integrated continuum of prevention, testing, and care that provides for coordination of services for individual PLWH and results in viral suppression.				
Objective 2.1 – Establish and maintain ongoing collaboration between prevention, testing, and care. **Strategies/Tasks/Activities:**				• Prevention and care planning bodies and providers that are aware of each other's work, consult on decisions in
a. The Planning Council will work with prevention planning bodies throughout the EMA to establish ongoing information sharing and collaborate on planning decisions.	Planning Council	Regular quarterly meetings	Ongoing beginning fall 2012	

Figure 66: Work Plan for the Comprehensive Plan				
Goals, Objectives, and Strategies/Tasks	**Lead Responsibility**	**Deliverable**	**Timeline**	**Expected Outcome**
b. The Planning Council, Grantee, and Administrative Agents will establish mechanisms between testing and care that contribute to increased and better targeted HIV testing in both clinical and non-clinical settings; this includes coordination with ECHPP and other CDC and jurisdiction-supported testing efforts.	Grantee	Written agreement/MOU	2012	areas of shared responsibility, and work together to maximize testing and entry into care • Improvements in treatment cascade measures by end of 2014, including increased testing, reduced late testing, increased entry into care within 90 days and one year, and improved outcomes such as viral suppression
c. Prevention and care officials in all jurisdictions will agree on shared operational definitions and measures that will allow for EMA-wide documentation and evaluation of testing and care outcomes; included are terms such as referral to care, linkage to care, treatment adherence, and retention in care.	Grantee	Set of agreed-upon definitions, disseminated to prevention and care providers throughout the EMA	2013	
d. The Planning Council, Grantee, and state Prevention officials will work together to develop a single EMA-wide standardized protocol for referral of newly diagnosed PLWH to care services and actual linkage to care, which specifies expectations of both testing and care personnel for working together to meet specified objectives within 30, 60, 90, and 180 calendar days following diagnosis.	Grantee	Written protocol, approved by all parties	2013	
Objective 2.2 – Establish operating models in each jurisdiction that provide for coordination of care for individual PLWH, through the use of medical homes, comprehensive care centers, co-located or virtual ("one-stop shops"), and/or other mechanisms. **Strategies/Tasks/Activities:**				• Implementation of system of care improvements that provide coordinated care using a medical home or related model • Collection of baseline and initial implementation data measuring impact of new models and system changes on PLWH entry into care, retention in care, and clinical
a. The Planning Council will work with the Grantee and Administrative Agents to explore how best to encourage the establishment of medical homes or similar models appropriate to each jurisdiction that provide for the coordination of medical care and the availability and coordination of medical-related and support services for all Ryan White Part A consumers.	CSCS Committee of Planning Council and Grantee	Roundtable and work sessions; documented model or models for testing	Development - 2012-2013 Pilot implementation – 2014	
b. The Planning Council will explore with the Grantee and Administrative Agents ways to enhance the concept of comprehensive care centers, co-located or virtual ("one-stop shops"), and include providers that target specific populations, perhaps by inviting such providers to assign staff to these centers.	CSCS Committee of Planning Council and Grantee	Roundtable and work sessions; agreement on specific actions		

Figure 66: Work Plan for the Comprehensive Plan				
Goals, Objectives, and Strategies/Tasks	**Lead Responsibility**	**Deliverable**	**Timeline**	**Expected Outcome**
c. The Planning Council will revise standards of care and use directives as appropriate to support each jurisdiction's adoption of a coordination of care model for all PLWH who receive some or all of their services through the Ryan White Part A program.	CSCS Committee of Planning Council	Revised Standards of Care and Directive(s) as needed		outcomes such as viral suppression
d. The EMA will explore and adopt case management refinements, renewed use of non-medical case management, and/or other procedures that enable PLWH to obtain the wraparound services (both core medical-related and support) they need to remain in medical care and adhere to treatment, whether these services are provided through Ryan White or other funding streams.	CSCS Committee of Planning Council	Recommendations to PC; appropriate action based on recommendations		
e. The EMA will explore the use of peers as members of interdisciplinary clinical teams as a means of ensuring care coordination and consumer access to needed services.	CSCS Committee of Planning Council	Special study and recommendations to PC; PC action based on recommendations	2013	
Objective 2.3 – Increase regular communication, coordination, and collaboration between Part A and other service providers. **Strategies/Tasks/Activities:**				• Documented evidence of increased communication, cross-referrals, and other collaboration among funded and non-funded providers • Evidence of reduced service gaps for clients based on client utilization data and data in PLWH surveys and/or client satisfaction surveys
a. The Grantee and Administrative Agents will review, refine, and monitor provider linkage/collaboration agreements to ensure that they are operational.	Grantee	Revised format for provider linkage/ collaboration agreements	2013	
b. Funded providers across all jurisdictions will meet at least twice a year – making use of "virtual meeting" technology if feasible – to address coordination needs, discuss the implications of changes in the continuum of care, and provide input to the Planning Council and Grantee; non-Part A providers will be invited to such meetings.	Grantee	Two provider meetings a year focusing on specified topics	Ongoing beginning fall 2012	
c. The EMA will establish a working group on collaboration to recommend strategies for enhancing communications between Ryan White and other parts of the health care safety net; the group will include representatives of Part A providers, other safety net clinics, area primary care associations and coalitions, hospitals, Medicaid Managed Care Organizations (MCOs), and private insurance providers.	Grantee	Work group membership and minutes	Beginning in early 2013	

Figure 66: Work Plan for the Comprehensive Plan				
Goals, Objectives, and Strategies/Tasks	**Lead Responsibility**	**Deliverable**	**Timeline**	**Expected Outcome**
d. The EMA will develop policies and procedures for formally engaging non-Part A funded safety net clinics (including CHCs/FQHCs) as partners in the delivery of HIV-related care, particularly non-HIV-related medical care.	Grantee	Written policies and procedure	2013	
Objective 2.4 – Improve the use of client data and health information technology as a means of coordinating and improving care. **Strategies/Tasks/Activities:**				Client-level data will be generated by Part A providers and used to evaluate services provided and treatment outcomes Data will be appropriately shared among Ryan White funded providers, with all HIPAA requirements met Appropriate non-Ryan White providers will share data to ensure coordination of care and prevent duplication of medical tests, with all HIPAA requirements met
a. The Grantee will ensure the full implementation of the Maven client-level data system throughout the EMA.	Grantee	Data reports from all specified providers throughout EMA	2013	
b. The EMA will support the adoption and full implementation of electronic medical records (EMR) by service providers, and support to ensure "meaningful use"* of health information technology by HIV/AIDS service providers; included will be sharing of medical records among providers and with hospitals, with appropriate confidentiality protections.	Grantee	Protocols and models	2013-2014	
c. The EMA will support and encourage maximum use of shared data systems within the Part A network and between Ryan White providers and hospitals, community health centers, and other safety-net providers.	Grantee	Guidance to providers; meetings and technical assistance	2013-2014	
Goal 3: Improve – and consistently measure – service linkage, retention, quality, and outcomes.				

* "Meaningful use" of electronic medical records (EMR) or electronic health records (EHR) means that service providers will have to do more than simply install these systems; they are expected to use them to improve patient care. The Affordable Care Act requires provides to use EMR systems in a meaningful way to avoid payment reductions and receive incentive payments. See, for example, "Meaningful Use of Health Care Information Technology: What It Is and Why It Matters to Patients and Purchasers," Consumer-Purchaser Disclosure Project, March 2010. Available at http://healthcaredisclosure.org/docs/files/Meaningful_Use_IssueBrief.pdf.

Figure 66: Work Plan for the Comprehensive Plan				
Goals, Objectives, and Strategies/Tasks	**Lead Responsibility**	**Deliverable**	**Timeline**	**Expected Outcome**
Objective 3.1 – Expand and support the use of peer community health workers (CHWs) and other publicly disclosed PLWH as provider staff throughout the system of care. **Strategies/Tasks/Activities:**				• Increased use of peer staff in multiple service categories • Increased client satisfaction with services, as measured by client satisfaction surveys • Improved clinical outcomes for clients served by providers using peers
a. The Planning Council will modify standards of care so that they strongly encourage the employment of peer CHWs in many service categories, to play a variety of roles that facilitate linkage to care, system navigation, health/HIV education, disease self-management, treatment adherence, and close connection to and retention in care.	CSCS Committee of Planning Council	Revised Universal and/or Service-Specific Standards of Care	Mid-2013	
b. The EMA will provide incentives to providers to employ peer CHWs and other disclosed PLWH, exploring such means as bonus points in the applications	CSCS Committee of Planning Council – Directive; Grantee – Method and Implementation	Directive and Implementation	Directive – 2013 Implementation – 2014	
Objective 3.2 – Provide rapid access to and entry into care for all newly diagnosed PLWH and for PLWH who have been out of care. **Strategies/Tasks/Activities:**				
a. The EMA will fully implement the Program Year 22 Planning Council directive that all new and re-entering consumers have a first medical appointment scheduled within 72 hours and completed within 30 days after diagnosis.	Grantee	Requirements inserted into subcontracts	2013	• Evidence of improvement in early linkage to care for newly diagnosed • PLWH • Evidence of reduced waiting time for first
b. The EMA will improve, expand, and monitor immediate-access mechanisms in each jurisdiction that minimize waiting time for first appointments and facilitate successful linkage into medical care.	Grantee	Documented monitoring and quality management (QM) results	2012-2013	

Figure 66: Work Plan for the Comprehensive Plan				
Goals, Objectives, and Strategies/Tasks	**Lead Responsibility**	**Deliverable**	**Timeline**	**Expected Outcome**
c. The Planning Council will establish and the Grantee will implement a standard of care that calls for all newly diagnosed PLWH and all other PLWH that wish to enter or re-enter care have the following completed within 30 days after the initial appointment is scheduled: a medical appointment with a clinician who has prescribing privileges, a medical assessment, laboratory tests and diagnosis, and development of a medical treatment plan, including prescriptions if needed.	CSCS Committee of Planning Council	Revised Standard of Care; requirement included in subcontracts	Directive - 2013 Implementation -2014	appointments for any PLWH entering or re-entering care • Evidence of positive client response to these systems changes
d. The Grantee and Administrative Agents will implement monitoring protocols that determine the level of success in implementing this standard and address the standard in quality management reviews.	Grantee	Summary monitoring and QM data by service category	2014	
e. The EMA will work towards establishing a centralized intake system that enables a consumer to provide documentation of HIV status, residence, and income only once, with the documents available to all Ryan White providers via a shared online information system; the system should also document eligibility recertification every six months and make that information accessible to all providers with appropriate confidentiality protections.	Grantee	Plan and timeline for Centralized Intake System	2014	
Objective 3.3 – Take action to reduce known barriers to testing, entry into and retention in care. **Strategies/Tasks/Activities:**				Increased routine testing and increased testing in non-traditional locations Provider and client reports indicating reduced wait time and improved access to "treatment on demand" Baseline and initial post-implementation data indicating Improvements in "treatment cascade"
a. The EMA will support expanded testing, especially routine testing and testing in non-traditional locations, to increase early diagnosis and reduce transmission of HIV; this includes targeting testing to reach individuals with specific risk factors.	HAHSTA – Grantee and Prevention	Documentation of actions taken	2012-2014	
b. The EMA will explore and implement a centralized, EMA-wide, well publicized source of information about HIV disease, testing, and available services and providers that has (but is not limited to) an online component and provides HIV facts and referral information and is accessible to individuals and both Ryan White and non-Ryan White providers, including private physicians.	Planning Council	Plan and Directive; Implemented information hub	Plan – 2013 Implementation – 2014	

Figure 66: Work Plan for the Comprehensive Plan				
Goals, Objectives, and Strategies/Tasks	**Lead Responsibility**	**Deliverable**	**Timeline**	**Expected Outcome**
c. The EMA will take steps to ensure that front desk personnel at all funded providers – with initial emphasis on medical providers – have the knowledge, training, and demonstrated capacity to protect consumer confidentiality and provide culturally competent and consumer-friendly services to all PLWH. This will include ensuring that standards of care specify clear requirements and expectations for front desk personnel; requiring and if appropriate providing or arranging training for them, and requiring providers to monitor staff performance in this area.	Planning Council – Directive and Standards of Care (SOC); Grantee - Implementation	Directive, revised Standards of Care, Documentation of training; monitoring and QM reports	Directive and SOC – 2012 Implementation – 2013	measures related to early testing, entry into care, retention in care, and viral suppression or other clinical outcomes Improved client satisfaction with confidentiality protections and professionalism of front desk personnel
d. The Planning Council will explore strategies to facilitate "treatment on demand," including access to care without an appointment for PLWH who need urgent care or are in danger of being lost to care without such efforts.	CSCS Committee of Planning Council	Roundtable and recommendations to PC for action; appropriate action by PC	2013	
e. The EMA will expand use of provider-based transportation assistance, strongly encouraging service providers to include a line item for transportation for their clients, then separately report such expenditures for aggregation as Medical Transportation expenses, and will document the impact on no-shows and client connection to care.	Grantee	Grantee guidance to providers; Do	2013	Reduced no-shows Improvements in client retention in care and treatment adherence measures
Objective 3.4 – Enhance access to appropriate services for specific PLWH populations with special care needs. **Strategies/Tasks/Activities:**				• Baseline data and initial data indicating improved connection to care, retention in care, and treatment outcomes for targeted special populations receiving special attention and access to services
a. The EMA will identify specific population groups (based on characteristics or geographic location) that require specialized or culturally focused care, such as transgenders, African and Latino immigrants, young adults transitioning out of pediatric care, PLWH aged 50 and over, and recently incarcerated people returning to the community, as well as PLWH living East of the River.	Needs Assessment and Comprehensive Planning (NACP) Committee	Committee listing of target populations; PC adoption of recommendations	2012	

Figure 66: Work Plan for the Comprehensive Plan				
Goals, Objectives, and Strategies/Tasks	**Lead Responsibility**	**Deliverable**	**Timeline**	**Expected Outcome**
b. The EMA will identify mechanisms to provide these selected populations access to providers with the expertise to meet their care needs; strategies to be explored include funding of providers with specific expertise, training of funded providers, increased flexibility to allow PLWH to cross jurisdictions to obtain services from appropriate providers, and training of clinicians, case managers, peer CHWs, and other staff to prepare them to provide culturally competent and expert care for various PLWH populations, including consideration of use of Culturally and Linguistically Appropriate Services (CLAS) Standards	Planning Council – Directive and Allocations; Grantee – Implementation	Directive, Allocations, AETC or other training, implementation of recommended mechanisms	Planning – 2013 Implementation – 2014	• Increased client satisfaction with cultural competence of care provided, based QM client satisfaction surveys and needs assessment findings
c. The EMA will implement standards and service models ensuring that 2012 provisions of the PHS guidelines addressing older PLWH are met or exceeded within the Part A program. The EMA will: – Ensure that all consumers aged 50 and over receive geriatric screening and assessment within 60 calendar days after they enter or re-enter care, and PLWH already in care receive such screening when they reach the age of 50, using a HAHSTA-approved geriatric assessment protocol. – Work with area AIDS Education and Training Centers (AETCs) to train clinicians – including physicians, physician assistants, nurse practitioners, and medical case managers – on how to provide age-appropriate care for long-term survivors and newly diagnosed PLWH aged 50 and over. – Update standards of care to require that providers have appropriate training and capacity to deliver age-appropriate services to this population.	CSCS Committee of Planning Council – Standards and Models; Grantee – Implementation; area AETCs - training	Directive, revised Standard of Care, Documented treatment model; Documentation of AETC training with broad attendance; Documentation of changes in provider procedures	Directive and revised Standard of Care – 2012; Implementation – 2013; AETC training – ongoing starting late 2012	• Evidence of geriatric screening for all PLWH in care who are 50 and older based on monitoring and QM reports • Improved connection to care, retention in care, and treatment outcomes for PLWH 50 and over • Increased client satisfaction with care by clients aged 50 and over, based on QM client satisfaction surveys and needs assessment findings
d. The EMA will provide funding to medical providers for specialty consultation services to clients who are dually diagnosed with HIV/AIDS and Hepatitis C and will develop standards and procedures for maximizing coordination of care for such individuals.	CSCS Committee of Planning Council	Directive, Standards of Care, Documentation of procedures in place	Directive – 2012 Implementation – 2013-2014	• Increased testing for Hepatitis C for PLWH • Increased evidence of Hepatitis C treatment for dually diagnosed PLWH

Figure 66: Work Plan for the Comprehensive Plan				
Goals, Objectives, and Strategies/Tasks	**Lead Responsibility**	**Deliverable**	**Timeline**	**Expected Outcome**
Objective 3.5 – Implement monitoring, quality management, and evaluation mechanisms that provide ongoing assessment of program success based on the "treatment cascade" of outcome and quality measures. **Strategies/Tasks/Activities:**				• Evidence of consistent use of a set of "treatment cascade" measures, such as CDC-required measures in DC, MD, and VA • Baseline data available, as well as initial outcomes data for 2014, using these measures
a. The EMA will adopt a set of consistently defined "treatment cascade" outcome measures available in at least the three largest jurisdictions, for use in assessing quality of care and client outcomes.	Planning Council and Grantee	Documentation of chosen measures	2012	
b. The Grantee and Administrative Agents will work with providers to ensure collection and reporting of the required data in all jurisdictions.	Grantee	Protocols and Documentation of training	2013	
c. The EMA will explore ways to continue the Cross-Part Quality Management Collaborative that engages providers, trains consumers as members of Quality Management teams, and generates regular client outcomes data from medical care and case management providers using a shared set of indicators.	Planning Council	Evidence of meetings and consultations with interested parties including HRSA/HAB	Late 2012	• Continuation of at least some components of Cross-Part Collaborative • Ongoing use of selected QM measures by EMA providers
Goal 4: Work towards full access, parity, and portability of care for PLWH throughout the EMA.				
Objective 4.1 - Explore and adopt policies and procedures to improve choice, portability, and parity in access to care for clients throughout the EMA. **Strategies/Tasks/Activities:**				• Increased equity in access to care across jurisdictions based on

Figure 66: Work Plan for the Comprehensive Plan				
Goals, Objectives, and Strategies/Tasks	**Lead Responsibility**	**Deliverable**	**Timeline**	**Expected Outcome**
a. The Planning Council will rethink the current formula used to allocate funds to the jurisdictions to include additional measures beyond number of living HIV and AIDS cases.	Planning Council: Financial Oversight and Allocations Committee (FOAC) with NACP and CSCS Committees	Recommendation regarding formula to PC; PC action on recommendation	2013	unmet need and other measures, plus client perceptions of access to care in QM satisfaction surveys and needs assessment findings • Documentation of number and characteristics of clients who participate in pilot efforts • Evidence of impact on entry into care, retention in car, and treatment outcomes for specified populations
b. The Planning Council will approve for pilot testing EMA-wide models that allow specific PLWH populations with special medical or cultural competence needs, stigma or confidentiality issues to cross jurisdictional lines to obtain appropriate care, based on recommendations from CSCS (See Objective3.4.b).	CSCS Committee of Planning Council	Documented and approved pilot program; Allocation of funds	Approval – 2013 Implementation – 2014	
c. The Planning Council will explore and implement other strategies that will increase portability and appropriateness of care for consumers, regardless of where they live in the EMA.	CSCS Committee of Planning Council	Roundtable; recommendations to PC	2013	
Objective 4.2 – Facilitate access to care for consumers living in rural parts of the EMA or facing other access challenges. **Strategies/Tasks/Activities:**				• Documentation of extent of use of telemedicine • Improvements in connection to care and client outcomes for rural clients in areas where telemedicine is used
a. The EMA will explore and test the use of telemedicine consultation services for clients with special needs and/or clients in rural areas with limited access to HIV care.	Planning Council – Directive; Grantee – Implementation	Directive; Allocations	Directive – 2012 Implementation – 2013	

Figure 66: Work Plan for the Comprehensive Plan				
Goals, Objectives, and Strategies/Tasks	**Lead Responsibility**	**Deliverable**	**Timeline**	**Expected Outcome**
b. The Planning Council will establish and support a PLWH subcommittee of the Consumer Access Committee in West Virginia.	Planning Council	PC approval of establishment and support of WV PLWH group under CAC	Late 2012	
c. The Planning Council will specifically include West Virginia as a participating jurisdiction in EMA-wide initiatives designed to fill service gaps or test new service models	Planning Council	Inclusion of WV in Directives and related Allocations	Ongoing, beginning with 2012 PSRA process	• Increased PLWH participation in needs assessment and PSRA activities • Increased PLWH satisfaction with access to information based on QM reports and PC follow up
Goal 5: Enhance EMA planning and decision making based on improved data systems and quality and enhanced collaboration between the Planning Council, Grantee, and Administrative Agents.				
Objective 5.1 – Continue to strengthen Planning Council operations to ensure that legislative mandates are met and best practices adopted or maintained. **Strategies/Tasks/Activities:**				• Decisions by the Planning Council will be increasingly data-based, and will reflect use of additional and better quality information that becomes available through needs assessment, increased provider cooperation with the needs assessment process, the client-level data system,
a. The Planning Council will fully implement a three-year needs assessment plan that includes all the recommended components of a Ryan White needs assessment and meets EMA needs for data on particular populations, services, and jurisdictions.	NACP Committee of Planning Council	Written 3-year plan; documentation of implementation and findings	Plan – 2012 Implementation – 2012-2014	
b. The Planning Council will receive and work with the Grantee to analyze client-level service utilization and other client and service-category-level provider data from the planned Maven system, and use this information to make data-based decisions about service priorities, allocations, and directives, including refinements in the system of care.	CSCS Committee of Planning Council	Reports received; Analyses completed; Data presentations to committees and PC	2013-2014	

Figure 66: Work Plan for the Comprehensive Plan				
Goals, Objectives, and Strategies/Tasks	**Lead Responsibility**	**Deliverable**	**Timeline**	**Expected Outcome**
c. The EMA will develop consistent units of service for identified service categories and ensure their use by all funded providers.	CSCS Committee of Planning Council	Units of Service developed and approved by the PC and Grantee	2014	and use of unit costs that are consistent across providers and jurisdictions
d. The Planning Council will prepare a directive and the Grantee and Administrative Agents will determine and implement a mechanism for ensuring that funded Part A providers cooperate with the Planning Council's needs assessment and comprehensive planning efforts and with quality management activities, which include providing data, completing surveys, and supporting consumer-based needs assessment.	Planning Council – Directive; Grantee - Implementation	Directive; requirement in subcontracts	Directive – 2012; inclusion in provider subcontracts – 2013	
e. The Planning Council will regularly review and as necessary refine its bylaws, committee structure, priority setting and resource allocations process, and other policies and procedures.	Bylaws Committee	Annual reviews and recommendations to PC for needed changes	2012-2014	PC continues to meet legislative requirements, implement best practices, and maximize PLWH input and use of committees
Objective 5.2 – Strengthen working relationships between the Planning Council, Grantee and Administrative Agents, and funded providers. **Strategies/Tasks/Activities:**				• Positive and mutually beneficial relationship between Grantee and Planning Council, with MOU provisions followed by both parties • Planning Council able to minimize vacancies and continuously meet HRSA/HAB membership requirements
a. The Planning Council and Grantee will fully implement the revised Memorandum of Understanding signed in March 2012, including annual reviews and updates.	Executive Committee of Planning Council and Grantee	MOU approved and signed by all parties	March 2012	
b. The Planning Council will work with DC Boards and Commissions to establish a Planning Council membership nominations process that reduces vacancies by re-establishing staggered terms, allows for vacancies to be filled during the year, and reduces the time between nominations and appointments.	Membership and Executive Committees of Planning Council	Meeting between PC leadership and Boards and Commissions; Written recommendations	2012-2013	

Figure 66: Work Plan for the Comprehensive Plan				
Goals, Objectives, and Strategies/Tasks	**Lead Responsibility**	**Deliverable**	**Timeline**	**Expected Outcome**
Objective 5.3 – Implement collaborative planning and information sharing with prevention planning groups across jurisdictions. **Strategies/Tasks/Activities:**				• Collaboration across jurisdictions on at least some specified aspects of prevention and care • Improved coordination of prevention and care services within and across jurisdiction, with emphasis on testing and linkage to care
a. The EMA will explore with all jurisdictions the feasibility of developing some form of shared prevention plan or agreement on collaborative prevention/testing efforts across all jurisdictions, to facilitate coordination of shared responsibilities and seamless referral of newly diagnosed PLWH into care.	Planning Council – recommend-dation; Grantee - implementation	Meeting of prevention personnel from all jurisdictions; recommendations based on meeting(s)	2012	
Objective 5.4 – Continue to increase and support active consumer involvement as program and outreach volunteers, Planning Council and committee members, and regular members of quality management teams. **Strategies/Tasks/Activities:**				• Increased and more diverse consumer engagement in the CAC and its related PLWH groups (e.g., inclusion of more women, newly diagnosed, younger PLWH) • Increased and improved PLWH input to PSRA process as documented in data provided to the NACP Committee • Increased PLWH satisfaction with their role and input into EMA decision making, as measured through PLWH surveys and PC feedback sessions • More training sessions
a. The Planning Council will work with the Consumer Access Committee and jurisdictional PLWH groups to prepare their members to assist other consumers in understanding health care reform.	Planning Council	Approved plan; training schedule; documentation of training	2012-2013	
b. The Planning Council will implement procedures that support the Consumer Access Committee (CAC) and jurisdictional PLWH groups as the active link between the PLWH community and the Planning Council. This includes having these entities receive regular information from the Planning Council each month, address questions and requests for input from the Planning Council, and provide reports and recommendations through CAC to the Planning Council; these entities will provide structured input at least twice yearly to inform priority setting and resource allocations and efforts to strengthen the system of care.	Planning Council	Revised protocols for CAC and PLWH group roles; Documentation of recommendations from CAC to PC; Documentation of twice-annual input sessions	Protocols – 2012 Implementation - 2013-2014	
c. The EMA will make provide continuing training for consumers and ensure that trained consumers a part of Quality Management site visit teams in the EMA's three major jurisdictions, building upon training provided through the Cross-Part Collaborative	Planning Council	Directive; Training for additional PLWH	Directive – 2012 Implementation – 2013	

Figure 66: Work Plan for the Comprehensive Plan				
Goals, Objectives, and Strategies/Tasks	**Lead Responsibility**	**Deliverable**	**Timeline**	**Expected Outcome**
d. The EMA will explore ways to provide a young PLWH voice as part of the Planning Council structure	Planning Council	Recommendation from CAC to PC; Action by PC; Documentation of implementation	Recommendation – 2012 Implementation - 2013	for PLWH and more PLWH involved in QM teams, needs assessment, and other PC activities

C. Activities to Implement Coordinating Efforts

Coordinating efforts are an integral component of the work plan. They are a focus of Goals 1 and 2 and are also addressed in Goals 3 and 5, as described below.

Coordination between Ryan White Part A and Other Providers: The work plan calls for enhancing Part A coordination with all types of providers regardless of their funding streams. Goal 2 of the comprehensive plan includes several objectives and strategies/tasks designed to increase service coordination and collaboration:

- Objective 2.2 is *to establish operating models in each jurisdiction that provide for coordination of care for individual PLWH, through the use of medical homes, comprehensive care centers, co-located or virtual ("one-stop shops"), and/or other mechanisms.* One proposed strategy is to explore and adopt case management refinements, renewed use of non-medical case management, and/or other procedures that enable PLWH to obtain needed wraparound services, whether provided through Ryan White or other funding streams. In addition, the medical home/comprehensive care center model calls for service coordination and collaboration.
- Objective 2.3 is to *increase regular communication, coordination, and collaboration between Part A and other service providers.* Strategies include reviewing, refining, and monitoring provider linkage/collaboration agreements to ensure that they are operational rather than simply "paper" agreements; increasing provider contact through meetings of funded and non-funded providers; establishing a working group on collaboration to recommend strategies for enhancing links between Ryan white and other parts of the health care safety net; and enhancing links with CHCs/FQHCs and other safety net clinics as partners in providing medical care to PLWH, especially non-HIV-related care.

Coordination between Prevention, Testing, and Care: Goals 2, 3, and 4 all include strategies and activities that will strengthen coordination between prevention, testing, and care.

- Because Goal 2 calls for establishing a seamless system of prevention, testing, and care, it requires a new level of communication, cooperation, joint planning, and coordinated service delivery. Objective 2.1 is to establish and maintain ongoing collaboration between prevention, testing, and care. One planned strategy will involve the Planning Council working with prevention bodies throughout the EMA to establish a process for ongoing information sharing and then build on it to identify areas for collaborative planning and decision making, for prevention overall and for DC ECHPP. Others will involve coordination with ECHPP and other CDC prevention testing efforts to strengthen testing and to agree on a shared protocol for referring newly diagnosed PLWH to care and actively linking them to care. In addition, leadership from the Grantee and state health officials (prevention, care, and surveillance) will be needed to motivate agreement on shared operational definitions and measures that will allow for EMA-wide documentation and evaluation of testing and care outcomes.
- Goal 3 calls for improving service linkages, and Objective 3.3 calls for helping to reduce barriers to testing. A related strategy is to support expanded testing, working collaboratively with Prevention.

- Goal 5 calls for enhanced EMA planning and decision making; Objective 5.3 is to implement collaborative planning and information sharing with prevention planning groups across jurisdictions. This calls for implementing the stated priority of the DC Secretary of Health and a recommendation from the 2011 Regional HIV/AIDS Forum, to develop some form of shared prevention plan or agreement on collaborative prevention and testing efforts that goes across jurisdictional lines and funding streams. Accomplishing this will require the leadership of the Grantee, suggestions from the Planning Council (since it is the one regional HIV planning body with legislative authority), and the engagement and support of prevention and care personnel and state or regional planning bodies from all four jurisdictions.

Coordination with Public and Private Insurance: Implementation of health care reform and related increases in use of third party payments make efforts to strengthen access to and use of other payers, especially public and private insurance. Goal 1 of the work plan includes specific objectives and strategies related to helping its providers prepare for changes in the health care system that will require EMRs and careful documentation of services, increased use of information technology, and increased billing capacity – as well as the ability to meet the differing requirements of multiple third party payers, public and private. Objective 1.2 calls for preparing Ryan White funded providers for regional insurance-based care under health care reform. While specific objectives, strategies, and tasks may need to be modified based on the Supreme Court decision, expected Grantee strategies and tasks include the following:

- **Encouraging Part A providers to obtain Medicaid certification in multiple jurisdictions**, if they serve clients from more than one state, as well as to maintain Medicare eligibility.
- **Encouraging providers of covered services to develop relationships with Medicaid MCOs and private insurance providers within the exchanges.** This will be important for the sustainability of many nonprofit providers, and will give consumers the option of retaining their medical-related providers even if they move from Ryan White to Medicaid or to a private health plan under the exchange. Maryland has indicated that providers in multiple jurisdictions will be typical for insurers in its exchange. If this approach is used throughout the region, it will offer added choices for PLWH.
- **Obtaining non-Ryan White funding, if feasible, for navigation/benefit counseling services,** to assist client making the transition from Ryan White to other payers.
- **Providing training and other capacity-building assistance to providers,** to help them prepare for health care reform and develop the capacity to obtain needed relationships with MCOs and private insurers. Where possible, this will be done through the Ryan White Technical Assistance Contract or other HRSA/HAB-related resources.
- **Exploring models to link providers without EMR systems to providers with fully implemented systems**, to obtain assistance and support in accessing and implementing EMRs.

The Planning Council will provide assistance as requested. In addition, the Planning Council will ensure that any experience with the PCIPs is documented and analyzed to gain lessons about the transition from Ryan White to an insurance program. In addition, the Planning Council will be preparing consumer leaders to help educate other consumers about health care reform – so that they take full advantage of covered services.

D. How the Plan Addresses Healthy People 2020 Objectives

Healthy People 2020 Objectives include 18 that are HIV-related; they address HIV diagnosis, treatment/health care, testing, and prevention. Figure 67, below, shows how the work plan addresses these objectives.

Figure 67: How the Work Plan Addresses Health People 2020 HIV-related Objectives

	Category/HIV Objective	How Addressed by Work Plan
Diagnosis of HIV Infection and AIDS		
1	**HIV diagnoses:** Reduce the number of new HIV diagnoses among adolescents and adults	The EMA works with and supports CDC-funded initiatives on HIV prevention, collaborating on a variety of efforts at risk reduction ranging from expanding testing and entry into care to providing risk reduction services to HIV-positive individuals and providing antiretrovirals that constitute "care as prevention." The work plan will help to reduce new transmissions under several different goals, objectives, and strategies/tasks/activities that are designed to: • Improve prevention efforts through close collaboration, including collaborative planning and program implementation, between prevention (including ECHPP) and care (See Objective 2.1, Strategies a-b, and Objective 5.3, Strategy a) • Ensure that newly diagnosed PLWH have immediate access to HIV education and linkage to care, access to antiretrovirals, treatment adherence, and retention in care – reducing HIV transmission through reduction of risky behaviors and treatment as prevention (See Objective 3.2, Strategies a-e) • Expand use of peers to support care entry, retention, risk reduction, and treatment adherence (Objective 2.2, Strategies d-e, and Objective 3.1, Strategies a-b).
2	**New HIV infection:** Reduce new (incident) HIV infections among adolescents and adults	
3	**HIV transmission rate:** Reduce the rate of HIV transmission among adolescents and adults	
4	**HIV transmission rate:** Reduce the rate of HIV transmission among adolescents and adults	
5	**AIDS among heterosexuals:** Reduce the number of new AIDS cases among adolescent and adult heterosexuals	
6	**AIDS among men who have sex with men:** Reduce the number of new AIDS cases among adolescent and adult men who have sex with men	
7	**AIDS among injection drug users:** Reduce the number of new AIDS cases among adolescents and adults who inject drugs	
8	**Perinatally acquired HIV and AIDS:** Reduce the number of perinatally acquired HIV and AIDS cases	
Death, Survival and Medical Healthcare After Diagnosis of HIV Infection and AIDS		
9	**Early HIV diagnosis**: Increase the proportion of new HIV infections diagnosed before progression to AIDS	Early diagnosis is addressed in the plan through: • Efforts to improve targeting and coordination of testing through linkages between prevention and care (See Objective 2.1, Strategy b) • Ensuring shared definitions and improved monitoring of factors including late testing in order to better understand what populations are not being reached and better target testing (Objective 2.1 Strategy c) • Efforts to reduce barriers to testing overall and for specific targeted populations (Objective 3.3, Strategy a)

Figure 67: How the Work Plan Addresses Health People 2020 HIV-related Objectives		
	Category/HIV Objective	**How Addressed by Work Plan**
		• Improved access to information about free and low-cost testing and care resources (Objective 3.3, Strategy b)
10	**HIV care and treatment:** Increase the proportion of HIV-infected adolescents and adults who receive HIV care and treatment consistent with current standards	Virtually the entire work plan is designed to ensure immediate access to and retention in HIV care that meets PHS treatment guidelines and EMA standards of care, and leads to positive clinical outcomes and long-term survival and good health for PLWH in care. There is a major focus on obtaining "treatment cascade" state to track PLWH through care and measure retention, adherence to treatments, and clinical outcomes such as viral suppression. Identifying cases where HIV is the primary or secondary cause of death is a continuing responsibility. Of particular importance to these Healthy People 2020 are objectives related to: • A coordinated, integrated system of care that results in viral suppression (Goal 2), including development of medical home/comprehensive care center models for coordinated care (Objective 2.2, Strategies a-e) • Enhanced access to appropriate services for PLWH populations with special care needs or (Objective 3.4, Strategies a-d and Objective 4.1, strategies b-c)
11	**Survival after AIDS diagnosis:** Increase the proportion of persons surviving more than 3 years after a diagnosis with AIDS	
12	**HIV deaths:** Reduce deaths from HIV infection	
HIV Testing		
13	**Awareness of HIV serostatus:** Increase the proportion of persons living with HIV who know their serostatus	While prevention programs play the primary role in testing, the Part A program now has legislative responsibility for helping HIV-positive/unaware individuals become aware of their status, through Early Identification of Individuals with HIV/AIDS (EIIHA). The work plan addresses this responsibility in several ways: • Strategies to improve targeting of HIV testing and also to obtain and use data needed to evaluate and improve the success of such efforts (as specified in Objective 2.1, Strategies b and c) • Expansion of testing, including both routine testing in health care settings and testing in non-traditional locations, including with targeted populations such as individuals with another STI or co-morbidity (Objective 3.3, Strategy a) • Increase public awareness of both the availability of free, confidential testing – and of the availability of free or low-cost care for PLWH, since needs assessment data indicate that some groups, particularly African immigrants) do not get tested because they belief they will have no access to care (See Objective 3.3, Strategy b)
14	**HIV testing:** Increase the proportion of adolescents and adults who have been tested for HIV in the past 12 months [sub-objectives on MSM, pregnant women, and adults and young adults]	
15	**HIV testing in TB patients:** Increase the proportion of adults with tuberculosis (TB) who have been tested for HIV	
HIV Prevention		
16	**HIV/AIDS education in substance abuse treatment programs;** Increase the proportion of substance abuse treatment facilities that offer	The work plan calls for greatly enhanced communications and collaboration in both planning and program implementation between prevention and care. There is already shared responsibility for encouraging testing and providing condoms.

Figure 67: How the Work Plan Addresses Health People 2020 HIV-related Objectives		
	Category/HIV Objective	**How Addressed by Work Plan**
	HIV/AIDS education, counseling, and support	In DC, for example, providing free male and female condoms throughout the city is a major priority, with engagement by HAHSTA and other public agencies, testing sites, service providers, and faith-based entities. In addition, risk reduction education is an integral part of Early Intervention Services and an important role for peer community health workers. The work plan supports HIV prevention efforts through the following: • Efforts to expand testing among populations whose behavior places them at high risk for HIV (See Objective 3.3, Strategy a) • Efforts to strengthen HIV provider linkage agreements, including collaboration with points of entry into care such as substance abuse treatment programs (See Objective 2.3, Strategy a) • Collaboration with prevention and testing (including ECHPP) at the planning and operational levels (See Objective 2.1, Strategies a-b,
17	**Condom use:** Increase the proportion of sexually active persons who use condoms [sub-objectives on unmarried females 15-44 and unmarried males aged 15-44]	
18	**Unprotected sex among men who have sex with men:** Decrease the proportion of men who have sex with men who reported unprotected anal sex in the past 12 months.	

E. How the Plan Reflects Existing Statewide Coordinated Statements of Need

The work plan is a result of extensive efforts to gain an understanding of needs within all four jurisdictions of the EMA, and is based on input obtained in early 2012 from well over 200 people, including PLWH, providers including those funded through all the other Ryan White Parts, public agency personnel, and other stakeholders. The existing Statewide Coordinated Statements of Needs (SCSNs) were reviewed, and work plan goals, objectives, and strategies/tasks/activities are consistent with them.

However, these SCSNs were developed in 2008, in preparation for each state's 2009-2011 comprehensive plan. The due date for this 2012-2014 comprehensive plan occurs about one month *before* the states are required to submit new SCSNs along with their comprehensive plans. As a result, SCSN meetings are just being held and SCSN documentation has not yet been prepared for the period 2012-2014. Because the prior plans were developed just as the great recession was beginning – and before the NHAS and ACA – they reflect a very different reality from the current one. In January 2009, there was no ADAP waiting list in Virginia. Budget cuts as a result of the recession were just beginning. Unemployment was high, but the impact of lost jobs and lost insurance on Ryan White and other public programs was not fully evident – nor was the duration of the economic situation. Thus much of the focus of this plan, though consistent with the SCSNs, goes well beyond this somewhat dated information.

Also important in considering SCSN data is the reality that except for DC, the EMA includes only a segment of each of the states covered by these SCSNs, and some of their issues may be less applicable in the EMA than in other regions of the state. For example, many of the examples in the Maryland SCSN come from Baltimore, the epicenter of the state's epidemic but not a part of the Metropolitan Washington EMA. Northern Virginia is sufficiently different in cost of living from other parts of Virginia that its income eligibility for ADAP is higher than that of the rest of

the state. West Virginia's SCSN reflects the realities of a largely rural state with 55 counties. Berkeley and Jefferson Counties seem rural by EMA standards, but Berkeley County has the second largest population among West Virginia counties. Only Kanawha, which includes Charleston, is more populous. Jefferson County is one of only 20% of WV counties with populations over 50,000.

The EMA views the most recent available SCSNs as important but – given these limitations – places most importance on data from its own, EMA-specific input sessions and needs assessment in preparing the plan. However, many issues and concerns identified in the SCSN were also identified in the EMA's own data gathering. Some were addressed in the previous comprehensive plan.

Figure 68, below, summarizes main findings from the four existing SCSNs and indicates how the work plan reflects Following are examples showing now the work plan is consistent with these existing SCSNs. For West Virginia, where the cross-part meeting for the new SCSN has been held, input from that session is included.

Figure 68: SCSN Key Issues/Priorities for EMA Jurisdictions: 2008 SCSN with 2012 Updates

Issue Area	DC	MD	VA	WV	Reflected in Work Plan
Funding Levels and Stability		• Growing needs; level funding • Funds used primarily for essential core services; little left for support services • Concern about system ability to serve newly diagnosed	ADAP	ADAP (funding instability)	Addresses in a variety of approaches to ensuring efficient use of available funds and ensuring parity in care despite jurisdictional resource differences. Also addresses support to providers to maximize access to third party reimbursements under health care reform. See especially: • Objective 4.1, Strategy a • Objective 1.2, Strategies b, d, e, and f
Unmet Need	Reduction in unmet need – need to prevent PLWH from falling out of care and bring people back into care		Reduction of unmet need	• Decreased level of unmet need • Improved retention in care through holistic support for PLWH	Addressed throughout the plan, in efforts to prevent and reduce unmet need. See especially: Objective 3.2, all strategies Objective 3.3, Strategies c-e Objective 3.4, Strategies a-c
Collaboration/ Seamless System of Care	• Collaboration to provide a seamless,	Improved coordination between health and social	Service coordination/ collaboration and	• Collaboration to increase resources for	A key focus of the ideal system of care and work plan is developing

Figure 68: SCSN Key Issues/Priorities for EMA Jurisdictions: 2008 SCSN with 2012 Updates					
Issue Area	**DC**	**MD**	**VA**	**WV**	**Reflected in Work Plan**
	integrated, culturally competent system of care including both core medical and support services, Ryan White and non-Ryan White funded • Client information sharing to improve coordination of care	services	streamlining	care and address insufficient funding • Linkages to address non-HIV service needs of PLWH • Access to and knowledge of support services	coordinated care model such as a medical home or comprehensive care center. See Goal 2, especially: • Objective 2.2, Strategies a-e • Objective 2.3, Strategies a-d • Objective 2.4, Strategies a-c
Core Service Gaps	• Substance abuse services • Mental health services	• Oral health care • Mental health services • Substance abuse services	• HIV-related medical care • Oral health care	• Substance abuse treatment • Mental health services • Oral health services	Addressed through the refined priority-setting and resource allocations process already adopted by the Planning Council, and through efforts to maximize access to Ryan White and non-Ryan White funded services. See especially Objectives 2.2 and 2.3, all strategies
Support Service Gaps	Food vouchers Food bank Housing services Transportation	Linguistics services (rural areas) Housing services Transportation	Transportation Housing Food	Transportation	
Data, Quality Management, and Outcomes Evaluation	• Increased accountability through improved data systems • Provider collaboration on quality management • Documentation of service outcomes				Improving data available for decision making and documenting treatment outcomes are key priorities in the work plan. Includes exploration of how to continue the Cross-Part Collaborative on Quality Management. See especially: • Objective 2.4, all strategies • Objective 3.5, all strategies

Figure 68: SCSN Key Issues/Priorities for EMA Jurisdictions: 2008 SCSN with 2012 Updates					
Issue Area	**DC**	**MD**	**VA**	**WV**	**Reflected in Work Plan**
Parity and Disparities	Parity in services for specific populations	• Access to quality health care and infectious disease doctors in rural areas • Culturally competent resources for sexual minorities, especially in rural areas	In rural areas, limited pool of providers, especially for: • Oral health • Mental health • Substance abuse treatment	Equal access to comprehensive care regardless of place of residence	Work plan prioritizes increasing parity in access to care for all PLWH regardless of characteristics or place of residence within the EMA, with a particular focus on rural areas and on populations facing HIV-related disparities. See especially: • Objective 3.4, all strategies • Objective 4.1, all strategies • Objective 4.2, all strategies
Populations	Transgenders Young MSM Adolescents transitioning into adult care Individuals returning to the community from jails or prisons	Immigrants, especially limited English proficient Adolescents Recently incarcerated Substance users HIV-positive pregnant women Homeless MSM, especially African Americans Other sexual minorities	Minority populations MSM	Aging population/ long-term survivors Women, including pregnant women Children and adolescents	Comprehensive plan explores needs of numerous specific populations, among them almost all the groups identified in the SCSNs. Work plan focuses on reducing disparities for such populations. See especially: Objective 3.4, all strategies Objective 4.1, Strategy b
Stigma and Confidentiality	Stigma, especially among substance users	• Stigma and discrimination • Need for provider training in confidentiality	Stigma, which negatively affects willingness to access services	Increase understanding of importance of confidentiality	Work plan focuses on several aspects of stigma, including protection of confidentiality through ensuring front desk and other staff understanding of these issues and providing care choices that help overcome these concerns. See especially: • Objective 3.3, Strategy c • Objective 4.1, Strategy b

Figure 68: SCSN Key Issues/Priorities for EMA Jurisdictions: 2008 SCSN with 2012 Updates					
Issue Area	**DC**	**MD**	**VA**	**WV**	**Reflected in Work Plan**
Access to Information		• Lack of PLWH knowledge about available services • HIV prevention/ risk reduction services for PLWH • HIV education for providers and PLWH	Lack of information for PLWH about available services	Need for information/ education about HIV for providers, consumers, and the public	Addressed directly in work plan through establishment of an EMA-wide source of HIV-related information including available services; see Objective 3.3, Strategy b
Co-Morbidities	Co-infection with Hepatitis C Linkage between STI and HIV testing			Hepatitis C testing for PLWH	Special focus on Hepatitis C testing and treatment. See: • Objective 3.3, Strategy a • Objective 3.4, Strategy d
Provider Capacity and Service Models	• Treatment adherence counseling • Medical case management • Discharge planning	• Case management (inconsistency) • HIV training for clinicians • Cultural sensitivity and competency training • Disease self-management training for PLWH		• Capacity building for providers • Use of peer advocates • Cultural competence training • Medication adherence through case management	Work plan strongly emphasizes expanded use of peer-based service models, a case manager assistant model, and expanded HIV training for providers in such areas as cultural competence; Planning Council's use of directives as part of priority setting and resource allocations facilitates exploration of such models. See especially: • Objective 2.3, all strategies • Objective 3.4, Strategies b-c
Personnel Shortages	• Nurses	• Case managers • Infectious disease doctors		• Dentists • Mental health providers with HIV training	Several innovative service strategies suggested to address personnel shortages, including use of telemedicine and a case manager assistant model. See • Objective 4.2, Strategy a • Objective 1.3, Strategy b

F. How the Plan Reflects Implementation of the Affordable Care Act (ACA)

As described in earlier sections of this comprehensive plan, preparing for health care reform – particularly implementation of Medicaid expansion and the state health insurance exchanges scheduled for 2014 – is among the most important requirements for the EMA. Great changes are likely in health care delivery and payment systems, and they are likely to affect the organization, delivery, and payment of care for a majority of the PLWH receiving Ryan White services in this EMA. Preparing for ACA implementation is a key component of the work plan, as reflected in Goal 1: *Prepare the EMA for changes in the health care system so that people living with HIV and AIDS make a seamless transition to new funding and service systems such as Medicaid and private insurance.*

Uncertainty about the Supreme Court's pending decision about the Affordable Care Act make it impossible for the EMA to fully project required actions. The pending reauthorization of the Ryan White legislation also leads to as yet unanswerable questions about its future role in the delivery of HIV/AIDS care. The EMA hopes that Ryan White will make possible the coordination and integration of care needed for maximum success in meeting NHAS goals. A centerpiece of the ideal system of care and work plan is the development of some form of medical/health home or comprehensive care model implementable in all jurisdictions to provide HIV-centered, coordinated services for PLWH who may have multiple payers including public and private insurance.

Given these uncertainties, the Planning Council and Grantee have identified three objectives that – based on available information – they believe must be met to ensure that the EMA is ready for health care reform implementation, each with related strategies and tasks/activities. They reflect a belief that preparation required education and active involvement of both consumers and providers. The first step is to ensure that the Planning Council, other PLWH, and providers are kept informed of plans for health care reform implementation in each of the four jurisdictions, as well as national actions influencing implementation. The second is to help providers develop or strengthen their capacity and systems for participation in a third-party, insurance-based system of care, and where feasible develop relationships that will enable them to continue providing HIV services to clients who become eligible for Medicaid or insurance under ACA. This includes learning from the early expansion of Medicaid in the District of Columbia, as well as experiences with the transition to health care encountered by PLWH served under federal or state PCIPs. The third step is to facilitate a seamless transition for clients, through ensuring appropriate benefit counseling and navigation services, providing case manager assistants, and offering other needed transitional support. This requires that PLWH – especially members of the Planning Council, Consumer Access Committee, and jurisdictional PLWH groups – have the training and structured opportunities to serve as community educators and ambassadors during ACA implementation.

In addition to the efforts related to Goal 1, the refined system of care presented in the plan and addressed specifically in Goal 2 is designed for implementation in the restructured health care system expected under health care reform. Thus much of the work plan directly addresses ways to meet NHAS goals under health care reform.

As noted earlier, some of the proposed objectives, strategies, and tasks may require revision, based on the Supreme Court decision, subsequent state decisions and plans regarding ACA implementation, Ryan White reauthorization, and the results of feasibility analysis. However, the work plan goals will not change, and most objectives should also remain unchanged.

G. How the Plan Addresses the Goals of the National HIV/AIDS Strategy (NHAS)

The EMA's 2011-2014 comprehensive plan goals and objectives and the strategies and tasks for implementing them are closely linked to the NHAS goals of reducing new infections, increasing access to care and optimizing health outcomes, and eliminating HIV-related health disparities. These goals accurately reflect the values, purpose, and priorities of the Metropolitan Washington Ryan White Part A program. The EMA's goals and priorities also relate at a regional level to the internal NHAS goal of achieving a more coordinated national response to the epidemic. Figure 69 shows how the vast majority of the EMA's five goals and 17 objectives for the next three years contribute directly to addressing NHAS goals.

Figure 69: Comprehensive Plan Goals and Objectives and Their Contributions to National HIV/AIDS Strategy Goals

2012-2014 Comprehensive Plan Goals and Objectives	Contributions to NHAS Goals
Goal 1: Prepare the EMA for changes in the health care system so that people living with HIV and AIDS make a seamless transition to new funding and service systems such as Medicaid and private insurance.	
Objective 1.1 - Provide ongoing information and updates about health care reform to the Planning Council, providers, and consumers.	Increase access to care and optimize health outcomes
Objective 1.2 - Prepare Ryan White funded providers for regional insurance-based care under health care reform.	Increase access to care and optimize health outcomes
Goal 2: Establish and maintain a coordinated, integrated continuum of prevention, testing, and care that provides for coordination of services for individual PLWH and results in viral suppression.	
Objective 2.1 – Establish and maintain ongoing collaboration between prevention, testing, and care.	Reduce HIV incidence Increase access to care and optimize health outcomes Internal: Achieve a more coordinated national response
Objective 2.2 – Establish operating models in each jurisdiction that provide for coordination of care for individual PLWH, through the use of medical homes, comprehensive care centers, co-located or virtual ("one-stop shops"), and/or other mechanisms.	Increase access to care and optimize health outcomes Reduce HIV-related health disparities

Figure 69: Comprehensive Plan Goals and Objectives and Their Contributions to National HIV/AIDS Strategy Goals	
2012-2014 Comprehensive Plan Goals and Objectives	**Contributions to NHAS Goals**
Objective 2.3 – Increase regular communication, coordination, and collaboration between Part A and other service providers.	Increase access to care and optimize health outcomes Internal: Achieve a more coordinated national response
Objective 2.4 – Improve the use of client data and health information technology as a means of coordinating and improving care.	Increase access to care and optimize health outcomes Internal: Achieve a more coordinated national response
Goal 3: Improve – and consistently measure – service linkage, retention, quality, and outcomes.	
Objective 3.1 – Expand and support the use of peer community health workers (CHWs) and other publicly disclosed PLWH as provider staff throughout the system of care.	Reduce HIV incidence Increase access to care and optimize health outcomes Reduce HIV-related health disparities
Objective 3.2 – Provide rapid access to and entry into care for all newly diagnosed PLWH and for PLWH who have been out of care.	Reduce HIV incidence Increase access to care and optimize health outcomes
Objective 3.3 – Take action to reduce known barriers to testing, entry into and retention in care.	Reduce HIV incidence Increase access to care and optimize health outcomes
Objective 3.4 – Enhance access to appropriate services for specific PLWH populations with special care needs.	Increase access to care and optimize health outcomes Reduce HIV-related health disparities
Objective 3.5 – Implement monitoring, quality management, and evaluation mechanisms that provide ongoing assessment of program success based on the "treatment cascade" of outcome and quality measures.	Increase access to care and optimize health outcomes
Goal 4: Work towards full access, parity, and portability of care for PLWH throughout the EMA.	
Objective 4.1 - Explore and adopt policies and procedures to improve choice, portability, and parity in access to care for clients throughout the EMA.	Increase access to care and optimize health outcomes Reduce HIV-related health disparities

Figure 69: Comprehensive Plan Goals and Objectives and Their Contributions to National HIV/AIDS Strategy Goals	
2012-2014 Comprehensive Plan Goals and Objectives	**Contributions to NHAS Goals**
Objective 4.2 – Facilitate access to care for consumers living in rural parts of the EMA or facing other access challenges.	Increase access to care and optimize health outcomes Reduce HIV-related health disparities
Goal 5: Enhance EMA planning and decision making based on improved data systems and quality and enhanced collaboration between the Planning Council, Grantee, and Administrative Agents.	
Objective 5.1 – Continue to strengthen Planning Council operations to ensure that legislative mandates are met and best practices adopted or maintained.	Increase access to care and optimize health outcomes
Objective 5.2 – Strengthen working relationships between the Planning Council, Grantee and Administrative Agents, and funded providers.	Internal: Achieve a more coordinated national response
Objective 5.3 – Implement collaborative planning and information sharing with prevention planning groups across jurisdictions.	Internal: Achieve a more coordinated national response
Objective 5.4 – Continue to increase and support active consumer involvement as program and outreach volunteers, Planning Council and committee members, and regular members of quality management teams.	Increase access to care and optimize health outcomes

H. How the Plan Responds to Changes in the Continuum of Care due to State or Local Budget Cuts

The work plan is designed to provide the best possible services to PLWH in the EMA with the funds available – whatever the level of funding. It does this by building on the EMA's capacity to:

- Prioritize and coordinate services to funds are used efficiently (Goal 2, especially strategies under Objective 2.2).
- Maximize client access to public and private insurance and to services supported through non-Ryan White funds, through increased linkages and coordination with non-Ryan White providers (See strategies under Goal 1, Objectives 1.2 and 1.3, and Goal 2, Objectives 2.2 and 2.3).
- Better address jurisdictional differences in funding and services, through such strategies as reviewing the current jurisdictional allocations formula and process to consider including factors related to resources and poverty, not just living HIV and AIDS cases, and increasing access to services for populations with the greatest HIV-related health disparities, regardless

of where they live (See strategies for implementing Goal 3, Objectives 3.4, and Goal 4, Objective 4.1).

- Continue to ensure that available resources are used efficiently and that budget challenges are addressed through the Planning Council's fully updated systems and procedures such as a greatly enhanced priority setting and resource allocations process, use of directives, multi-year needs assessment, and improved communication and coordination with the Grantee through a newly updated and signed MOU (See Goal 5, strategies under Objectives 5.1 and 5.2).

The entire comprehensive planning effort reflects a high level of Planning Council and community engagement and commitment to data-based decision making. The Planning Council is now in the desirable position of having many more applicants than membership slots, and a large group of nominees waiting only for final appointment by the Mayor. This reflects growing community recognition of the Council's ability to meet legislative requirements and make difficult decisions as necessary to ensure that available resources are used efficiently to serve PLWH throughout the EMA.

Section 4: How Will We Monitor Our Progress?

Chapter 10: Plans for Monitoring and Evaluating Progress

A. Overview

This chapter describes the EMA's plans for monitoring and evaluating progress towards the goals and objectives of the 2012-2014 comprehensive plan. The Planning Council will integrate the comprehensive plan work plan into committee work plans and calendars, and will provide for regular reporting of progress as part of committee reports.

Progress reports will be made quarterly, outcome measures presented biannually or annually (depending on the measure), and overall progress assessed annually and used as input to the needs assessment and priority setting/ resource allocations (PSRA) process. Community input and response sessions are already a part of the Planning Council's ongoing work, and will provide for feedback on system changes occurring as a result of the comprehensive plan.

B. Monitoring and Evaluation Plan and Timeline

Monitoring and evaluation will be led by the Planning Council, through the Needs Assessment and Comprehensive Planning (NACP) Committee, but will be a shared responsibility of the Planning Council and the Grantees and Administrative Agents, as shown in Figure 70, below. As with all the Council's work, the Bylaws and Policies Committee will assist in the development of appropriate reporting forms and protocols, and Grantee reporting will be instituted using the procedures specified in the Memorandum of Understanding between the Grantee and Planning Council. The Planning Council's logistics contractor and technical consultant will provide support for the monitoring and evaluation effort. Once procedures are in place, the implementation, review, reporting, decision-making, and community feedback process will be part of an annual cycle.

Figure 70: Monitoring and Evaluation Plan and Timeline

	Monitoring and Evaluation Task	Description	Responsibility	Timeline
1	Agreement on Planning Council responsibilities for implementation of comprehensive plan	Committee review of work plan and finalizing of assignments of each objective and strategy to the appropriate committee	Needs Assessment and Comprehensive Planning (NACP) Committee, with input from other committees	June 2012
2	Development of an evaluation measures master chart for each objective and strategy	Development of a chart that shows each goal, objective, and strategy/tasks/activities, and identifies specific monitoring and evaluation measures (based on the expected results already	NACP Committee, with technical support and Grantee input	July 2012

Figure 70: Monitoring and Evaluation Plan and Timeline				
	Monitoring and Evaluation Task	**Description**	**Responsibility**	**Timeline**
		included in the work plan) to guide the monitoring and evaluation process, as well as responsibilities for obtaining the required data		
3	Establishment of reporting requirements for each strategy/task	Development and approval of process and format for quarterly reports on work plan progress as part of committee reports and for annual reports to Planning Council	NACP with Bylaws, Policies, and Procedures Committee	July 2012
4	Agreement on Reporting by Grantee on its Objectives and Strategies	Agreement with Grantee on quarterly reports from Grantee (including data from Administrative Agents), using agreed-upon format, as part of Grantee report to appropriate committee and then the full Planning Council	Executive Committee with help from Bylaws Committee	July 2012
5	Integration of plan responsibilities and reporting into Planning Council committee work plans	Comprehensive plan tasks and planned outcomes added to 2012 committee plans, with budget adjustments as needed, determination of support and assistance needs, and process for Planning Council review/approval	Each Committee, with review by Executive Committee and full Planning Council	August 2012
6	Monthly committee discussion and quarterly review of progress	Committees to address plan tasks as a part of ongoing work, reviewing progress internally each month and providing a report on progress and challenges to the NACP Committee, with review by the Executive Committee and full Planning Council	NACP Committee, with review by Executive Committee and full Planning Council	Quarterly (covering each 3-month period): October 2012 January 2013 April 2013 July 2013 October 2013 January 2014 April 2014 July 2014 October 2014 January 2015
7	Biennial outcomes data review	Data on agreed-upon outcomes measures provided by Grantee (aggregated so	Grantee; review by NACP Committee and then full Planning	January 2013 July 2013 January 2014

Figure 70: Monitoring and Evaluation Plan and Timeline				
	Monitoring and Evaluation Task	**Description**	**Responsibility**	**Timeline**
		data from Administrative Agents are included), plus use of Cross-Part Collaborative data as feasible; data reviewed by NACP Committee and Planning Council	Council	July 2014 January 2015
8	Annual summary of progress	Data from Grantee and committees aggregated, analyzed, reviewed, and presented to Planning Council	NACP Committee with technical support	February 2013 February 2014 February 2015
9	Analysis of outcomes	Outcomes data analyzed along with changes in system of care to assess success of system changes and compared to national data as appropriate,	NACP Committee with technical support	March 2013 March 2014 March 2015
10	Community (PLWH and provider) feedback and input sessions	Presentations/feedback to community on accomplishments and outcomes and input sessions held to obtain community perspectives on both system changes and outcomes – to include providers and consumers	Presentations and feedback questions developed by NACP Committee with technical support; PLWH sessions organized and chaired by Consumer Access Committee and PLWH group chairs with logistical support; Provider session organized by logistics contractor in consultation with Grantee	Integrated with PSRA and provider town halls held in April 2013 and April 2014
11	Assessment of community response	Inclusion of questions about comprehensive-plan-based system changes in needs assessment efforts – PLWH surveys, focus groups, and key informant sessions – and sharing of results with the community as part of annual EMA and jurisdictional data presentations	NACP Committee, with technical support	Needs assessments scheduled for completion in May 2013 and May 2014; reports to community as part of Data Presentations
12	Adjustments in	Review of progress and	Committee	March 2013

Figure 70: Monitoring and Evaluation Plan and Timeline				
	Monitoring and Evaluation Task	**Description**	**Responsibility**	**Timeline**
	work plan	outcomes used to identify needed changes in the work plan objectives or strategies, and obtain Planning Council approval for any needed changes	recommendations; NACP Committee review	March 2014 [New Plan in 2015]

C. Tracking Changes/Progress

In the past, progress towards comprehensive plan goals and objectives has been measured primarily through documenting the completion of tasks and activities. While this continues to be necessary, the EMA is committed to measuring the ultimate success of efforts to improve the system of care by determining the extent to which these changes are affecting clinical outcomes for clients. The intent is to identify a set of outcome measures that reflect a form of treatment cascade, use data gathered for the comprehensive plan as baseline measures, and then assess changes regularly – with some data available quarterly and other data annually – using these measures. The measures need to use data that are available and can be reported consistently by all four jurisdictions if feasible, and at least by the three with the largest numbers of PLWH – DC, Maryland, and Virginia.

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

Measures will be reviewed and refined during 2012, but are expected to include most of the following. They include the data being used by the Grantee to measure progress on EIIHA, widely used treatment outcomes data, and some additional ECHPP measures and HRSA/HAB performance measures as used by the Cross-Part Collaborative. Data for some measures will be available only after MAVEN is fully implemented. Following are the desired measures:

1. Number of individuals tested
2. Number and percent of these individuals receiving test results
3. Number and percent of these individuals testing positive
4. Number and percent of these individuals who were late-tested (diagnosed with AIDS at time of testing or within 12 months after testing)
5. Number and percent of individuals testing negative successfully referred to prevention services
6. Number and percent of newly diagnosed HIV-positive individuals who entered care within the following periods after testing: less than 1 month, 1-3 months, 3-6 months, 6-12 months,

and more than 12 months; and number and percent who did not enter care within one year after diagnosis (The current definition of linkage to care is the reporting of a CD4 or viral load test to surveillance; additional measures are needed if feasible, such as first visit with a clinician who has prescribing privileges)

7. Number and percent of those connected to care who obtain antiretrovirals (and length of time after entry into care before antiretroviral therapy begins)
8. Number and percent of those connected to care who remain connected to in care (to be assessed annually); several measures needed, probably including two laboratory tests during the year, at least three months apart (the current measure), and two medical visits at least three months apart (used by ECHPP in DC), and/or other ECHPP-consistent measures
9. Number and percent of those prescribed antiretrovirals who remain on antiretrovirals, as measured by regularly obtaining prescribed medications (requires data from state ADAPs)
10. Number and percent of all diagnosed and of those retained in care with viral suppression

Data will be reported for the EMA and by jurisdiction, overall and broken down by race/ethnicity, age at diagnosis, gender, and mode of transmission. This will ensure available of data needed for decision making about PLWH targeting and the system of care across the EMA and for specific jurisdictions.

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

The DC ECHPP program plans use of several additional measures of care coordination and referrals that would be useful if available across jurisdictions, such as increased linkage of PLWH to substance abuse and mental health services. Once the MAVEN system is implemented, such additional measures should be available for PLWH served by Ryan White Part A throughout the EMA.

D. Community Feedback

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

The Planning Council will use several existing mechanisms for reporting to the community on its efforts to strengthen the system of care and for receiving community feedback on how these changes are working for them. The Consumer Access Committee not only serves as the standing committee that links the Planning Council to the community; it also coordinates the work of jurisdictional PLWH committees in the various jurisdictions. In Program Year 22, the Planning Council expects to add a PLWH committee in West Virginia. These groups meet monthly. The

Planning Council reports back to these entities and receives their input several times a year, and will make comprehensive plan feedback and input a part of these meetings twice a year. As described earlier in this comprehensive plan, the Planning Council also works with the Northern Virginia HIV Commission, which includes providers and consumers, the Maryland Regional Advisory Committees, and the DC HIV prevention community planning group. The Planning Council expects to increase communications with these entities as part of the EMA's commitment to cross-jurisdictional prevention planning. It will use these contacts to provide feedback and seek input from these entities regarding comprehensive plan progress.

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

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

E. Use of Monitoring Results in Planning Council Decision Making

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

- The Needs Assessment and Comprehensive Planning Committee oversees the needs assessment process, community input sessions, and development of the data presentations, as well as comprehensive plan development and monitoring.
- The Consumer Access Committee manages the input and feedback sessions with PLWH, through an EMA-wide town hall plus jurisdictional sessions hosted by the PLWH groups.
- The Care Strategy, Coordination, and Standards Committee is responsible for identifying possible directives from the input sessions and needs assessment, and coordinating the development of a set of directives for Planning Council action.
- The Financial Oversight and Allocations Committee oversees the allocations process.
- The Bylaws, Policies, and Procedures Committee ensures that interaction with the Grantee is based on the MOU, and ensures that Planning Council policies and procedures are followed and that recommendations to the Planning Council reflect "best practice" formats and procedures.

The major tasks include the following, listed in chronological order as they occur each year:

- NACP Committee completion of specified needs assessment tasks (which will include questions related to system changes based on the comprehensive plan)
- Obtaining of community input/feedback (which will include feedback on impact of comprehensive plan actions/changes) and PLWH suggestions for directives
- Obtaining of annual summary of outcomes data along with epi, utilization, and cost data from the Grantee and Administrative Agents
- Analysis and review of the implications of these data by the NACP Committee, then summarizing of this information as part of an updated annual Data Matrix provided to Planning Council members and other participants in the PSRA process
- Preparation and implementation of an EMA-wide data presentation including all these elements, which is followed by a review of service priorities
- Preparation and implementation of jurisdiction-specific data presentations, followed by adjustment of services priorities as needed to fit jurisdictional needs
- Off-the-top allocation of funds for services that are to be available to PLWH in all jurisdictions, based on needs identified through the data and the input sessions
- Setting of priorities and then development of recommending resource allocations at jurisdictional sessions, all based on data for that jurisdiction
- Agreement on EMA-wide directives to the grantee on how best to meet the identified priorities, following careful data-based review of proposed directives
- Planning Council review and approval of final priorities and combined allocations for the EMA

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

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Appendix: 1 Metropolitan Washington Regional Ryan White Planning Council Member, 2012-2014

Stephen Bailous, Chair
Steve Bailey
Alexis Blackmon
Henry Bishop
Ralph Black
James Brown
Keith Callahan
Martha Cameron
Melvin Cauthen
Barbara Chinn
Reginald Davis
Maureen Deely
William Dunnington
Mark Fischer
Shella Fon
Sharon Franks-Dunbar
Debra Frazier
Patricia Hawkins
Orlando Xavier Hixon
David Hoover
Herbert Jackson
Renee Kelly
Alis Marachelian
Tarsha Moore
Anna Pilskaya
David Purdy
Cornett Roberts-Njoku
Yolanda Santirosa
Ronald Scheraga
Linda Scruggs
Nicolette Solan-Pegler
Ervin Robert Smith
Dedra Spears-Johnson
Tyranny Smith
Ronald Swanda

Appendix 2: Epidemiologic Data for the Metropolitan Washington Eligible Metropolitan Area as of December 31, 2010

EMA Epi Data as of December 31, 2010
(District of Columbia and Parts of Maryland, Virginia, and West Virginia)

EMA - Demographic Group/Exposure Category	AIDS Incidence* 01/01/09 to 12/31/09		AIDS Incidence* 01/01/10 to 12/31/10		AIDS Prevalence** as of 12/31/2010		HIV/Not AIDS Prevalence*** as of 12/31/2010		HIV/AIDS Prevalence as of 12/31/2010	
Race/Ethnicity	**Number**	**% of Total**	**Number**	**% of Total**	**Number**	**% of Total**	**Number**	**% of Total**	**Number**	**% of Total**
White, not Hispanic	111	12%	89	10%	3,417	18%	3,325	21%	6,795	20%
Black, not Hispanic	684	75%	667	76%	13,219	71%	10,480	68%	23,700	70%
Hispanic	83	9%	84	10%	1,473	8%	1,119	7%	2,598	8%
Asian/Pacific Islander	14	2%	6	1%	188	1%	167	1%	354	1%
American Indian/Alaska Native	0	0%	3	0%	14	0%	15	0%	28	0%
Other/Unknown	22	2%	23	3%	237	1%	381	2%	619	2%
Total	**914**	**100%**	**872**	**100%**	**18,548**	**100%**	**15,487**	**100%**	**34,094**	**100%**
Gender										
Male	621	68%	567	65%	13,142	71%	10,572	68%	23,770	70%
Female	290	32%	300	34%	5,406	29%	4,914	32%	10,323	30%
Unknown	3	0%	5	1%	0	0%	1	0%	1	0%
Total	**914**	**100%**	**872**	**100%**	**18,548**	**100%**	**15,487**	**100%**	**34,094**	**100%**
Age at Diagnosis (Years)										
<13 years	2	0%	2	0%	170	1%	259	2%	428	1%
13 - 19 years	28	3%	28	3%	403	2%	568	4%	973	3%
20-29 years	182	20%	199	23%	4,090	22%	4,121	27%	8,226	24%
30-39 years	252	28%	235	27%	7,051	38%	4,989	32%	12,043	35%
40-49 years	259	28%	239	27%	4,799	26%	3,608	23%	8,425	25%
50+ years	190	21%	146	17%	2,034	11%	1,905	12%	3,963	12%
Unknown	1	0%	23	3%	1	0%	37	0%	36	0%
Total	**914**	**100%**	**872**	**100%**	**18,548**	**100%**	**15,487**	**100%**	**34,094**	**100%**

EMA - Demographic Group/Exposure Category	AIDS Incidence* 01/01/09 to 12/31/09		AIDS Incidence* 01/01/10 to 12/31/10		AIDS Prevalence** as of 12/31/2010		HIV/Not AIDS Prevalence*** as of 12/31/2010		HIV/AIDS Prevalence as of 12/31/2010	
Current Age (as of 12/31/2010)	**Number**	**% of Total**	**Number**	**% of Total**	**Number**	**% of Total**	**Number**	**% of Total**	**Number**	**% of Total**
13 - 19 years	6	1%	12	1%	103	1%	199	1%	299	1%
20-29 years	131	14%	154	18%	848	5%	2,039	13%	2,888	8%
30-39 years	217	24%	208	24%	2,929	16%	3,556	23%	6,483	19%
40-49 years	295	32%	260	30%	6,821	37%	5,030	32%	11,854	35%
50-59 years	186	20%	182	21%	5,581	30%	3,242	21%	8,841	26%
60+ years	78	9%	56	6%	2,243	12%	1,299	8%	3,584	11%
Unknown	1	0%	0	0%	1	0%	10	0%	11	0%
Total	**914**	**100%**	**872**	**100%**	**18,526**	**100%**	**15,376**	**99%**	**33,961**	**100%**
Adult/Adolescent AIDS Exposure Category										
Men who have sex with men	281	31%	252	29%	6,838	37%	5,633	37%	12,510	37%
Injection drug users	65	7%	62	7%	2,776	15%	1,200	8%	3,987	12%
Men who have sex with men and inject drugs	14	2%	17	2%	668	4%	280	2%	954	3%
Heterosexual	256	28%	249	29%	5,074	28%	3,827	25%	8,894	26%
Other/Hemophilia/blood transfusion	0	0%	0	0%	84	0%	32	0%	124	0%
Risk not reported or identified	293	32%	290	33%	2,926	16%	4,255	28%	7,183	21%
Total	**909**	**100%**	**870**	**100%**	**18,366**	**100%**	**15,227**	**100%**	**33,652**	**100%**
Pediatric AIDS Exposure Categories	0	0%	0	0%	0	0%	0	0%	0	0%
Mother with/at risk for HIV infection	5	100%	1	50%	163	90%	137	53%	300	68%
Other/Hemophilia/blood transfusion	0	0%	0	0%	5	3%	0	0%	5	1%
Risk not reported or identified	0	0%	1	50%	14	8%	123	47%	137	31%
Total	**5**	**100%**	**2**	**100%**	**182**	**100%**	**260**	**100%**	**442**	**100%**

AIDS incidence is defined as the number of new AIDS cases diagnosed during the period specified.

****AIDS Prevalence is defined as the number of people living with AIDS as of the date specified.***

*****HIV Prevalence is defined as the estimated number of diagnosed people living with HIV/Not AIDS as of the date specified.***

District of Columbia Epi Data as of December 31, 2010

DC - Demographic Group/ Exposure Category	AIDS Incidence* 010109 to 123109		AIDS Incidence* 01/0/1/10 to 12/31/10		AIDS Prevalence** as of 12/31/2010		HIV/Not AIDS Prevalence*** as of 12/31/10		HIV/AIDS Prevalence as of 12/31/2010	
Race/Ethnicity	**Number**	**% of Total**	**Number**	**% of Total**	**Number**	**% of Total**	**Number**	**% of Total**	**Number**	**% of Total**
White, not Hispanic	48	10%	40	8%	1,231	14%	1,594	20%	2,825	16%
Black, not Hispanic	411	82%	398	79%	7,228	79%	5,767	71%	12,995	75%
Hispanic	24	5%	26	5%	507	6%	465	6%	972	6%
Asian/Pacific Islander	4	1%	2	0%	52	1%	50	1%	102	1%
American Indian/Alaska Native	0	0%	2	0%	8	0%	6	0%	14	0%
Other/Unknown	14	3%	10	2%	82	1%	282	3%	364	2%
Total	**501**	**100%**	**478**	**95%**	**9,108**	**100%**	**8,164**	**100%**	**17,272**	**100%**
Gender										
Male	330	66%	316	66%	6,584	72%	5,769	71%	12,353	72%
Female	168	34%	157	33%	2,524	28%	2,394	29%	4,918	28%
Unknown	3	1%	5	1%	0	0%	1	0%	1	0%
Total	**501**	**100%**	**478**	**100%**	**9,108**	**100%**	**8,164**	**100%**	**17,272**	**100%**
Age at Diagnosis (Years)										
<13 years	2	0%	0	0%	97	1%	129	2%	226	1%
13 - 19 years	15	3%	18	4%	243	3%	280	3%	523	3%
20-29 years	103	21%	112	23%	2,097	23%	1,925	24%	4,022	23%
30-39 years	131	26%	122	26%	3,290	36%	2,529	31%	5,819	34%
40-49 years	146	29%	131	27%	2,411	26%	2,083	26%	4,494	26%
50+ years	103	21%	72	15%	969	11%	1,183	14%	2,152	12%
Unknown	1	0%	23	5%	1	0%	35	0%	36	0%
Total	**501**	**100%**	**478**	**100%**	**9,108**	**100%**	**8,164**	**100%**	**17,272**	**100%**

DC - Demographic Group/ Exposure Category	AIDS Incidence* 01/01/09 to 12/31/09		AIDS Incidence* 01/0/1/10 to 12/31/10		AIDS Prevalence** as of 12/31/2010		HIV/Not AIDS Prevalence*** as of 12/31/10		HIV/AIDS Prevalence as of 12/31/2010	
Current Age (as of 12/31/2010)	**Number**	**% of Total**	**Number**	**% of Total**	**Number**	**% of Total**	**Number**	**% of Total**	**Number**	**% of Total**
13 - 19 years	3	1%	5	1%	55	1%	110	1%	165	1%
20-29 years	65	13%	88	18%	442	5%	1,054	13%	1,496	9%
30-39 years	114	23%	100	21%	1,345	15%	1,853	23%	3,198	19%
40-49 years	167	33%	141	29%	3,266	36%	2,657	33%	5,923	34%
50-59 years	102	20%	111	23%	2,857	31%	1,746	21%	4,603	27%
60+ years	49	10%	33	7%	1126	12%	681	8%	1,807	10%
Unknown	1	0%	0	0%	1	0%	10	0%	11	0%
Total	**501**	**100%**	**478**	**100%**	**9,092**	**100%**	**8,111**	**99%**	**17,203**	**100%**
Adult/Adolescent AIDS Exposure Category										
Men who have sex with men	145	29%	138	29%	3,467	38%	3,160	39%	6,627	39%
Injection drug users	40	8%	41	9%	1,721	19%	785	10%	2,506	15%
Men who have sex with men and inject drugs	9	2%	10	2%	367	4%	163	2%	530	3%
Heterosexual	164	33%	164	34%	2,480	28%	2,308	29%	4,788	28%
Other/Hemophilia/blood transfusion	0	0%	0	0%	21	0%	13	0%	34	0%
Risk not reported or identified	141	28%	125	26%	955	11%	1,606	20%	2,561	15%
Total	**499**	**100%**	**478**	**100%**	**9,011**	**100%**	**8,035**	**100%**	**17,046**	**100%**
Pediatric AIDS Exposure Categories										
Mother with/at risk for HIV infection	2	100%	0	0%	84	87%	49	38%	133	59%
Other/Hemophilia/blood transfusion	0	0%	0	0%	3	3%	0	0%	3	1%
Risk not reported or identified	0	0%	0	0%	10	10%	80	62%	90	40%
Total	**2**	**100%**	**0**	**0%**	**97**	**100%**	**129**	**100%**	**226**	**100%**

AIDS incidence is defined as the number of <u>new</u> AIDS cases diagnosed during the period specified.

****AIDS Prevalence is defined as the number of people living with AIDS as of the date specified.***

*****HIV Prevalence is defined as the estimated number of diagnosed people living with HIV/Not AIDS as of the date specified.***

Suburban Maryland Epi Data as of December 31, 2010
(Metropolitan Washington EMA)

MD - Demographic Group/Exposure Category	AIDS Incidence* 01/01/09 to 12/31/09		AIDS Incidence* 01/01/10 to 12/31/10		AIDS Prevalence** as of 12/31/2010		HIV/Not AIDS Prevalence*** as of 12/31/2010		HIV/AIDS Prevalence as of 12/31/2010	
Race/Ethnicity	**Number**	**% of Total**	**Number**	**% of Total**	**Number**	**% of Total**	**Number**	**% of Total**	**Number**	**% of Total**
White, not Hispanic	13	6%	10	4%	666	13%	498	13%	1,164	12.6%
Black, not Hispanic	175	79%	188	85%	4,074	77%	3,084	78%	7,158	77.2%
Hispanic	26	12%	22	10%	427	8%	257	7%	684	7.4%
Asian/Pacific Islander	2	1%	1	0%	44	1%	43	1%	87	0.9%
American Indian/Alaska Native	0	0%	0	0%	0	0%	5	0%	5	0.1%
Other/Unknown	5	2%	8	4%	110	2%	60	2%	170	1.8%
Total	**221**	**100%**	**229**	**104%**	**5,321**	**100%**	**3,947**	**100%**	**9,268**	**100%**
Gender										
Male	142	64%	130	57%	3,384	64%	2,328	59%	5,712	62%
Female	79	36%	99	43%	1,937	36%	1,619	41%	3,556	38%
Unknown	0	0%	0	0%	0	0%	0	0%	0	0%
Total	**221**	**100%**	**229**	**100%**	**5,321**	**100%**	**3,947**	**100%**	**9,268**	**100%**
Age at Diagnosis (Years)										
<13 years	0	0%	2	1%	58	1%	86	2%	144	2%
13 - 19 years	6	3%	7	3%	121	2%	182	5%	303	3%
20-29 years	53	24%	61	27%	1,303	24%	1,154	29%	2,457	27%
30-39 years	64	29%	67	29%	2,030	38%	1,229	31%	3,259	35%
40-49 years	57	26%	53	23%	1,229	23%	819	21%	2,048	22%
50+ years	41	19%	39	17%	580	11%	477	12%	1,057	11%
Unknown	0	0%	0	0%	0	0%	0	0%	0	0%
Total	**221**	**100%**	**229**	**100%**	**5,321**	**100%**	**3,947**	**100%**	**9,268**	**100%**

MD - Demographic Group/Exposure Category	AIDS Incidence* 01/01/09 to 12/31/09		AIDS Incidence* 01/01/10 to 12/31/10		AIDS Prevalence** as of 12/31/2010		HIV/Not AIDS Prevalence*** as of 12/31/2010		HIV/AIDS Prevalence as of 12/31/2010	
Current Age (as of 12/31/2010)	**Number**	**% of Total**	**Number**	**% of Total**	**Number**	**% of Total**	**Number**	**% of Total**	**Number**	**% of Total**
13 - 19 years	1	0%	6	3%	37	1%	68	2%	105	1%
20-29 years	40	18%	47	21%	276	5%	650	16%	926	10%
30-39 years	57	26%	56	24%	959	18%	958	24%	1,917	21%
40-49 years	69	31%	68	30%	2,005	38%	1,214	31%	3,219	35%
50-59 years	41	19%	37	16%	1,462	27%	711	18%	2,173	23%
60+ years	13	6%	15	7%	577	11%	299	8%	876	9%
Unknown	0	0%	0	0%	0	0%	0	0%	0	0%
Total	**221**	**100%**	**229**	**100%**	**5,316**	**100%**	**3,900**	**99%**	**9,216**	**99%**
Adult/Adolescent AIDS Exposure Category										
Men who have sex with men	49	22%	38	17%	1,430	27%	848	22%	2,278	25%
Injection drug users	11	5%	13	6%	598	11%	176	5%	774	8%
Men who have sex with men and inject drugs	1	0%	3	1%	121	2%	34	1%	155	2%
Heterosexual	53	24%	44	19%	1,838	35%	940	24%	2,778	30%
Other/Hemophilia/blood transfusion	0	0%	0	0%	25	0%	9	0%	34	0%
Risk not reported or identified	107	48%	129	57%	1,251	24%	1,854	48%	3,105	34%
Total	**221**	**100%**	**227**	**100%**	**5,263**	**100%**	**3,861**	**100%**	**9,124**	**100%**
Pediatric AIDS Exposure Categories										
Mother with/at risk for HIV infection	0	0%	1	0%	52	1%	43	1%	95	1%
Other/Hemophilia/blood transfusion	0	0%	0	0%	2	0%	0	0%	2	0%
Risk not reported or identified	0	0%	1	0%	4	0%	43	1%	47	1%
Total	**0**	**0%**	**2**	**1%**	**58**	**1%**	**86**	**2%**	**144**	**2%**

AIDS incidence is defined as the number of new AIDS cases diagnosed during the period specified.

****AIDS Prevalence is defined as the number of people living with AIDS as of the date specified.***

*****HIV Prevalence is defined as the estimated number of diagnosed people living with HIV/Not AIDS as of the date specified.***

Virginia Data as of December 31, 2010
(Metropolitan Washington EMA)

VA - Demographic Group/Exposure Category	AIDS Incidence* 01/01/09 to 12/31/09		AIDS Incidence* 01/01/10 to 12/31/10		AIDS Prevalence** as of 12/31/2010		HIV/Not AIDS Prevalence*** as of 12/31/2010		HIV/AIDS Prevalence as of 12/31/2010	
Race/Ethnicity	**Number**	**% of Total**	**Number**	**% of Total**	**Number**	**% of Total**	**Number**	**% of Total**	**Number**	**% of Total**
White, not Hispanic	47	26%	38	24%	1,441	36%	1,177	36%	2,618	36%
Black, not Hispanic	90	50%	77	43%	1,839	46%	1,580	48%	3,419	47%
Hispanic	33	18%	36	20%	535	14%	395	12%	930	13%
Asian/Pacific Islander	8	4%	3	2%	90	2%	74	2%	164	2%
American Indian/Alaska Native	0	0%	1	1%	5	0%	4	0%	9	0%
Other/Unknown	3	2%	5	3%	45	1%	39	1%	84	1%
Total	**181**	**100%**	**160**	**88%**	**3,955**	**100%**	**3,269**	**100%**	**7,224**	**100%**
Gender										
Male	139	77%	117	73%	3,038	77%	2,400	73%	5,438	75%
Female	42	23%	43	27%	917	23%	869	27%	1,786	25%
Unknown	0	0%	0	0%	0	0%	0	0%		0%
Total	**181**	**100%**	**160**	**100%**	**3,955**	**100%**	**3,269**	**100%**	**7,224**	**100%**
Age at Diagnosis (Years)										
<13 years	0	0%	0	0%	15	0%	40	1%	55	1%
13 - 19 years	6	3%	3	2%	36	1%	101	3%	137	2%
20-29 years	26	14%	26	16%	675	17%	1,010	31%	1,685	23%
30-39 years	56	31%	45	28%	1,665	42%	1,198	37%	2,863	40%
40-49 years	54	30%	53	33%	1,106	28%	682	21%	1,788	25%
50+ years	39	22%	33	21%	458	12%	238	7%	696	10%
Unknown	0	0%	0	0%	0	0%	0	0%	0	0%
Total	**181**	**100%**	**160**	**100%**	**3,955**	**100%**	**3,269**	**100%**	**7,224**	**100%**

VA - Demographic Group/Exposure Category	AIDS Incidence* 01/01/09 to 12/31/09		AIDS Incidence* 01/01/10 to 12/31/10		AIDS Prevalence** as of 12/31/2010		HIV/Not AIDS Prevalence*** as of 12/31/2010		HIV/AIDS Prevalence as of 12/31/2010	
Current Age (as of 12/31/2010)	**Number**	**% of Total**	**Number**	**% of Total**	**Number**	**% of Total**	**Number**	**% of Total**	**Number**	**% of Total**
13 - 19 years	2	1%	1	1%	11	0%	17	1%	28	0%
20-29 years	25	14%	19	12%	125	3%	323	10%	448	6%
30-39 years	45	25%	51	32%	603	15%	724	22%	1,327	18%
40-49 years	58	32%	49	31%	1,493	38%	1,133	35%	2,626	36%
50-59 years	38	21%	32	20%	1,204	30%	752	23%	1,956	27%
60+ years	13	7%	8	5%	518	13%	309	9%	827	11%
Unknown	0	0%	0	0%	0	0%	0	0%	0	0%
Total	**181**	**100%**	**160**	**100%**	**3,954**	**100%**	**3,258**	**100%**	**7,212**	**100%**
Adult/Adolescent AIDS Exposure Category										
Men who have sex with men	84	47%	73	46%	1,877	48%	1,582	49%	3,459	48%
Injection drug users	9	5%	7	4%	410	10%	219	7%	629	9%
Men who have sex with men and inject drugs	4	2%	4	3%	174	4%	82	3%	256	4%
Heterosexual	39	22%	41	26%	731	19%	555	17%	1,286	18%
Other/Hemophilia/blood transfusion	0	0%	0	0%	38	1%	10	0%	48	1%
Risk not reported or identified	42	24%	35	22%	698	18%	779	24%	1,477	21%
Total	**178**	**100%**	**160**	**100%**	**3,928**	**100%**	**3,227**	**100%**	**7,155**	**100%**
Pediatric AIDS Exposure Categories										
Mother with/at risk for HIV infection	3	2%	0	0%	27	1%	42	1%	69	1%
Other/Hemophilia/blood transfusion	0	0%	0	0%	0	0%	0	0%	0	0%
Risk not reported or identified	0	0%	0	0%	0	0%	0	0%	0	0%
Total	**3**	**2%**	**0**	**0%**	**27**	**1%**	**42**	**1%**	**69**	**1%**

AIDS incidence is defined as the number of <u>new</u> AIDS cases diagnosed during the period specified.

****AIDS Prevalence is defined as the number of people living with AIDS as of the date specified.***

*****HIV Prevalence is defined as the estimated number of diagnosed people living with HIV/Not AIDS as of the date specified.***

West Virginia Epi Data as of December 31, 2010
(Berkeley and Jefferson Counties – Metropolitan Washington EMA)

WV - Demographic Group/ Exposure Category	AIDS Incidence* 01/01/09 to 12/31/09		AIDS Incidence* 01/01/10 to 12/31/10		AIDS Prevalence** as of 12/31/2010		HIV/Not AIDS Prevalence*** as of 12/31/2010		HIV/AIDS Prevalence as of 12/31/2010	
Race/Ethnicity	**Number**	**% of Total**	**Number**	**% of Total**	**Number**	**% of Total**	**Number**	**% of Total**	**Number**	**% of Total**
White, not Hispanic	3	27%	1	20%	79	48%	56	52%	188	57%
Black, not Hispanic	8	73%	4	36%	78	48%	49	46%	128	39%
Hispanic	0	0%	0	0%	4	2%	2	2%	12	4%
Asian/Pacific Islander	0	0%	0	0%	2	1%	0	0%	1	0%
American Indian/Alaska Native	0	0%	0	0%	1	1%	0	0%	0	0%
Other/Unknown	0	0%	0	0%	0	0%	0	0%	1	0%
Total	**11**	**100%**	**5**	**45%**	**164**	**100%**	**107**	**100%**	**330**	**100%**
Gender										
Male	10	91%	4	80%	136	83%	75	70%	267	81%
Female	1	9%	1	20%	28	17%	32	30%	63	19%
Unknown	0	0%	0	0%	0	0%	0	0%	0	0%
Total	**11**	**100%**	**5**	**100%**	**164**	**100%**	**107**	**100%**	**330**	**100%**
Age at Diagnosis (Years)										
<13 years	0	0%	0	0%	0	0%	4	4%	3	1%
13 - 19 years	1	9%	0	0%	3	2%	5	5%	10	3%
20-29 years	0	0%	0	0%	15	9%	32	30%	62	19%
30-39 years	1	9%	1	20%	66	40%	33	31%	102	31%
40-49 years	2	18%	2	40%	53	32%	24	22%	95	29%
50+ years	7	64%	2	40%	27	16%	7	7%	58	18%
Unknown	0	0%	0	0%	0	0%	2	2%	0	0%
Total	**11**	**100%**	**5**	**100%**	**164**	**100%**	**107**	**100%**	**330**	**100%**

WV - Demographic Group/ Exposure Category	AIDS Incidence* 01/01/09 to 12/31/09		AIDS Incidence* 01/01/10 to 12/31/10		AIDS Prevalence** as of 12/31/2010		HIV/Not AIDS Prevalence*** as of 12/31/2010		HIV/AIDS Prevalence as of 12/31/2010	
Current Age (as of 12/31/2010)	**Number**	**% of Total**	**Number**	**% of Total**	**Number**	**% of Total**	**Number**	**% of Total**	**Number**	**% of Total**
<13 years	0	0%	0	0%	0	0%	1	1%	1	0%
13 - 19 years	0	0%	0	0%	0	0%	4	4%	1	0%
20-29 years	1	9%	0	0%	5	3%	12	11%	18	5%
30-39 years	1	9%	1	20%	22	13%	21	20%	41	12%
40-49 years	1	9%	2	40%	57	35%	26	24%	86	26%
50-59 years	5	45%	2	40%	58	35%	33	31%	109	33%
60+ years	3	27%	0	0%	22	13%	10	9%	74	22%
Unknown	0	0%	0	0%	0	0%	0	0%	0	0%
Total	**11**	**100%**	**5**	**100%**	**164**	**100%**	**107**	**100%**	**330**	**100%**
Adult/Adolescent AIDS Exposure Category										
Men who have sex with men	3	27%	3	60%	64	39%	43	41%	146	45%
Injection drug users	5	45%	1	20%	47	29%	20	19%	78	24%
Men who have sex with men and inject drugs	0	0%	0	0%	6	4%	1	1%	13	4%
Heterosexual	0	0%	0	0%	25	15%	24	23%	42	13%
Other/Hemophilia/blood transfusion	0	0%	0	0%	0	0%	0	0%	8	2%
Risk not reported or identified	3	27%	1	20%	22	13%	16	15%	40	12%
Total	**11**	**100%**	**5**	**100%**	**164**	**100%**	**104**	**100%**	**327**	**100%**
Pediatric AIDS Exposure Categories										
Mother with/at risk for HIV infection	0	0%	0	0%	0	0%	3	3%	3	1%
Other/Hemophilia/blood transfusion	0	0%	0	0%	0	0%	0	0%	0	0%
Risk not reported or identified	0	0%	0	0%	0	0%	0	0%	0	0%
Total	**0**	**0%**	**0**	**0%**	**0**	**0%**	**3**	**3%**	**3**	**1%**

AIDS incidence is defined as the number of new AIDS cases diagnosed during the period specified.

****AIDS Prevalence is defined as the number of people living with AIDS as of the date specified.***

*****HIV Prevalence is defined as the estimated number of diagnosed people living with HIV/Not AIDSas of the date specified.***

Appendix 3: Estimates of Uninsured Residents of the EMA under Age 65, By Income Level

Estimated Number and Percent of Uninsured Residents of EMA Jurisdictions, Under 65 Years, by Income Level, 2009

Jurisdiction	Number Uninsured, All Income Levels	Number - All Income Levels	Percent Uninsured - All Income Levels	Number Uninsured - ≤400% of Poverty	Number ≤400% of Poverty	Percent Uninsured - ≤400% of Poverty	Number Uninsured - 138% of Poverty	Number ≤138% of Poverty	Percent Uninsured - ≤ 138% of Poverty
District of Columbia	**40,951**	**500,517**	**8.2**	**33,296**	**294,839**	**11.3**	**14,043**	**115,770**	**12.1**
Maryland	627,606	4,881,770	12.9	496,440	2,430,272	20.4	190,628	718,314	26.5
Calvert County	7,712	77,947	7.3	5,667	31,498	18.0	2,006	6,883	29.2
Charles County	13,119	124,952	7.8	9,758	55,455	17.6	3,423	13,224	25.9
Frederick County	20,825	199,271	7.7	15,380	83,510	18.4	5,223	19,313	27.0
Montgomery County	103,270	835,929	9.4	78,721	316,072	24.9	26,780	77,756	34.4
Prince George's County	118,644	728,718	12.7	92,304	390,072	23.7	34,038	111,416	30.6
Total, MD EMA Jurisdictions	**201,830**	**1,966,817**	**10.3**	**201,830**	**876,607**	**23.0**	**71,470**	**228,592**	**31.3**
% of State Population in EMA	40.3%								
% of State Uninsured in EMA	32.2%								
Virginia	908,234	6,699,874	13.6	772,180	3,712,705	20.8	307,189	1,078,783	28.5
Northern Health Region									
Alexandria City	16,849	128,956	13.1	13,639	52,924	25.8	5,207	13,431	39
Arlington County	22,651	192,356	11.8	17,552	66,697	26.3	6,145	14,936	41.1
Fairfax County	99,958	915,022	10.9	76,414	311,051	24.6	25,776	71,496	36.1
Fairfax City	2,937	20,658	14.2	2,286	8,476	27.0	760	1,806	42.1
Falls Church City	713	10,047	7.1	502	2,536	19.8	148	325	45.6
Loudoun County	19,621	275,214	7.1	13,997	76,398	18.3	4,438	12,818	34.5
Prince William County	43,883	343,002	12.8	35,844	154,989	23.1	14,771	38,235	38.6
Manassas City	5,707	32,025	17.8	4,798	18,480	26.0	1,975	5,565	35.5
Manassas Park City	2,129	10,877	19.6	1,806	6,896	26.2	738	2,079	35.5

Jurisdiction	Number Uninsured, All Income Levels	Number - All Income Levels	Percent Uninsured - All Income Levels	Number Uninsured - ≤400% of Poverty	Number ≤400% of Poverty	Percent Uninsured - ≤400% of Poverty	Number Uninsured - 138% of Poverty	Number ≤138% of Poverty	Percent Uninsured - ≤ 138% of Poverty
Northwest Health Region									
Clarke County	1,518	11,890	12.8	1,227	5,706	21.5	438	1,226	35.8
Culpepper County	6,229	39,703	15.7	5,262	23,812	22.1	2,149	7,255	29.6
Fauquier County	6,910	58,354	11.8	5,302	24,115	22.0	1,922	5,217	36.8
King George County	2,434	20,614	11.8	2,028	10,705	18.9	808	2,555	31.8
Spotsylvania County	12,870	106,383	12.1	10,448	54,233	19.3	4,215	14,310	29.5
Stafford County	11,390	112,363	10.1	8,780	48,341	18.2	3,194	10,592	30.2
Fredericksburg City	3,316	18,727	17.7	2,932	12,140	24.2	1,430	4,338	33.0
Warren County	4,730	31,188	15.2	4,057	19,027	21.3	1,751	5,551	31.5
Total, VA EMA Jurisdictions	**263,845**	**2,327,379**	**11.3**	**206,874**	**896,526**	**23.1**	**75,865**	**211,735**	**35.8**
% of State Population in EMA	34.7%								
% of State Uninsured in EMA	29.1%								
West Virginia	250,222	1,493,154	16.8	226,591	1,076,444	21.0	114,964	404,472	28.4
Berkeley County	13,856	90,117	15.4	12,067	58,216	20.7	5,561	18,870	29.5
Jefferson County	6,526	45967	14.2	5,521	25,677	21.5	2,348	7,379	31.8
Total, WV EMA Jurisdictions	**20,382**	**136,084**	**15.0**	**17,588**	**83,893**	**21.0**	**7,909**	**26,249**	**30.1**
% of State Population in EMA	9.1%								
% of State Uninsured in EMA	8.1%								

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