Washington, DC Regional Eligible Metropolitan Area

Comprehensive HIV Care Plan

2009-2011

Government of the District of Columbia
Adrian M. Fenty, Mayor

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

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Letter of Concurrence

Metropolitan Washington, D.C. Regional HIV Health Services Planning Council
64 New York Avenue NE Suite 5001
Washington, DC 20002

December 29, 2008

Mr. Douglas H. Morgan, MPA
Health Resources and Services Administration
5600 Fishers Lane
Rockville, Maryland 20657

Dear Mr. Morgan,

On behalf of the Washington DC Metropolitan Regional HIV Health Services Planning Council, I am proud and pleased to present the Comprehensive Care Plan 2009-2011.

The plan is the product of a dynamic partnership among the Planning Council, the HIV/AIDS Administration as Grantee and the three additional administrative agencies in the EMA, the Northern Virginia Regional Commission, Prince George's County Health Department and the AIDS Network of the Tri-State Area.

This effort was led by Henry Bishop, chair of the Needs Assessment and Planning Committee of the Planning Council and Amy Richter of the HIV/AIDS Administration, and I want to thank both of them for their many efforts.

We look forward to using this plan to improve the systems of care available for people with HIV in every part of our area, and look forward to your comments.

Very truly yours,

Wallace Corbett, Chair
Metropolitan Washington, D.C. Regional HIV Health Services Planning Council

Laurence Smith, Community Chair
Metropolitan Washington, D.C. Regional HIV Health Services Planning Council

Letters of Support

GOVERNMENT OF THE DISTRICT OF COLUMBIA
Executive Office of the Mayor

Greetings:

I am pleased to present the 2009-2012 Comprehensive Plan for the implementation of Ryan White Treatment Modernization Act funds in the District of Columbia and the surrounding Eligible Metropolitan Area. The Comprehensive Plan was developed by the Metropolitan Washington Regional Health Services Planning Council in conjunction with the District of Columbia's HIV/AIDS Administration, Prince George's County Health Department, the Northern Virginia Regional Consortium, and the AIDS Network of the Tri-State Area in West Virginia.

The Comprehensive Plan furthers the goal set by my Administration of reducing the impact of HIV/AIDS in our community. Specifically, the Plan establishes the format for improving access to vital treatment services for people living with HIV/AIDS and addresses the complicated problem of providing high-quality, accessible treatment for our residents throughout the entire metropolitan region including Washington DC, parts of Northern Virginia, Southern Maryland and West Virginia. By coordinating services among our Government entities, area medical institutions, community health systems, faith-based and non-profit agencies, the treatment continuum will reach an unparalleled number of HIV-positive residents in diverse communities and provide cutting edge medical treatment with both skill and compassion.

On behalf of the residents of the District of Columbia, I wish to thank the many volunteers and staff members whose hard work and commitment to people living with HIV is reflected in this Comprehensive Plan. With your continued dedication, we will continue the fight against HIV/AIDS!

Sincerely,

Adrian M. Fenty
Mayor, District of Columbia

GOVERNMENT OF THE DISTRICT OF COLUMBIA
DEPARTMENT OF HEALTH

Office of the Director

December 31, 2008

Dear Colleagues:

It is my pleasure to congratulate the members of the Greater Washington Regional HIV Health Services Planning Council for their tireless efforts to prepare the 2009-2011 Comprehensive Plan for HIV care and treatment for the metropolitan region. This thoughtful review of issues critical to the implementation of federal funds for HIV medical care, treatment and support services establishes a firm foundation for improving the response to the HIV/AIDS epidemic in the greater Washington, DC region.

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 the HIV/AIDS Administration. 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,

Pierre N.D. Vigilance, MD, MPH
Director, Department of Health

825 North Capitol Street, N.E. Washington, D.C. 20002 (202) 442-5955 FAX (202) 442-4795

GOVERNMENT OF THE DISTRICT OF COLUMBIA
Department of Health

HIV/AIDS Administration

Greetings:

It gives me great pride to join the Metropolitan Washington DC Regional HIV Health Services Planning Council in launching a comprehensive plan for HIV care and treatment services.

The HIV/AIDS epidemic in the greater Washington DC Metropolitan Area is a "modern epidemic" that increasingly impacts all individuals regardless of age, gender, race, ethnicity, or sexual identity. The complex nature of the epidemic requires bold, decisive action to ensure that our response is consistent with the needs of people with or at risk for HIV.

The 2009-2011 Comprehensive Plan is an important step towards improving the HIV/AIDS service systems in the District of Columbia, five counties in suburban Maryland, two counties in West Virginia, and eleven counties and six cities in suburban Northern Virginia.

Some of the vitally important activities of this plan are

- Re-affirming our commitment to planning based on sound evidence and best practices.
- Improving our ability to consume data regarding trends and changes in the need for services.
- Re-tooling a service delivery system to focus on improving the health status of those we served.
- Ensuring that all available resources for services to people with HIV/AIDS are considered when planning the allocation of funds from the CARE Act.
- Considering the complex issues associated with ensuring a consistently high-quality of HIV care in all parts of an eligible metropolitan area composed of four different states, with significantly distinct epidemics and significantly different underlying health care systems.

I want to thank the members of the Metropolitan Washington, DC Regional HIV Health Services Planning Council and the staff of the HIV/AIDS Administration who forged a partnership to develop this plan. It is meant to guide our efforts through the year 2011, which will mark thirty years since the HIV epidemic was detected in this country. As we approach this exciting, important and challenging work of the next three years, I ask that we do this in honor of those we have lost, and in the hope that we can continue to offer life-saving services to those in need.

Very truly yours,

Shannon L. Hader, M.D., MPH
Senior Deputy Director

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Northern Virginia Regional Commission

December 10, 2008

The Hon. Adrian M. Fenty, Mayor
Washington, DC

Dear Mayor Fenty:

The Northern Virginia Regional Commission (NVRC) has demonstrated its commitment to facilitating services to persons living with the human immunodeficiency virus (HIV) and acquired immune deficiency syndrome (AIDS) since the enactment by Congress of the Ryan White HIV/AIDS Treatment Modernization Act of 2006 and its predecessor legislation, as amended -- collectively referred to herein as the CARE Act.

NVRC receives a subaward of CARE Act Part A funds for HIV/AIDS services that the U.S. Health Resources and Services Administration (HRSA) distributes to the Washington, D.C. Department of Health, HIV/AIDS Administration, as the Grantee for the entire Washington, D.C. Eligible Metropolitan Area (EMA). NVRC administers these funds on behalf of the Virginia jurisdictions within the EMA.

CARE Act legislation requires that a Comprehensive Plan be prepared by the Grantee every three years to describe the organization and service delivery mechanisms for health and supportive services to persons with HIV/AIDS living within the DC EMA. NVRC staff has been engaged in the current Comprehensive Plan development process that provides for reviewing the existing system of care, developing a shared vision for what the system could and should be, determining changes that will improve accessibility and availability of care, and suggesting how progress will be measured toward attainment of system revision goals.

Through its years of involvement with the CARE Act, NVRC has demonstrated a commitment to a health care system that values accessibility; coordination; service excellence contributing to quality of life; compassionate and respectful care; and services that seek out individuals whose disengagement from treatment detracts from public health in the region. NVRC's own actions have been consistent with a Comprehensive Plan that evaluates access and retention in care, funding parity across the EMA, service access where clients live and work, and service provider aptitude in the nuances of HIV/AIDS care.

As a subgrantee for CARE Act funds, NVRC has expressed support for the aforementioned concepts in HIV/AIDS care and expects to participate in the implementation of the Comprehensive Plan as the vehicle through which care improvements will be made.

Sincerely,

Michelle Simmons
Director, Human Services

HEALTH DEPARTMENT
Prince George's County

Office of the Health Officer

December 11, 2008

Mr. Wallace Corbett, Chair
Metropolitan Washington Regional
Health Services Planning Council
64 New York Avenue, 5th Floor
Washington, DC 20002

Dear Mr. Corbett:

The Prince George's County Health Department supports the Metropolitan Washington Regional Health Services Planning Council's efforts as outlined in the Comprehensive HIV Care Plan for 2009 – 2011.

To effectively address the HIV/AIDS epidemic in the Washington, DC Metropolitan Area, we must undoubtedly partner to improve access to care, strengthen our service delivery system, ensure improved health outcomes, and maximize resources. The Comprehensive Plan developed by the Council embraces these goals and outlines a strategically focused path to achieve them.

I applaud the multijurisdictional collaboration undertaken in the planning for and development of the Comprehensive Plan. This worth while effort made efficient and effective use of the collective knowledge and experience of a diverse variety of community stakeholders including clinicians, consumers and other individuals who work in the field of HIV/AIDS.

As the Health Officer for Prince George's County, Maryland and as the lead representative of the Suburban Maryland Ryan White Part A Administrative Agency, I commend the Planning Council for their continued efforts as we combat the HIV/AIDS epidemic.

Sincerely,

Donald Shell M.D., M.A.
Health Officer

cc: Devi Ramey, Suburban Maryland Administrative Agency

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County Executive

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As the Jurisdictional Agent and Service Provider for the West Virginia Jurisdiction of the Washington D.C. EMA, the AIDS Network concurs with the proposed 2009-2011 Comprehensive Plan. The Comprehensive Plan provides an overview of the similarities and differences in providing comprehensive HIV care within the four (4) distinct jurisdictions that comprise the Washington D.C. EMA. The plan should be helpful in providing guidance for all community members, who participate in the planning process for Ryan White Part A funding, and service providers, who are responsible for providing comprehensive HIV care.

Thank you for opportunity to participate in this process.

Judith A. Friend, PhD
Executive Director

Executive Summary

The Comprehensive HIV Care Plan for 2009-2011 tells the story of a modern epidemic in an eligible metropolitan area (EMA) that spans four states with unique public health care systems, political environments, and disease profiles. The Washington D.C. Metropolitan Regional HIV Health Services Planning Council and the Washington Department of Health, HIV/AIDS Administration (HAA) began the process of creating this strategic plan by studying how HIV/AIDS and HIV/AIDS health care services fit into the overall picture of care for underserved residents in each jurisdiction and in the EMA. By looking at the EMA in parts and then as a whole, the Planning Council was able to create a set of goals and objectives with enough flexibility to improve health outcomes and access for people living with HIV/AIDS (PLWH/A) across all parts of the EMA.

HIV/AIDS in the Washington D.C. Eligible Metropolitan Area

The Washington, D.C. EMA is composed of the District of Columbia, five counties in suburban Maryland, eleven counties and six cities in northern Virginia, and two counties in West Virginia. The geographic area of the EMA spans more than 150 miles from end to end and encompasses over 6,900 square miles of land area. The EMA includes urban centers such as the District of Columbia home to a population of 588,292 residing in 68.3 square miles to rural areas such as Clarke County, Virginia home to a population of 12,652 people residing in178 square miles.

Within the four states the public health care safety nets vary greatly. For example, the District of Columbia spends on average $3295 more per Medicaid enrollee than the State of Virginia.[1] Additionally, the District of Columbia and the State of Maryland established locally funded public health insurance programs that extend services to a greater number of under-insured residents and that do not exist in West Virginia and Virginia. This variability impacts both service capacity in the jurisdictions and the ability of the Planning Council, the Grantee, and the Administrative Agent in Northern Virginia to effectively and equitably address health care gaps for PWLH/A.

When compared to the nation as a whole, the Washington, D.C. EMA is disproportionately impacted by HIV/AIDS, with the EMA having approximately twice as many living AIDS cases per 100,000 people as the nation as a whole. The epidemic in the Washington D.C. EMA is a modern epidemic with an estimated 42,085 people living with HIV/AIDS, 63% residing within the urban boundaries of the nation's capital. The District of Columbia had the most cases and the highest mortality rate in the EMA. The minority community of the EMA is disproportionately impacted by HIV with 82% of cases being classified as racial/ethnic minorities although the EMA total population is only 46% minority. The greatest impact of HIV/AIDS is among persons described as Black/African American with 2% of all Blacks in the EMA estimated to be living with HIV/AIDS. Male sexual contact continues to be the leading mode of exposure reported for all cases, followed by heterosexual sex. The majority of estimated living cases are aged 30-49, accounting for 62% of all cases. Although the number of newly diagnosed AIDS cases has decreased, there was an increase in the estimated number of people living with HIV in the EMA. Among AIDS cases, despite declines in the number of

newly diagnosed AIDS cases, a significant number of AIDS cases continue to be diagnosed with AIDS less than 1 year after learning their HIV status.

Unlike other EMAs, the Washington Regional area must examine some of the differences among the jurisdictions in order to get a clear picture of the disease profile for the EMA. The District of Columbia had the most cases and the highest mortality rate in the EMA. Overall D.C. accounts for 10.8% of the population, yet account for 62% of the living HIV/AIDS cases. African Americans make up 81% of HIV/AIDS cases in the District and nearly 79% of the cases in Maryland. And while African Americans are still disproportionately affected in Virginia (45%) and West Virginia (34%), they make up a significantly lower percentage of HIV/AIDS cases in those areas. In Maryland, 34.2% of the adults living with AIDS contracted the disease through heterosexual contact (compared to 27% nationally[2]). In Virginia, 12% of the PWLH/A identify as Latino/as. The percent for the EMA is far lower at nearly 7%.

The Continuum of Care

The challenge for the EMA continues to be how best to design the service continuum to address parity among the jurisdictions. The Planning Council has designed a unique process for developing priorities and resource allocations that includes input from each jurisdiction. As a result there are currently 55 Part A funded direct service providers throughout the EMA providing 30 different services

Although the EMA has a wide range of services, the geo-political differences of each jurisdiction in the EMA challenges planners around single solutions that improve access and parity across the EMA. Of particular interest to the Planning Council and the Grantee are the barriers caused by the recent down turn of the area's economy; the lack of accessibility of affordable housing and the resulting increase in client movement across jurisdictions caused by the current housing market; the large immigrant population residing in the area who present with a complex array of health care, language, and cultural competency requirements; capacity building needs to address transportation issues and health care access in the rural communities within the EMA; the systemic challenge of adapting the Ryan White continuum to fill gaps in four different health care systems with different financing and eligibility requirements; and finally, the challenges posed by collecting client level data across four states with four different surveillance systems.

As the EMA moves forward, education, public awareness and other risk reduction activities will be vital to prevent new HIV infections in the EMA. HIV treatment includes not only the provision of services designed to meet the needs of persons living with HIV but also strategies to close disparities in HIV care and health care outcomes, access and services for underserved populations.

Shared Vision, Guiding Principles and Goals and Objectives

Our vision is guided by the following principles:

- Creating an integrated and comprehensive system of care that provides culturally and linguistically appropriate services for all persons living with HIV disease.

- Ensuring a seamless system designed to identify persons at the earliest stage of disease.

- Achieving equality in access to medical and support services for persons living with HIV throughout the EMA.

- Ensuring high quality core medical and support services consistent with appropriate standards of care.

- Encouraging optimum communication and collaboration across CARE act funded entities and non-CARE Act systems to guarantee seamless linkage for persons with complex need throughout the EMA and to ensure that Ryan White funding is the dollar of last resort.

The Planning Council takes very seriously its obligation to implement this three-year plan. As part of the Comprehensive Planning Process, the Grantee and the Planning Council met to develop a unified vision of services in the EMA. This vision tackles the problems of this complex EMA. The Planning Council and Grantee intend over the course of this Comprehensive Plan to implement action steps to achieve four goals:

- ***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.***

- ***Goal 2: Ensure improved health outcomes through access to comprehensive, high quality, culturally competent medical and support services.***

- ***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)***

- ***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.***

The goals and objectives of this plan serve as a common ground for the stakeholders to serve the residents of the Washington D.C. EMA. The Planning Council and the Grantee intends for the Comprehensive Plan to operate as a living document and have incorporated into the Comprehensive Plan mechanisms to ensure annual reviews of the goals, the creation of annual activities to move toward achieving the goals, and monitoring to track progress. As we embark on implementing this new plan, each stakeholder is committed to ensuring that the PLWH/As in the Washington receive quality HIV care.

Acknowledgements

The following members of the Metropolitan Washington Regional HIV Health Services Planning Council, staff of the Department of Health HIV/AIDS Administration, and Consultants all contributed to the completion of the this Comprehensive HIV Care Plan for 2009-2011.

Greater Washington, D.C. Eligible Metropolitan Area Planning Council

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Section 1: Where are we now? What is our current system of care?

Chapter 1: Introduction

The Ryan White Treatment Modernization Act provides emergency assistance to localities most impacted by the HIV/AIDS epidemic. Part A funds are awarded to eligible metropolitan areas (EMAs) which have reported at least 2,000 AIDS cases during the previous five years and have a population of at least 500,000.[3] For the Washington D.C. EMA, the Grantee is the District of Columbia, Department of Health and the primary administrative agency is the HIV/AIDS Administration (HAA).

This Comprehensive HIV Care plan is concerned with identifying and addressing the needs of and access to services for persons living with HIV/AIDS (PLWH/As) throughout the Washington D.C. EMA. The Comprehensive Plan summarizes the challenges the EMA faces in creating and sustaining an equitable healthcare system for PLWH/A across four states characterized by different health care structures, disease profiles, and political environments. With this Comprehensive Plan, the Grantee and the Washington D.C. Metropolitan Regional HIV Health Services Planning Council (see Appendix 1 for the list of official Planning Council members) provide a framework for examining the nature of these differences and implementing changes that improve access to HIV care and treatment services for all residents of the EMA.

There are nine chapters in the Comprehensive HIV Care Plan. Chapter one describes the Washington D.C. EMA in terms of the population, subpopulations and jurisdictions served by Part A funds. Chapter two describes the nature of the HIV/AIDS epidemic in the Washington region and in each of the jurisdictions in terms of emerging trends, utilization of services, and distinct subpopulations. Chapter three details each jurisdiction's historical response to the epidemic. Chapter four describes the results of surveys, forums and focus groups conducted recently throughout the EMA to assess the care and prevention needs of PLWH/A. Chapter five explains the current CARE Act funded continuum of care in the Washington D.C. region. Chapter six outlines existing barriers that exist for clients to access and remain in health care. Chapter seven and eight describe the values and vision of an ideal system of health care in the EMA and then detail the specific goals and objectives for achieving that vision. Finally, chapter nine describes how the Planning Council and the Grantee intend to work collaboratively to monitor the implementation of the Comprehensive Care Plan.

The Washington, D.C. EMA is composed of the District of Columbia, five counties in suburban and rural Maryland, eleven counties and six cities in northern Virginia, and two counties in West Virginia (see Figure 1). The geographic area of the EMA spans more than 150 miles from end to end, encompasses over 6,900 square miles of land area and includes twenty-five political jurisdictions.

Each jurisdiction of the EMA is distinct geographically, demographically, socioeconomically and politically. The public health care systems in each jurisdiction are also profoundly different. These differences influence the distribution and impact of Part A services for each jurisdiction.

The emphasis that each state's political structure places on budget and programs for public health care affects the need for Part A services to fill health care gaps. One way to begin to highlight the differences throughout the EMA is by comparing Medicaid expenditures. According to the Henry J. Kaiser Family Foundation in 2005, the Medicaid programs in each of the states spent very different amounts per individual enrollee compared to one another and the national average. Tabled below are the expenditures for the general population of Medicaid beneficiaries, and the per capita expenditures for those beneficiaries categorized as "disabled."

Table 1: Medicaid Expenditures Per Enrollee[4]

	Medicaid Enrollees	
	General	"Disabled"
District of Columbia	7,941	20,040
Maryland	5,760	17,984
Virginia	4,646	11,945
West Virginia	6,121	9,872
Nation-wide	4,664	13,524

Also, each jurisdiction presents a unique disease profile. To design a continuum of care for the entire EMA, the Grantee and the Planning Council must ensure enough flexibility in the system for each jurisdiction to create culturally competent programming. For example, the distribution of HIV/AIDS cases in the District of Columbia is predominantly African American (75.4%) while in West Virginia the distribution of cases is mostly White (55.8%). Also, Virginia has a significantly higher proportion of HIV positive Latino/a(s) than any of the other jurisdictions: Virginia (11% of cases), D.C. (4.8%), Maryland (5.3%) and West Virginia (5.8%).[5]

The Comprehensive HIV Care Plan fully explores the similarities and differences among the jurisdictions incorporated in the EMA. Through this examination, the Planning Council and the Grantee developed goals and objectives that guarantee an increase in positive health outcomes for HIV positive EMA residents by allowing for flexibility and equitability in the system design.

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

The EMA also includes five counties located in Maryland – Calvert, Charles, Frederick, Montgomery and Prince George's Counties. The counties in Maryland vary from suburban to rural but are collectively referred to in the EMA as "Suburban Maryland". In the Suburban Maryland region, with significant numbers of Spanish-speaking Latinos and groups of African and Caribbean immigrants, providers report challenges finding interpreters for persons with limited English proficiency. As a result, some providers report utilizing interpreters acquainted with the client thereby impacting both the client's confidentiality and perceived stigma.

Seventeen jurisdictions make up the Virginia region – the cities of Alexandria, Fairfax, Falls Church, Fredericksburg, Manassas, and Manassas Park; and the counties of Arlington, Clarke, Culpeper, Fairfax, Fauquier, King George, Loudoun, Prince William, Spotsylvania, Stafford, and

Warren. Northern Virginia's population growth is explosive and currently outstrips public health human services, transportation systems and other publicly funded infrastructure.[6] The population of Northern Virginia has grown 12% between 2000 and 2004, compared to a flat rate in D.C.'s population.[7] The growth rate of immigrant populations in the northern portion of Virginia outpaced that of Virginia overall, with especially higher percentages of new Asian and Hispanic/Latino residents.

Two counties in West Virginia are also included – Berkeley and Jefferson. Although this jurisdiction represents a small number of cases for the Washington D.C. EMA, these counties have some of the highest total number of AIDS cases in the state of West Virginia.[8] One notable characteristic of this jurisdiction is that clients are served by an extensive Veteran's healthcare system with three Veterans Integrated Service Networks. This Veterans Capitol Health Care Network serves eligible veterans from Berkeley and Jefferson counties, Maryland and the District of Columbia. In FY 2002, the Veterans Capitol Health Care Network served 2,073 HIV positive persons.[9]

The combining of three states and the District poses many geo-political challenges for the Washington, D.C. EMA planning process. Since the EMA covers portions of different states outside of the District of Columbia, the Grantee must contract with designated administrative agencies in Suburban Maryland, Northern Virginia and West Virginia to provide administrative oversight and procurement services. In addition, EMA planners must also simultaneously create systems appropriate for urban, suburban and rural settings within each jurisdiction. This process requires immense amounts of data and analyses in order to understand who is infected and how to create effective service delivery models within each jurisdiction. In spite of these challenges, the partners in the Washington D.C. EMA find the comprehensive planning process to explore the strengths and weaknesses within our EMA and as an opportunity to meet the expectations of the Ryan White Treatment Modernization Act for all in need in the EMA.

Jurisdictional Processes

Each of the four jurisdictions has a local planning process that meets and considers local needs and priorities for services, as well as allocations of funds for services. An EMA-wide Planning Council, (the Washington D.C. Metropolitan Regional HIV Health Services Planning Council) conducts EMA-wide studies, needs assessments and has the authority and responsibility to set priorities and allocations for the EMA as a whole.

District of Columbia

The D.C. Delegation serves as the planning and advisory body for the distribution of both Part A and Part B dollars in the District of Columbia. The mission of the D.C. Delegation is to improve HIV/AIDS services in the District, guide long-range planning, allocate funds, set policies and advocate for quality services. The Delegation annually develops priority and allocation recommendations for the distribution of Part A dollars based on community input, epidemiologic data and trends, existing priorities, service utilization data, expenditures by service categories and current needs assessment data. The Delegation presents these priority and resource allocation recommendations to the EMA-wide Planning Council. In determining priority setting and resource allocation for the EMA as a whole, the Planning Council may decide to adopt,

reject, or amend the D.C. Delegation's recommendations or may send those recommendations back to the D.C. Delegation for further consideration.

In addition, utilizing their knowledge of Part A distribution, HIV/AIDS trends and utilization, and service needs in the District of Columbia, the D.C. Delegation serves as an advisory body making recommendations to the HIV/AIDS Administration on the distribution of Part B funds. The Grantee considers these recommendations when making final decisions about the distribution of these funds. The D.C. Delegation also provides additional advisory recommendations for funding decisions for the District when input is needed for reprogramming of funds during the grant year or when HRSA creates a new mandate that affects service delivery. The Delegation is given this opportunity to weigh in on the Grantee's decisions to ensure that services meet the needs of local PLWH/As.

Suburban Maryland

The Prince George's County Health Department serves as the Administrative Agent for the distribution and implementation of Part A dollars in Suburban Maryland. As such, they are responsible for completing the priority setting and resource allocation (PSRA) process and for the procurement of HIV service providers. As part of the annual planning process, the Health Department conducts pubic input meetings and holds data presentations to establish recommendations for priorities and allocations in Suburban Maryland. Upon completion of the recommendations, in a process identical to the process completed by the D.C. Delegation, the Prince George's County Health Department presents its recommendations for priorities and allocation to the Washington D.C. Metropolitan Regional HIV Health Services Planning Council for consideration in the development of EMA-wide plan for priorities and resource allocations. The Planning Council may decide to adopt, reject, or amend the Health Department's recommendations or may send those recommendations back to the Health Department for further consideration. For the procurement of service providers in the area, the administrative agency uses an annual competitive application process to select providers and is responsible for monitoring each contract.

West Virginia

The Administrative Agent for Jefferson and Berkeley County West Virginia is the AIDS Network of the Tri-State Area (ANTSA). The Planning Council sets the priority and allocation process. Members of the community (mostly PLWH/As) who attend the priority setting and allocations meeting, set the West Virginia priorities and allocations. Those results are submitted to the Planning Council for approval and inclusion into the EMA-wide roll up.

Because of the unique nature of rural Jefferson and Berkeley Counties, the AIDS Network of the Tri-State Area (ANTSA) operates as both an Administrative Agent for the area and as a Part A funded services provider. This creates some challenges in ensuring that operations for planning and for service delivery remain objective and unique. HAA works with ANTSA to ensure separate procedures for both of these roles and that the monitoring process complies with regulations for both administrative agency and service delivery functions.

A second issue regarding the Part A program in West Virginia is the issue of scale. This part of the EMA includes less than one percent of the total number of PLWH/A in the EMA and the entire region is comparatively rural and remote. While the practice has been to implement a needs assessment and priority setting process in West Virginia that mirrors the needs assessment and priority setting processes in other parts of the EMA, there are indications that this may be impractical for this area. The Planning Council and the Grantee are discussing this matter, and a revised process may be in place as early as 2009 for West Virginia.

Northern Virginia

The Part A Administrative Agent is the Northern Virginia Regional Commission (NVRC). The NVRC is a regional council of fourteen member local governments in the Northern Virginia suburbs of Washington D.C. According to Virginia's Regional Cooperation Act, NVRC is a political subdivision (a government agency) within the Commonwealth charged with providing information and coordinating crosscutting regional issues such as transportation, communication, homelessness, and health issues. An Ad Hoc Committee within NVRC focuses on HIV/AIDS issues. The NVRC receives feedback and advice on service priorities and resource allocations from the Northern Virginia HIV Consortium. The Consortium, which is composed of 110 HIV service providers, consumers and AIDS activists, serves as both the Northern Virginia advisory committee for the EMA Planning Council and as the Part B Consortium. The Consortium reviews data, needs assessments findings and consumer /provider surveys in its decision-making process. Allocations are based on funding scenarios and priorities are sent to the Washington D.C. EMA Planning Council for review and recommended for adoption.

Washington D.C. EMA Priority Setting and Resource Allocation Process

Although the EMA-wide Planning Council ultimately determines priorities and allocations, each jurisdiction completes an annual planning process and makes recommendations to the Planning Council. The goal is to develop an EMA-wide funding plan and continuum of care that addresses the different health care systems, capacity issues, and PLWH/A needs in each jurisdiction.

In order to promote equity in the overall distribution of Part A funds across the jurisdictions, the EMA uses a formula for the allocation of dollars to the jurisdictions. This distribution creates a process for the distribution of the Part A award from the Health Resources Services Administration (HRSA). Funding allocations for the EMA are guided by the following rules after the administration and Quality Management percentages are applied:

- There is an off the top allocation for EMA-wide services which includes primary medical care for the LEP (Limited English Proficiency) population, an Information and Referral service, and a psychosocial support program.

- Of the remaining funds, allocations are based on living AIDS cases; however, there is a 1% minimum for each jurisdiction, with funds redirected from the District of Columbia to ensure that minimum.

- The rural allocation is a fixed allocation of funds.

The Planning Council determines the priorities and ultimately the resource allocation within each of the allowable service categories across all of the jurisdictions. This process ensures that the EMA meets the legislative mandate that 75% of funding support core medical services and that the needs of the localities are represented in the final allocation to each service category. The final determination is based on the overall award amount for each of the jurisdictions; the recommendations presented by each of the local planning committees in the jurisdictions; and epidemiological and service utilization data, and needs assessments. For both the priority setting process and the final resource allocation process, the Planning Council starts by setting priorities and allocations for each service category at the jurisdictional level and then combining those documents into a final EMA-wide service prioritization and resource allocation document. The process is as follows:

- Each jurisdiction meets to get community input from PLWH/A and to review epidemiological data, needs assessments, and service utilization data. Based on this information the Administrative Agents develop a local recommendation for service priorities and resource allocation.

- Council meets to review the recommendations made by each jurisdiction in the context of epidemiological data, needs assessments, and service utilization.

- Although the Planning Council considers the recommendations for service priorities and resource allocations made by each of the jurisdictions, the Planning Council must ultimately make sure that the distribution of funds meets legislative mandates and incorporates EMA-wide needs assessments and unmet needs determinations. Therefore, the final service priorities and resource allocation may or may not mirror those recommended by the jurisdictions.

- Planning Council approves a set of services priorities and resource allocations for each of the jurisdictions in order to create an EMA wide plan that meets all of the legislative requirements and community needs.

- Once the Planning Council approves the EMA-wide resource allocation, the Administrative Agent in each of the jurisdictions ensures that those priorities are implemented in each of the jurisdictions.

- Requests by the Administrative Agents in the jurisdictions to move money from one service category to another must receive approval from the Planning Council.

Parity

The Treatment Modernization Act anticipates parity of services within each state, and within each EMA. However, neither the Act nor HRSA offers clear or compelling guidance on how to define or achieve parity. The Washington D.C. EMA comprises parts of four states, with distinct and very different public health infrastructure -- Medicaid and the AIDS Drug Assistance Program (ADAP) are two examples of programs that vary considerably among the different jurisdictions – which make the work of understanding and ensuring parity particularly difficult for this EMA.

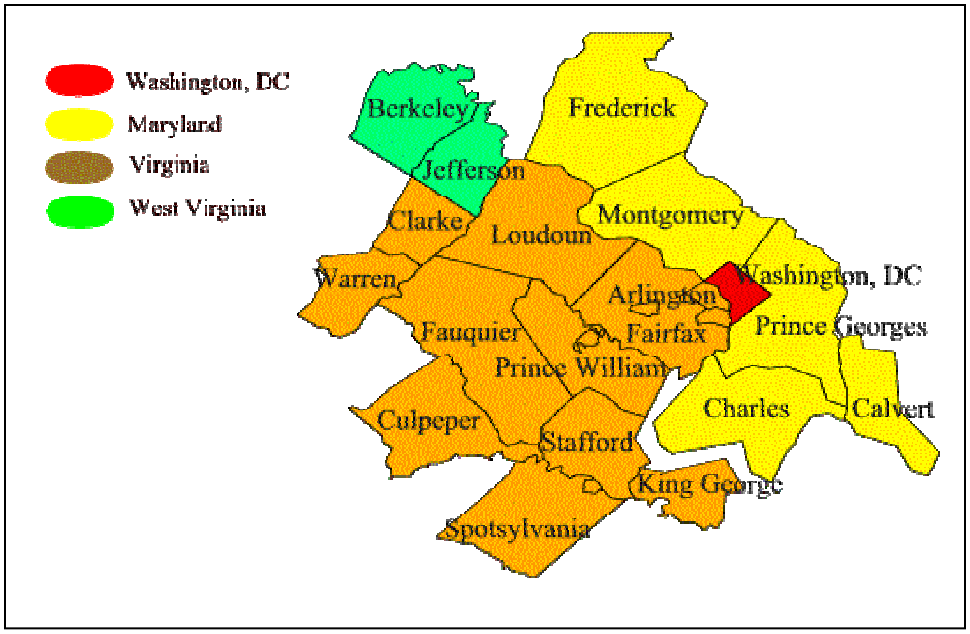
However, the EMA is working to understand how parity fits the needs of its diverse PLWH/A population. The work for assessing parity in the EMA began with a meeting convened at the request of the Grantee by HRSA in January 2007. The meeting included key stakeholders from the Grantee, each administrative agency, each State and HRSA. Next steps were outlined including regular discussions with administrative agencies, Planning Council and the Planning Committee of the Planning Council, but the EMA continues to struggle with this issue. In the FY 2009 Washington D.C. EMA application, there is a commitment to "exploring portability of care throughout the entire EMA and considering a standardized package of services through all areas of the EMA"[10]

Portability of services is one strategy to improve parity of services, but is not sufficient. Portability will likely improve the ability of current clients and especially high-functioning and relatively affluent clients to consume services, but may not provide a commensurate level of assistance to new, low-income clients. An unintended consequence of increasing portability may be the increased geographic concentration of services, and could adversely affect the distribution of services in remote and rural areas of the EMA.

The 2009-2011 Comprehensive Plan for HIV Services in the Washington, D.C. EMA strives to expand and implement these efforts. The plan builds on the principles of the Treatment Modernization Act through its focus on universal access to high-quality primary care and treatment throughout the EMA. This Comprehensive Plan is concerned about the needs of and the access to services by persons living in each of the jurisdictions, in spite of jurisdictional barriers.

The Washington, D.C. EMA is shown in Figure 1 below.

Figure 1: Map of the Washington, D. C. Eligible Metropolitan Area



Socio-Economic Description of the EMA

According to 2007 U.S. census data, the estimated total population of the racially and ethnically diverse Washington, D.C. EMA is 5,474,642. Of these, 53.79% self-identified as White, 25.69% self-identified as Black, 11.29% as Hispanic/Latino, 8.08% as Asian, 0.26% as American Indian/Alaska Native, and 0.06% as Native Hawaiian/Pacific Islander. Nearly 22% of the EMA population is foreign-born, and according to the 2006 American Community Survey of the U.S. Census, nearly 27% have limited English proficiency.[11]

The population of the EMA represents a diverse demographic. The differences among the jurisdictions present a unique challenge for creating appropriate treatment and prevention services. Therefore, it is important to understand the resources available for Ryan White care planning in each jurisdiction. The following section provides an overview of the demographic and economic factors in each of the jurisdictions comprised in the Washington, D.C. EMA.

District of Columbia

According to the U.S. Census, the estimated population for the District of Columbia in 2007 was 588,292, a 1% increase from the 2005 census population. The general demographic characteristics for the District reveal 47.1% male and 52.9% female; median age 34.9 years; 251,039 total households with 108,181 family households (family households with children under 18 and/or blood related, married couple families, female households with no husband present) and 142,858 non-family households (householder living alone and householder 65 years and over). 80,749 individuals or 13% of the population residing in the District of Columbia in 2007 were born outside of the United States and of foreign-born 35,437 (44%) were born in Latin America, 13,453 (17%) were born in Europe, 13,267 (16%) were born in Asia, and 9,747 (12%) were born in Africa.

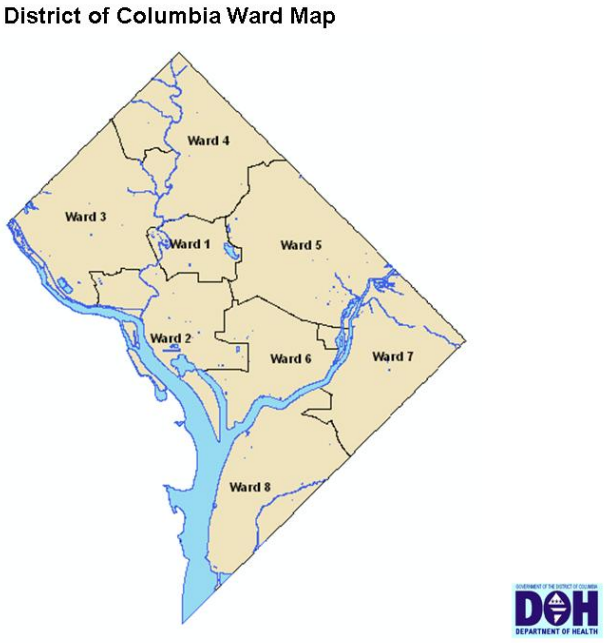
The District of Columbia median household income in 2007 was $54,317, slightly higher than the national median of $ 50,740. The District ranks first in the country in the proportion of professional and technical workers and has one of the highest concentrations of women in the work force. Its civilian workforce has a higher percentage of adults with 16 or more years schooling than 46 states. The racial and ethnic diversity in the District by Ward can be found in Table 2 below.

Table 2: Racial/Ethnic Diversity for All Wards, District of Columbia, 2007[12]

	Total Pop.	White	African American or Black	Asian or Pacific Islander	Hispanic (all races)	Mixed race
D.C.	572,059	30.8%	60.0%	2.7%	6.2%	0.3%
Ward 1	80,014	35.2%	43.2%	4.2%	23.4%	4.4%
Ward 2	82,845	56.2%	30.4%	7.2%	8.6%	2.7%
Ward 3	79,566	83.6%	6.3%	1.2%	6.5%	2.5%
Ward 4	71,393	10.33%	77.9%	1.1%	12.8%	3.1%

	Total Pop.	White	African American or Black	Asian or Pacific Islander	Hispanic (all races)	Mixed race
Ward 5	66,457	7.9%	88.2%	1.5%	2.5%	1.6%
Ward 6	65,457	27.2%	68.7%	0.4%	2.4%	1.6%
Ward 7	64,704	1.4%	96.9%	2.0%	0.9%	1.0%
Ward 8	61,532	5.8%	91.8%	0.3%	1.5%	1.1%

Figure 2: District of Columbia Ward Map



Maryland

There are five counties in Maryland (Calvert, Charles, Frederick, Montgomery and Prince George's Counties) included in the EMA. These localities encompass 2,661 square miles of Maryland, or about 22% of the state's land area. The area is very diverse in terms of the concentration of the population. Two of these counties (Montgomery and Prince George's) average 1,762 and 1,651 people per square mile, respectively. At the other extreme, only 261 people reside in the 643 square miles in rural Charles County.

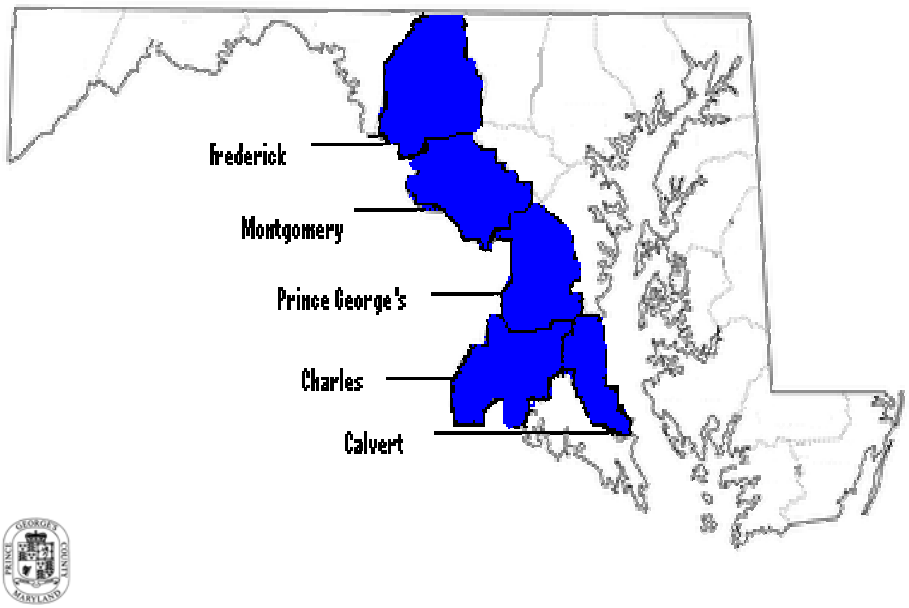
In total, 2,212,955 people live in these five counties, representing less than 40% of the state's population. Montgomery and Prince George's County account for about eighty percent (79.5%) of the population of the five counties. Since 2000, the population in Montgomery and Prince George's Counties has increased by 0.95% while the population in the remaining 3 counties has increased by 0.85%.[13]

The racial and ethnic composition of the five counties is also diverse. Table 3 provides an overview as reported by residents to the American Community Survey by the U.S. Census in 2007.

Table 3: Racial/Ethnic Diversity for Suburban Maryland, 2007[14]

County	Total Pop.	White	African American or Black	Asian or Pacific Islander	Hispanic (All races)
STATE OF MARYLAND TOTAL	5,618,344	62.0%	30.0%	6.4%	6.3%
SUBURBAN MARYLAND TOTAL	2,212,955	50.5%	35.9%	9.4%	11.5%
Calvert	88,223	85.0%	15.2%	3.1%	2.4%
Charles	140,444	58.2%	39.3%	5.9%	3.6%
Frederick	224,705	84.0%	9.6%	4.9%	5.7%
Montgomery	930,813	62.1%	17.2%	15.1%	14.3%
Prince George's	828,770	23.5%	65.6%	5.4%	12.2%

Figure 3: Map of Suburban Maryland



Map Courtesy of Prince George's County Health Department, Suburban Maryland Ryan White Part A Administrative Agency

In the State of Maryland, 694,590 individuals or 12% of the people living in the state were born outside of the United States and 775,267 individuals or 15% of the population spoke a language other than English at home. The numbers for the State of Maryland are slightly below the

national average of 13% born outside of the US and 20% speaking a language other than English at home. But of particular importance to the EMA, both Prince George's and Montgomery County reported in 2007 a higher than average percent of residents born outside of the US. Prince George's and Montgomery Counties report that 19% (155,836) and 30% (276,576) of their populations respectively were born outside of the US, with 19% and 35% of those individuals respectively speaking a language other than English at home. In Prince George's County, foreign-born residents reported the following world origins: 3.9% from Europe, 16.3% from Asia, 27.7% from Africa, 0.1% from Oceania, 0.7% from Northern America, and 51.3% from Latin America. Similarly, foreign-born residents from Montgomery County reported the following world origins: 11.7% from Europe, 37.4% from Asia, 13.7% from Africa, 0.1% from Oceania, 1.1% from Northern America, and 36.0% from Latin America.[15]

According to the 2007 U.S Census Bureau's American Community Survey, the total percent of the population living below poverty in the State of Maryland dropped from 9.5% in 2000 to 8% in 2007. The five Suburban Maryland Counties generally had a lower average poverty level than the State of Maryland as a whole (Calvert County 5%, Charles County 5%, Frederick County 5%, Montgomery County 5% and Prince George's County 8%).[16]

Similarly, the median family income in Maryland is $68,080 higher than the national median income of $50,740. All of the Maryland counties in the EMA are generally wealthier than the state's average, with median family income ranging from a low of $68,370 in Prince George's County to the high of $95,134 in Calvert County, with the remaining three falling in the middle.

Virginia

Seventeen jurisdictions make up the Virginia area included in this EMA – the cities of Alexandria, Fairfax, Falls Church, Fredericksburg, Manassas, and Manassas Park; and the counties of Arlington, Clarke, Culpeper, Fairfax, Fauquier, King George, Loudoun, Prince William, Spotsylvania, Stafford, and Warren. Covering over 3,600 square miles in land area, the Virginia cities and counties of the EMA include urban and remotely rural areas. The population density (persons per square mile) in Arlington (7,323) and Alexandria (8,452) is comparable to the urban nature of the D.C. density (9,316 persons per square mile). However, the rural county of Clarke is home to only 71 persons per square mile.

This area of the EMA has one of the country's fastest growing populations. Loudoun County nearly doubled its population in the last 10 years. In the State of Virginia 10% (794,246) of the residents were foreign born and 13% reported speaking a language other than English at home. Of the foreign-born residents, 12.0% are from Europe, 39.8% are from Asia, 10.0% are from Africa, 0.5% are from Oceania, 1.8% are from Northern America, and 39.8% are from Latin America. The growth rate of foreign-born residents in Northern Virginia outpaced that of the state overall. Northern Virginia has the largest population of Ethiopian immigrants in the country. Although PLWH/As are distributed geographically throughout Virginia, PLWH/As are more concentrated in urban areas[17].

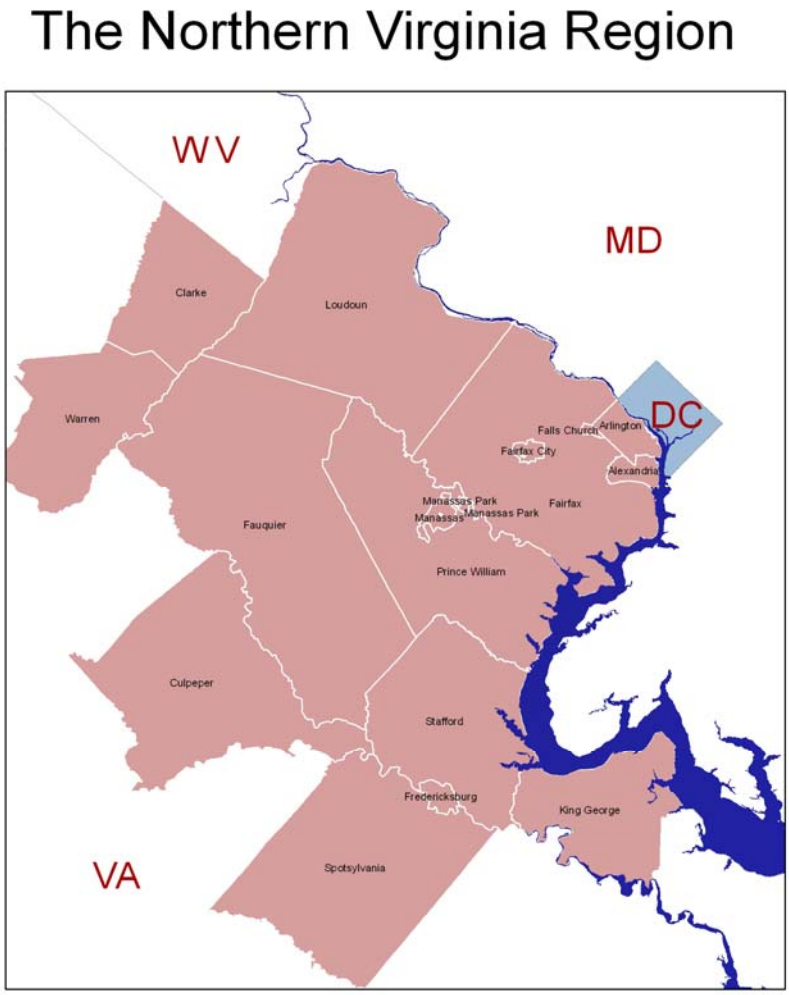
Table 4 provides an overview of the racial/ethnic composition of the Northern Virginia jurisdiction.

Table 4: Racial/Ethnic Diversity for Selected Counties, State of Virginia, 2007

County / City	Total Pop.	White	African American or Black	Asian or Pacific Islander	Hispanic (All Races)
STATE OF VIRGINIA TOTAL	7,712,091	72.1%	20.6%	6.4%	6.5%
NORTHERN VIRGINIA TOTAL	2,491,242	70.6%	13.0%	12.0%	12.8%
Alexandria City	140,024	67.8%	22.0%	7.4%	12.8%
Arlington Co.	204,568	70.7%	8.3%	8.6%	15.8%
Clarke*	12,652	91.1%	7.1%	.01%	1.5%
Culpeper*	34,262	79.5%	18.9%	1.8%	2.5%
Fairfax City*	21,498	75.6%	5.8%	14.3%	13.6%
Fairfax County	1,010,241	68.3%	10.2%	17.6%	13.6%
Falls Church*	10,377	87.2%	3.8%	8.5%	8.4%
Fauquier	65,957	88.0%	7.9%	8.8%	5.3%
Fredericksburg*	19,279	74.8%	21.3%	2.8%	4.9%
King George*	16,803	79.1%	19.4%	2.5%	1.8%
Loudoun	278,797	74.2%	9.3%	14.2%	10.2%
Manassas*	35,135	74.8%	13.9%	5.0%	15.1%
Manassas Park*	10,290	75.7%	12.0%	6.0%	15.0%
Prince William	360,411	62.0%	21.1%	9.1%	19.2%
Spotsylvania	119,194	78.9%	16.6%	4.6%	6.5%
Stafford	120,170	76.2%	18.6%	4.8%	7.6%
Warren*	31,584	93.9%	5.3%	1.6%	1.6%

* Most recent US Census Bureau data from 2000 American Community Survey.

Figure 4: Map of Northern Virginia



Map Courtesy of Northern Virginia Regional Commission

The Virginia portion of the EMA reflects a diverse population ranging from the largest and richest county, Fairfax County, with just over 1 million residents and a large contingent of Hispanic citizens, to the smallest city, Manassas Park, with just over 10,000 residents nestled within 2 1/2 square miles in the suburban county of Prince William. About 320,000 Hispanic persons live in the Virginia jurisdictions of the EMA, compared to approximately 47,775 in the District of Columbia, 254,352 in Maryland jurisdictions, and about 2,633 in West Virginia. In fact, the percentage of Hispanic residents in the Northern Virginia is nearly double the percentage for the State of Virginia.

According to the US Census Bureau's 2007 American Community Survey, the median family income in Virginia is $59,562. This is slightly higher than the national median income of $50,740. As in Maryland, the Virginia suburban jurisdictions are wealthy compared to the rest of the state, with a median income of $87,629 for those cities and counties with updated 2006 US Census Data. For those Counties with only 2000 US Census Bureau data available, income

statistics still show the median income in Northern Virginia ($51,601) as significantly higher than the national median income ($41,994).

The percentage of persons in poverty also reflects the wealth of the region. In Virginia 10% of the people lived below poverty lines, the average of the 17 counties and cities in this EMA, only 5.6%. Fredericksburg, with a percentage of 17.8%, exceeds the state average to a low of 3.5% in the Fairfax County.

West Virginia

Two counties in West Virginia are included in the Washington D.C. EMA – Berkeley and Jefferson counties. West Virginia is divided into eight public health districts. Encompassing more than 500 square miles, these two counties are located in the state's Public Health District VIII. The 2000 Census lists the total population of the Public Health District as 212,483, 13% of the state's total. Berkeley and Jefferson are the fastest growing counties in the state and make up more than half of the total population of District VIII. While often considered the most rural counties in the EMA, population density in these two counties actually exceeds that in five counties in Virginia.

In the past ten years, the population has increased in every county and the population of Berkeley and Jefferson counties combined (118,095) make up more than half of the total population of Public Health District VIII. Jefferson and Berkeley counties have the highest percentage of African American residents in Public Health District VIII, 6.1 percent and 4.7 percent respectively as compared to 3.2 percent for the state.

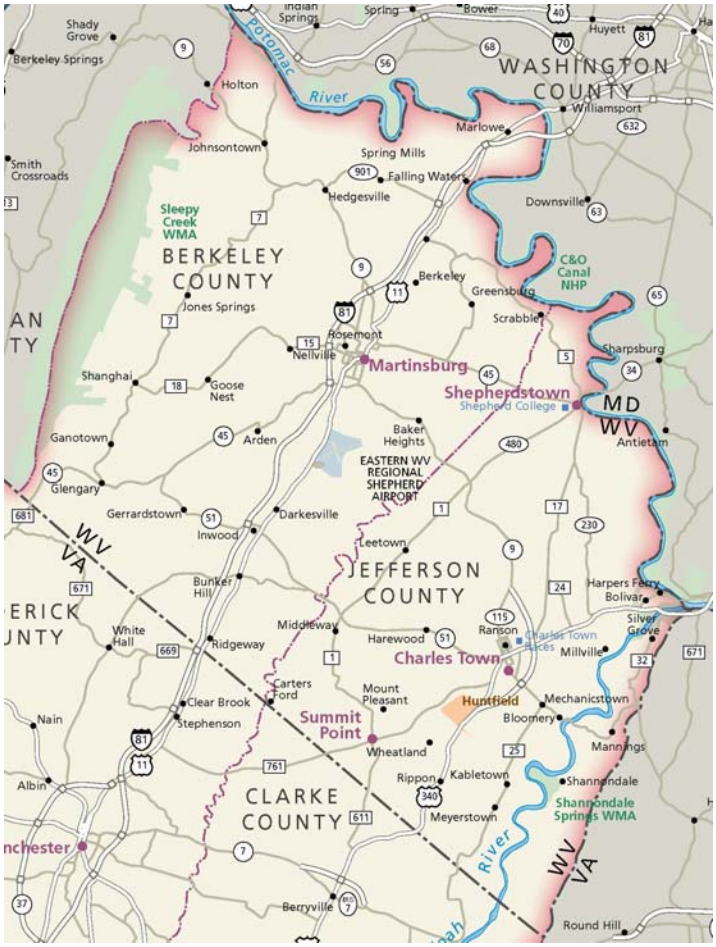
Table 5: Racial/Ethnic Diversity for Selected Counties, State of West Virginia

County / City	Total Pop.	White	African American or Black	Asian or Pacific Islander	Hispanic (All races)
STATE OF WEST VIRGINIA TOTAL	1,812,035	95.5%	4.0%	1.4%	1.1%
JEFFERSON & BERKELEY TOTAL	141,924	91.4%	7.3%	1.1%	2.7%
Berkeley*	99,734	91.5%	7.8%	1.2%	3.1%
Jefferson**	42,190	91.0%	6.1%	.09%	1.7%

*Data from US Census Bureau, 2007 American Community Survey

** Most recent US Census Bureau data from 2000 American Community Survey.

Figure 5: Map of West Virginia[18]



According to the US Census Bureau's 2007 American Community Survey, the median income for the state of West Virginia, $37,060, is substantially lower than the national median income of $50,740. The median income for Berkeley County at $54,625 is higher than both the national median income and the median income for the State of West Virginia. According to the 2000 American Community Survey (the most recent US Census Bureau data available), the median income for Jefferson County was $44,374, slightly higher than the national median income of $41,994 at that time.

In 2007, 17% of people in the State of West Virginia and 13% of people nationally live below the poverty level. Fewer residents of Jefferson and Berkeley Counties live below the poverty level. Ten Percent of persons living in Berkeley and 10.0% of person living in Jefferson County are at or below the poverty level.

Fewer foreign-born residents live in West Virginia as a State, as well as, the two counties part of the Washington D.C. EMA. In the state only 1% of residents are foreign born and only 2% report speaking a language other than English at home. Of those foreign-born residents, 26.7% are from Europe, 37.4% are from Asia, 4.3% are from Africa, 0.4% are from Oceania, 5.4% are from Northern America, and 25.7% are from Latin America. The numbers of foreign-born

residents in Berkeley and Jefferson Counties, according to the US Census Bureau, are statistically insignificant.

Conclusion

The diversity of the Washington D.C. EMA presents many challenges for planners striving to create a comprehensive and comparable system of care for all residents living in the EMA. These include different health care systems, different demographics including a unique section of racial/ethnic minority subpopulations, and different geographical profiles. Currently priority processes are designed to ensure individual jurisdictions tailor services to meet the unique needs of its residents. The members of the EMA look forward to refining processes and striving to achieve a consistently high quality of care available to all people with HIV in the EMA.

Chapter 2: Epidemiological Profile of the Washington, D.C. EMA

This section of the Comprehensive Plan reviews the HIV epidemic in the Washington, D.C. EMA, compares the EMA to national rates, examines those groups disproportionately affected by HIV/AIDS within the EMA and discusses the jurisdictional differences.

In presenting the EMA's story, the Planning Committee of the Planning Council stressed the importance of creating a Comprehensive Plan that fully explored the inherent differences and the unique nature of the epidemic in each jurisdiction. This section reflects the differences among the jurisdictions. It is important to consider these differences in determining the best way to structure a dynamic, cross-jurisdictional continuum of care that does not treat the EMA as a monolithic entity. The inclusion of the comparison among jurisdictions highlights the planning challenges faced by the EMA's Planning Council.

Current HIV/AIDS Epidemiology in the Washington D.C. EMA

The discussion of HIV/AIDS Epidemiology uses newly diagnosed AIDS cases data from January 1, 2006 – December 31, 2007 as well as the estimates of all living HIV cases (non-AIDS cases) combined with all living AIDS cases by demographic group and exposure category through December 2007. These are required tables submitted with the annual Ryan White Part A application and show a current snapshot of the epidemic in the EMA. The HAA's epidemiological team used AIDS surveillance data from all of the jurisdictions, HIV surveillance data provided from Virginia and West Virginia counties and estimates of HIV case counts from Maryland and the District of Columbia to compute both the newly diagnosed AIDS cases and the living HIV/AIDS cases in the EMA by demographic group and exposure category. The tables for the EMA as a whole and for each of the jurisdictions are located in the Appendix section of the application (See Appendix tables 2-6). EMA data are useful in characterizing the epidemic as a whole; however, it does mask very important differences among jurisdictions. The following is a comparison of the epidemic by jurisdiction, which will highlight the complexity of planning for persons within the different parts of the Washington D.C. EMA.

Estimated Living HIV/AIDS Cases by Jurisdiction

As of December 31, 2007, an estimated 42,085 persons were living with HIV/AIDS in the Washington, D.C. EMA. Of these, 68.5% were male and 31.5% were female. The largest portion, (62.5%) were between the ages of 30-49, while 15.7% were over the age of 50 and just under 2% were pediatric cases. People of color accounted for 82% of these individuals, with 69% Black, 6% Hispanic, and 1% Asian/Pacific Islander with another 7% of other/unknown race/ethnicity. The exposure category for 23% of adults and adolescents was not reported at the time, while 33% were men who have sex with men, 27% contracted HIV through heterosexual contact, and 14% of the cases identified injection drug use as the mode of exposure. Men who have sex with men and use injection drugs account for 2.5% of all people living with HIV. Table 6 breaks down the number of people living with both HIV and AIDS by race and ethnicity.

Table 6: Distribution of Estimated HIV/AIDS Cases by race/ethnicity and jurisdiction

	D.C.		MD		VA		WV		EMA	
	#	%	#	%	#	%	#	%	#	%
White Non Hispanic	4,386	16.4%	974	10.6%	2,291	38.2%	96	55.8%	7,747	18.4%
African American or Black	20,143	75.4%	6,071	65.9%	2,909	48.5%	69	40.1%	29,192	69.4%
Latino/Hispanic	1,291	4.8%	489	5.3%	666	11.1%	6	3.5%	2,452	5.8%
Asian / Pacific Islander	137	0.5%	65	0.7%	121	2%	0	0%	323	0.8%
American Indian	26	0.1%	4	0.0%	2	0%	1	0.6%	33	0.1%
Other	721	2.7%	1,604	17.4%	13	0.2%	0	0%	2,338	5.6%
Total	26,704	63%	9,207	22%	6,002	14%	172	0%	42,085	100

Distribution of Cases by Jurisdiction

The epicenter of the epidemic is the District of Columbia, which accounts for 10.8% of the population, yet account for 63% of the living HIV/AIDS cases.

The section below provides statistics to help describe the epidemic in the EMA as a whole and in each jurisdiction. Table 7 shows the number living AIDS cases by race and ethnicity. Table 8 breaks down by number and by percentage the primary modes of HIV transmission for people living with AIDS. Table 9 shows both by number and percentage the number of males and females living with AIDS.

Living AIDS Cases

An estimated 16,462 persons in the EMA were living with AIDS in 2007. More AIDS cases in the EMA were male (71%) than female (29%). People living with AIDS tended to be older than people living with HIV, with 67% between the ages of 30-49, 17% over the age of 50, and just under 1% (.9%) of the total described as pediatric cases. As with HIV, people of color are most severely impacted by AIDS, with 73% of AIDS cases in the EMA among Blacks, 7% among Hispanics, and 1% among Asian/Pacific Islanders, with less than 1% other/unknown and the remaining 19% among whites. In the EMA, the largest exposure category for adult and adolescent AIDS cases is men who have sex with men (36%) followed by heterosexual contact (27%) and injection drug use (18%). Men who have sex with men and inject drugs accounted for 3% of the people living with AIDS in the EMA.

Table 7: Living AIDS Cases by Race and Ethnicity[19]

Race/Ethnicity	D.C.		MD		VA		WV		EMA	
	#	%	#	%	#	%	#	%	#	%
White	1,130	13.0%	634	13.8%	1,255	41.1%	54	61.4%	**3,073**	**18.7%**
African American or Black	7,064	81.1%	3,622	78.6%	1,370	44.9%	30	34.1%	**12,086**	**73.4%**
Latino/Hispanic	445	5.1%	311	6.8%	368	12.0%	3	3.4%	**1,127**	**6.8%**
Asian/Pacific Islander	47	0.5%	39	0.8%	60	2.0%	0	0.0%	**146**	**0.9%**
American Indian	8	0.1%	1	0.0%	1	0.0%	1	1.1%	**11**	**0.1%**
Other	19	0.2%	0	0.0%	0	0.0%	0	0.0%	**19**	**0.1%**
Total	**8,713**		**4,607**		**3,054**		**88**		**16,462**	**100%**

Table 8: Living Adult AIDS Cases by Mode of Transmission and Jurisdiction

Mode of Transmission	D.C.		MD		VA		WV		EMA	
	#	%	#	%	#	%	#	%	#	%
MSM	3,212	37.2	1,242	27.3	1,431	47.1	38	43.2	5,923	36.3
IDU	2,062	23.9	586	12.9	338	11.1	20	22.7	3,006	18.4
MSM/IDU	357	4.1	96	2.1	102	3.4	3	3.4	558	3.4

Mode of Transmission	D.C.		MD		VA		WV		EMA	
	#	%	#	%	#	%	#	%	#	%
Heterosexual	2,202	25.5	1,558	34.2	550	18.1	15	17	4,325	26.5
Other	58	.7	35	.8	171	5.6	0	0	264	1.6
Not Identified	734	8.5	1,034	22.7	446	14.7	12	13.6	2,226	13.7
Total	8,625	53%	4,551	28%	3,038	19%	88	1%	16,302	100

Table 9: Living AIDS Cases by Gender and Jurisdiction

	D.C.		MD		VA		WV		EMA	
	#	%	#	%	#	%	#	%	#	%
Male	6,331	72.7	2,986	64.8	2,369	77.6	69	78.4	11,755	71.4
Female	2,382	27.3	1,621	35.2	685	22.4	19	21.6	4,707	28.6
Total	8,713	53%	4,607	28%	3,054	19%	88	1%	16,462	100

Estimated Living HIV Cases

As of December 31, 2007, an estimated 25,622 persons were living with HIV (not AIDS) in the Washington, D.C. EMA. Of these, 67% were male and 33% were female. The largest portion, (60%) were between the ages of 30-49, while 15% were over the age of 50 and just over 1% were pediatric cases. People of color accounted for 82% of these individuals, with 67% Black, 5% Hispanic, and 1% Asian/Pacific Islander with another 9% of other/unknown race/ethnicity. The exposure category for 29% of adults and adolescents was not reported at the time, while 31% were men who have sex with men, 27% contracted HIV through heterosexual contact, and 10% of the cases identified injection drug use as the mode of exposure. Men who have sex with men and use injection drugs account for 2% of all people living with HIV.

Newly Diagnosed AIDS Cases

For the two-year period of time between January 1, 2006 and December 31, 2007, a total of 2,403 new AIDS cases were reported in the EMA, representing an average of more than 3 new cases of AIDS diagnosed in the EMA every single day. In 2006, the Washington, D.C. EMA had the third highest newly diagnosed AIDS case rate in the nation (31.8 cases per 100,000 population) and includes the District of Columbia which has the highest newly diagnosed AIDS case rate in the nation.[20]

Two-thirds (67%) of the AIDS cases diagnosed during the two-year period are male; 33% are female. The new AIDS cases show the aging of the population with HIV/AIDS, as 22% of the cases are age 50 or older, and 62% are between the ages of 30-49. This reflects ages at diagnosis. Similar to data related to living AIDS and HIV cases, data related to newly diagnosed AIDS cases for the two years indicate 79% of the cases are Black, 8% are Hispanic, 1% are Asian/Pacific Islander, and 11% are white. Among adult and adolescent cases, 29% are

attributed to heterosexual contact, 28% to male-to-male sexual contact, and 13% to injection drug use.

National Comparison

When compared to the nation as a whole, the Washington, D.C. EMA is disproportionately impacted by HIV/AIDS, with the EMA having approximately twice as many living AIDS cases per 100,000 people as the nation as a whole. Table 10 includes information from the CDC HIV/AIDS Surveillance Report and the EMA's HIV/AIDS epidemiology table. To calculate AIDS case rates per 100,000 as July 1, 2007, the HAA utilized census estimates from the US Census Bureau.[21]

Table 10: Living AIDS Case Rates by Gender and Race for the Washington, D.C. EMA and United States*

	Washington D.C. EMA	United States	Ratio
Gender			
Male	440.40	224.17	1.96 : 1
Female	168.59	65.16	2.59 : 1
Race / Ethnicity			
White, not Hispanic	104.62	64.06	1.63 : 1
Black, not Hispanic	861.82	494.34	1.74 : 1
Hispanic	182.72	117.60	1.55 : 1
Overall Population	301.44	144.78	2.08 : 1

** Living AIDS Cases per 100,000*

Epidemic Trends in the Washington D.C. EMA for 2001-2006

The U.S. epidemic is more than thirty years old, during which time medical science has learned much about the human immunodeficiency virus. Antiretroviral drug therapy now extends the lives of infected persons and these treatment advances have required new responses from Ryan White funded services. As the EMA takes on the challenges of setting priorities among populations and deciding resource allocations for appropriate interventions and services, there is a need to be aware of the changing nature of HIV/AIDS and surveillance data. The EMA is

confronted with trends of "late testers" and "concurrent diagnoses" and experiencing new emerging populations.

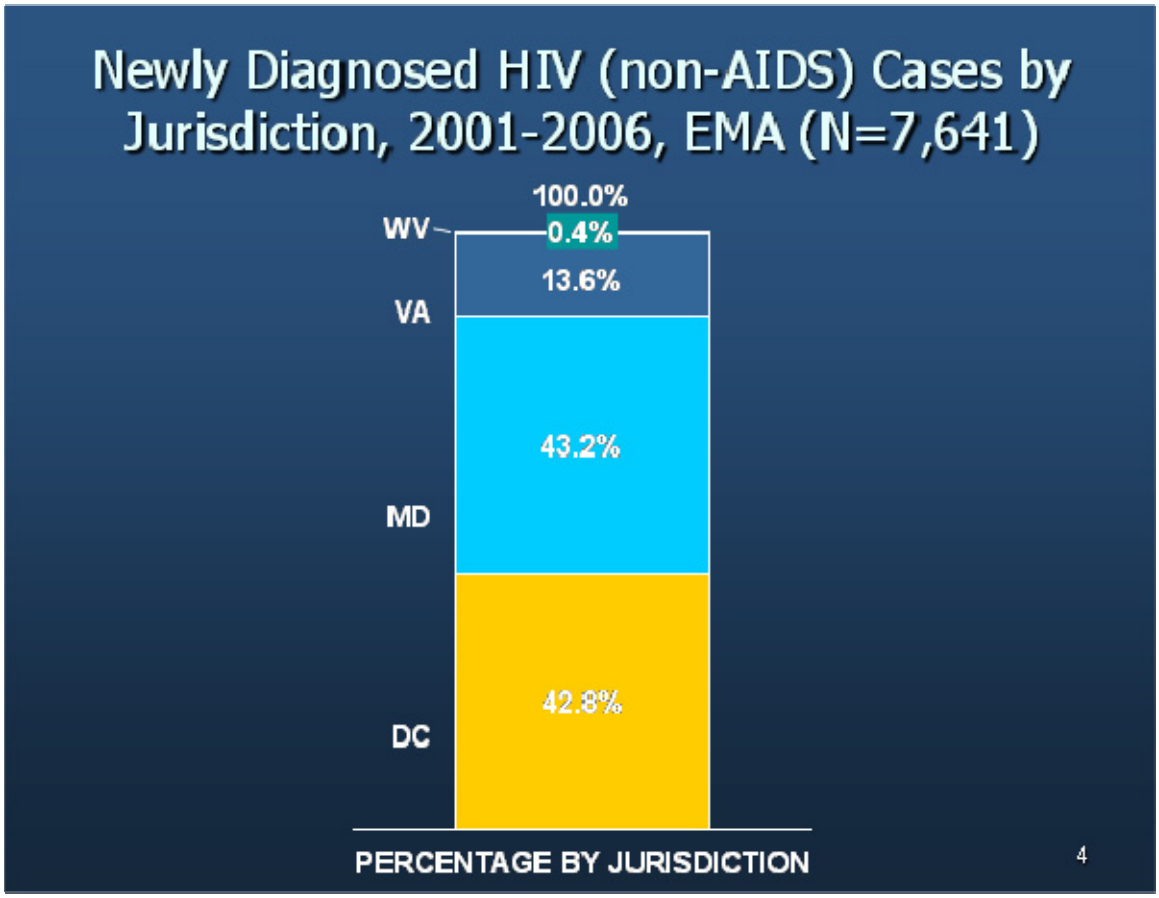
However, surveillance data on HIV infection is imperfect in the EMA. Only West Virginia and Virginia are areas with mature (i.e., since at least 2003) confidential name-based HIV reporting for accurate presentation of HIV infections. The District and Maryland use different methodologies to estimate HIV. This limits the full picture of the HIV epidemic in the EMA, particularly when looking at trend data. Improving the capacity of the EMA for data collection is an objective of the Comprehensive Plan. The data presented here were used in priority setting presentations to the Planning Council and differ from data presented in the section above entitled *Current HIV/AIDS Epidemiology in the Washington D.C. EMA*. The portion of data contributed by the District of Columbia includes code-based surveillance data for HIV (non-AIDS) cases. Prior to November 2006, HIV cases were reported using a code-based system and cases of HIV were recorded in a system separate from the AIDS case reporting system. As of December 31, 2007, surveillance activities were incomplete and the actual number of HIV cases had been under-reported.

In the Washington D.C. EMA, there are definite trends emerging: the epidemic reflects greater percentage of women, heterosexual transmission, late testers and concurrent diagnoses. Men who have sex with men, particularly MSM of color, continue to be disproportionately affected. The following reviews the trends of HIV/AIDS in the Washington D.C. EMA. The data related to both newly diagnosed HIV/AIDS cases and all living HIV/AIDS cases reflect the period 2001-2006.[22] These data were used in developing the priorities for the Planning Council and when used in conjunction with the current data sets show a broader picture of epidemic in the EMA over the last 7 years.

Newly Diagnosed HIV (non-AIDS) Cases, 2001-2006

The number of newly diagnosed cases in the EMA for the jurisdiction from 2001-2006 totaled 7,641 with 43.2% of the cases from Maryland, 42.8% of the cases in the District of Columbia, 13.6% of the cases in Virginia and 0.4% of the cases in West Virginia. As for gender, 62.9% were male and 37.3% were female and the remainder statistically missing. African Americans comprised 60.9% of the cases followed by Whites (12%), Hispanic (5.3%), Asian/Pacific Islander (0.7%), Other (5.3%) and Missing (15.8%). Of the newly diagnosed HIV non-AIDS cases, heterosexual transmission risk factor dominated with 28.4% of cases, followed by MSM (21%), IDU (7.7%), Unknown (41.3%) and Blood/Other (0.3%). In addition, 70% of newly diagnosed cases occurred in individuals between 30 and 49 years old. Figure 6 below shows the distribution of newly diagnosed HIV Cases by jurisdiction for this time period.

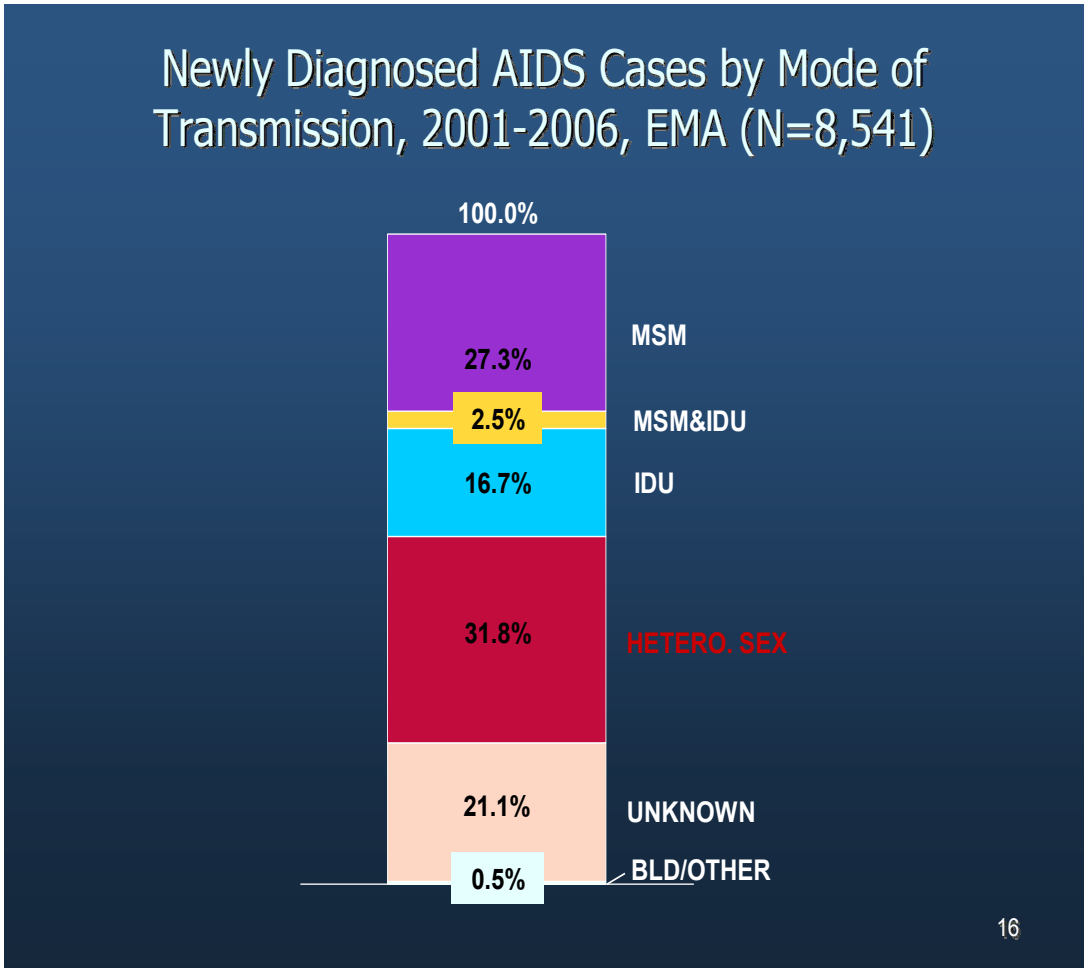
Figure 6: Newly Diagnosed HIV Cases by Jurisdiction, 2001-2006



Newly Diagnosed AIDS, 2001-2006

For the period 2001-2006, there were 8,541 new cases of AIDS in the EMA with 54.8% of the cases in the District of Columbia, 29% in Maryland, 15.6% in Virginia and 0.6% in West Virginia. As for gender, 67% were males and 33% females. The majority of cases were African American (80%), with 12% White, 6.9% Hispanic, 0.8% Asian/ Pacific Islander and 0.6% Other/Missing. Approximately 72% of newly diagnosed AIDS cases occurred among individuals between the ages of 30 and 49. Between 2001-2006, there was a 20% decrease in the number of newly diagnosed AIDS cases. This is consistent with national trends and may be attributed to HAART. Figure 7 below depicts the newly diagnosed AIDS cases by mode of transmission for this time period.

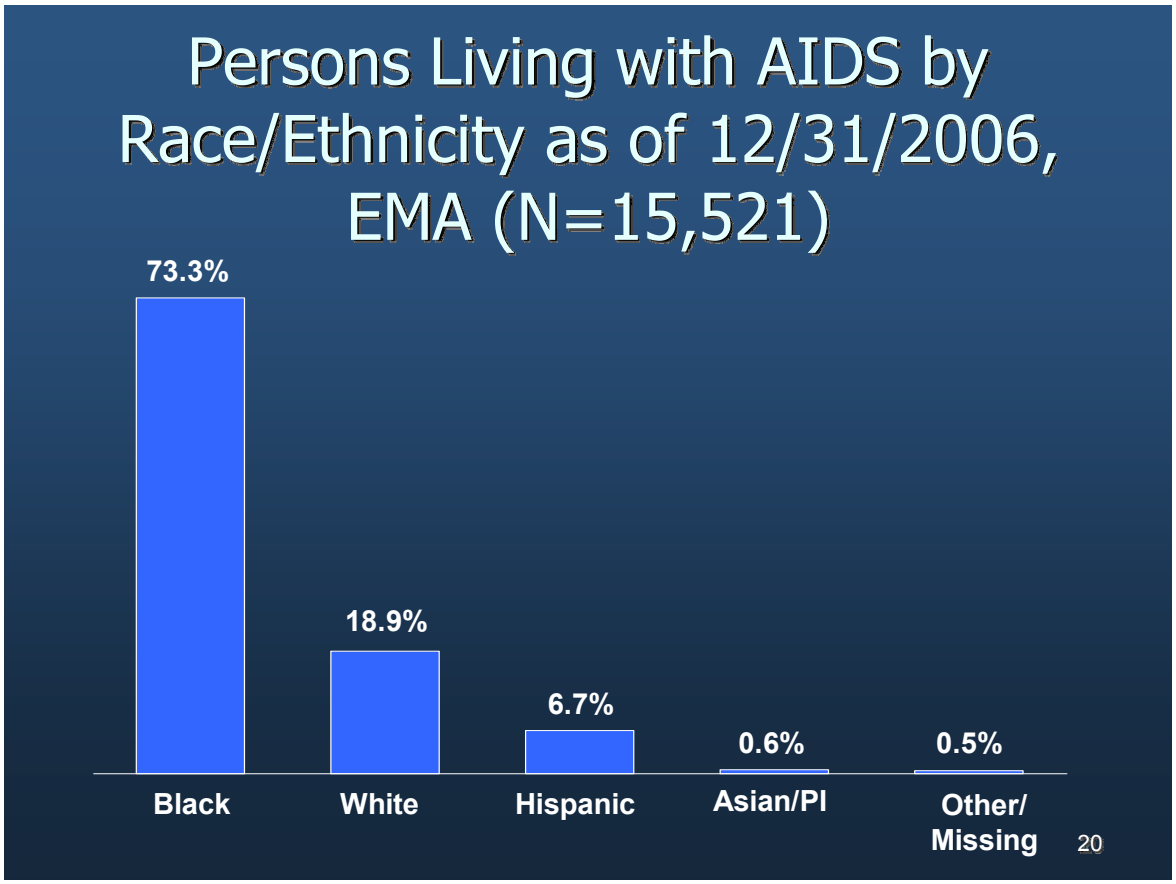
Figure 7: Newly Diagnosed AIDS Cases by Mode of Transmission, 2001-2006



Living AIDS Cases 2001-2006

Although the District makes up just over 10% of the total EMA population, it has the largest proportion of living AIDS cases in the EMA. The majority of persons living with AIDS (15,521) are in the District (53.9%), Maryland (27.1%), Virginia (18.8%) and West Virginia (0.3%). The majority are Black/African American. Although Black/African Americans comprise 26% of the EMA residents, they account for approximately 3 in 4 or 73.3% of living AIDS cases. During this period, the number of people living with AIDS increased by 54%. Just over 70% of living AIDS cases occurred among individuals between the ages of 30 and 49. Figure 8 below depicts persons living with AIDS by race/ethnicity as of December 31, 2006.

Figure 8: Persons Living with AIDS, by Race/Ethnicity as of 12/31/2006



HIV/AIDS Mortality EMA 2001-2006

In the EMA, there was a 40% decrease in the number of AIDS deaths between 2001 and 2006 (See Figure 10). Nearly two thirds of the EMA's HIV/AIDS deaths were among D.C. residents while 1 in 4.5 deaths were among Maryland residents (See Figure 9). Approximately 56% of the HIV/AIDS deaths in the EMA occurred between the ages of 30 and 49, consistent with the overall distribution of estimated living HIV/AIDS cases. IDUs account for only about 14% of estimated living HIV/AIDS cases yet 29% of HIV/AIDS deaths in the EMA were among IDU, followed by MSM (26.6%), and heterosexuals (25.8%).

Figure 9: HIV/AIDS Deaths by EMA Jurisdiction, 2001-2006

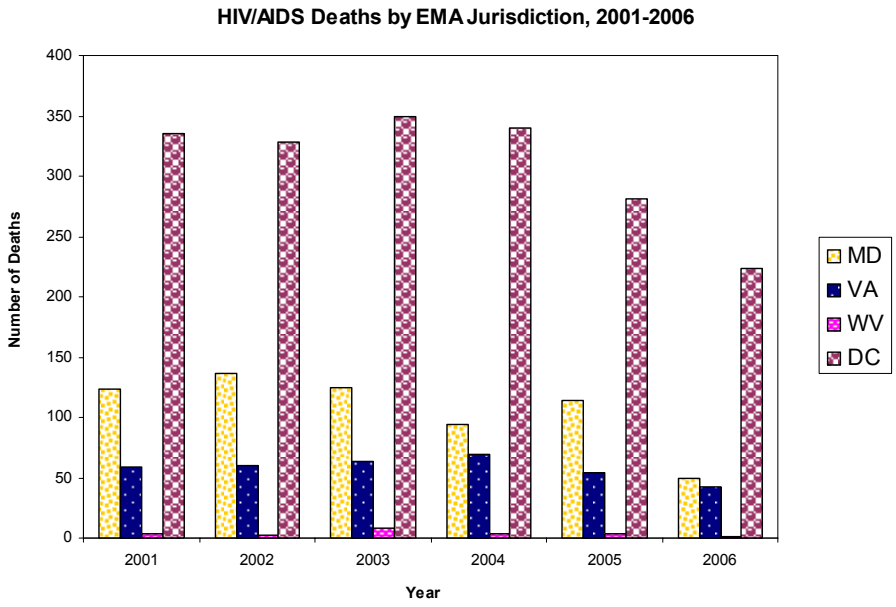
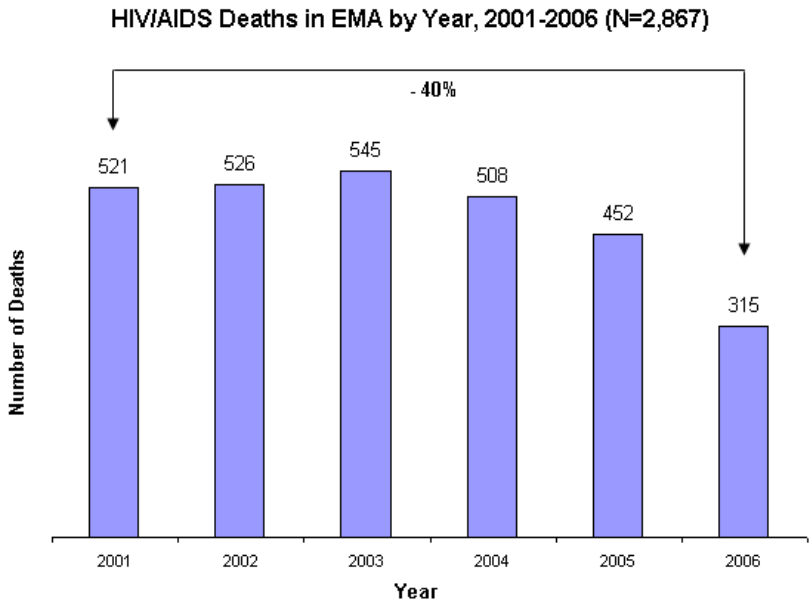


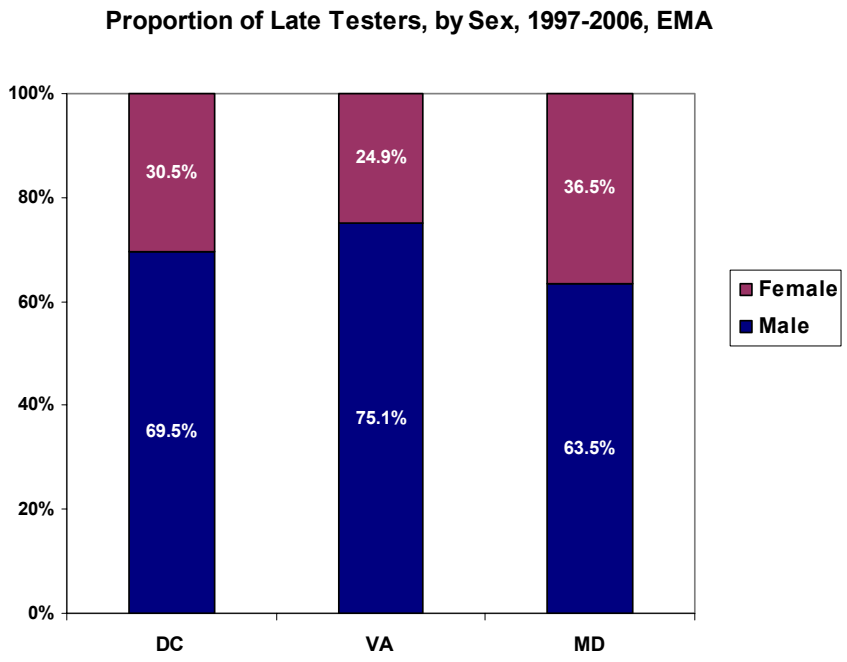
Figure 10: HIV/AIDS Deaths in EMA by Year, 2001-2006



Special Issues – Late Testers 1997-2006

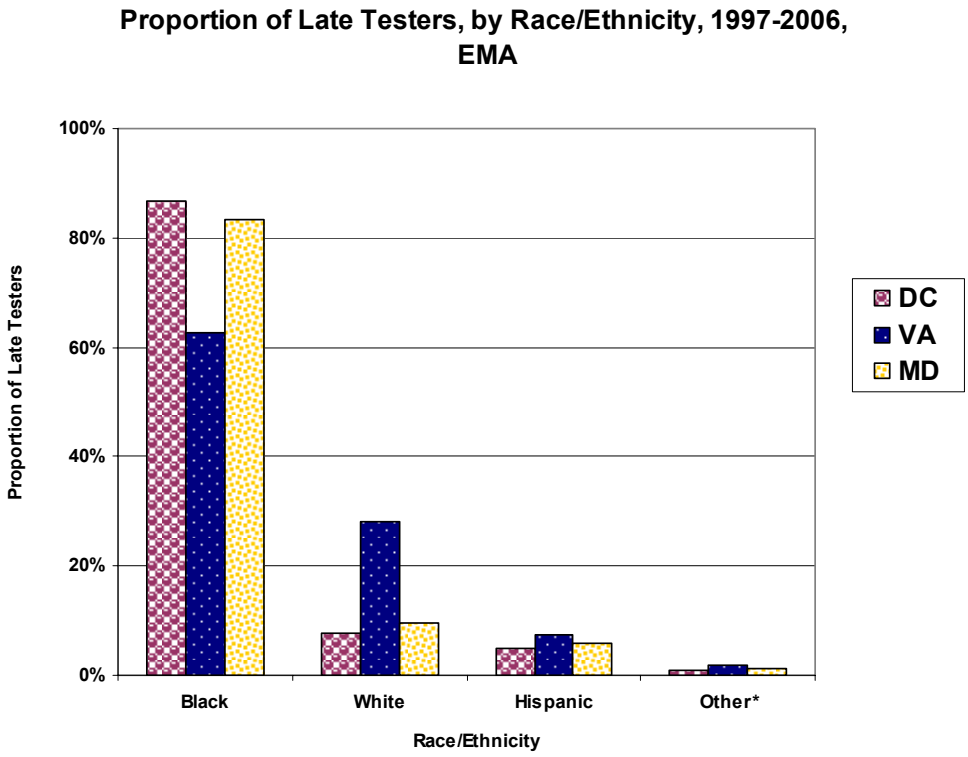
Within the EMA, there is a persistent problem of "late testers." Among person living with AIDS, a late tester is defined as a person with an AIDS diagnosis that occurred within 12 months of their initial HIV diagnosis. This population is a subset of AIDS cases. The total proportion of late testers in the EMA is 64.9%. The number and proportion of late testers by jurisdiction is D.C. 5,096 of 7,423 or (68.7%), VA 4,048 of 7,299 or (55.5%) MD 2,839 of 3,749 or (75.7%). Nationally, 39% of AIDS cases are late testers.

Figure 11: Proportion of Late Testers, by Sex, 1997-2006



Late testers do not differ significantly from all persons with AIDS, indicating no particular group disproportionately defined as a late tester. The largest proportion of late testers is made up of Blacks, males and individuals between the ages of 30 to 49, similar to the distribution person not classified as late testers.. The same is true by mode of exposure. The mode of transmission among the majority of late testers is attributed to heterosexual contact and men who have sex with men. The largest proportion of late testers residing in the District has public insurance while just over 40% of late testers in Maryland have private insurance. The high number of late testers in the EMA may result from the lack of HIV testing as a part of routine medical care, the lack of routine medical care, increasing assessment of HIV risk, or other factors.

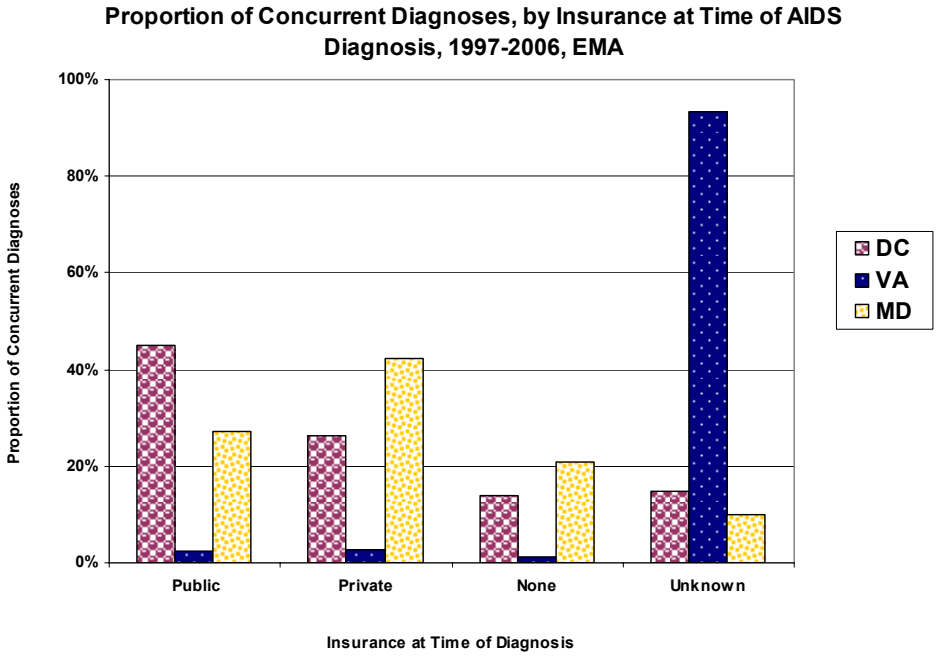
Figure12: Proportion of Late Testers, by Race/Ethnicity, 1997-2006



Concurrent Diagnoses 1997-2006

Concurrent diagnosis is defined as a diagnosis of AIDS within 31 days of initial diagnosis of HIV. This is a subset of AIDS cases that would also be classified as late testers. The proportion of concurrent diagnoses in the EMA is 49.7%. The number and proportion of concurrent diagnoses by jurisdiction is as follows: D.C.- 4,137 of 7,423 or (55.7%), VA -2,745 of 7,299 or (37.6%) and MD -2,292 of 3,749 or (61%). Similar to trends noted for late testers, the largest proportion of concurrent diagnoses is made up of Blacks, males, and individuals between the ages of 30 to 49. In addition, the largest proportion of concurrent diagnoses residing in the District have public insurance (45%) while just over 42% of concurrent diagnoses in Maryland have private insurance.

Figure 13: Proportion of Concurrent Diagnosis, by Insurance at Time of AIDS Diagnosis, 1997-2006



Emerging and Special populations living with HIV/AIDS in the EMA

The Planning Council is legislatively mandated to assess the EMA's service needs. This includes determining the size of the HIV infected populations, assessing the needs of those who know their HIV status but are not in care and minimizing disparities in the health care system. Using epidemiological data, the unmet need framework and on-going needs assessments, the EMA has identified subpopulations that require special focus. The Planning Council uses this information during the annual priority setting and resource allocation process.

Prioritizing services and funding to assist those most in need will require special attention in the future, as the Planning Council must incorporate changes mandated under the 2009 Ryan White Treatment Modernization Act reauthorization as well as respond to national goals set by Healthy People 2010. Currently both the Ryan White Treatment Modernization Act of 2006 as well as Health People 2010, emphasize access to health care services, decreases in health care outcome disparities, and disease prevention as a routine pieces of treatment services. Developing quality effective services for hard-to-reach and disenfranchised populations in the EMA is the mission of the Planning Council and Grantee. Following is a discussion of these groups.

Minorities

Racial and ethnic minorities account for 81% of all people living with HIV/AIDS in the EMA, while they comprise less than half (46.21%) of the total population of the EMA. There is a continuing trend in the EMA of disproportionate impact of HIV/AIDS on African Americans. Blacks/African Americans[23] accounted for 79% of newly diagnosed AIDS cases from January 1, 2006, to December 31, 2007, and 69% of people estimated to be living with HIV (not AIDS) in the EMA as of December 31, 2007, yet represent about one-fourth (25.69%) of the total population in the EMA. Minorities, in general, and Blacks /African Americans, in particular, carry a disproportionate share of the disease burden in the EMA across jurisdictions.

Service providers in the EMA report an increasing number of immigrants from Latin America, the Caribbean and Africa. As the EMA sets priorities and allocation amounts, the Planning Council will keep in mind how an increasing immigrant population might affect the HIV financing and delivery system. Linguistic, cultural and clinical requirements for an immigrant population require special services and more resources. Other challenges of serving an a large immigrant population include locating appropriate resources for clients with undocumented residency status, reducing language barriers for individuals with no or limited English proficiency, increasing accessibility of services for uninsured individuals and families, and treating persons with advanced HIV disease and co-morbidities that are more common in other countries, such as tuberculosis.[24]

According to the U.S. Census Bureau estimates for 2006, the percentage of persons age 5 and over who do not speak English proficiently in the Washington D.C. EMA is 8%; in the District of Columbia, it is 7.1%, followed by Maryland at 5%, Virginia at 4.6% and West Virginia at 0.8%. However, the distribution of population in each of the counties and cities within the EMA is quite different. The largest proportions of persons who do not speak English well reside in the following top five counties and/or cities within the EMA: Arlington County (16.6), Fairfax City (15.0%), Alexandria City (14.3%), Fairfax County (13.2%) and Montgomery County (12.9%). This reflects clustering in the four Northern Virginia counties and one county in Suburban Maryland.[25]

In alignment with goals established by the national health agenda, Healthy People 2010, the EMA has prioritized services and programs that target special populations and racial/ethnic minority communities disproportionately affected by HIV. This will enable the EMA to improve health outcomes for racial/ethnic minority groups by identifying and linking people into care at earlier stages of the disease.

Men Who have Sex with Men (MSM)

A September 2005 CDC report indicates that 6.5% of men have engaged in male-male sexual behavior.[26] However, MSM (including MSM who inject drugs) account for 33% of people living with HIV/AIDS in the EMA and 30% of the AIDS cases diagnosed between January 1, 2006, and December 31, 2007, demonstrating a clear disproportionate impact of HIV/AIDS on this population in the EMA.

Injection Drug Users (IDUs)

Injection drug users (IDU), including men who have sex with men and inject drugs, make up approximately 17% of people living with HIV or AIDS in the EMA. Two-thirds (66%) of IDUs living with HIV/AIDS in the EMA reside in the District of Columbia, while the remaining one-third live in the other jurisdictions of the EMA.

Although each state captures the data about the relationship between IDU and race/ethnicity a little differently, it is clear that African Americans are over-represented in this exposure category. Between 2001-2006, a disproportionate number of individuals exposed to HIV through IDU in the District of Columbia were African American (94% of the individuals diagnosed with HIV and 95% of the individuals diagnosed with AIDS).[27] In West Virginia although African Americans only comprise 3% of the total population, they account for 25% of those who became HIV positive due to risks associated with IDU.[28] In 2006, 68% of individuals diagnosed with HIV/AIDS in Virginia who reported IDU as a risk were also African American.[29] Similarly, Maryland reported that of all African American males living with HIV, 38% indicated that they were exposed as a result of IDU.[30] According to the CDC, the national average for this statistic is 9%.[31] Therefore, addressing the treatment and prevention needs of the IDU population also addresses the disparate rate of HIV among African Americans in the District.

Transgendered Individuals

HIV providers in the EMA report and document an increasing numbers of transgendered individuals entering into care. Research reveals that this group experiences severe employment, housing, and health care discrimination and may engage in behaviors that put them at high risk for HIV.[32]

The Virginia Department of Health in 2003 conducted a study entitled *The Virginia Transgender Health Initiative Study (THIS)* to examine the barriers to care for the transgendered population. The study used a focus group format. There were seven focus groups with 48 participants. Results revealed a variety of barriers across life domains that affect the ability of transgendered individuals to access health care. Transgendered individuals are not able to get adequate health insurance due to discriminatory practices. Even with health insurance, health care providers are not culturally sensitive. This is compounded for those with HIV because many medical providers are not knowledgeable of hormones and their potential interactions with HIV medications. The study recommended cultural competency training for medical, social service, shelter and transitional housing providers; specialized medical training for providers who care for transgendered individuals; and expansion of culturally appropriate outreach strategies and education materials targeting the transgendered individuals at risk for exposure to HIV.

Formerly incarcerated PLWH/As

The EMA's criminal justice system is large and complex. Multiple correctional systems operate in the EMA—one in each of its four jurisdictions plus the federal system and numerous county and regional systems. The eleven counties and six cities in Northern Virginia are home to 25 different state, county, and regional correctional and detention facilities.

The criminal justice system plays a large role in the lives of many of the EMA residents. Although 60% of the District of Columbia's population identify as African American, African Americans comprise 89% of the inmate population who are in prison or jail or on probation, parole, or pretrial release, according to the District of Columbia's Department of Corrections Facts & Figures 2008.[33] This has broad reaching implications for the continued disproportionate impact on African Americans in the District. In the District of Columbia alone, 21,000 people pass through local correctional facilities each year. Over 2,500 former prisoners return to the EMA each year from facilities located outside of the area. This includes former prisoners from the federal system and from local jails and detention facilities in the States comprised in the EMA. In 2006, of the individuals with active cases with the Maryland Department of Corrections, 25% of the population or 16,385 individuals resided within the five counties associated with the D.C. EMA.

The federal, state and local prison population within the EMA has hundreds of diagnosed cases of HIV and AIDS. In the District, 15,966 incoming inmates were screened for HIV between June 2006 and August 2007.[34] Heterosexual contact and non-injection drug use were the primary risk factors among those identified as living with HIV/AIDS in this screening. In 2003 in Maryland, 988 incarcerated individuals had HIV infection and 253 had AIDS for a total of 1,241 incarcerated individuals or 4% of the incarcerated population. In Virginia, there were 361 incarcerated individuals with HIV infection, representing 1% of the state's incarcerated population. This number reflects inmates receiving HIV care while in the detention center. In West Virginia, 14 prisoners had HIV infection and two had AIDS, for a total prevalence rate of 0.4%.[35]

Of additional concern is the connection between drug use and incarceration. According to the D.C. Department of Corrections, "drug-related offenses" accounted for nearly 24% of those incarcerated in 2008; nearly double the rate of incarceration for any other type of offense.[36] Drug use can lead to an increase in high-risk behaviors including sharing needles, trading sex for drugs/money, multiple sexual partners, and/or a decreased capacity to negotiate condom usage. According to the District of Columbia's Addiction Prevention and Recovery Administration (APRA), over one-third of reported HIV/AIDS cases in the District of Columbia are connected to substance abuse and approximately 12% of APRA patients have HIV/AIDS.[37] Without significant programming to address the primary medical needs of formerly incarcerated individuals including substance abuse treatment and prevention for positives, those individuals may be at risk for recidivism and for spreading HIV in the community. Pre-release planning around emergency and short-term housing needs, job readiness and placement services are essential for re-integration into the community.

Homeless

The EMA utilizes the U.S. Department of Housing and Urban Development's definition of homelessness that includes individuals residing in a place not met for human habitation, such as cars, parks, sidewalks, abandoned buildings, or on the street as well as individuals living in an emergency shelter, transitional, or supportive housing program.[38] An estimated 5,751 individuals in the EMA were homeless when diagnosed with HIV/AIDS, representing 49% of the total 11,752 homeless individuals in the EMA identified in the 2008 homeless enumeration report[39,40] and 13.6% of total PLWH/A in the EMA on December 31, 2007 Homeless

individuals experience higher rates of morbidity and mortality; increased barriers to care and prevention such as substance abuse, lack of insurance, mental illness; and challenges to adherence.[41] Because of these risks, the Planning Council is working to support strategies that facilitate early entry into and maintenance of care for homeless individuals.

Women

Early in the epidemic, HIV/AIDS was a disease that primarily affected gay and bisexual men. Nationally, women accounted for about 23% of living adult and adolescent AIDS cases at the end of 2006. In the EMA 28% of living AIDS cases are women. Among newly diagnosed AIDS cases women account for one-third (33%) of AIDS cases diagnosed between January 1, 2006, and December 31, 2007. Similarly, women account for 33%of the estimated number of people living with HIV (not AIDS) as of December 31, 2007. The impact on black women is even more striking. For example, in the District of Columbia, African American women constitute 58% of the female population, but accounted for 90% of all new female HIV cases as reported in November 2007.[42]

Conclusion

When compared to the nation as a whole, the Washington, D.C. EMA is disproportionately impacted by HIV/AIDS, with the EMA having approximately twice as many living AIDS cases per 100,000 people as the nation as a whole. The epidemic in the Washington D.C. EMA is a modern epidemic with an estimated 42,085 people living with HIV/AIDS, 63% residing within the urban boundaries of the nation's capital. The District of Columbia had the most cases and the highest mortality rate in the EMA. The minority community of the EMA is disproportionately impacted by HIV with 82% of cases being classified as racial/ethnic minorities although the EMA total population is only 46% minority. The greatest impact of HIV /AIDS is among persons described as Black/African American with 2% of all Blacks in the EMA estimated to be living with HIV/AIDS. Male sexual contact continues to be the leading mode of exposure reported for all cases, followed by heterosexual sex. The majority of estimated living cases are aged 30-49, accounting for 62% of all cases. Although the number of newly diagnosed AIDS cases has decreased, there was an increase in the estimated number of people living with HIV in the EMA. Among AIDS cases, despite declines in the number of newly diagnosed AIDS cases, a significant number of AIDS cases continue to be diagnosed with AIDS less than 1 year after learning their HIV status. Because the Washington D.C. EMA is comprised of 4 different states, the EMA must monitor differences in each jurisdiction. As the Washington D.C. EMA looks to design systems to promote equal access to care it is important to continue to research affected populations, keep in mind the differences and similarities among the jurisdictions and promote health care access to groups most at risk for HIV.

Chapter 3: History of the Response to the HIV Epidemic

Most consider 1981 as the year acquired immune deficiency syndrome first emerged in the United States. The June 5, 1981 issue of *Morbidity and Mortality Weekly Report (MMWR)* discussed unexplained rare cases of pneumonia. By 1982, researchers determined that the cause was an infectious agent named human immunodeficiency virus (HIV). Each jurisdiction within the Washington D.C. EMA found itself responding to the HIV virus and affected groups.

Washington D.C. EMA was among the first funded EMAs under the Ryan White CARE Act (now known as the Treatment Modernization Act). The early EMA included the District, along with the counties and cities in Maryland and Virginia closest to the District. In the mid-1990s, the EMA was significantly expanded to include additional rural jurisdictions in Maryland, Virginia, and West Virginia adjacent to the original EMA. This addition increased the number of PLWH/As needing service coordination, almost tripled the geographic area and created a rural component of care for planners in the EMA. The geography of the EMA is a constant challenge to the Washington D.C. EMA since treating HIV/AIDS goes beyond a prescription, it requires continuum of interconnected, wrap-around services to address HIV/AIDS and associated needs concomitantly. While each jurisdiction has overcome obstacles in the past, there are continuing new challenges as the epidemic takes on new faces.

While each region's historical response was relevant to those in the region who were affected initially, there are common themes among the jurisdictions: locally mobilizing a multi-agency response, developing comprehensive approaches bridging prevention and treatment and demonstrating genuine concern for those affected. Each jurisdiction has shown a willingness to confront challenges and to work with other members of the EMA to overcome barriers. Lastly, each jurisdiction has shown compassion in dealing with an at-risk population that has become increasingly impoverished and marginalized.

A chronology for each jurisdiction's experience follows. This helps to remind all stakeholders of the history and steps taken to create a multi-faceted service continuum within the EMA.

District of Columbia

Both the Department of Health and the Planning Council for the Washington D.C. Region have been proactive in its response to HIV/AIDS in the District. The chronology lists key legislative mandates and mayoral orders in the District of Columbia.

- In April 1983, the first Forum on AIDS hosted by Whitman-Walker Clinic was held at George Washington University and 1,100 people attended.
- In August 1983, the Whitman-Walker Clinic received the public funds for an AIDS Hotline. This was the first public funding in the country.
- The Director of the Department of Human Services amended Chapter 5, Title 8, and District of Columbia Health Regulations to require that all AIDS cases be reported to the Department of Human Services, Commission of Public Health, effective October 7, 1983.
- In 1983, Chapter 20, Title 29 of the D.C. Code of Municipal Regulations was amended to permit financial assistance for payment of health benefit premiums for unemployed persons infected with HIV/AIDS.
- In 1985, The Mayor, in response to the emergence of AIDS, established the Office of AIDS Activities in the Commission of Public Health. A DHS Director's Organizational Order to the Agency later changed this to HIV/AIDS. In 1987, the Office of AIDS

Activities (OAA) was established in the D.C. Commission on Public Health. Prior to that time, AIDS was handled within the Bureau of Preventative Health.

- D.C. Act 6-123, effective December 30, 1985, The AIDS Health Care Response Emergency Act of 1985, gave the mayor the power to deal with the emergence of HIV/AIDS. This authority was later delegated to the Director, Department of Human Services on March 1986. With the creation of the Department of Health (DOH), this authority was delegated to the DOH Director in April 2000.

- D.C. Act 6-156 of April 1986 required the Mayor to develop a comprehensive AIDS health-care response plan, to investigate the need for a residential health care facility for AIDS patients, and to establish an AIDS Coordination Office.

- Mayor's Order #88-209 of September 1988 mandated that each government agency should designate an AIDS Coordinator responsible for development and implementation of an AIDS education plan of action within each respective agency.

- In 1989, the Metropolitan AIDS Services Coalition (MASC) was established bringing together AIDS service providers and PLWH/As from the District, Maryland and Virginia to meet monthly at the Reeves Center. This group discussed issues, made recommendations to public officials, advocated for services, developed planning activities, and raised concerns. This group was the foundation for the Ryan White Planning Council, the D.C. Care Consortium, and the 1990 planning activities for the first D.C. Comprehensive Plan 1992-96.

- In 1989, the Board of Education amended Chapter 10, of Title 5, of the D.C. Municipal Regulations, to establish procedures governing the school system's conduct/response to employees/students with communicable diseases including HIV/AIDS.

- D.C. Law 7-208, effective March 16, 1989, amended the Prohibition of Discrimination in the Provision of Insurance Amendment Act of 1988. The 1989 amendment permitted life insurance companies to request an HIV/AIDS test of any individual applying for life insurance. It also specified the conditions of the test, informed consent, strengthened confidentiality requirements and revised penalty provisions for breach of confidentiality.

- D.C. Act 8-284, the Real Estate Transaction Amendment Act of 1990, amended the D.C. Real Estate Licensure Act to discourage discrimination against owners and occupants of real property, including individuals with HIV/AIDS. It was effective 12/14/90.

- Spring 1991, the Ryan White Planning Council and the D.C. Title II CARE Consortium were formed. The Mayor approved the first Washington D.C. EMA Comprehensive Plan for Ryan White Services later that year.

- D.C. Act 9-299, effective November 23, 1993, provided that following death, the medical certification of cause of death be restricted from distribution unless specifically requested by family members, legal representatives, insurers and other official representatives.

- D.C. Act 9-252, effective March 25, 1993, amended the Drug Paraphernalia Act of 1982, to provide an exemption for hypodermic syringes and needles, which are distributed by the Commission of Public Health as part of a defined needle exchange program.

- In January 1993, the Director of DHS adopted guidelines for the placement of children with HIV in childcare placements.

- In May 1994, the first HIV Prevention Community Planning Committee (now called the HIV Prevention Community and Planning Group) was formed to address the HIV/AIDS prevention needs of residents within the District of Columbia.

- In 1995, the Commission of Public Health developed a series of policy initiatives to reduce the peri-natal transmission of HIV, suggesting that all adults and adolescents, especially pregnant women, receive HIV counseling and testing as part of their comprehensive medical care.

- D.C. Act 11-101, effective March 22, 1996, amended the Drug Paraphernalia Act of 1982, to allow qualified community based organizations or other qualified individuals, specifically designated by the Commission of Public Health, to exchange needles and syringes under the Needle Exchange Program in the District of Columbia. The Federal Government banned the District to use local dollars to fund needle exchange in 1998.

- In August 26, 1997, the Mayor ordered the establishment of the D.C. Community HIV/AIDS Advisory Committee and appointed 40 public members.

- In March 2006, The D.C. Appleseed, a non-for-profit advocacy group[43] responsible for monitoring progress in HIV within the District, issues the first report card to chronicle achievement or lack there of for HIV/AIDS in the nation's capital.

- On April 4, 2007, The Mayor convened an HIV/AIDS summit that pulled together 120 representatives from government, provider, faith-based and community organizations to brainstorm how the HIV/AIDS Administration could improve response to the epidemic. Key stakeholders identified strengths and weaknesses. Key findings from this Summit included: more community involvement, increased accountability, sustained leadership and increased collaboration and communications across agencies.

- On November 26, 2007, the Washington D.C. health office released its first report since 2000 on HIV/AIDS in the city. According to the report, "one in twenty district residents are HIV positive and one in 50 is living with AIDS".[44]

- In 2004, the District of Columbia changed from code to names reporting of HIV.

- In 2008, the ban was lifted for use of local dollars to fund needle exchange services.

- In September 2008, The D.C. Appleseed report card recognizes that the government has made important strides in combating the disease but still finds the HIV/AIDS epidemic poses an ominous treat to residents.

Maryland

The AIDS Administration of the Maryland Department of Health and Mental Hygiene was established in 1987 and spearheaded efforts in Maryland. From the beginning, there was a multi-agency response in Maryland with early collaboration among administrations in Alcohol and Drug Abuse, Family Health, Community Health and the Mental Hygiene Administration. The intent was to ensure an integrated approach to care for persons living with HIV/AIDS. At the local level, county and city health departments offered prevention, counseling and testing, and, eventually, added treatment services.

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 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. In addition, PLWH/As in the state came together, and became a significant force and outspoken advocates for prevention and treatment services across Maryland.

Initially, HIV services were funded through state general funds and federal HIV demonstration grants. When Part A funds became available to the Washington D.C. EMA in 1991, the 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. As the rate of new of HIV/AIDS 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 targeted communities and provided technical assistance and capacity building to assist CBOs in becoming independent Ryan White-funded vendors. In the early 1990's the Suburban Maryland HIV Alliance developed as a coalition of public and private agencies providing services to PLWH/As and participated in collaboration with the Prince George's County Health Department in the first needs assessment for both Title I and Title II funds (now Part A and B).

Once HRSA expanded the geographic area of the Washington D.C. EMA, the PLWH/As living in these suburban and rural counties surrounding Montgomery and Prince George's counties saw expansions in the availability of services. As with other parts of the EMA, service delivery systems in Maryland have adapted to the changes in treatment methodologies and the changing demographics of persons living with HIV/AIDS in Maryland.

Key milestones of the governmental and community response to HIV/AIDS in the state of Maryland are outlined chronologically below:

- Starting in1983, numerous organizations and groups across the state formed to address AIDS issues at the local level including the St. Mary's County Commissioners' AIDS Task Force, which was formed in 1986.

- In 1987, the AIDS Partnership Council of Maryland formed, bringing together providers and PLWH/As from across the state to meet on a regular basis, primarily in Columbia and Baltimore, to discuss issues, develop advocacy strategies, and increase public awareness.

- In 1988, the Maryland Department of Human Resources in Baltimore City established the Women's Services AIDS Task Force. Providers, PLWH/As, and government officials met regularly to discuss the needs and issues of women and children.

- In 1989, the Maryland Department of Health and Mental Hygiene created the HIV Services Coordinators Network where program staff from across the state came together to improve service delivery and raise public and agency staff awareness in coordination with State officials.

- In 1997, the Maryland Medicaid Program implemented its managed care program, HealthChoice to provide special capitation rates for HIV and AIDS and to reimburse participating managed care organizations (MCOs) for the care of HIV positive clients.

- Maryland continues its work to improve collaboration with key agencies, to improve communications with communities across the state and to work for improved financing of HIV medical care.

- In 2008, Maryland instituted names reporting for HIV.

Virginia

The first case of AIDS was reported in Virginia in 1982. HIV became reportable by name in 1989. The Virginia Department of Health began its first HIV prevention services in 1985 with the establishment of an AIDS Hotline. Virginia was the first state to offer routine HIV testing in STDs (sexually transmitted disease) clinics in 1986.

In 1983 prior to the passage of the CARE Act and the award of Part A funds to the EMA, the public health departments in Northern Virginia joined forces with interested non-profits and formed the Northern Virginia HIV Consortium. A system of care was developed for HIV testing, almost exclusively provided at the local health departments. With the advent of Part A funds, persons testing positive at the health department were immediately referred to treatment services.

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/As living in the rural areas of Virginia. Infectious disease specialists previously unavailable to PLWH/As then became willing to work with the Virginia administrative agency to develop clinics and other systems to provide services in rural area. These systems have changed over the years, but what remains in place is a network of support service and treatment providers striving to insure that the widest range of services are available to PLWH/As no matter where they live in Northern Virginia.

As treatment methodologies have changed, access to care has expanded, with a focus on providing the consumer a range of services from multiple points of entry. A variety of confidential and anonymous testing sites is found at both public and private non-profit providers. PLWH/As who learn of their status elsewhere and move into the region choose their own access point, through case management, primary medical, or other service providers.

However, new challenges are facing Northern Virginia area. Increasing demand for HIV services and extended survival of clients are outstripping capacity and funding. Many clients are not able to transition to federally funded entitlement programs for health insurance and income assistance. This creates enormous challenges as HOPWA and Ryan White funds, which must serve as the payer of last resort.

West Virginia

Ryan White Part A funds became available to support services in Berkeley and Jefferson Counties in the mid-1990 with the expansion of the Washington D.C. EMA. The proportion of the EMA's PLWH/As living in West Virginia remains very small, at less than 1%. The decision to dedicate funds to the Rural areas at a minimum of 1% of the funds was made to provide West Virginia with sufficient funding to supplement services offered to PLWH/As through the local health departments and the Veterans Administration Health Services. The Veterans Administration provides a comprehensive range of services for veterans in West Virginia area.

The "Rural Set Aside" funds had a significant influence on the EMA's ability to enhance services in the outlying areas of the EMA. Today, the services supported with Part A funds are provided by one agency, the AIDS Network of the Tri-State Area based in Martinsburg, West Virginia. That agency is also instrumental in representing PLWH/As in Berkeley and Jefferson counties to the state's Health Department and its statewide planning bodies.

Conclusion

Each jurisdiction found itself working on the frontlines against HIV/AIDS. The history reflects their dedication and perseverance. The history shows both similarities and differences in the responses by each jurisdiction in tackling such issues as the inclusion of HIV specialty services into public health funding, needle exchange programs, and the role of informed consent in HIV screening. Planning for care in the Washington D.C. EMA requires each entity to represent their constituency but also plan for the EMA as a whole. For the Planning Council and the Grantee, understanding the historical response to HIV in each jurisdiction impacts the design of today's service continuum and the plan for ensuring equitable access to PLWH/A throughout the EMA.

Chapter 4: Assessment of Care and Prevention Needs

This chapter discusses activities conducted to collect information about the need for services among PLWH/A. It is a legislative requirement that EMAs conduct needs assessments so they can better plan on how to use the EMA's resources to fill in gaps in care. The focus of planning is to understand the primary health care needs of those both in and out of care. The needs assessment process includes developing an epidemiological profile (discussed in a prior chapter), collecting information from people living with HIV through focus groups, surveys and community forums, developing a resource inventory, and assessing service needs.

For the EMA, the needs assessment processes requires the coordination and integration of information from a variety of sources specific to each jurisdiction. As part of the process the jurisdictions look to examine the needs of consumers in care and out of care as well as emerging

populations. To do this the EMA uses several sources. First, the Grantee works with representatives across the different Parts of the CARE act to determine the Statewide Coordinated Statement of Need (SCSN) for the District of Columbia. It is then the job of the Planning Council and the Grantee to examine the SCSN produced in D.C., Maryland, Virginia, and West Virginia for similarities and for differences. Second, the EMA conducts needs assessment studies for each jurisdiction. Every other year the EMA conducts focused interviewing groups (FIGS) and client surveys to determine met and unmet needs for each jurisdiction. The Planning Council and Grantee must then coordinate these FIGS and surveys into an EMA-wide needs assessment Overall, the challenge for the Planning Council is then coordinate all of this information into a flexible and equitable system of care for PLWH/A.

This chapter begins by looking at gaps in care and prevention needs as reflected in the respective Statewide Coordinated Statements of Need; the needs identified from the Council's 2008 FIGS with targeted populations in the different regions of the EMA; the EMA's estimated unmet need; the 2007 client survey; resource directory; and a discussion of next steps.

Statewide Coordinated Statement of Need

The State government of each jurisdiction is required to develop a Statewide Coordinated Statement of Need (SCSN). The intent of the SCSN process is to increase the collaboration, cooperation, leveraging and linkages of activities and funding among the Ryan White providers in a respective jurisdiction. The outcome of the SCSN process is to identify emerging trends in HIV/AIDS health and support services, critical gaps in services and the cross cutting issues across all parts of a State. The SCSN includes input from consumers and providers throughout the jurisdictions.

The Washington D.C. EMA is unique in that four different SCSNs are reviewed, and the Planning Council seeks to identify common themes as well as unique differences important to sustaining care in each jurisdiction. The Washington, D.C. EMA reviews the results of each SCSN process during its annual priority setting resource allocation process. Table 11 summarizes the issues identified in the last SCSNs from the District of Columbia, Virginia, Maryland and West Virginia. This chart helps to summarize the similarities and differences among consumers and providers in each of the jurisdictions.

This data was used as a basis for planning Part A resources in the EMA during the 2008 priority setting and resource allocation process.

Table 11: Summary of Issues Identified in the SCSN of Each Jurisdiction

Issues	D.C.	VA	MD	W.VA
Emerging Trends – "Evolving circumstances, polices, procedures or resources that affect service delivery"				
Increasing co-morbidity of HEP- B and care complications	X			X
Increasing co-morbidity of HEP-C and care complications	X	X	X	X
High risk for co-infection of Tuberculosis and HIV	X	X	X	X
High rates of substance abuse and the difficulty of care issues for IDUs substance abuse	X	X	X	X

Issues	D.C.	VA	MD	W.VA
Increasing use of crystal methamphetamine and the likely rise in new HIV infections	X			
Impact of the Ryan White Reauthorization and the modification of formulas from AIDS cases to include number of living HIV cases			X	
Implementation of Medicare Part D and its impact on case management services, including increased access to entitlement specialists for the full range of entitlement needs			X	X
Using “Rapid Response Teams” to target testing for high risk groups such as MSM, substance users			X	X
Transitioning HIV+ youth into adult care programs			X	
Improving capacity to calculate unmet need estimate			X	
Need for pre-release services for HIV+ incarcerated and newly released persons		X		X
Lack of service providers specifically dental, infectious disease and other specialty care		X		
Need for mobile medical services for hard-to-reach and rural populations		X		X
Increased availability of counseling services for long-term survivors				X
More treatment adherence services in order to decrease antiretroviral resistance and improve health status				X
Increasing need for mental health services	X	X	X	X
Enhanced ability to provide services for HIV infection among women/pregnant women, adolescents and aging populations newly entering into care				X
Critical Gaps and Barriers to Service -				
Housing services	X	X	X	X
Case Management	X	X	X	X
Transportation	X			X
Cultural sensitivity, specifically the need for interpretation services	X	X		
Dental	X	X	X	X
Discharge planning for the incarcerated and newly released sub-populations	X	X		
Substance abuse treatment	X	X	X	X
Ambulatory outpatient services, specifically accessibility and reduction of waiting lists	X	X	X	X
Medication and treatment adherence	X	X	X	
Mental Health treatment	X	X	X	X
Prevention and education		X	X	
Funding		X		X
General need for a wide range of support services		X		
Food assistance		X		
ADAP waiting list				X
Geographic discrimination				X
Breaches of confidentiality				X
Ignorance and stigma				X
Fear of disclosure				
Lack of knowledgeable HIV care providers		X		X
Lack of communication between primary care providers and HIV care providers				X
Lack of a strong effective lobbying system				X
Fragmentation of special interest groups				X

Issues	D.C.	VA	MD	W.VA
Improved collaboration among rural areas to address disproportionate funding and disparities in care				X
Continued integration of HIV awareness into faith communities				X
Cross Cutting Issues – "Concerns shared by a number of CARE partners"				
Coordination of care among CARE Act providers	X	X	X	X
Expansion of Client Level data, specifically standardization among all CARE providers			X	
Client self-management techniques as clients are benefiting from antiretroviral therapy			X	X
Stigma and discrimination at various levels of care and as it impacts limited English proficient populations, residents in rural areas, GLBTQ persons, incarcerated persons, homeless persons, substance abusers and youth		X	X	
Vocational training is needed for PLWH/A due to improved health status	X	X		
More funding as more persons are identified needing care			X	
Limited housing resources allocated for special needs	X			
Communications through updating a website	X			
Geographical focus – East of the Anacostia River	X			
Accessibility to medical and support services		X		X
Ensuring providers are maximizing third party reimbursement	X			X
Need for more service monitoring		X		
Certification and training for providers to improve quality of services		X		
Stability of the ADAP program in order to eliminate a wait list				X
Reduce unmet need through collaboration across Ryan White Parts A-F				X
Increase parity of services regardless of geographical location				X
Improve the capacity of HIV/AIDS service agencies				X

Recent Needs Assessments

The Ryan White planning process mandates that Planning Councils conduct needs assessments that examine the unmet health care and service needs of PLWH/As. HRSA encourages EMAs to seek information on both unmet needs and service gaps. "Unmet need" is defined as the need for health care by those who know they have HIV but are not currently receiving primary care. A "service gap" is the need for a non-medical service. Over the years, the Planning Council has conducted or participated in various needs assessment activities to gather data around the unmet need and service gaps for residents of the EMA. The Planning Council uses an alternating schedule of FIGS or client surveys to assess need. Through these activities, the Planning Council aims to identify unmet needs, trends in service utilization, priorities, gaps and barriers.

Focus Interviewing Groups (FIGS)

The most recent needs assessment undertaken in the EMA occurred in 2008 using a focus interviewing group (FIGS) format. The FIGS were designed to capture the services accessed by target population and region. The FIGS targeted the following populations: African American heterosexual women in D.C. and MD; African American MSM in D.C.; Latino/as in D.C. and Northern Virginia; persons living with hepatitis C in D.C.; homeless individuals in D.C.; and

community forums in Maryland, the District of Columbia, and West Virginia. The process gleaned information on, "what services were working, what services were not working, retention in care factors and gaps." Sixty-nine individuals participated in seven focus groups. The members of the groups were reflective of the population represented. The results of these groups shed light on the barriers clients face in accessing and maintaining care in each of the jurisdictions.

African American Heterosexual Women- D.C. and MD Groups

African American heterosexual women in both the District and Maryland accessed a similar array of services. Participants in these groups accessed services in both the core medical areas including primary medical care, case management, and substance abuse treatment and the support services areas including emergency financial assistance, and housing. Women in the District mentioned access to vocational rehabilitation services not currently funded under Ryan White sources as a service gap. In the District, participants reported that case management services were particularly helpful while in Maryland participants mentioned that primary care physicians and medical care were superior.

For women in the District, service problems centered on case managers' lack of knowledge about comprehensive resources, inability to properly inform clients about eligibility and referral processes for different services, and lack of understanding about re-certification needs for entitlement services Women also reported a lack of food services and food vouchers, a need for water filters, long wait list for oral health services, limited affordable housing options, lack of physicians specializing in HIV care and inadequate transportation.

African American women in Maryland found concerns with the high case management caseloads negatively impacting service quality, long waits for food vouchers and limited access to childcare services particularly when they were not feeling well.

Both African American women in the District and Maryland stated that limited access to primary care prior to their HIV diagnosis presented limited options for early testing. Furthermore, both groups stated that they were not offered HIV testing during regular pre-natal visits.

Service gaps identified by African American females were common, stressing the need for more counseling and support around disclosure of their HIV status and the need for a newsletter on services so members could do more on their own identifying and securing resources.

African American MSM- D.C. Group

The group cited mental health services as the primary service accessed, and there was general satisfaction with this service. The group expressed concern about the lack of culturally competent providers sensitive to their sexual orientation. The members thought that because young people no longer see the early devastating effects of the disease, HIV prevention education should be increased to help young persons understand their risk for HIV. Participants did not think health care providers were doing a good job of making clients aware of the side effects of medications and discussing the meaning of lab work. Participants cited the social stigma attached to being HIV-positive as a barrier for clients to access services. Participants

thought that stigma was especially true for substance abuse and mental health treatment services. Reported service gaps encompassed the need for chronic health services, more complimentary/alternative care services, and more cultural competence training for providers.

HIV Positive Persons living with hepatitis C- D.C. Group

Participants cited rising housing and utility costs, declining incomes, and lack of subsidized housing as a major barriers to maintaining stable housing. Members felt that the co-morbidity of hepatitis complicated medical care and made it difficult to navigate the health care system. Transportation remains a huge barrier to care for participants of this group. Participants reported severe side effects to the hepatitis treatment limited their ability to work. But for most participants the side effects did not qualify them for disability benefits from the Social Security Administration. This creates a barrier for clients to maintaining hepatitis treatment. The group felt that care was fragmented and a "one-stop" venue for medical care would make it easier. Unfortunately, participants found that many HIV medical providers were not knowledgeable about hepatitis C and recommended better coordination between HIV and Hepatitis C providers. Participants felt that services could be improved with peer educators.

Latino/a- D.C. and Northern Virginia Groups

The groups in both the District and Northern Virginia cited access to quality medical and support services as high needs. The D.C group cited a need for more available interpreter service, but the Virginia group did not cite interpreter services as a need. The Northern Virginia focus group reported consistent problems with key staff not knowing Spanish and because of that they felt language was a barrier to care. Stigma was mentioned by both groups as problematic in the provider setting and within their community. The participants thought counseling services were important and in Northern Virginia, one participant stated that it took seven years for the center to get a Spanish-speaking therapist. The Latino group in Northern Virginia stated that the traditional hours of operation were a barrier to care since many worked during these hours. The Latino group in the District did not report any anti-immigration problems but the Northern Virginia group feared the possibility of deportation when accessing services. In the District and Northern Virginia, both Latino participants expressed a need for support counseling in dealing with the medication side effects as well as more information about strategies for living with HIV. Additional needs expressed by the D.C. group were water filters and oral health services. In Northern Virginia legal services was mentioned as a service need.

Homeless- D.C. Group

Participants in this focus group expressed satisfaction with services and stated that their case managers often attended medical care appointments with them and discussed their medications often. They commented that the case mangers made them feel "real." Participants reported that their lack of stable permanent housing created problems with confidentiality, loss of important papers associated with HIV, loss of prescriptions and difficulty receiving mail. Participants cited gaps including a clothing bank services, spiritual groups, transportation and housing.

All Groups- Retention and Recruitment into Care

As a surrogate for "out of care" issues, all groups commented on what factors kept them in care. The following are reasons identified across groups:

- Feeling that service needs are being met.
- Wanting to live and be healthy.
- Feeling a responsibility to their friends and love ones.
- Experiencing a sense of responsibility to those who have died.

Maryland Forum

Forty- two individuals participated in a community form in Maryland in November 2008. Demographics of the forum reveals 60% males, 38% females and 2% transgender, 36% were 50 and older, 29% were ages 35-44, 10% ranged in ages from 19-24, 14% ranged in ages 25-34 and 12% ranged in ages 45-49. Sixty-nine percent were Black/African American, 9% were Latino, 2% were American Indian/Alaska Native, 2% were Asian and 2% were Other. Thirty-eight percent indicated they were "men who have sex with men", 2% were injection drug users and 7% reported Other as their HIV exposure category.

The forum used a breakout group format based on demographic characteristics: a) MSM group, b) African American women's group, c) heterosexual men group; d) Latino/a group. Below is a summary of the issues and concerns identified by each group.

Table 12: Summary of Maryland Forum

Problems and Concerns with HIV/AIDS Services identified at the Maryland Forum	MSM	African American Women	Heterosexual Men	Latino
Case management service issues including sensitivity, knowledgeable of services, cultural and linguistically competent and follow up	X	X	X	X
Transportation	X	X	X	
Need for referrals	X			X
Medication adherence assistance	X			X
Stigma associated with being HIV positive	X			
Prevention education, including need for materials in Spanish	X			X
Housing services		X		
Limited publications about HIV/AIDS services		X		
Food vouchers		X		
Doctors not diagnosing HIV soon enough		X		
Better counseling for the newly diagnosed		X		
Limited clinic hours		X		
Immigration issues (status and service barriers)			X	X
Support groups for heterosexual males			X	
Need for "buddy companion" services			X	
Lack of communication between HIV/AIDS case managers and social service case managers			X	
Insurance			X	
Requirements for accessing medical care				X

Problems and Concerns with HIV/AIDS Services identified at the Maryland Forum	MSM	African American Women	Heterosexual Men	Latino
Limited options for care				X
Language barriers				X
Insufficient number of culturally competent case managers				X
Need for free condoms				X

Participants made a wide range of recommendations including more culturally and linguistically appropriate case management services, more services to encourage client self-management, improved communication between clients and primary care providers, more assistance in completing complicated paper work, increased access to substance abuse and mental health services, expanded Buddy services, case management, psychosocial groups, medication adherence and transportation.

West Virginia Forum

Seventeen individuals participated in the West Virginia Forum. Demographic profile of participants included 82% males and 18% females; 18% were 35-44 years of age, 18% were 45-49 years of age, 65% were 50 years of older. Fifty-nine percent were Black/African American, 24 % were White (non-Hispanic) and 12% were 'Other." Fifty-three percent reported heterosexual transmission, 12% identified male-male sexual activity as their mode of transmission, and 12% identified risk behavior associated with injection drug use as their exposure category.

Participants expressed concerns and problems covering a wide range of matters, including problems with food vouchers, not being able to make medical co-payments, lack of support groups, need for more culturally reflective service providers, increased confidentiality, lack of transportation for Planning Council participation and medical services.

Participants raised a number of service delivery issues. Participants reported that providers were inflexible and uncaring and that communication between clients and primary care providers were difficult and not culturally competent. Some clients commented they experienced racism when interacting with providers.

Recommendations for an improved service delivery system included better information on housing services, knowledgeable legal services and vocational services including employment readiness and flexible job placement.

Participants identified numerous support factors to improve client retention rates including increased access to nutritional assistance, stable housing, peer-to-peer counseling, financial assistance and spiritual counseling. Participants also emphasized the need to incorporate outreach strategies into care programs to re-engage clients who fall out of care.

District of Columbia Community Forum

In May 2008, the District of Columbia hosted a community forum that attracted 69 participants. PLWH/A were asked to complete a survey that listed service categories and then asked participants to identify those that they had accessed within the past 12 months, as well as those services that they needed but were unable to access.

Tabled (Table 13) below are the survey results for those service categories for which at least 25% percent of respondents reported utilization or an unmet need in the previous twelve months, and ordered by the number of respondents. The table also shows for each service categories the number and proportion of those who needed the service and reported receiving it, and the number and proportion of those who needed the service and reported that the need remained unmet.

Table 13: Service Gaps Indicated by May 2008 Community Forum Participants

Service	Reported Need		Reported Need Met		Reported Need Unmet	
Case management (non-medical)	35	51%	26	74%	9	26%
Psychosocial support groups	29	42%	21	72%	8	28%
Emergency financial assistance	26	38%	13	50%	13	50%
Legal services	25	36%	16	64%	9	36%
Health insurance premiums/cost-sharing	25	36%	18	72%	7	28%
Early intervention services	23	33%	14	61%	9	39%
Rehabilitative services	21	30%	14	67%	7	33%
Medical transportation	19	28%	11	58%	8	42%
Home health care	19	28%	12	63%	7	37%
Child care services	16	23%	3	19%	13	81%
Respite care	16	23%	9	56%	7	44%
Partner counseling (assistance with disclosing HIV status to partner)	15	22%	8	53%	7	47%

Service	Reported Need		Reported Need Met		Reported Need Unmet	
Pediatric developmental assessment and early intervention services	13	19%	4	31%	9	69%
Permanency planning	13	19%	7	54%	6	46%
Linguistic services	8	12%	3	38%	5	63%

Consumer Survey

In 2007, the Planning Council conducted its bi-annual survey of people living with HIV/AIDS. A total of 829 individuals participated in the survey. The survey asked clients to identify services that they needed but were unable to obtain. The largest service gaps identified through this survey were primary medical care (60, 9%); ADAP (52, 9%); oral health care (128, 21%); health insurance continuation assistance (51, 9%); mental health services (61, 11%); and case management (80, 13%).

Estimate of Unmet Need

It is a legislative requirement to estimate, assess and address unmet needs. The Planning Council has used multiple approaches to implement this requirement, including the aforementioned FIGS and community forums. This information is used as a basis for developing this comprehensive plan and for setting targets of population most at risk for disparities in access to health care.

A critical component of needs assessment is estimating the size of the epidemic in the EMA. HRSA has developed a framework in which to make this calculation. The estimation of unmet need in the Washington, D.C. EMA was updated for the FY 2009 application. The four jurisdictions of the EMA independently completed their met and unmet need calculations using disparate data sets. This creates limitations when combining these frameworks to calculate the EMA-wide unmet need. Below is a discussion of each jurisdiction's unmet need framework.

The District of Columbia estimated met need primarily through linking three databases: the XPRES database, Medicaid, and the HIV/AIDS Reporting System (HARS). Secondarily, Hospital Discharge Data for the District of Columbia was used to ascertain rates of individuals with specific payer mix – private, other public and self. An extract of the 2005 Hospital Discharge Data with selected HIV/AIDS related diagnosis codes provided information on the type of payers in this cohort of population. Additionally, the D.C. Medical Assistance Administration, which implements two HIV waiver programs, provided information on utilization and cost of care. All data sets were first matched using a commercial analytical application, and analyzed using the criteria for evidence of a primary care visit, namely antiretroviral use and CD4 or viral load count.

In the Virginia and West Virginia jurisdictions, met need was estimated from linked provider service database, Medicaid, and HARS. No new sources of data for estimation were used for the 2009 calculation.

In the Maryland jurisdiction, the Department of Health and Mental Hygiene utilized data from the CDC funded Medical Monitoring Project[45] where patient level antiretroviral prescription was extracted from the national IMS Health LRx Database. HARS was used to quantify the total HIV/AIDS cases in the Suburban Maryland region. Additionally, other payer mix, both public and private was used to develop a count of people who received primary medical care.

The use of different methodologies for calculating the separate jurisdictional frameworks poses many data challenges particularly when examining newly diagnosed and living HIV case data for the EMA. This can also be problematic when trend data is reviewed.

Despite this limitation, the frameworks were combined to calculate the EMA's unmet need. The Planning Council deemed the results as reasonable despite the differences. The Unmet need estimation indicates that met need in the Washington D.C. EMA is 56% with the unmet need estimated at 44%. Looking closer, jurisdictional results indicate regional variances.

The total number of cases estimated to have primary medical care in the EMA is 21,167. The total number of cases with an unmet need for primary medical care is 16,420. Table 14 depicts the distribution of cases of both met and unmet need by each jurisdiction within the EMA, and notes the proportion of total cases for which each group accounts.

Table 14: Cases of "Met" and "Unmet" Need by Jurisdiction

Jurisdiction	"Met Need"		"Unmet Need"		Total	
	HIV/AIDS Cases	Proportion	HIV/AIDS Cases	Proportion	HIV/AIDS Cases	Proportion
District of Columbia*	12,510	56%	9,696	44%	22,206	100%
Suburban Maryland	5,847	64%	3,360	36%	9,207	100%
Northern Virginia	2,769	46%	3,233	54%	6,002	100%
West Virginia	41	24%	131	76%	172	100%
EMA Total	21,167		16,420		37,587	100%

***Excludes 25% of estimated HIV Cases for the District of Columbia who are unaware of their HIV status**

The pooled estimate of unmet for the Washington D.C. EMA is 44% or 16,420 cases. These data indicates that the West Virginia jurisdiction has the highest proportion of unmet need for primary medical care, followed by Virginia.

The distribution of unmet need is roughly comparable to the distribution of individuals who are aware they have HIV or AIDS. About 59% reside in D.C., 19.6% reside in Northern Virginia, and 20.4% reside in Suburban Maryland, while close to 1% reside in the West Virginia counties of the EMA.

The relative proportion of cases with unmet need with the distribution of HIV/AIDS cases suggest the disparity of access to care. Despite a high proportion of met need in the District of Columbia, it still carries the highest burden of cases in real numbers.

Resource Inventory

The Washington D.C. EMA funds twelve core medical services and eighteen support services across the jurisdictions. However, Ryan White is only part of the continuum of service needs. Inventories of all resources are available at the EMA, state, and local level to assist PLWH/As in finding needed located geographically close to home. Typically, the first resource used by PLWH/As is often the case manager. Case managers are critical staff to support effective access to services. The case managers use a variety of tools to keep informed including printed Information & Referral Directories, 1-800 numbers, personally maintained resource guides, information from peers, clients, consumers and the internet.

The Internet has become an increasingly effective method of sharing information about services. All the Administrative Agents serving the EMA are accessible by the web. Resource inventories are maintained at the regional level by the Planning Council at http://www.hivservices.com. Links lead to information maintained at the local level, each site using a slightly different approach. In the District of Columbia, information on HIV/AIDS services and providers can be found within the Department of Health's site at http://www.dchealth.dc.gov. This resource directory was recently updated and the new directory will be available at this same web site. For Maryland, the AIDS Administration of the Maryland Department of Health and Mental Hygiene maintains information on testing, counseling, and care services with links to treatment and therapies sites at www.dhmh.state.md.us/treatment/moreresourcePLW. In Virginia, there is a regional resource site at http://novaregion.org/hiv. In West Virginia the website of the primary AIDS service organization http://www.antsa.org provides information on services supported with Ryan White funds. In addition, the Veteran's Administration maintains a site of health care and other services for West Virginia and can be accessed at http://vagov/opa/fact/statesum/wvss.asp.

Conclusion

The needs assessment process enables Washington D.C. EMA to identify common needs, as well as, regional specific needs. This information becomes the basis for priority setting and resource allocation. In addition, it helps to shape recommendations for strategies to improve access to care. However, if the EMA should move from a formula approach to a needs based approach in allocating funds to the various jurisdictions, there will be a need to change the needs assessment strategies. Currently needs assessments focus on clients in care with the use of Statewide Coordinated Statement of Need compiled in the four states within the EMA, focus interview groups, and client surveys. These assessments looked specifically at the needs of special populations in each of the jurisdictions to determine what services clients accessed, what they liked about those services, and what gaps in services they experienced. This data is utilized by the Planning Council and the jurisdictional planning groups as part of the annual priorities and resource allocation process. As the EMA moves forward, there will be a need to gather more comprehensive information about persons not in care.

There is considerable surveillance and epidemiological data on the characteristics of those entering into care at late stages. The Planning Council intends to explore out of care issues within the next planning period as reflected in the objectives outlined for this upcoming planning period.

Chapter 5: The Current Continuum of Care

Introduction

"Continuum of care" is a term used to describe the range of services available to meet the needs of individuals at any point of time for a particular condition. In the case of care for persons with HIV/AIDS, HRSA defines a comprehensive continuum of care as a "a coordinated delivery system, encompassing a comprehensive range of services needed by individuals or families with HIV infection to meet their health care and psychological service needs throughout all stages of illness". This including primary medical care, HIV-related medications, mental health treatment, substance abuse treatment, oral health care, and case management services that assist PLWH in accessing treatment of HIV infection consistent with Public Health Services Treatment Guidelines. In addition this continuum may include supportive services that enable individuals to access and remain in primary medical care".[46]

The Ryan White Part A services program infrastructure in the Washington D.C. EMA must serve residents located in the District of Columbia, five counties located in suburban Maryland, eleven counties and six cities in Northern Virginia and two counties in West Virginia. In some respects this results in four distinct service continuums. Each jurisdiction's continuum is the product of local factors. However, the Washington D.C. EMA has strived to create and support a comprehensive HIV/AIDS primary health care system within every part of the EMA. The core medical services are outpatient medical care, AIDS drug assistance, AIDS pharmaceutical assistance (local), oral health care, early intervention services, health insurance premium and cost sharing, home health care, home and community based health services, day treatment, hospice services, mental health services, medical nutrition therapy, medical case management, treatment adherence and substance abuse services.

Supportive services are also critical in the continuum. In addition to maintaining clients in primary care, improving quality of life, and providing stabilizing factors to help clients maximize adherence to care, supportive services can be the final connection that prevents a client from being lost entirely from the system of services.[47] In addition to the core medical services across the EMA, the jurisdictions through individual priority setting processes add other support services that are based on particular needs and other funding streams available in the region. The exact mixture results from an elaborate planning process that assures input from all segments of the affected population within the four jurisdictions.

The Washington D.C. EMA benefits from an Early Intervention Network, financed through Ryan White Part A, Part B and Part C funds. An important portal into the HIV continuum of care, early intervention services include intensive outreach for medical services that are designed to ensure that hard-to-reach individuals are identified and linked with HIV health and support services. There is a diverse multi-cultural client population in the Washington D.C. EMA. With Part A Minority AIDS Initiative (MAI) funding, the EMA has been able to expand culturally

specific programs that support a "cluster of services." This concept is built around the notion of providing an intensive set of care and support services for very high-risk need clients.

There are 55 Part A funded direct service providers throughout the EMA providing 30 different services.[48] Most of the providers funded are community based organizations (62%) with health departments (11%) next, followed by hospitals (9%), other (7.2%), community health centers (5.4%), solo/group practice (1.8%), substance abuse treatment center (1.8%), community services board (1.8%), and PWA coalition (1.8%). However, within each jurisdiction, the number of providers varies. West Virginia has one provider, Virginia has twelve, Maryland has eleven, and the District of Columbia has 24 providers.

Ryan White funded services are only part of a primary care health system in a community. Most persons with HIV in the EMA are dependent on multiple facets of the publicly supported health care system. This public system of health care varies greatly among the jurisdictions. For example, federally qualified health centers (FQHCs) play a critical role as "safety net "providers by enhancing the provision of primary care services in underserved urban and rural communities. Unfortunately, the distribution of FQHCs in the EMA is limited. Provider qualifications to be a FQHC depend on area poverty levels and its designation as a medically underserved area. There are no FQHCs in Northern Virginia or Montgomery County and there is one in Prince George's County and one in West Virginia. This creates disparity in care in the EMA and places more burden on Ryan White funding to be the safety net in the Washington D.C. EMA for low-income PLWH/As.

In addition, both consumers and providers have expressed the need for capacity building and expansion of services under Ryan White. In response, the EMA continues its work around capacity building and this is addressed in the Goals and Objectives of the Comprehensive Plan for 2009 -2011.

Systems of Care in the EMA

Given limited Part A resources and the availability of other funding streams, the continuum of care in each jurisdiction is unique. In the District of Columbia, the continuum is rich with a wide array of services conveniently located in a compact urban area. The District overall has more nonprofit HIV/AIDS service providers than the other jurisdictions. Within Suburban Maryland, a case management model drives the service system and the funded providers have a strong commitment to networking and coordination with primary medical providers. In West Virginia, maintaining a continuum of care is more challenging, particularly due to limited options for transportation. Bus services between counties are very limited creating a need for transportation support service. Northern Virginia does not have a full continuum of care due to contracting challenges. There are not enough providers and they vary greatly in size and capacity. The Northern Virginia region still needs to improve provider coordination that mainly suffers from competition from insufficient funding.[49]

Other funding streams pay an important role in financing primary medical care. The Washington D.C. EMA operates within a complex array of different Medicaid, substance abuse, and mental health services. This creates many more challenges for planning Ryan White resources and allocation of funds and achieving true parity. Table 15 on the following pages examines and

compares the major health care funding sources for low-income PLWH/As in the EMA. It highlights the complexity and variability across the jurisdictions.

Table 15: Health Care System Eligibility as of 11/18/2008

	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 in gaps • 300% of FPL for EFA only • Eligibility for other services based on whether or not client qualifies for other coverage	• Fills in gaps • Eligibility based on whether or not client qualifies for other coverage	• 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 in West Virginia	• Fills in gaps • 300% of FPL for EFA only • Eligibility for other services based on whether or not client qualifies for other coverage	• Baltimore EMA-300% of FPL • Cecil County included in Wilmington, DE TGA
Medicaid	• 100% of FPL with disability dx (AIDS). • 1115 Waiver-100% of FPL with HIV dx only but has capped no. of slots	• 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 covered		• 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		• 42% of FPL with a disability diagnosis • Will soon be expanding to 116% of FPL for up to 100,000 new people mostly targeting individuals/families with children • Primary Adult Care (PAC) program- 116% of FPL. Has a good drug formulary, but does not cover HIV care visits. • Requires that clients use Medicaid CM	
ADAP	• 500% of the FPL • 24 hr enrollment • Pays for insurance co-payments and COBRA premiums • Direct Drug procurement	• 333% 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 ARVs covered but no lab testing		• 500 % FPL • Cannot be eligible for PAC or other Medicaid programs • Pays for insurance premiums and drug co-pays	
Part B	• Fills in gaps • Eligibility based on whether or not client qualifies for other coverage • No specific Income cap	• 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 and submit back to MAA. • Most of the dollars go toward Case Management and outpatient/ambulatory health services.	
Other	• DC Healthcare Alliance-200% of FPL • Alliance is locally funded primary care insurance. Not HIV specific • Alliance does not pay for HIV medications.	• Indigent Care Fund- Two hospitals have been funded to provide comprehensive medical care to indigent residents throughout the State of Virginia. Free for people at or below 100% of FPL. For residents between 101% and 200% there is a sliding scale fee. • Premium Assistance Program- Small fund to help with insurance premiums. Not currently open for enrollment.		• No other insurance programs in West Virginia		• Maryland Health Insurance Plan (MHIP)-State-run, high risk insurance pool open to people who cannot qualify for other insurances based on pre-existing conditions • Comprehensive Healthcare coverage • Does have deductibles and co-payments so may not be appropriate for very low income individuals. • Maryland Senior Prescription Drug Assistance Plan (MSDAP)- Pays any Medicare Part D eligible individual a $25 subsidy to help with medication co-pays. • Will also pay up to $1200 per year to help with medications in the donut hole • State General Funds are used to fund seropositive clinics established to "boost" rural care by paying for HIV specialists to go to rural counties to see patients.	

Other factors affect the system of care in the EMA. In the District of Columbia, the Ticket to Work demonstration program ends December 2008, and the HIV/AIDS Administration (HAA) is

working on developing multiple transition endpoints for PLWH/A who are enrolled in the program, including assessing Medicare, Medicaid, and other public funding sources as potentials. In Virginia and Maryland, State Pharmacy Assistance Programs provide support for prescription deductibles, premiums and co-pays for people living with HIV/AIDS.[50]

Many individuals who are on Medicare Part D face challenges with the coverage gap ("donut hole") and co-payment fees. In the District, ADAP funds cover premiums, co-payments, deductibles and the coverage gap for eligible patients, so efforts are made to encourage all service providers to refer individuals to ADAP for screening and enrollment. This coverage is not universal across the EMA.

There are 44 WIC sites located throughout the EMA. Of these, 16 are co-located with Part A service providers, making it easier for women with children to access HIV/AIDS services and needed nutritional support.

A number of veterans with HIV/AIDS in the EMA reside in the two counties of West Virginia. The case management agency in the area works closely with the Veterans Administration (VA) facility located in Martinsburg, West Virginia, and screens every client for eligibility for services provided through the VA. Common service gaps for which veterans frequently turn to for Ryan White funded services include oral health care, specialty outpatient medical care, and emergency financial assistance.

While HOPWA is available throughout the EMA, it does not meet all of the housing needs of PLWH/A. All regions are losing low-income housing as the EMA grapples with the issue of clients being forced to move to other jurisdictions for cheaper housing.[51] This creates a complex problem and challenges for continuity of care within in the EMA.

HIV counseling, testing and referral services funded by CDC in the EMA are yielding many newly identified HIV-positive individuals. Increasingly, testing services are co-located with medical care, including emergency rooms, substance abuse treatment facilities, and labor and delivery suites, so that newly diagnosed individuals can be linked directly to a service provider upon receiving his/her positive test result. The EMA has emphasized the importance of follow-up to these linkages to assure that newly identified PLWH/As enter primary medical care at the earliest stage and have access to medications.

Monthly collaborative meetings among the HIV/AIDS Administration (HAA), D.C. Addiction Prevention, Recovery Administration (APRA) and the D.C. Department of Mental Health (DMH) have been taking place since 2007. The focus is on joint efforts related to mutual concerns across these three areas, such as addressing housing issues, co-morbidity, prevention, and linking people to care.

Utilization of Part A Services in the EMA

Generally, there are a number of entry points into the HIV system of care within the EMA. Persons needing to access the Ryan White care system can be referred through prevention programs funded by the Centers for Disease Control and Prevention, through testing initiatives, from hospitals and other medical providers, or self-referred. Many of the testing and counseling

sites are co-located within primary medical care programs and case management services. If testing does not occur within a case management program, test sites have referral list of agencies. Once the client selects a site, a counselor assists the client in arranging for an initial appointment with a case manager at the selected agency. The counselor conducts follows up to assure that the initial appointment is kept.

Assuring that all clients have access to primary care is a priority for all case managers. This helps the EMA address the HRSA goal of 100% access and zero percent disparity. However, this is challenging for the EMA. Particularly since based on the unmet need framework calculation, an estimated 36% of people living with AIDS and 50% of people living with HIV who know their status are not in medical services. Epidemiological data also point out the significant numbers of persons entering into care at late stages of disease.

Examining service utilization data provides one method for estimating whether the continuum is meeting needs in the EMA. In 2007, a number of service categories experienced greater demand than expected.[52] This suggests that clients needed more of these services than the Planning Council originally anticipated and planned.

While there may be limitations to this approach since it blurs the line between wants and needs, it does help the Planning Council ensure flexibility in the expenditures of Ryan White funds. The Grantee, Administrative Agents and Planning Council, work throughout the year to re-allocate funds to specific service categories in order to adequately address ongoing needs. Table 16 below displays the service categories that spent more than their original allocation, and the percentage by which they exceeded the initial allocation.

Table 16: Service categories in which Expenditures Exceeded Initial Allocations in 2007

Service	Allocated Amount	Actual Expenditures	Percent Expended
Home delivered meals	$1,173,366	$1,553,074	132%
Food vouchers	$345,260	$388,235	112%
Food bank	$437,749	$484,751	111%
Outreach services	$57,041	$61,031	107%
Linguistic services	$135,637	$139,938	103%
Case management (non-medical)	$115,293	$118,133	102%

Another way to assess if the continuum of care is meeting needs in the EMA is to consider services that served more clients than originally targeted in the Implementation Plan. The Implementation Plan serves as the roadmap for the provision of services during the course of each year. This is especially important if funding levels do not increase in future years to meet the anticipated increased numbers of persons who need to receive care. Table 17 below displays the service categories that served more clients than indicated in the Implementation Plan for this

year, the original targeted number of clients to be served, the actual number of clients served, and the percentage of targeted clients that were served in that category.

Table 17: Service categories in which Actual Clients Served Exceeded Targets in 2007

Service	Clients Targeted	Clients Served	Percent
Medical nutrition therapy	588	1,996	339%
Outreach services	310	593	191%
Medical case management	2,134	3,456	166%
Early intervention services	1,245	1,879	151%
Medical transportation	492	693	141%
Mental health services	1,128	1,489	132%
Legal services	155	203	131%
Case management (non-medical)	178	222	125%
Substance abuse services-outpatient	996	1,226	123%
Linguistic services	129	159	123%
Child care services	130	145	111%
Food bank	1,650	1,837	111%
Home delivered food	1,199	1,316	110%
Treatment adherence counseling	1,020	1,052	103%

Service Utilization by Special Populations

Given scarce resources, Part A services seek to serve populations that are historically underserved. Each year, the Planning Council through it needs assessment process determines emerging populations with special needs. These populations are "emerging" in that the data show increases in HIV rates and service utilization (CARE Act, Part A). For that reason in FY 2009, the Washington D.C. EMA designated the following as emerging populations: homeless, seniors over 50, African American heterosexual females, African American MSM, Latino/as, persons with HIV and Hepatitis C.

The Grantee specifically tracks service utilization by each of the emerging populations. Utilization is measured by service units and cost per person. This information is provided to the Planning Council to monitor priorities and to target services to each of these populations as projected in the Implementation Plan for 2009. This ensures that significant resources are targeted to those most in need. Below is a discussion of the service utilization patterns of each special population and service expansion planned for FY 2009. This strategy is used each planning year for meeting those most in need.

Homeless

Table 18 below depicts the number of homeless individuals enrolled in six core Part A services and the associated costs of those services in 2007. In 2007, a total of $1,203,051 of Part A funds was spent on four core and two support services for homeless individuals, representing 5% of the total service expenditures for those categories.

Table 18: 2007 Service Utilization by Homeless Individuals of Four Core and Two Support Service Categories

Services Utilized	No. served	Units delivered	Per person Cost of care	Total
Primary and Specialty Medical Care Medical	148	1,540	$1,561	$231,000
Medical Case Management	141	2,216	$990	$139,608
Oral Healthcare	65	549	$3,699	$240,462
Mental Health Services	34	2,553	$12,239	$416,139
Emergency Financial Assistance	31	440	$3,747	$116,160
Food Bank/Home delivered food	87	8,526	$686	$59,682
				$ 1,203,051
Average cost per client				$ 6,138

In 2007, 196 individuals without a permanent address accessed Part A services. For FY 2009, the Planning Council and Grantee plan to reach and serve a minimum of 246 homeless individuals with Part A services. However, based on the estimated 5,751 homeless individuals living with HIV/AIDS in the EMA, there remains a large service gap for homeless individuals.

Persons Over 50

In 2007, the EMA served 2,536 individuals over the age of 50 and services to those seniors utilized 6% of the total services budgeted in six key service areas during the 2007 fiscal year as shown in Table 19 below. Service utilization in the D.C. EMA shows that seniors rely heavily on the Ryan White continuum of care for essential medical services including primary and specialty medical care, medical case management, oral health care, and mental health services.

Table 19: 2007 Service Utilization by Seniors of Four Core and Two Support Service Categories

Services Utilized	No. Served	Units delivered	Per person Cost of care	Total
Primary and Specialty Medical Care Medical	1,015	3,968	$586	$595,200
Medical Case Management	837	3,065	$231	$193,095
Oral Healthcare	225	466	$907	$204,108
Mental Health Services	275	621	$368	$101,223
Emergency Financial Assistance	427	659	$407	$173,976
Home delivered food	995	97,510	$686	$682,570
				$1,950,172
Average cost per client				$769

In 2007, 2,536 individuals over the age of 50 accessed Part A services. For FY 2009, the Planning Council and grantee plan to reach and serve a minimum of 2,916 people living with HIV/AIDS over the age of 50 with Part A services.

African American Heterosexual Women

In 2007, the EMA served 1,344 African American heterosexual women and those services utilized 6% of the total services budgeted in six key service areas during the past fiscal year as shown in Table 20 below.

Table 20: 2007 Service Utilization by African American Heterosexual Women of Four Core and Two Support Service Categories

Services Utilized	No. served	Units delivered	Per person Cost of care	Total
Primary and Specialty Medical Care Medical	853	4,147	$729	$622,050
Medical Case Management	768	4,608	$378	$290,304
Oral Healthcare	134	424	$1,386	$185,712
Mental Health Services	252	1,008	$652	$164,304
Emergency Financial Assistance	350	1,085	$818	$286,440

Services Utilized	No. served	Units delivered	Per person Cost of care	Total
Home delivered food	315	30,870	$686	$216,090
				$1,764,900
Average cost per client	$1,313			

In 2007, 1,344 African American heterosexual women accessed Part A services. For FY 2009, the Planning Council and grantee plan to reach and serve a minimum of 1,546 African American heterosexual women with Part A services.

African American MSM

In 2007, the D.C. EMA served 1,845 African American MSM. The cost associated with providing care in six key service areas for these individuals appears in Table 21 below.

Table 21: 2007 Service Utilization by African American MSM of Four Core and Two Support Service Categories

Services Utilized	No. served	Units delivered	Per person Cost of care	Total
Primary and Specialty Medical Care Medical	1,423	5,694	$600	$854,100
Medical Case Management	1,402	8,899	$400	$560,637
Oral Healthcare	387	820	$928	$359,160
Mental Health Services	480	4,736	$1,608	$771,968
Emergency Financial Assistance	302	1,550	$1,355	$409,200
Home delivered food	427	41,927	$687	$293,489
				$3,248,554
Average cost per client				$1,761

In 2007, 1,845 African American MSM accessed Part A services. For FY 2009, the Planning Council and grantee plan to reach and serve a minimum of 2,050 African American MSM with Part A services.

Latino/a

In 2007, the D.C. EMA served 854 Latinos. Table 22 below displays the costs associated with their care in six key service categories.

Table 22: 2007 Service Utilization by Latino/as in Four Core and Two Support Service Categories

Services Utilized	No. Served	Units delivered	Per person Cost of care	Total
Primary and Specialty Medical Care Medical	744	2,581	$520	$387,150
Medical Case Management	403	5,989	$936	$377,307
Oral Healthcare	211	525	$1,090	$229,950
Mental Health Services	252	1,574	$1,018	$256,562
Emergency Financial Assistance	251	1,111	$1,169	$293,304
Food/Bank/Home delivered food	181	17,730	$686	$124,110
				$1,668,383
Average cost per client				$1,954

In 2007, 854 Latino/as accessed Part A services. For FY 2009, the Planning Council and grantee plan to reach and serve a minimum of 897 Latino/as with Part A services.

Persons living with HIV and Hepatitis C

In 2007, the EMA served 1,129 people living with HIV and HCV. Table 23 below shows the associated costs of providing services to these individuals in six key service areas.

Table 23: 2007 Service Utilization of Four Core and Two Support Service Categories by People Living with HIV & HCV

Services Utilized	No. Served	Units delivered	Per person Cost of care	Total
Primary and Specialty Medical Care Medical	1,129	5,645	$750	$846,750
Medical Case Management	1,022	3,066	$189	$193,158
Oral Healthcare	250	138	$242	$60,444
Mental Health Services	112	266	$387	$43,358
Emergency Financial Assistance	115	1,208	$2,773	$318,912
Food Bank/Home delivered food	250	24,203	$678	$169,421
				$1,632,043
Average cost per client				$1,446

Conclusion

Washington D.C. EMA's continuum of care is both complex and challenging, spanning four jurisdictions with different overall health care systems, needs and governance structures. The Planning Council strives to prioritize resources to meet the needs of those most vulnerable in the EMA and to utilize CARE act funding to best address service gaps. The challenge for the EMA continues to be how best to design the service continuum to address parity among the jurisdictions. There is a process in place to target core medical and support services to those most in need. While the comprehensiveness of each jurisdiction's continuum of care varies, there is a commitment to make parity a high priority during this planning period.

Chapter 6: Barriers to Care

Barriers to the HIV/AIDS continuum of care can limit or prevent PLWH/As from receiving services that are essential to improving or maintaining their quality of life. Barriers may differ among regions and jurisdictions within the EMA, and can be very different for specific populations.

Consistent with national trends, the ability of governments within the Washington, D.C. EMA to maintain and expand services to low-income people is challenged by declining tax revenues, uncertain economic systems and increased demand for services. These trends jeopardize the stability and continuation of programs critical to the care and treatment of people with HIV, including substance abuse treatment, mental health services, housing, and other support services.

An estimated 51% of PLWH/A are living below the federal poverty level. In Prince George's County Maryland, one of out of every 341 households is in foreclosure, the highest percentage in Maryland, prompting a drop in property tax revenues and an imposed furlough on county employees.[53]

Case managers continue to work hard to locate appropriate referral sources both within and outside of the Ryan White care system in a volatile economic climate. Getting appropriate services to individuals who have multiple needs and who are often unable to meet their basic living necessities is a complex and difficult proposition. The overall concern for the Planning Council and Grantee is that decreases in other funding streams will increase the necessity of Ryan White funds to complete the continuum of care.

Even in the parts of the EMA characterized by higher median income levels, housing costs continue to rise, resulting in displacement of individuals and families in need of low-income and affordable housing. In Northern Virginia, affordable housing has resulted in significant and growing unmet need among HIV infected Northern Virginians.[54] Factors that can contribute to this effect are changes in eligibility that arise from moving across state lines and the lack of transportation to services.

This can compound the cost of care especially if the client returns to care in an advanced disease state. As the EMA continues to tackle questions surrounding equity, one of the primary goals will be to ensure a system with enough stability and flexibility to accommodate individuals who are negatively impacted by the lack of affordable housing options and by economic down turns.

In the EMA, there is the critical problem of late testers, defined as persons whose AIDS diagnosis occurred within twelve months of the initial detection of HIV infection. The 2007 District of Columbia HIV/AIDS Epidemiology Annual Report stated that "between 1997 and 2006, almost 70% of all AIDS cases progressed from HIV to AIDS in less than 12 months after initial diagnosis, primarily due to late testing."[55] The reason for the problem of "late testers" is a complicated issue and may vary among jurisdictions and populations.

There is a wide variability in the implementation of the CDC recommendations on including HIV screening as a part of routine health care, and the laws governing consent for HIV testing vary among the states. For example, at this time Maryland law requires each patient to give specific permission for an HIV test. This approach to HIV testing is inconsistent with CDC recommendations, which are based on their assessment that routine HIV screening in all health care settings reduces stigma associated with HIV testing, and fosters earlier detection of HIV status.

Transportation is not readily available across the EMA. The topography of West Virginia isolates one region from another and makes travel from region to region difficult. Public bus systems offer limited routes and schedules. Many persons with HIV/AIDS must often travel great distances to access care. A survey conducted for the West Virginia AIDS Network revealed that 38% of respondents traveled more than 50 miles to medical and social service appointments.[56] Equally, affordable transportation is a significant and persistent barrier for persons living in Northern Virginia and Suburban Maryland. Less than half of suburban Virginia jurisdictions have mass transit. Consumer needs assessments throughout the EMA cite lack of transportation as a barrier to entering and staying in health care. As the EMA considers how best to address equitable access to care, lack of transportation among the jurisdictions may be an important consideration. As the EMA considers portability as a strategy to improve the equity of services available to clients, it must also consider the impact of the increased costs associated with supporting transportation.

There are linguistic challenges across the EMA. A 2003 Brookings Institution study reported that the Washington Metropolitan area ranked seventh among all U.S. Metropolitan areas for number of foreign-born residents. Immigration into the area has increased attracting a large number of different populations. Representing over 193 countries, immigrants come from Latin America and the Caribbean (39%), Asia (36%), Europe (12%), Africa (11%) and other countries (2%). Many arrive from developing countries where HIV is widespread, particularly Sub-Saharan Africa.

In Montgomery and Prince George's County, Maryland, approximately 35% of PLWH/As in care were born in Africa, prompting a recent consultation with HRSA around cultural competence and eligibility of immigrants. In Northern Virginia, HIV clinics have limited linguistic accessibility for patients that do not speak English or Spanish.[57] In all, PLWH/A in the D.C. EMA represent more than 25 different countries, cultures, languages, and dialects and present multi- faceted challenges.

The EMA tracks services to persons with limited English proficiency (LEP). It is estimated that 5% of the PLWH/A may potentially have a challenge in proficiency of spoken English. Based on clients in the 2007 XPRES data system, 3,698 clients had a record of primary spoken language,

of which 507 were non-English or 5% of the total RW clients reported. Of this sample population, 42% resided in Northern Virginia, 32% are in D.C., 26% in Suburban Maryland.

In the EMA, the majority of the clients with LEP were from the Caribbean, South and Central America (73%) with Africans ranking second at 14.6%. The District and Maryland account for the highest proportion of Caribbean, South and Central American immigrants while the District and Virginia accounts for the highest proportion of African immigrants.

HIV/AIDS related stigma and the fear of being stigmatized are defining issues across the EMA. Traditional and cultural norms discourage identification and reporting of HIV/AIDS among immigrants and foreign-born citizens. In West Virginia, stakeholders and advocates believe that many people are in denial that HIV/AIDS is an issue of concern in their community and that residents do not want HIV/AIDS services provided in their communities.[58] Gender inequality and imbalance of power in relationships create stigma for women to access services freely. Oftentimes, the power imbalance increases particularly when a couple moves from a foreign country to the U.S. Immigrants are less likely to use mainstream and preventive health services, may be more likely to depend on traditional folk medicine and home remedies and may experience cultural stigma and loss of support due to an HIV diagnosis.

With a large immigrant population throughout the EMA, health literacy is an urgent need. Misconceptions about HIV disease persist in immigrant communities. Many believe that they can avoid infection by engaging in anal or oral sex, or by older men having sex with younger women. Contrarily, these and other sexual practices commonly used for birth control may actually increase the risk of HIV transmission. The process of migrating to the US may play a role in the increased likelihood of infection. Immigrants who come to the US via refugee camps may experience overcrowding, violence, rape, and the need to sell or exchange sex to survive. These factors have been reported by the UNAIDS Program as contributing to the increase in HIV infection.

These behaviors were substantiated by a 2004 survey conducted by the District of Columbia Department of Health (DOH) that highlighted the risk behaviors of immigrants who have resettled in the District. Entitled, *A Survey of the Health Status, Risk Behavior and Health Care Access of Immigrant Populations in the District of Columbia,* the study revealed that 4% of 1,281 respondents reported being HIV positive with another 18% refusing to answer. Of concern are the risk behaviors acknowledged, 16% reported using non-injection, injection, and chewing drugs; 54% reported using alcohol to varying degrees; 5% had exchanged sex for money; and 25% never used a condom. In spite of these circumstances, 80% did not perceive themselves at risk of acquiring the HIV, and 25% had never been tested for HIV antibodies. Of those who had never been tested, 48% reported fear of knowing their HIV status, 36% reported costs as the reason for not being tested, and 59% lacked information about testing sites. Of those who had been tested, 12% did not obtain their test results.

Providing culturally specific and competent services for immigrants is a major undertaking that requires specialized training. Agencies planning to provide services to this population will require organizational capacity building in order to identify and provide quality services for foreign-born individuals living with HIV disease. In summary, meeting the complex service

needs of individuals from different cultures will require a more defined assessment of needs and attention around capacity building for providers.

The EMA covers a wide geographic area. Ensuring quality services are available in all areas requires availability of qualified HIV providers across the EMA. It is difficult to attract health care providers to rural areas that are geographically extensive and sparsely populated. Providing services in the rural areas of the EMA costs more than providing the similar services in urban areas. When services are not available in rural areas, then clients must be transported to urban or suburban parts of the EMA. This not only necessitates additional allocations for client costs for transportation, but also fiscal and programmatic costs for administering transportation services and for tracking expenditures. In West Virginia, with the exception of the Veterans Administration facility for veterans, persons face challenges in accessing medical care due to the limited availability of providers in the region. Most local health departments in Northern Virginia do not provide direct patient care (the exceptions being the City of Alexandria and Loudon County). Providers in Northern Virginia are facing crises and with the current level of funding, it is not possible to expand the number of contractors.[59]

Financing and regulatory issues vary across the EMA. Each jurisdiction varies in the safety net and public health care and supportive services it provides from other sources of funding. Private insurance rates among PLWH/A are lower in D.C. and West Virginia. Medicaid is less accessible in Maryland and Virginia. Each jurisdiction has a very different Medicaid program and different levels of health care for the uninsured. Medicaid is a significant source of financing treatment services for a majority of PLWH/As in the EMA overall. In states with more generous Medicaid program and covered benefits, expenses can be shifted from Ryan White programs to Medicaid. However, eligibility requirements and covered services varies significantly from one jurisdiction to the next and particularly when compared to the D.C. Medicaid coverage (See Table 16).

Lastly, obtaining reliable client level data continues to be a barrier and challenge. Understanding access to care and differences in access by jurisdiction and the effort to meet changing mandates around collecting client level data will require a solid database that can be used across jurisdictions. The current database used by Part A has limitations. There are a very large number of different, often incompatible data sources across the jurisdictions. Special attention must be directed at rectifying this dilemma, particularly since this will be a reporting requirement of HRSA starting January 2009. The calculation of the unmet need data is also questioned when the reliability of unmet need data varies by jurisdiction. Cross-jurisdictional collaboration is needed to explore how differences in laboratory reporting can be minimized.

Conclusion

Although the EMA has a wide range of services, the geo-political differences of each jurisdiction in the EMA challenges planners around single solutions that improve access and parity across the EMA. Of particular interest to the Planning Council and the Grantee are the barriers caused by the recent down turn of the area's economy; the lack of accessibility of affordable housing and the resulting increase in client movement across jurisdictions caused by the current housing market; the large immigrant population residing in the area who present with a complex array of health care, language, and cultural competency requirements; capacity building needs to address

transportation issues and health care access in the rural communities within the EMA; the systemic challenge of adapting the Ryan White continuum to fill gaps in four different health care systems with different financing and eligibility requirements; and finally, the challenges posed by collecting client level data across four states with four different surveillance systems.

Section 2: Where do we need to go? What is our vision of an ideal system?

Chapter 7: The Ideal System

The intent of this section is to propose the ideal system of care that addresses barriers and gaps, reaches historically underserved populations and proactively responds to emerging trends in HIV/AIDS care consistent with national and international methodologies.

HRSA defines a continuum of care, as "…a coordinated delivery system, encompassing a comprehensive range of services needed by individuals or families with HIV infection to meet their health care and psychological service needs throughout all stages of illness." The Washington D.C. EMA has worked diligently to create a continuum of care that is responsive to the needs of persons living with and affected by HIV/AIDS in the District of Columbia, Northern Virginia, West Virginia and Suburban Maryland. Given the four jurisdictions and the differences among their different health care systems, no single set of services can effectively address the needs of the wide range of races, ethnicities, social identities, risk behaviors, clinical statuses and service expectations of clients throughout the Washington D.C. EMA. With that said, the EMA is working towards eliminating the current fragmented system of care clients are accessing. Unfortunately, resources have not been adequate. Together the Grantee and the Planning Council are working with key stakeholders and providers in the Ryan White system to further define and implement a basic package of services labeled as "clusters" that through bundling and ready availability enhance demand for and use of critical services by clients.[60]

The Comprehensive Plan process affords an opportunity for the Planning Council to envision the ideal system and to use the planning process to move in the direction of that ideal. The Council through this Comprehensive Plan envisions an ideal system of care that in collaboration with other funding streams will achieve the following:

1) Shorten the time between diagnosis and entry into care

2) Reduce the transmission of the virus to others

3) Reduce the transition to AIDS diagnosis

4) Reduce the number and severity of complications and episodes of illness

5) Reduce AIDS-related mortality

To achieve this, an effective continuum is characterized by the full complement of client-focused, culturally competent and multi-directional interventions. The service delivery system

model will include coordination, collaboration, comprehensiveness, co-location, cultural competence and chronic care. Client access, enrollment, and retention in outpatient/ambulatory medical care are central to the healthcare delivery system in the Washington D.C. EMA. It is a system that is flexible, with multiple points of entry and yet ensures that the many services delivered to clients contribute to improving health outcomes. It is a system that embraces the reality that clients consume services in different proportions, sequences and frequencies- that one-size does not fit all. It is designed to improve integration, collaboration and focused outreach among an extensive provider network system and to incorporate early intervention, prevention, counseling and testing and care services.

The continuum is designed to be flexible to model the many, varied ways in which clients experience their service needs. It is a vision along with common expectations that this will increase the likelihood that all eligible persons with HIV, including the newly diagnosed, historically underserved and disproportionately affected populations and hard-to-serve individuals, will be effectively linked to care. To ensure that all infected and affected persons of the EMA are able to access services, special emphasis is placed on recapturing clients who are out of care for six months or more. Tracking systems and feedback loops are well defined.

The integration of care and prevention services is a key component of the continuum of care, and one that is especially challenging for an EMA with overlapping jurisdictions. As we move forward with our planning process, planning for care and prevention services will expand and be able to field complex questions unique to our multi-jurisdictional EMA, including variable access to services, differential challenges to retention, multiple funding sources with different requirements and expectations, and the difficulties of coordinating four prevention/care planning groups for a single EMA perspective.

A critical step for envisioning is the formulation of a vision statement and the identification of common values and guiding principles. These values and principles guide responses to barriers, gaps and emerging trends in the EMA. The mission and values are presented below.

Shared Vision and Guiding Principles

The Washington D.C. EMA continuum consists of engaged consumers and best practice providers who are dedicated to cross-jurisdictional coordination of services for optimal clinical outcomes for persons living with HIV in the four jurisdictions of the EMA. Our vision is guided by the following principles:

- Creating an integrated and comprehensive system of care that provides culturally and linguistically appropriate services for all persons living with HIV disease.
- Ensuring a seamless system designed to identify persons at the earliest stage of disease.
- Achieving equality in access to medical and support services for persons living with HIV throughout the EMA.
- Ensuring high quality core medical and support services consistent with appropriate standards of care.

- Encouraging optimum communication and collaboration across CARE act entities and non-Care Act systems to guarantee seamless linkage for persons with complex need throughout the EMA and that CARE act funding is the dollar of last resort.

Our Values

Core values are defined as those strong desires, which no member will yield on. These are the bedrock of future actions in the EMA. The following are the core values of the Washington D.C. EMA.

Parity and portability

There will be geographic equity in access to quality core medical and necessary support services to enable persons to access and remain in care, regardless of jurisdiction. These medical and support core services will be selected and funds will be allocated each year through a priority setting resource allocation process.

Essential High Quality Core Services

Regardless of geographical location, PLWH/As will have access to quality and necessary medical care and support services that are consistent with appropriate standards and guidelines, and which ensure continuity of care. Protocols and polices will be in place, infrastructures will be appropriate, providers will properly be trained and competent to deliver services. Technical assistance will be available to enhance administrative and provider performance.

Improved and Measured Results

Procedures will be in place to encourage data driven decision-making and to track health outcomes. These efforts will ensure that decisions take into account the current epidemiology of the epidemic and its trends. Decisions will address the overall needs of the EMA.

Proactive Outreach, Retention and Access to Care

Services will be provided by culturally competent staff and will be delivered within a service delivery paradigm that is respectful of linguistic, religious, gender identity, gender expression, sexual orientation, gender, age, racial and other differences. In addition, the system of care will be flexible to meet the changing demands of the epidemic. There will be appropriate medical and support services that enable PLWH/As to seek out treatment, remain in care, and adhere to medication regimens such as medical and non-medical case management.

Informed Providers

Providers will be knowledgeable of standards of care and will be committed to provide services that meet or exceed Public Health Standards or other professional standards. Providers will participate, will bring their expertise to the Planning Council and will operate as a continuum of care.

Empowered Consumers

Consumer participation will be paramount to the planning process. Consumers will have information, knowledge of the Ryan White process and skills to advocate for the needs of the entire community and effectively carry out mandated planning council responsibilities

Future Planning

The Planning Council, using its vision, guiding principles and a variety of data including the SCSNs from each jurisdiction, needs assessment activities and epidemiological data will improve the care system and move in the direction of the ideal system of care.

Key planning activities that support achieving the ideal system of care include:

- Needs Assessment activities such as focus groups with special populations, client satisfaction surveys, out-of-care needs assessments, community forums and provider surveys.
- Monthly service category updates for the Planning Council.
- Annual planning between the Grantee and the Planning Council.
- Review of epidemiological data on emerging trends to guide decisions at priority setting and during the course of the year for re-allocations of funds.
- Ongoing presentations of service utilization and fiscal data for re-allocation processes.
- Quality assessments for all service categories.
- Coordination with other program sand funding streams.
- Priority setting and development of annual application.
- Assessment of the administrative mechanism.
- The Comprehensive Plan itself as a guide for future actions.

Conclusion

As the EMA moves forward, education, public awareness and other risk reduction activities will be vital to prevent new HIV infections in the EMA. HIV treatment includes not only the provision of services designed to meet the needs of persons living with HIV but also strategies to close disparities in HIV care and health care outcomes, access and services for underserved populations. Of particular interest to the EMA are services targeting the emerging populations defined by needs assessment activities, utilization data, and epidemiological data including homeless individuals, seniors (males and females 50 years of age and older), African American heterosexual women, African American men who have sex with men, Latino/as, and persons living with HIV and Hepatitis C co-infection.

The ideal system will include outreach and education activities targeted at those most at risk; linkages and coordination of services, particularly substance abuse treatment and mental health services, to overcome barriers; early intervention strategies and strategies for linking into care those who know their status but are not in care. The ideal system of care will provide persons living with HIV with tools and services that promote health, self-sufficiency, housing opportunities, and skills development. The system will be responsive to emerging new populations, new or improved drug therapies, and the changing health care environment. The Ideal system will be flexible to adapt to future health care policies. Finally, the ideal system will include quality assurance mechanisms to ensure that the needs of persons are being met and if not, generate recommendations as to what can be done.

The Planning Council has described its ideal system of care and the process it will use to move from the current system to the Ideal System. While there are many challenges and a need for coordinated efforts by many collaborators, the Comprehensive Plan develops a roadmap to guide this achievement. The goals and objectives outline critical steps to guide the EMA in this direction.

Section 3: How will we get there? How does our system need to change to assure availability of and accessibility to core services?

Chapter 8: Goals and Objectives

The plan is set within the context of an assessment of the outcomes of the plan. The Planning Council reviewed the 2006 -2008 plan and the achievements. This served as the basis for formulating the new goals and objectives. A summary of the achievements of the 2006 -2009 Comprehensive Plan is located in the Appendix section (See Appendix 7).

The following are the Goals and Objectives for the next three years for the Washington D.C. EMA.

Table 24: 2009-2011 Comprehensive Plan, Goals and Objectives

Objective	Party Responsible	Deliverable	Time Line
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.	Planning Council	Needs Assessment Plan outlining specific activities	Annually-2009, 2010 and 2011
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
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, co-morbidity, methamphetamine, substance abuse, homelessness.	Grantee	Scheduled presentations to Planning Council committees and Priority Setting	Ongoing
Objective 1.4 Strengthen the service delivery system EMA-wide through targeted capacity building activities and coordination with non-CARE Act funding sources that will improve the organizational capacity of providers to reach historically underserved populations.	Grantee	Planned capacity-building initiative for providers	Ongoing
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

Objective	Party Responsible	Deliverable	Time Line
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
Objective 2.3 Evaluate the cost effectiveness of service delivery.	Grantee Planning Council	Reports at Priority Setting and Resource Allocation meetings	Ongoing
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
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
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
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
Objective 3.2 Determine the level of compliance of providers with regard to third party reimbursement, sliding fee and cap requirements.	Grantee	Report	2010

Objective	Party Responsible	Deliverable	Time Line
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
Objective 3.4 Assess provider current capacities for core medical and support services within each jurisdiction of the EMA.	Grantee	Report	2010
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
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
Objective 4.2 Work closely with HRSA-funded technical assistance to ensure that all Planning Council activities operate according to federal requirements.	Grantee Planning Council	Assessment and request for continued technical assistance	2009
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
Objective 4.4 Establish and implement an MOU between the Grantee and Planning Council outlining responsibilities and activities.	Planning Council Grantee	MOU	2009

Section 4: How will we monitor our progress? How will we evaluate our progress in meeting short- and long-term goals?

Chapter 9: Monitoring

Various strategies will be used to improve quality of care and monitor progress in meeting the goals and objectives of the Comprehensive Plan. These strategies include the following: 1) Quality Management Program 2) Contract Monitoring Process 3) Collaborative planning between the Grantee and the Planning Council on an annual basis for tracking progress on goal attainment and 4) Community feedback.

Quality Management Program

The Grantee has an established quality management program that is responsible for the oversight and management of quality assurance activities throughout the EMA and works in partnership with the Care Strategy, Coordination and Standards (CSCS) Committee of the Planning Council. The purpose of the program is to ensure that all clients receiving health care services through a Ryan White-funded program across the different jurisdictions receive high-quality HIV medical and health-related care based on public health and professional standards.

The HAA has established a Quality Assurance Program to ensure that funded providers apply best practices in order to produce the best possible health outcomes for participating patients. As part of this process, the Grantee has established clear outcome measures for monitoring progress throughout the EMA. These measures are communicated to providers during the procurement process. For outpatient medical care, providers are required to provide information on the number and type of clients in care, percentage on antiretroviral therapy (ART), percentage on ART regimen longer than 6 months with undetectable viral load, along with target of achievement, plans for achieving or maximizing viral suppression at a rate of 70% or higher. These measures are consistent with the recent (July 2008) HAB HIV Core Clinical Performance Measures.

HAA will use its Quality Assurance program to identify deficiencies, collect data, strengthen program activities, and improve service delivery through comprehensive site visits by subject matter experts who cover administrative, financial and programmatic areas. This information in a summary format will be presented to the Planning Council for monitoring resource allocations and the quality of care. There will be regular reports to the CSCS Committee of the Planning Council.

The HIV/AIDS Administration (HAA) is currently reviewing the system requirements for the collection of client level data that will be required by HRSA in grant year 19. A selected database system will be deployed in each of the EMA's four jurisdictions. In addition, in January 2008, the District of Columbia began utilizing an electronic medical record, e-clinica, which has tested well with primary medical care providers, and data can be easily extracted and

uploaded to the XPRES data system. The success of this system may provide a model for data collection across the EMA.

XPRES is the Grantee's current electronic database system for collecting client and service level information, including population demographics and service utilization by service category. Sub-grantees are able to query the database to assist in program management and service delivery. Electronic reporting can be generated at the Grantee and sub-grantee levels to identify strengths and areas for improvement and to assist in operational and program planning, implementation and quality management efforts. However, there are weaknesses in this database. The Grantee will be exploring alternative strategy to measure client-level service utilization in the EMA as reflected as an objective for the planning period.

Contract Monitoring

The EMA has implemented a process to monitor contracts across the different jurisdictions and to ensure compliance with local and federal regulations. HAA monitors sub-grantees in the District of Columbia as well as each of the Administrative Agents for the jurisdictions. Monitoring of the sub-grantees focuses on the sub-grantees' ability to administer the fiscal and programmatic requirements for each awarded contract while the monitoring of the Administrative Agents focuses on the Agents' ability to plan, implement and monitor the continuum of care within their jurisdiction. The Administrative Agents monitor the sub-grantees in their jurisdictions for programmatic and fiscal compliance for each awarded contract. This process ensures that providers successfully implement Ryan White program dollars across the jurisdictions and is useful in assessing provider capacity and in determining local technical assistance needs.

Program Officers and Grants Management Specialists for the District and for the Administrative Agents assure progress of providers in meeting program goals, client targets, expenditures, as well as providing technical assistance to help providers address barriers. Both the Grantee and the Administrative Agents in each jurisdiction monitor sub-grantees by reviewing monthly programmatic and grant reports and conducting regular site visits that focus on the scope of work, program implementation, work plan, grant agreement, budgets, and financial management requirements. This process helps the Grantee and Administrative Agents keep track of services to target populations and collect utilization information on the service system. Although program and contract monitoring is a function of the Grantee and the Administrative Agents, the Planning Council receives reports necessary for reviewing the continuum of care during resource allocation and re-allocation processes.

Collaborative Planning

The Plan for 2009 -2011 outlines a bold plan to move the EMA in the direction of the vision articulated. Each year, the Grantee, Administrative Agents and Planning Council leadership will review objectives, outline, and an action plan to meet the deliverables cited. This plan will include a time line for completion and assignments for monitoring progress. This collaboration will strengthen the relationship and help both stakeholders improve services for persons living in the Washington D.C. EMA.

In addition, the Planning Council, on an annual basis will develop a comprehensive action plan to guide its deliberations during the year in order to meet objectives outlined in the plan. During this process each committee of the Planning Council will meet to develop a work plan for implementing the goals and objectives of the Comprehensive Plan. Then during an annual retreat the Planning Council as a whole body will review the work plans developed by the committees and incorporate them into the annual calendar of activities for the Planning Council. This process ensures that the annual activities designed to further the goals and objectives of the Comprehensive Plan have both flexibility and accountability.

Community Feedback

The Grantee will continue its commitment to the community and will hold ongoing community forums across the EMA to discuss the plan, to review its benchmarks and to lay down the groundwork for achieving the highest levels of service for the residents of the Washington D.C. EMA.

Conclusion

The Planning Council takes very seriously its obligation to implement this three-year plan. As part of the Comprehensive Planning Process the Grantee and the Planning Council met to develop a unified vision of services in the EMA. This vision tackled the problems created by incorporating healthcare systems and epidemics from four different states. The Planning Council and Grantee intend over the course of this Comprehensive Plan to implement action steps to achieve four goals:

- ***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.***
- ***Goal 2: Ensure improved health outcomes through access to comprehensive, high quality, culturally competent medical and support services.***
- ***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)***
- ***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.***

The Planning Council and the Grantee have established a system to ensure the implementation of the HIV Comprehensive Care Plan that includes collaboratively defining actions steps on an annual basis, instituting an EMA-wide Quality Management Program, actively monitoring contracts, and incorporating community feedback. As we embark on implementing this new plan, each stakeholder is committed to ensuring that the PLWH/As in the Washington receive quality HIV care.

Appendix

Appendix 1: Washington D.C. Metropolitan Regional HIV Health Services Planning Council

The following individuals were appointed for a term to end on December 31, 2009:

James Albino
William Barnes
Henry Bishop
Karen Blanton
Elliot Bovelle
Larry Bryant
Raul Burgos
Robert Cooke
Wallace Corbett
Barbara Davis
Maureen Deely
William Dunnington, III
Mark Fischer
Ronald Flowers
Everett Foy
Corrie Franks
Debra Frazier
Jennifer Jones George
Shirley Graham
Natalie Greene
Shannon Hader
Patricia Hawkins
David Hoover
Margot Isaac
Paulette Johnson
Lorin Jones
Renee Kelly
John Knotts
Yevette Lindsey
Benjamin Mararnara
Philip Mason
Curtis Matthews
Wade Menear
Danielle Pleasant
Karen Reynolds
Michael Robinson
Rigoberto Ruiz
Shirley Shears
Kevin Shipman
Ervin Robert Smith
Laurence Smith
Father Rusty Smith
Catalina Sol
Nicolette Solan-Pegler
Terry Tahir
Brian Watson
RonWilder

Appendix 2: Entire Washington D.C Eligible Metropolitan Area

Demographic Group/ Exposure Category	AIDS Incidence: * 01/01/06 to 12/31/07		AIDS Prevalence** as of 12/31/07		Estimated HIV (not AIDS) Prevalence*** as of 12/31/07		Estimated HIV/AIDS as of 12/31/07	
Race/Ethnicity	**Number**	**% of Total**	**Number**	**% of Total**	**Number**	**% of Total**	**Number**	**% of Total**
White, not Hispanic	273	11.4%	3,073	18.7%	4,674	18.2%	7,747	18.4%
Black, not Hispanic	1893	78.8%	12,086	73.4%	17,106	66.8%	29,192	69.4%
Hispanic	202	8.4%	1,127	6.8%	1,325	5.2%	2,452	5.8%
Asian/Pacific Islander	32	1.3%	146	0.9%	177	0.7%	323	0.8%
American Indian/Alaska Native	0	0.0%	11	0.1%	22	0.1%	33	0.1%
Other/Unknown	3	0.1%	19	0.1%	2,319	9.1%	2,338	5.6%
Total	**2403**	**100.0%**	**16,462**	**100.0%**	**25,623**	**100.0%**	**42,085**	**100.0%**
Gender	**#**	**% of Total**	**#**	**% of Total**	**#**	**% of Total**	**#**	**% of Total**
Male	1,605	66.8%	11,755	71.4%	17,071	66.6%	28,826	68.5%
Female	798	33.2%	4,707	28.6%	8,534	33.3%	13,241	31.5%
Unknown	0	0.0%	0	0.0%	18	0.1%	18	0.0%
Total	**2,403**	**100.0%**	**16,462**	**100%**	**25,623**	**100.0%**	**42,085**	**100.0%**
Age at Diagnosis (Years)	**#**	**% of Total**	**#**	**% of Total**	**#**	**% of Total**	**#**	**% of Total**
<13 years	3	0.1%	145	0.9%	467	1.8%	612	1.5%
13 - 19 years	29	1.2%	167	1.0%	718	2.8%	885	2.1%
20-29 years	354	14.7%	2,218	13.5%	5,435	21.2%	7,653	18.2%
30-39 years	700	29.1%	5,597	34.0%	8,054	31.4%	13,651	32.4%
40-49 years	799	33.3%	5,477	33.3%	7,196	28.1%	12,673	30.1%
50+ years	518	21.6%	2,858	17.4%	3,752	14.6%	6,610	15.7%
Unknown	0	0.0%	0	0.0%	1	0.0%	1	0.0%
Total	**2,403**	**100.0%**	**16,462**	**100.0%**	**25,623**	**100.0%**	**42,085**	**100.0%**
Adult/Adolescent AIDS Exposure Category	**#**	**% of Total**	**#**	**% of Total**	**#**	**% of Total**	**#**	**% of Total**
Men who have sex with men	672	28.0%	5,923	36.3%	7,789	31.0%	13,712	33.1%
Injection drug users	310	12.9%	3,006	18.4%	2,620	10.4%	5,626	13.6%
Men who have sex with men and inject drugs	50	2.1%	558	3.4%	474	1.9%	1,032	2.5%
Heterosexual	691	28.8%	4,325	26.5%	6,852	27.3%	11,177	27.0%
Other/Hemophilia/blood transfusion	29	1.2%	264	1.6%	215	0.9%	479	1.2%
Risk not reported or identified	646	26.9%	2,226	13.7%	7,189	28.6%	9,415	22.7%
Total	**2,398**	**100.0%**	**16,302**	**100.0%**	**25,139**	**100.0%**	**41,441**	**100.0%**
Pediatric AIDS Exposure Categories	***#***	***% of Total***	***#***	***% of Total***	***#***	***% of Total***	***#***	***% of Total***
Mother with/at risk for HIV infection	2	40.0%	149	93.1%	207	42.8%	356	55.3%
Other/Hemophilia/blood transfusion	3	60.0%	9	5.6%	66	13.6%	75	11.6%
Risk not reported or identified	0	0.0%	2	1.3%	211	43.6%	213	33.1%
Total	**5**	**100.0%**	**160**	**100.0%**	**484**	**100.0%**	**644**	**100.0%**

**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 people living with HIV (not AIDS) as of the date specified and is a combination of case surveillance data from Virginia and West Virginia and estimates of HIV cases from The District and Maryland.*

Appendix 3: The District of Columbia

Demographic Group/ Exposure Category	AIDS Incidence: * 01/01/06 to 12/31/07		AIDS Prevalence** as of 12/31/07		Estimated HIV (not AIDS) Prevalence*** as of 12/31/07		Estimated HIV/AIDS as of 12/31/07	
Race/Ethnicity	**Number**	**% of Total**	**Number**	**% of Total**	**Number**	**% of Total**	**Number**	**% of Total**
White, not Hispanic	98	8.2%	1,130	13.0%	3256	18.1%	4,386	16.4%
Black, not Hispanic	1,035	86.5%	7,064	81.1%	13079	72.7%	20,143	75.4%
Hispanic	51	4.3%	445	5.1%	846	4.7%	1,291	4.8%
Asian/Pacific Islander	9	0.8%	47	0.5%	90	0.5%	137	0.5%
American Indian/Alaska Native	0	0.0%	8	0.1%	18	0.1%	26	0.1%
Other/Unknown	3	0.3%	19	0.2%	702	3.9%	721	2.7%
Total	**1,196**	**100.0%**	**8,713**	**100.0%**	**17,991**	**100.0%**	**26,704**	**100.0%**
Gender	**#**	**% of Total**	**#**	**% of Total**	**#**	**% of Total**	**#**	**% of Total**
Male	816	68.2%	6,331	72.7%	12,269	68.2%	18,600	69.7%
Female	380	31.8%	2,382	27.3%	5,722	31.8%	8,104	30.3%
Unknown	0	0.0%	0	0.0%	0	0.0%	0	0.0%
Total	**1,196**	**100.0%**	**8,713**	**100.0%**	**17,991**	**100.0%**	**26,704**	**100.0%**
Age at Diagnosis (Years)	**#**	**% of Total**	**#**	**% of Total**	**#**	**% of Total**	**#**	**% of Total**
<13 years	3	0.3%	93	1.1%	414	2.3%	507	1.9%
13 - 19 years	12	1.0%	108	1.2%	522	2.9%	630	2.4%
20-29 years	149	12.5%	1,277	14.7%	3,922	21.8%	5,199	19.5%
30-39 years	306	25.6%	3,160	36.3%	5,595	31.1%	8,755	32.8%
40-49 years	435	36.4%	2,887	33.1%	5,001	27.8%	7,888	29.5%
50+ years	291	24.3%	1,188	13.6%	2,537	14.1%	3,725	13.9%
Unknown	0	0.0%	0	0.0%	0	0.0%	0	0.0%
Total	**1,196**	**100.0%**	**8,713**	**100.0%**	**17,991**	**100.0%**	**26,704**	**100.0%**
Adult/Adolescent AIDS Exposure Category	**#**	**% of Total**	**#**	**% of Total**	**#**	**% of Total**	**#**	**% of Total**
Men who have sex with men	377	31.6%	3,212	37.2%	6,327	36.0%	9,539	36.4%
Injection drug users	231	19.4%	2,062	23.9%	2,215	12.6%	4,277	16.3%
Men who have sex with men and inject drugs	43	3.6%	357	4.1%	369	2.1%	726	2.8%
Heterosexual	379	31.8%	2,202	25.5%	5,748	32.7%	7,950	30.3%
Other/Hemophilia/blood transfusion	6	0.5%	58	0.7%	35	0.2%	93	0.4%
Risk not reported or identified	157	13.2%	734	8.5%	2,883	16.4%	3,617	13.8%
Total	**1,193**	**100.0%**	**8,625**	**100.0%**	**17,577**	**100.0%**	**26,202**	**100.0%**
Pediatric AIDS Exposure Categories	***#***	***% of Total***	***#^***	***% of Total***	***#***	***% of Total***	***#***	***% of Total***
Mother with/at risk for HIV infection	0	0.0%	84	95.5%	184.0	44.4%	268	53.4%
Other/Hemophilia/blood transfusion	3	100.0%	4	4.5%	23.0	5.6%	27	5.4%
Risk not reported or identified	0	0.0%	0	0.0%	207.0	50.0%	207	41.2%
Total	**3**	**100.0%**	**88**	**100.0%**	**414.0**	**100.0%**	**502**	**100.0%**

**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 people living with HIV (not AIDS) as of the date specified.*

Sources: *DC Department of Health, Maryland Department of Health and Mental Hygiene, Virginia Department of Health, West Virginia Department of Health*

Appendix 4: Suburban Maryland

Demographic Group/ Exposure Category	AIDS Incidence: * 01/01/06 to 12/31/07		AIDS Prevalence** as of 12/31/07		Estimated*** HIV (not AIDS) Prevalence as of 12/31/07		Estimated HIV/AIDS as of 12/31/07	
Race/Ethnicity	**Number**	**% of Total**	**Number**	**% of Total**	**Number**	**% of Total**	**Number**	**% of Total**
White, not Hispanic	59	7.5%	634	13.8%	340	7.4%	974	10.6%
Black, not Hispanic	649	82.2%	3,622	78.6%	2,449	53.2%	6,071	65.9%
Hispanic	69	8.7%	311	6.8%	178	3.9%	489	5.3%
Asian/Pacific Islander	13	1.6%	39	0.8%	26	0.6%	65	0.7%
American Indian/Alaska Native	0	0.0%	1	0.0%	3	0.1%	4	0.0%
Other/Unknown	0	0.0%	0	0.0%	1,604	34.9%	1,604	17.4%
Total	**790**	**100.0%**	**4,607**	**100.0%**	**4,600**	**100.0%**	**9,207**	**100.0%**
Gender	**#**	**% of Total**	**#**	**% of Total**	**#**	**% of Total**	**#**	**% of Total**
Male	485	61.4%	2,986	64.8%	2,608	56.7%	5,594	60.8%
Female	305	38.6%	1,621	35.2%	1,974	42.9%	3,595	39.0%
Unknown	0	0.0%	0	0.0%	18	0.4%	18	0.2%
Total	**790**	**100.0%**	**4,607**	**100.0%**	**4,600**	**100.0%**	**9,207**	**100.0%**
Age at Diagnosis (Years)	**#**	**% of Total**	**#**	**% of Total**	**#**	**% of Total**	**#**	**% of Total**
<13 years	0	0.0%	50	1.1%	42	0.9%	92	1.0%
13 - 19 years	12	1.5%	48	1.0%	175	3.8%	223	2.4%
20-29 years	137	17.3%	823	17.9%	1,238	26.9%	2,061	22.4%
30-39 years	258	32.7%	1,883	40.9%	1,697	36.9%	3,580	38.9%
40-49 years	231	29.2%	1,261	27.4%	1,025	22.3%	2,286	24.8%
50+ years	152	19.2%	542	11.8%	423	9.2%	965	10.5%
Unknown	0	0.0%	0	0.0%	0	0.0%	0	0.0%
Total	**790**	**100.0%**	**4,607**	**100.0%**	**4,600**	**100.0%**	**9,207**	**100.0%**
Adult/Adolescent AIDS Exposure Category	**#**	**% of Total**	**#**	**% of Total**	**#**	**% of Total**	**#**	**% of Total**
Men who have sex with men	138	17.5%	1,242	27.3%	164	3.6%	1,406	15.4%
Injection drug users	55	7.0%	586	12.9%	76	1.7%	662	7.3%
Men who have sex with men and inject drugs	3	0.4%	96	2.1%	9	0.2%	105	1.2%
Heterosexual	229	29.1%	1,558	34.2%	566	12.4%	2,124	23.3%
Other/Hemophilia/blood transfusion	1	0.1%	35	0.8%	12	0.3%	47	0.5%
Risk not reported or identified	362	45.9%	1,034	22.7%	3,731	81.9%	4,765	52.3%
Total	**788**	**100.0%**	**4,551**	**100.0%**	**4,558**	**100.0%**	**9,109**	**100%**
Pediatric AIDS Exposure Categories	***#***	***% of Total***	***#***	***% of Total***	***#***	***% of Total***	***#***	***% of Total***
Mother with/at risk for HIV infection	2	100.0%	52	92.9%	0	0.0%	52	53.1%
Other/Hemophilia/blood transfusion	0	0.0%	3	5.4%	42	100.0%	45	45.9%
Risk not reported or identified	0	0.0%	1	1.8%	0	0.0%	1	1.0%
Total	**2**	**100.0%**	**56**	**100.0%**	**42**	**100.0%**	**98**	**100.0%**

**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 for Maryland is defined as the estimated number of people living with HIV (not AIDS) as of the date specified.*

Appendix 5: Northern Virginia

Demographic Group/ Exposure Category	AIDS Incidence: * 01/01/06 to 12/31/07		AIDS Prevalence** as of 12/31/07		HIV (not AIDS) Prevalence*** as of 12/31/07		HIV/AIDS as of 12/31/07	
Race/Ethnicity	**Number**	**% of Total**	**Number**	**% of Total**	**Number**	**% of Total**	**Number**	**% of Total**
White, not Hispanic	110	27.2%	1,255	41.1%	1,036	35.1%	2,291	38.2%
Black, not Hispanic	203	50.2%	1,370	44.9%	1,539	52.2%	2,909	48.5%
Hispanic	81	20.0%	368	12.0%	298	10.1%	666	11.1%
Asian/Pacific Islander	10	2.5%	60	2.0%	61	2.1%	121	2.0%
American Indian/Alaska Native	0	0.0%	1	0.0%	1	0.0%	2	0.0%
Other/Unknown	0	0.0%	0	0.0%	13	0.4%	13	0.2%
Total	**404**	**100.0%**	**3,054**	**100.0%**	**2,948**	**100.0%**	**6,002**	**100.0%**
Gender	**#**	**% of Total**	**#**	**% of Total**	**#**	**% of Total**	**#**	**% of Total**
Male	293	72.5%	2,369	77.6%	2,129	72.2%	4,498	74.9%
Female	111	27.5%	685	22.4%	819	27.8%	1,504	25.1%
Unknown	0	0.0%	0	0.0%	0	0.0%	0	0.0%
Total	**404**	**100.0%**	**3,054**	**100.0%**	**2,948**	**100.0%**	**6,002**	**100.0%**
Age at Diagnosis (Years)	**#**	**% of Total**	**#**	**% of Total**	**#**	**% of Total**	**#**	**% of Total**
<13 years	0	0.0%	2	0.1%	10	0.3%	12	0.2%
13 - 19 years	4	1.0%	10	0.3%	14	0.5%	24	0.4%
20-29 years	66	16.3%	109	3.6%	249	8.4%	358	6.0%
30-39 years	131	32.4%	518	17.0%	736	25.0%	1,254	20.9%
40-49 years	130	32.2%	1,297	42.5%	1,152	39.1%	2,449	40.8%
50+ years	73	18.1%	1,118	36.6%	786	26.7%	1,904	31.7%
Unknown	0	0.0%	0	0.0%	1	0.0%	1	0.0%
Total	**404**	**100.0%**	**3,054**	**100%**	**2,948**	**100.0%**	**6,002**	**100.0%**
Adult/Adolescent AIDS Exposure Category	**#**	**% of Total**	**#**	**% of Total**	**#**	**% of Total**	**#**	**% of Total**
Men who have sex with men	148	36.6%	1,431	47.1%	1,260	43.1%	2,691	45.2%
Injection drug users	23	5.7%	338	11.1%	313	10.7%	651	10.9%
Men who have sex with men and inject drugs	4	1.0%	102	3.4%	92	3.1%	194	3.3%
Heterosexual	81	20.0%	550	18.1%	528	18.1%	1,078	18.1%
Other/Hemophilia/blood transfusion	22	5.4%	171	5.6%	168	5.8%	339	5.7%
Risk not reported or identified	126	31.2%	446	14.7%	560	19.2%	1,006	16.9%
Total	**404**	**100.0%**	**3,038**	**100.0%**	**2,921**	**100.0%**	**5,959**	**100.0%**
Pediatric AIDS Exposure Categories	***#***	***% of Total***	***#***	***% of Total***	***#***	***% of Total***	***#***	***% of Total***
Mother with/at risk for HIV infection	0	0.0%	13	81.3%	22	81.5%	35	81.4%
Other/Hemophilia/blood transfusion	0	0.0%	2	12.5%	1	3.7%	3	7.0%
Risk not reported or identified	0	0.0%	1	6.3%	4	14.8%	5	11.6%
Total	**0**	**0.0%**	**16**	**100.0%**	**27**	**100.0%**	**43**	**100.0%**

**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.*

Appendix 6: West Virginia

Demographic Group/ Exposure Category	AIDS Incidence: * 01/01/06 to 12/31/07		AIDS Prevalence** as of 12/31/07		HIV (not AIDS) Prevalence*** as of 12/31/07		HIV/AIDS as of 12/31/07	
Race/Ethnicity	**Number**	**% of Total**	**Number**	**% of Total**	**Number**	**% of Total**	**Number**	**% of Total**
White, not Hispanic	6	46.2%	54	61.4%	42	50.0%	96	55.8%
Black, not Hispanic	6	46.2%	30	34.1%	39	46.4%	69	40.1%
Hispanic	1	7.7%	3	3.4%	3	3.6%	6	3.5%
Asian/Pacific Islander	0	0.0%	0	0.0%	0	0.0%	0	0.0%
American Indian/Alaska Native	0	0.0%	1	1.1%	0	0.0%	1	0.6%
Other/Unknown	0	0.0%	0	0.0%	0	0.0%	0	0.0%
Total	**13**	**100.0%**	**88**	**100.0%**	**84**	**100.0%**	**172**	**100.0%**
Gender	**#**	**% of Total**	**#**	**% of Total**	**#**	**% of Total**	**#**	**% of Total**
Male	11	84.6%	69	78.4%	65	77.4%	134	77.9%
Female	2	15.4%	19	21.6%	19	22.6%	38	22.1%
Unknown	0	0.0%	0	0.0%	0	0.0%	0	0.0%
Total	**13**	**100.0%**	**88**	**100.0%**	**84**	**100.0%**	**172**	**100.0%**
Age at Diagnosis (Years)	**#**	**% of Total**	**#**	**% of Total**	**#**	**% of Total**	**#**	**% of Total**
<13 years	0	0.0%	0	0.0%	1	1.2%	1	0.6%
13 - 19 years	1	7.7%	1	1.1%	7	8.3%	8	4.7%
20-29 years	2	15.4%	9	10.2%	26	31.0%	35	20.3%
30-39 years	5	38.5%	36	40.9%	26	31.0%	62	36.0%
40-49 years	3	23.1%	32	36.4%	18	21.4%	50	29.1%
50+ years	2	15.4%	10	11.4%	6	7.1%	16	9.3%
Unknown	0	0.0%	0	0.0%	0	0.0%	0	0.0%
Total	**13**	**100.0%**	**88**	**100.0%**	**84**	**100.0%**	**172**	**100.0%**
Adult/Adolescent AIDS Exposure Category	**#**	**% of Total**	**#**	**% of Total**	**#**	**% of Total**	**#**	**% of Total**
Men who have sex with men	9	69.2%	38	43.2%	38	45.8%	76	44.4%
Injection drug users	1	7.7%	20	22.7%	16	19.3%	36	21.1%
Men who have sex with men and inject drugs	0	0.0%	3	3.4%	4	4.8%	7	4.1%
Heterosexual	2	15.4%	15	17.0%	10	12.0%	25	14.6%
Other/Hemophilia/blood transfusion	0	0.0%	0	0.0%	0	0.0%	0	0.0%
Risk not reported or identified	1	7.7%	12	13.6%	15	18.1%	27	15.8%
Total	**13**	**100.0%**	**88**	**100.0%**	**83**	**100.0%**	**171**	**100.0%**
Pediatric AIDS Exposure Categories	**#**	***% of Total***	**#**	***% of Total***	**#**	***% of Total***	**#**	***% of Total***
Mother with/at risk for HIV infection	0	N/A	0	N/A	1	100.0%	1	100.0%
Other/Hemophilia/blood transfusion	0	N/A	0	N/A	0	0.0%	0	0.0%
Risk not reported or identified	0	N/A	0	N/A	0	0.0%	0	0.0%
Total	**0**	**N/A**	**0**	**N/A**	**1**	**100.0%**	**1**	**100.0%**

**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*

Appendix 7: Comprehensive Plan 2006-2008, Summary of Goals and Objectives

Goal 1: Ensure that clients have access to an innovative system of care that improves health and quality of life.

Objective	Monitoring/Evaluation Questions	Status
1.1 Strengthen core services by implementing stage appropriate interventions that are client driven and respond specifically to the client's level of need throughout the next funding cycle	• Were protocols developed for staged appropriate interventions? The purpose is to increase retention and linkage to care. • Did the Administrative agents place requirements in the RFA and contracts?	• Protocols for each service category are in process. Primary Medical and non-medical case management protocols have been developed and presented to the Planning Council. • Primary Medical and non-case management has been included in the jurisdictions protocols and in the RFA process. The others will be included upon completion.
1.2 Strengthen core services by developing critical service components of each core service to be accessible to clients across the EMA throughout the next funding cycle	• Define critical service components of each core service (Standards of care?) • Disseminate information to providers • Needs assessment • Priority setting directives developed around any issues or concerns	• See above • See Above • Focus groups (FIGS) and surveys are completed every other year. In 2008 the Focus Groups were not all fully attended. The most thorough FIGS groups seemed to be the West Virginia Forum, the Latino/a, the homeless, and the African American Women groups. The survey from 2007 had over 800 participants and provided good information. • Priority setting happens annually and includes multiple data sets around emerging and special populations in all of the jurisdictions.
1.3 Engage in a meaningful, planned approach to enhance capacity and capacity for serving targeted, special populations during the next funding cycle.	• Have you determined service utilization of special populations? • Have targets been set (MAI funding) and met? • Have reports on this been given to the PC?	• Yes, as part of the annual grant application. • Yes. Targets are set for MAI, Part A, Part B, and HOPWA funding. • Reports are given annually as part of the data presentation for planning and allocations.
1.4 Develop and implement a plan to increase and improve client education targeting the importance of care and methods of accessing the delivery system	• Inventory of client education programs • Did you track client education activities?	• No • No

1.5 Reduce health outcome disparities by addressing service disparities across jurisdictional boundaries within the EMA by next funding cycle.	• Was eligibility redefined to include "EMA residency meets eligibility for any Ryan White Title I service in the EMA"? • Do contracts include health outcome disparity objectives?	• EMA has continued to look at the complex issues associated with parity across jurisdictions. There has been an effort to increase providers in areas known to have lack of access. This is an on-going process and is complex as it concerns different geo-political structures, different HIV-positive populations, and differential access to services. The complexities of this should be examined to determine a best course of action. • The contracts in the District the contracts do contain health outcomes.
1.6 Strengthen service delivery system by increasing the availability and capacity of providers to offer services, especially in underserved geographical areas by next funding cycle.	• Determine geographical areas of need • Were capacity building activities conducted for new providers? • Was the RFA process made user friendly?	• The District created a capacity building grant called the Effi Barry initiative. It is designed to provide capacity building training for new providers. There has not been a formalized effort to build capacity in the jurisdictions. • RFA for Effi Barry was made user friendly.

Goal 2:
Enable providers to offer sustainable, efficient and high quality services to clients in an innovative system of care that improves health and quality of life

Objective	Monitoring/Evaluation Questions	Status
2.1 Implement capacity-building activities to improve technical, administrative and clinical practices of providers during the next three program years.	• Was there a review of provider surveys to determine capacity building needs • Were capacity building activities conducted	• This was completed as part of the Effi Barry application process. There has been no significant capacity building activity in the jurisdictions. • This was completed as part of the Effi Barry application process. There has been no significant capacity building activity in the jurisdictions.

2.2 Coordinate an integrated approach to prevention and care services by hosting quarterly meetings of providers and ensuring standardized protocols reflect both care and prevention issues by December 2006	• Were quarterly meetings held • Were protocols developed	• No • No

2.3 Establish partnership relationships between CARE Act funded programs and other providers of human and social services (such as Medicaid, Medicare, Department of Corrections, Veterans Administration, SAMHSA, etc) by April 2006	• Status of partnerships
	• Has the PC met designated membership requirements?
		• NVRC, the Administrative Agent for Northern Virginia, is a consortium of regional governments and is actively involved in a regional planning. The Administrative Agent in West Virginia partners with local CBOs and with the Veteran's Medical Affairs Center. In the District various levels of partnerships have been created:
		  • Medicaid/Medicare: Data sharing
		  • Dept. of Corrections: The CTR division of HAA does regular HIV testing in correctional facilities and an agency has been funded to provide services to positive inmates.
		  • SAMSHA- works directly with prevention division. Funds services directly.
		  • APRA- HAA has partnered directly with APRA to coordinate HIV and substance abuse services
		  • VAMC- not yet
		• The EMA has not met the requirements for designated membership but is working with a HRSA funded technical assistance provider to meet those requirements.

2.4 Conduct cross –training with substance abuse and mental health providers by March 2007	• Were cross training activities conducted	• All Mental Health and Substance Abuse providers must be licensed, trained, and certified by their local regulatory bodies in order to receive funding. D.C., Suburban Maryland, and Northern Virginia's jurisdictional agents all established case management committees to conduct on-going trainings cross trainings for case managers.

2.5 Identify and address service provider's needs for capacity building and infrastructure development through an ongoing capacity-building program during the next program year.	• Was a needs assessment conducted • Were capacity development activities conducted	• Focus groups (FIGS) and surveys are completed every other year. In 2008 the Focus Groups were not all fully attended. The most thorough FIGS groups seemed to be the West Virginia Forum, the Latino/a, the homeless, and the African American Women groups. The survey from 2007 had over 800 participants and provided good information. • Effi Barry grant for capacity building was established in D.C. There has not been as organized an effort to build capacity in the jurisdictions.

Goal 3:

Ensure that the EMA documents sustainable, efficient and high quality services to clients in an

Objective	Monitoring/Evaluation Questions	Status
3.1 Develop and implement a methodology to determine unit costs in each jurisdiction of the EMA by March 2008	• What is the status of unit costs activities	• No
3.2 Improve service sustainability, efficiency and level of quality by reviewing quarterly vendor spending and outcome performance	• What is the PC review process	• Fiscal Oversight Committee is the Planning Council body assigned to review spending and outcome performance as a whole. HAA program and grant monitors review individual programs using monthly reports, monthly invoices, and scheduled site visits.
3.3 Develop and implement standardized protocols of care for the EMA by March 2008	• Have standardized protocols been developed	• Primary Medical and non-medical case management protocols have been developed and presented to the Planning Council. Protocols for the other service categories are in process.

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Goal 4:

Improve the Planning Council's capability in completing HRSA's mandated planning functions

Objective	Monitoring/Evaluation Questions	Status
4.1 Improve surveillance and client service data collection and dissemination processes within the EMA during the current grant year	• Was an assessment of XPRESS conducted? • Is there a MOU regarding the sharing of data?	• Yes. XPRESS was found to have some problems. HAA has conducted a nationwide search to determine several possible programs that would meet the need for the EMA as well as meet HRSA's increasing mandate for client-level data. • No
4.2 Create positive , working relationships with Medicaid, SAMSHA, and others to obtain data for priority setting and allocations by April 2006	• Does the PC have relevant data?	• Information is presented annually during the data presentation meeting as part of the allocation and priority setting process.
4.3 Define roles of Planning Council members to include EMA wide quarterly reporting from at-large members holding federally mandated seats and others determined by the Planning Council by June 2006	• Did the PC establish reporting protocols?	• Not at this time. HRSA has funded a TA provider to work with the PC on defining roles and on filling all the mandated slots. Currently the jurisdictions and committees report to the planning council.
4.4 Respond to changes in planning requirements contained in reauthorized CARE Act within 90 days of reauthorization	• Did the PC receive a report on changes and if so, were appropriate modifications made?	• The overall assessment is that the EMA responded well to the changes mandated in the 2006 version of the Ryan White Treatment Modernization Act. The EMA met and exceeded the 75/25% split on spending in the core vs. supportive services categories. The EMA changed the categories of services funded to meet the 2006 legislation. As with many EMAs, we are still hammering out the details on the implementation of Medical Case Management vs. non-medical case management.

Comments:

During the time period the EMA also accomplished goals not outlined in the previous comprehensive plan:

- Instituted Names-Based Reporting for the jurisdictions in the EMA not previously doing so.
- Implemented a quality management plan that included health outcomes. HAA has continues to work toward examining those outcomes measured to balance quality, provider reporting requirements, and HRSA's guidelines.

1 All statistics on Medicaid expenditures per enrollee were pulled from the Henry J. Kaiser Family Foundation's website www.statehealthfacts.org on December 23, 2008 and can be accessed at http://www.statehealthfacts.org/comparetable.jsp?ind=183&cat=4.
2 *HIV and AIDS in the United States: A Picture of Today's Epidemic.* CDC. Modified August 2008. Downloaded from {http://www.cdc.gov/hiv/topics/surveillance/united_states.htm} on December 30, 2008.
3 CARE Act 2000
4 All statistics on Medicaid expenditures per enrollee were pulled from the Henry J. Kaiser Family Foundation's website www.statehealthfacts.org on December 23, 2008 and can be accessed at http://www.statehealthfacts.org/comparetable.jsp?ind=183&cat=4.
5 See Tables 2, 3 and 4.
6 Washington AIDS Partnership, The Northern Virginia HIV Services and Financing System: Assessing Resources to address an Era of Constrained Funding, January 2006.
7 Washington AIDS Partnership, The Northern Virginia HIV Services and Financing System: Assessing Resources to address an Era of Constrained Funding, January 2006
8 AIDS Action State Facts, HIV/AIDS in West Virginia,2006
9 Department of Veterans Affairs , Center for Quality Management in Public Health, Caring for Veterans with HIV Disease, FY 2002, July 2003
10 Washington EMA FY 2009 Application to HRSA for Part A services September 2008.
11 FY 2009 Washington EMA Part A Application, September 2008
12 Department of Health, District of Columbia HIV/AIDS Epidemiology Annual Report, 2007
13 All statistical information pulled from the U.S. Census Department American Community Survey, Fact Finder tool. The tool can be accessed at {http://www.census.gov/acs/www/index.html}. Information downloaded on Nov. 20, 2008.
14 U.S. Census Bureau, American Community Survey. http://factfinder.census.gov/home/saff/main.html?_lang=en. Downloaded Nov. 20, 2008.
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18From newhomes.org. Downloaded December 24, 2008, www.newhomesguide.com/forms/maps./nhg_map_k.pdf
19 EMA estimate as of 12/31/07, Submitted to HRSA as a part of the FY 2009 Application
20 HIV AIDS Surveillance Report, Vol.18, Cases of HIV Infection and AIDS in the United States, 2006
21 Washington, DC EMA, FY 2009 Part A Application
22 HIV/AIDS Surveillance and Epidemiology Division, HIV/AIDS Administration, Presentation for Priority Setting, April 24, 2008
23 The 2008 Ryan White HIV/AIDS Program Data Report uses the designation Black or African American to track services to American born Blacks and Blacks from foreign counties. For the purpose of discussing epidemiological data, the term Black/African American will be used.
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25 Special Report prepared for the Planning Council, January 2008 by Luau Temprosa, MS for allocation of LEP services.
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