District of Columbia 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.

Table of Contents

Executive Summary

The Part B Comprehensive HIV Care Plan for 2009-2011 tells the story of a modern epidemic in the District of Columbia. 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 and the relationship with other funding sources, particularly Part A funds. By looking at the District both from a total perspective and the individual needs of each Ward, we have been 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 the entire District.

HIV/AIDS in Washington, D.C.

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. 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.

When compared to the nation as a whole, Washington, D.C. is disproportionately impacted by HIV/AIDS. It was estimated that the District of Columbia living AIDS case rate was 12 times the national average (2,016.5 versus 178.6 per population of 100,000). The epidemic in Washington D.C. is a modern epidemic with an estimated 26,704 people living with HIV/AIDS. In addition, PWLH/A in the District of Columbia experienced a very high mortality rate. HIV disproportionately impacts the minority community of the District with 84% of cases being classified as racial/ethnic minorities although the total population is only 61% minority. The greatest impact of HIV /AIDS is among persons described as Black/African American with 6% of all Blacks in the District 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 62.3% 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 District. 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 one year after learning their HIV status.

The Continuum of Care

The continuum of care in the district is very rich under Part B, 22 sub-grantees provide Ryan White Part B funded services in the following service categories: medical case management (9 funded providers), family-centered case management (7 funded providers), case management for peri-incarcerated (2 funded providers), early intervention (3 funded providers), health insurance (1 funded provider), and treatment adherence counseling (6 funded providers). The Grantee ensures that clients utilizing Part B services link as appropriate to the Part A Continuum of Care.

Under Part A funding, there are 24 providers under a variety of medical and support core services. Medical core services include outpatient ambulatory care, AIDS drug assistance, oral health, early intervention services, home and community based health services, hospice, mental health services, medical nutrition therapy, medical case management, and substance abuse services. Core support services include case management, child care, developmental assessment, emergency financial assistance, food bank, health education, housing, legal services, linguistic services, medical transportation, outreach, psychosocial support, referral to health and support, rehabilitation services, respite care, substance abuse (residential) and treatment adherence.

The major focus of Part B funding is to enhance the capacity of the service system to re-connect diverse target populations to care. The District changed its focus in response to the needs of disproportionately impacted populations and the high lost to care levels across providers. This has stimulated new grant requirements for all providers.

Shared Vision, Guiding Principles, Goals and Objectives

Improved Care Coordination

The system will ensure the provision of family-centered medical case management, peri-incarcerated medical case management and treatment adherence services and also address the unmet need for care coordination and access to antiretrovirals.

Improved and Measured Results

Due to the complex needs of diverse populations served, different types and appropriate levels of interventions (ranging from limited to intense and comprehensive) will be available in order to achieve desired health outcomes.

Proactive Outreach, Access to Care and Retention

The HAA will facilitate and ensure joint medical management through improved linkages and referral systems across medical and support services.

Informed Providers

The continuum will provide culturally competent education on clinical treatments and the health care service system.

Informed Consumers

Self-management training shall be provided to ensure continuous support for PLWH/A to improve health outcomes and quality of life.

Goals and Objectives

- **Goal 1: To ensure that HIV-positive persons learn their HIV status early and also enter care early through the promotion of effective strategies that increases access to and retention in care.**
- **Goal 2: To ensure improved health outcomes and access to core medical and support services.**
- **Goal 3: To maximize resources throughout the District by increasing linkages and coordination among Ryan White programs and non-Ryan White programs (including Medicaid, Medicare, HIV prevention, housing, as well as District programs provided by the Addictions Prevention and Recovery Administration (APRA), Maternal and Child Health, Mental Health Administration).**
- **Goal 4: To improve the operations of the D.C. Delegation to ensure that the District-wide system of care meets the needs of communities affected by HIV disease and fulfills legislative requirements.**
- **Goal 5: To ensure the availability of emerging and state of the art pharmaceuticals and treatments in Washington D.C.**

The goals and objectives of this plan serve as a cornerstones upon which common stakeholders shall commit to ensuring that PLWH/A in the District receive optimal quality HIV care. In this aspect, as we embark on actual implementation of this new plan, the DC Delegation and the HAA intend for the Comprehensive Plan to operate as a document to be actualized with mechanisms to ensure annual review of goals, designated activities to advance achievement of those goals, and periodic monitoring and evaluation to track progress.

Section I Where Are We Now? What Is Our Current System of Care?

Chapter 1: Introduction

A major requirement of the Ryan White Treatment Modernization Act mandates the preparation of a Statewide Coordinated Statement of Need (SCSN) and a Comprehensive HIV Care Plan every three years. Both the process and development of these documents are the responsibility of the Grantee for Ryan White Part B funding, the District of Columbia Department of Health, HIV/AIDS Administration (HAA). The Comprehensive Plan reflects service and resource allocation priorities as well as goals and objectives for the Part B funded services in the District of Columbia. The SCSN details plans for increasing collaboration, leveraging funds, coordination of activities and funding among the different Ryan White programs. This document combines both processes to *map out* maintenance and improvement of a District-wide system of care that is responsive to the changing epidemic and the unmet health care needs of those currently not in care.

There are nine chapters in the Comprehensive HIV Care Plan. Chapter One describes Washington, D.C. in terms of the population, subsets of populations and Wards served by Part B funds. Chapter two describes the nature of the HIV/AIDS epidemic in the District in terms of emerging trends, utilization of services, and distinct target groups. Chapter Three chronicles the District's historical response to the epidemic. Chapter Four summarizes the results of surveys, forums and focus groups recently conducted to assess the care and prevention needs of PLWH/A. Chapter Five explains the current CARE Act funded continuum of care in Washington, D.C. Chapter Six outlines existing barriers that hinder client access and retention in HIV health care. Chapters Seven and Eight describe the values and vision of an ideal system of health care in the District and also detail specific goals and objectives for achieving that vision. Finally, Chapter Nine describes how the D.C. Delegation and the HAA intend to work collaboratively to monitor and evaluate implementation of the Comprehensive Care Plan.

Description of the District

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) local jurisdictions referred to as Wards. The District of Columbia is unique in that it operates simultaneously as a city, a state, and special district of the federal government. It is a densely populated urban area.

According to the U.S. Census, the estimated population for the District of Columbia in 2007 was 588,292, a one percent increase from the 2005 census population. The general demographic characteristics for the District reveal 47.1% males and 52.9% females; median age of 34.9 years;

80,749 individuals or 13% of the population born outside of the United States. Of those foreign-born residents 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. In addition, there were: 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).

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 workforce. Its civilian workforce has a higher percentage of adults with 16 or more years of education than 46 other states. The racial and ethnic diversity in the District by Wards can be found in Table 1 below.

Table 1: Racial/Ethnic Diversity for All Wards, District of Columbia, 2000*[1]

	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%
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%

* Table is based on population data taken from the 2000 U.S. Census

Figure 1 below depicts a map of the District of Columbia by Wards.

District of Columbia Ward Map

Washington D.C. Priority Setting and Resource Allocation Process

The D.C. Delegation serves as the planning and advisory body for the distribution of Ryan White Parts A and B funds in the District of Columbia. It also provides the HAA with funding recommendations, including how to re-program funds during the grant year and how to implement new HRSA mandates that affect overall service delivery. The mission of the D.C. Delegation is to: improve HIV/AIDS services in the District, guide long-range planning, allocate funds, formulate policies, and advocate for optimal services. Members of this advisory body include PLWH/A, providers of Ryan White services, and affected or concerned members of the community.

Each year the D.C. Delegation is involved in the priority setting and resource allocation process for Ryan White Part B funds. In order for the participants of this process to make viable contributions and informed recommendations, the HAA makes the following qualitative and quantitative information available:

1. *Epidemiological Data*, which reflect the trends/changes in the demographics of the general population living with HIV/AIDS and infected with HIV/AIDS in the District.
2. *Outcome Evaluation Data*, which include the effects of clients receiving specific services.
3. *Service Utilization Data*, which encompass the demographics of who is/is not receiving care, how many clients are receiving care, and how much it costs to provide these services.
4. *Qualitative and Needs Assessment Data*, which provide feedback from focus groups, client surveys, and key informant interviews regarding gaps and barriers to services.
5. *Other Relevant Data*, which denote type of services supported by other sources of funding and insurance data.

In addition to this quantitative and qualitative information, personal testimonies from participants are considered during the priority setting and resource allocation processes. The D.C. Delegation often serves as a venue where PLWH/A and providers can share experiences and expertise since the opinions, experiences, and expertise of these individuals are valuable contributions to the planning process.

Conclusion

The Wards that compose the District are distinctively different. The process established by Part B funding includes the D.C. Delegation, which works with the HAA to make funding recommendations. Additionally, data from formative and summative assessments and input from active PLWH/A participants are used to make Part B funding decisions.

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

This section of the Comprehensive Plan examines the *Human Immunodeficiency Virus (HIV)* epidemic in the District of Columbia and groups disproportionately affected by HIV/AIDS.

Current HIV/AIDS Epidemic in Washington, D.C.

The discussion of HIV/AIDS epidemiology includes data on newly diagnosed AIDS cases from January 1, 2006–December 31, 2007, as well as estimates of all living HIV/AIDS cases by demographic group and exposure category through December 2007. The HAA epidemiological team used AIDS surveillance data and estimates of the number of persons living with HIV (not AIDS). The estimates were derived from the 2005 CDC estimation of the number of persons living with HIV as of 2003 and the 2008 CDC estimation of the number of newly infected cases of HIV occurring every year. Appendix 1 summarizes AIDS cases newly diagnosed during 2006 and 2007, living AIDS cases and the estimated number of living HIV (not AIDS) cases by demographic group and exposure category. The third page of the attachment describes methods of calculations and sources used in compiling the estimated HIV (not AIDS) case counts described in Appendix 2.

Estimated Living HIV/AIDS Cases in Washington, D.C.

As of December 31, 2007, there were an estimated 26,704 people living with HIV or AIDS (PLWH/A) in Washington, D.C., representing an estimated 4.5% of District residents. Of the estimated PLWH/A, more than two-thirds (69.7%) are male. The most common exposure category is male-male sex (36.4%), closely followed by heterosexual sex (30.3%) and injection drug use (16.3%). There is no known or recorded exposure for 13.8% of the estimated cases. Thirty-three percent of the estimated PLWH/A are people living with AIDS (N=8,713).

PLWH/A are overwhelmingly and disproportionately people of color. African Americans comprise the majority of cases (75.4%) with an estimated 6% of African Americans in the District living with HIV/AIDS. Whites and Hispanics account for 16.4% and 4.8% of PLWH/A respectively.

Description of Estimated Number of People Living with HIV (non-AIDS)

On December 31, 2007, an estimated total of 17,991 people were living with HIV (not AIDS) in Washington, D.C. HIV estimates for the District of Columbia are based on the recently released CDC estimates of those living with HIV/AIDS and newly infected HIV cases. These estimates modify earlier estimates of 40,000 new HIV infections per year to 56,300 per year and includes person *unaware* of their HIV status. 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 cases has been under-reported. Code-based cases are in the process of being re-reported by name. The District of Columbia collaborates with the Centers for Disease Control and Prevention to improve its HIV/AIDS surveillance activities and anticipates significant number of new cases being reported in the near future.

Of those estimated to be living with HIV (not AIDS), 68.2% are male and 31.8% are female; 72.7% are black, 18.1% white, and 4.7% are Hispanic. While cases range widely in age, more than half (58.9%) of people living with HIV (not AIDS) in Washington D.C. were diagnosed between the ages of 30-49. More than 14% of cases were diagnosed when they were over the age of 50, thereby complicating medical care since aging and geriatric-associated ailments compound HIV care. The largest portion of people living with HIV (not AIDS) contracted the virus through male-to-male sexual contact (36.0%), followed by heterosexual sexual contact (32.7%), and injection drug use (12.6%).

Description of People Living With AIDS (PLWA)

On December 31, 2007, a total of 8,713 people were living with AIDS in Washington, D.C. According to the Centers for Disease Control and Prevention (CDC), in 2006, the District of Columbia had the highest newly reported AIDS case rate per 100,000 and the highest number of living AIDS cases per 100,000 by area of residence in the United States. It was estimated that the District of Columbia living AIDS case rate was 12 times the national average (2,016.5 versus 178.6 per population of 100,000).

Of those living with AIDS in Washington, D.C. on December 31, 2007, 72.7% were male, 27.3% were female; 81.1% were black, 13.0% were white, and 5.1% were Hispanic. Similar to people living with HIV (not AIDS), the majority of people living with AIDS in Washington, D.C. were diagnosed between the ages of 30-49 (69.4%). The largest percentage of people living with AIDS were those who report male-to-male sexual contact as the route of infection (37.2%), followed by those who contracted the HIV through heterosexual sexual contact (25.5%) and injection drug use (23.9%).

Description of Newly Diagnosed AIDS Cases, 2006-2007

Between January 1, 2006, and December 31, 2007, a total of 1,196 new AIDS cases were diagnosed in Washington, D.C. This represents an average of 99 new cases each month, or more than three new AIDS cases diagnosed in Washington, D.C. per day.

Among those diagnosed with AIDS in 2006-2007, 68.2% were male and 31.8% were female; 86.5% were black, 8.2% were white, and 4.3% were Hispanic. More than half (62%) were diagnosed between the ages of 30-49.

Transmission through heterosexual and male-to-male sexual contact account for the largest portion of newly-diagnosed AIDS cases at 31.6% and 31.8% respectively, followed by injection drug use (19.4%).

Epidemic Trends in Washington, D.C. for 2001-2006

The U.S. epidemic is more than thirty years old, during which time medical science has learned much about the HIV. Antiretroviral therapy (ART) now extends the lives of infected persons, and consequently, these advances in drug treatment required new responses from Ryan White-funded services. As the District takes on the challenges of setting priorities among populations and deciding resource allocations for appropriate interventions and services, there is also a need to be aware of the changing nature of HIV/AIDS and surveillance data. The District is confronted with trends of "late testers" and "concurrent diagnoses" and is identifying emerging populations.

The trend data presented here uses 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. These data are also presented in more detail in the *2007 District of Columbia HIV/AIDS Epidemiology Report*.

In Washington, D.C., there are definite trends emerging: the epidemic reflects greater percentages of women, heterosexual transmission, late testers, and concurrent diagnoses. The following data reveal the trends of HIV/AIDS in the Washington D.C. The data related to both newly diagnosed HIV/AIDS cases and all living HIV/AIDS cases reflect the period 2001-2006.[2] These data were used in developing the priorities for the Planning Council and, when used in conjunction with the current data sets and estimates, show a broader picture of the epidemic in the District over the last seven years.

Newly Diagnosed HIV/AIDS Cases, 2001-2006

Between 2001 and 2006, there were 7,947 new HIV/AIDS cases among District residents, of which 4,468 were AIDS cases. HIV/AIDS in the District disproportionately affects Blacks (84.3%) and males (67.0%). Of all new HIV/AIDS cases, 31.0% were attributed to heterosexual contact, followed by cases attributed to men who have sex with men (MSM) (26.9%). In comparison, the most commonly reported mode of transmission among persons living with HIV/AIDS at the end of 2006 was attributed to MSM (n=4,121), followed by heterosexual contact (n=3,670) and injection drug use (n=2,586). Approximately 34.2% of all new HIV/AIDS cases reported were 40 to 49 year olds, followed closely by those ages 30 to 39 year olds (31.3%). The majority of persons living with HIV/AIDS were diagnosed between the ages of 30 to 39 (35.7%) and 40 to 49 years old (32.3%).

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

There were 3,269 newly diagnosed HV (non-AIDS) cases from 2001-2006. As for gender, 64.7% were male and 35.3% were female. African Americans comprised 81% of the cases followed by Whites (11%) and Hispanics (4%). Of the newly diagnosed HIV non-AIDS cases, heterosexual transmission risk factors dominated (37.3% of cases), followed by MSM (25.7%) and IDU (13.2%). New HIV cases with *no identifiable risk (NIR)* represented 21.8%. In addition, 63% of newly diagnosed HIV cases occurred in individuals between 30 and 49 years old.

Among both females and males, Blacks make up the overwhelming proportion of newly reported HIV cases (91.9% and 75.1%, respectively). The most commonly reported mode of transmission among newly reported cases of HIV among females was heterosexual contact. The most commonly reported mode of transmission among newly reported cases of HIV among males was men who have sex with men.

Figure 2: Newly Diagnosed HIV Cases by Gender and Race, 2001-2006

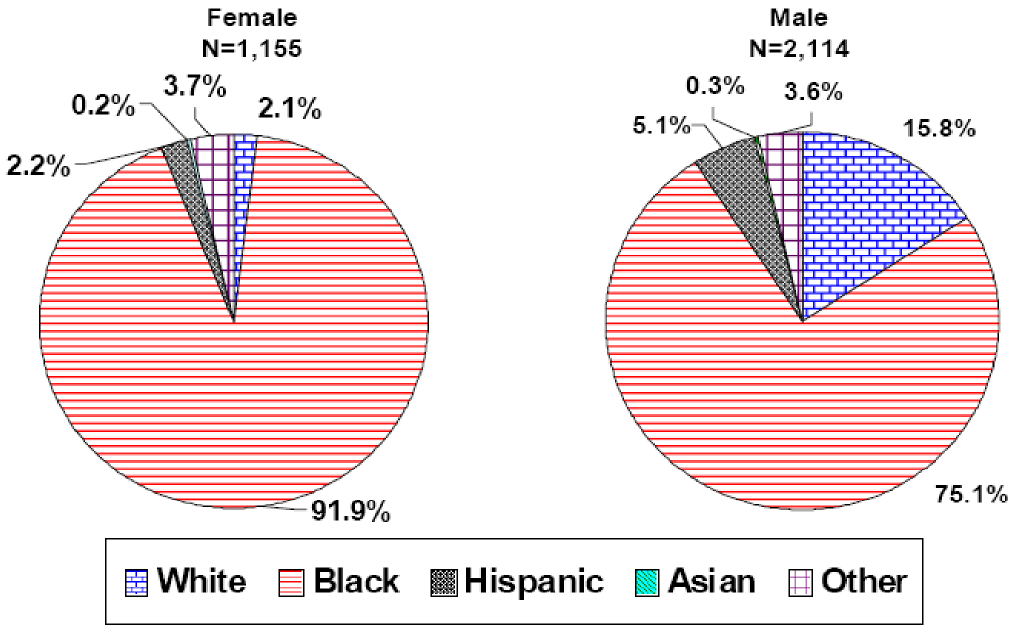
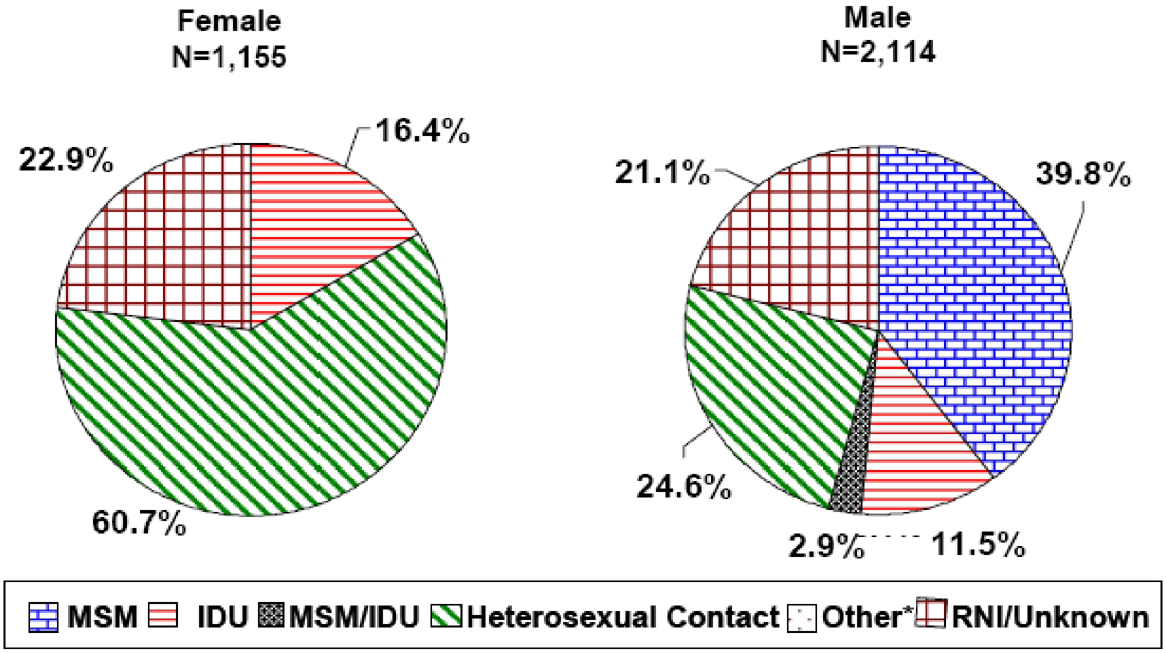


Figure 3: Newly Diagnosed HIV Cases by Gender and Mode Transmission (2001-2006)

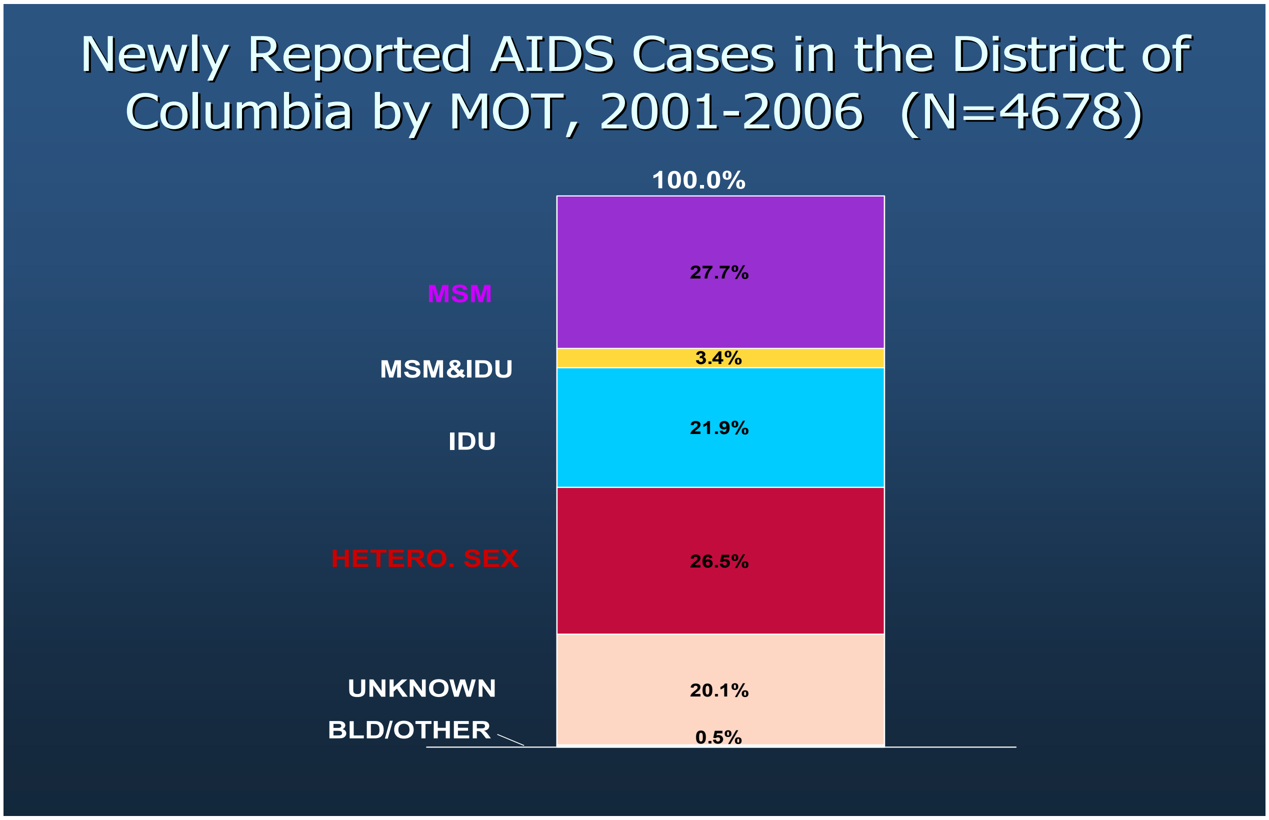


*Other race includes mixed race individuals, Alaska Natives, American Indians, Native Hawaiian, Pacific Islanders, and unknown races.

Newly Diagnosed AIDS, 2001-2006

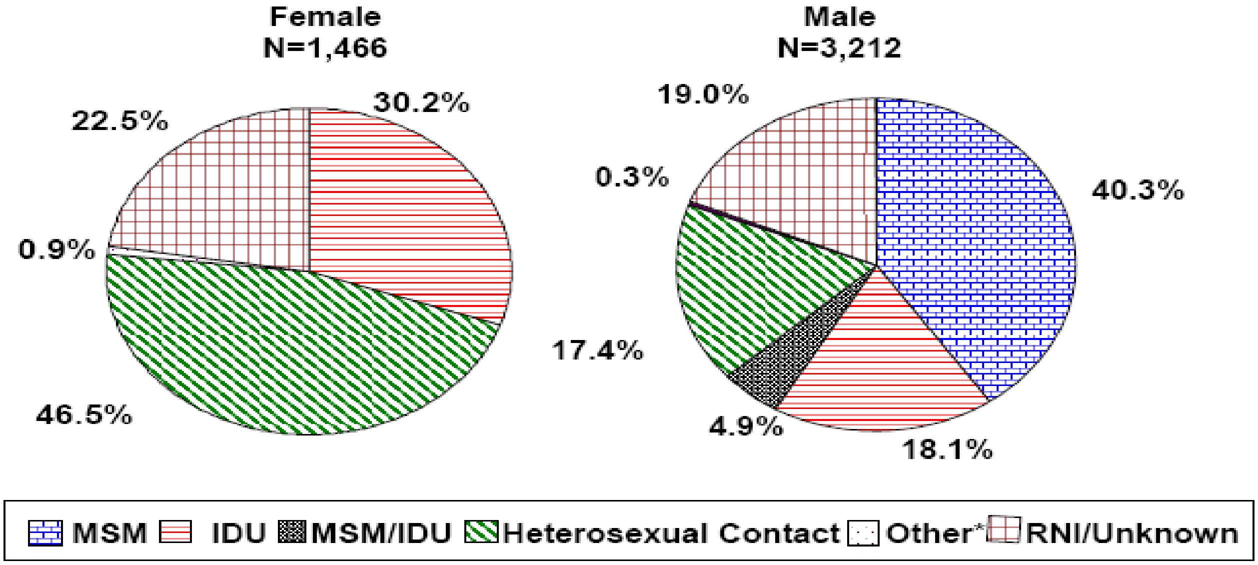
There were approximately 4,678 cases of AIDS diagnoses during the period 2001-2006 in the District of Columbia. Of these, 68.7% were male; 86.6% were Blacks; 67.1% were diagnosed with AIDS between the ages of 30 and 49. Geographically, Ward 8 accounted for 15.9% of the cases, followed by Wards 5, 7, 6, and 1 (15.5%, 15.4%, 14.6%, and 14.4%, respectively). Overall, MSM and heterosexual sexual contact accounted for nearly equal proportions of newly diagnosed AIDS cases, 27.7% and 26.5% respectively.

Figure 4: Newly Diagnosed AIDS Cases by Mode of Transmission (2001-2006)



The most common mode of transmission for males was men who have sex with men (MSM) (43.40%), followed by no identifiable risk (NIR) (19.94%), high-risk heterosexual contact (16.37%), and injection drug use (IDU) (15.19%). Among females, the most common mode of transmission was high-risk heterosexual contact (48.20%), followed by IDU (27.07%) and NIR (23.79%).

Figure 5: Newly Diagnosed AIDS Cases by Gender and Mode of Transmission (2001-2006)



Case rate data comparisons (made between the nation and Washington D.C.) are not reliable since case rate estimates for HIV (not AIDS) are not nationally available by race/ethnicity or gender. However, case rate data by race, ethnicity and gender are available for AIDS both nationally and locally, making it possible to calculate and compare crude rates for newly reported AIDS cases in Washington D.C. and the United States, using information from the *CDC HIV/AIDS Surveillance Report for 2006*. Table 2 displays the calculation of crude, newly reported AIDS case rates using these sources.

Table 2: Rate of AIDS Cases among Adults and Adolescents by Gender and Race for Washington, D.C. and the United States (2006)

	New AIDS Cases per 100,000		
	Washington D.C.*	**United States****	**Ratio**
Gender			
Male	206.2	22.4	**9.2 : 1**
Female	83.6	7.8	**10.7 : 1**
Race / Ethnicity			
White, not Hispanic	32.4	5.4	**6.0 : 1**
Black, not Hispanic	230.1	47.6	**4.8 : 1**
Hispanic	78.7	15.6	**5.0 : 1**
Asian	0.0	3.7	**-**

** Washington D.C. AIDS case rate using the District of Columbia HIV/AIDS Epidemiology Annual Report (Figures 32 and 33)*

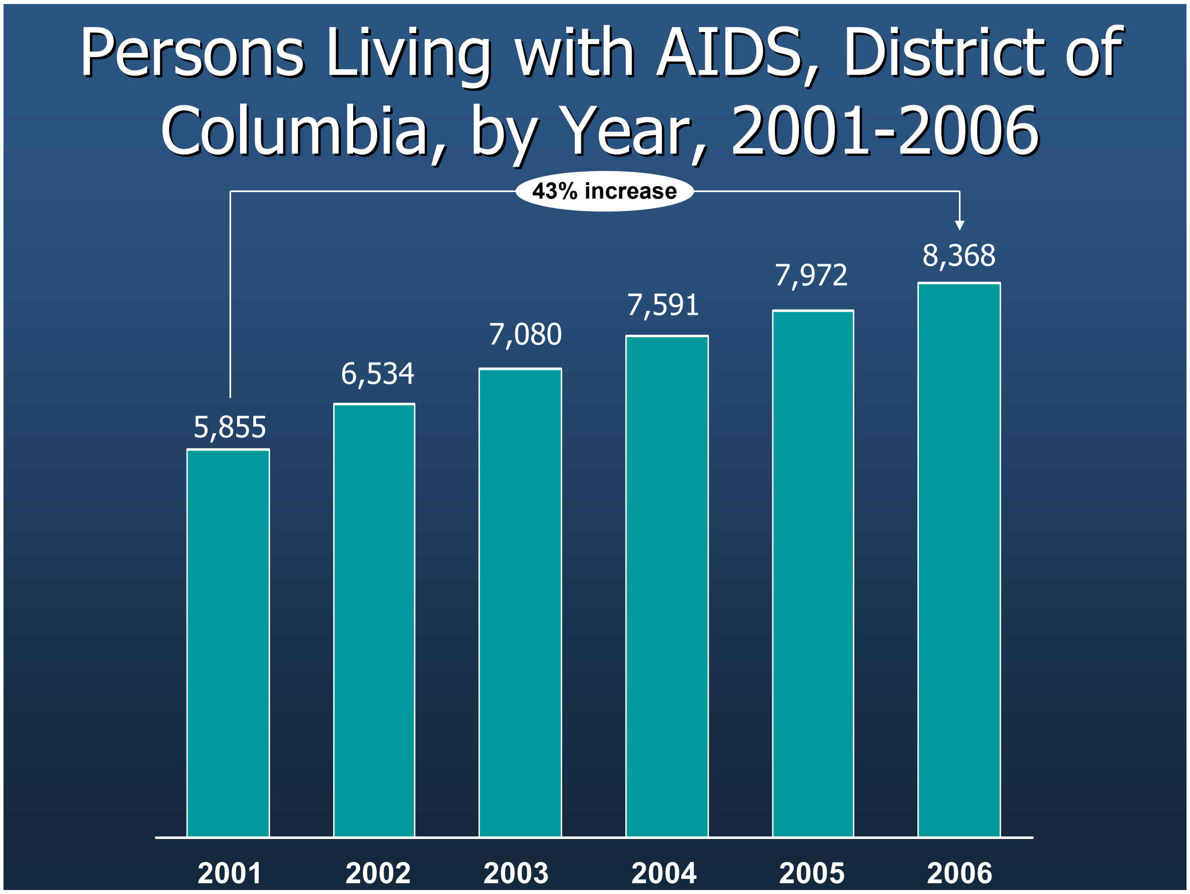
****US rates were calculated using CDC's 2006 HIV/AIDS Surveillance Report (Table 5a)*

Comparing the new AIDS case rates, per 100,000 for men, women, Whites, Blacks, Hispanics, and Asians, in the District with the same populations in the U.S. demonstrates that the District has a much higher HIV/AIDS case rate. This analysis underscores the severe impact of HIV/AIDS and the consequent severe need for Ryan White CARE Act Part B services in Washington D.C.

Living AIDS Cases 2001-2006

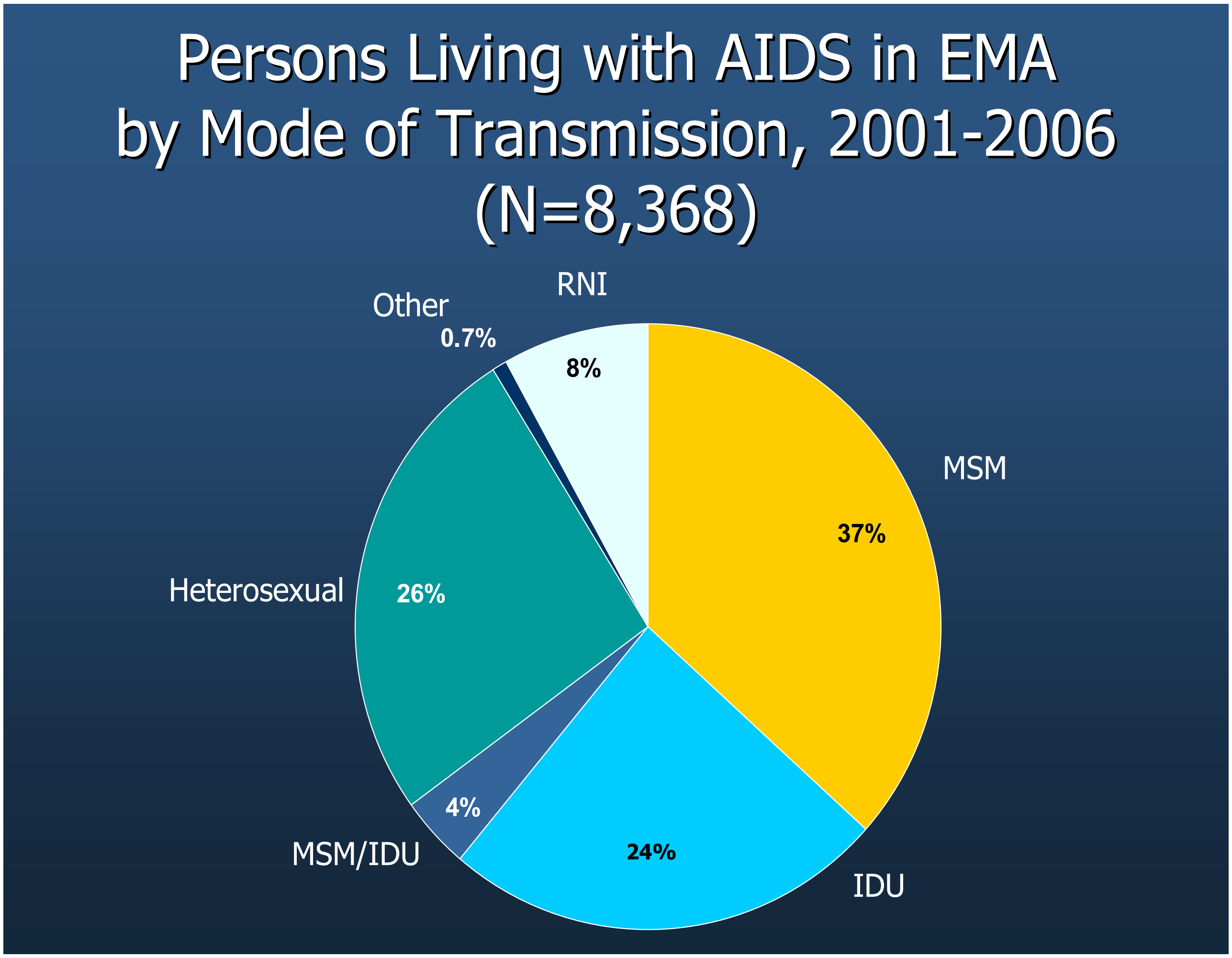
As of 12/31/2006, persons living with AIDS between the ages of 30-39 made up the largest proportion of cases (37%). As of 12/31/06, Blacks made up just over 81% of all cases of persons living with AIDS. Between 2001 and 2006, there was a 43% increase in the number of persons living with AIDS in the District of Columbia.

Figure 6: Persons Living with AIDS by Year (2001-2006)



Thirty-seven percent of living AIDS cases were reported as MSM. Heterosexual transmission and injection drug use accounted for 26% and 24% of living AIDS cases, respectively.

Figure 7: Persons Living with AIDS, by Mode of Transmission, as of 12/31/2006

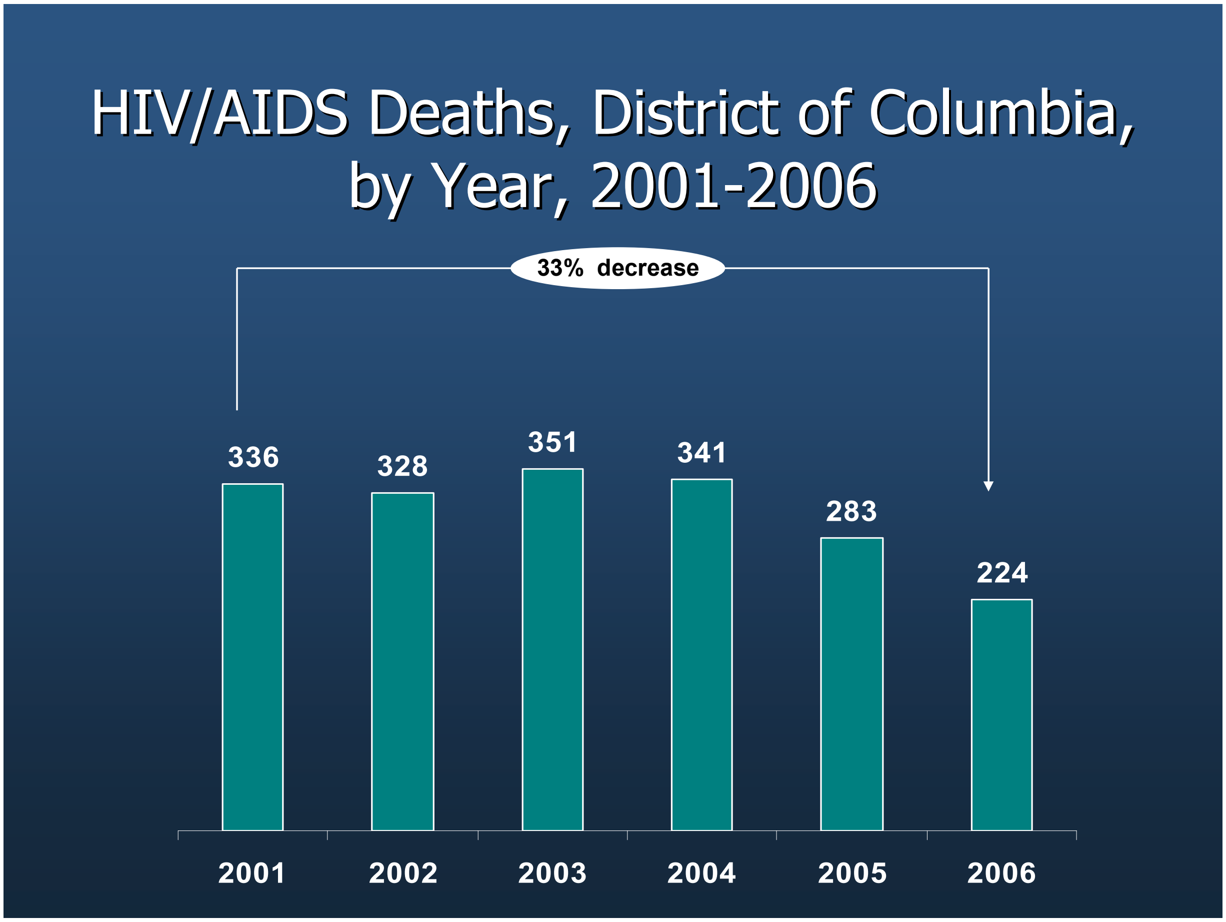


Persons Living with AIDS in EMA by Mode of Transmission, 2001-2006 (N=8,368)

HIV/AIDS Mortality (2001-2006)

In Washington, D.C., there was a 33% decrease in the number of AIDS deaths between 2001 and 2006 (See Figure 8). Approximately 63% of the HIV/AIDS deaths occurred among persons between the ages of 30 and 49. The burden of HIV/AIDS deaths in the District disproportionately occurred among IDU, accounting for 32.9% of deaths during this period despite accounting for only 21% of living HIV/AIDS cases as of December 31, 2006. Similarly, Blacks accounted for 81% of living HIV/AIDS cases with 90% of deaths, indicating a disproportionate burden of deaths as well. Persons infected through heterosexual transmission and MSM accounted for, respectively, 25.3% and 24.4% of deaths.

Figure 8: HIV/AIDS Deaths, 2001-2006

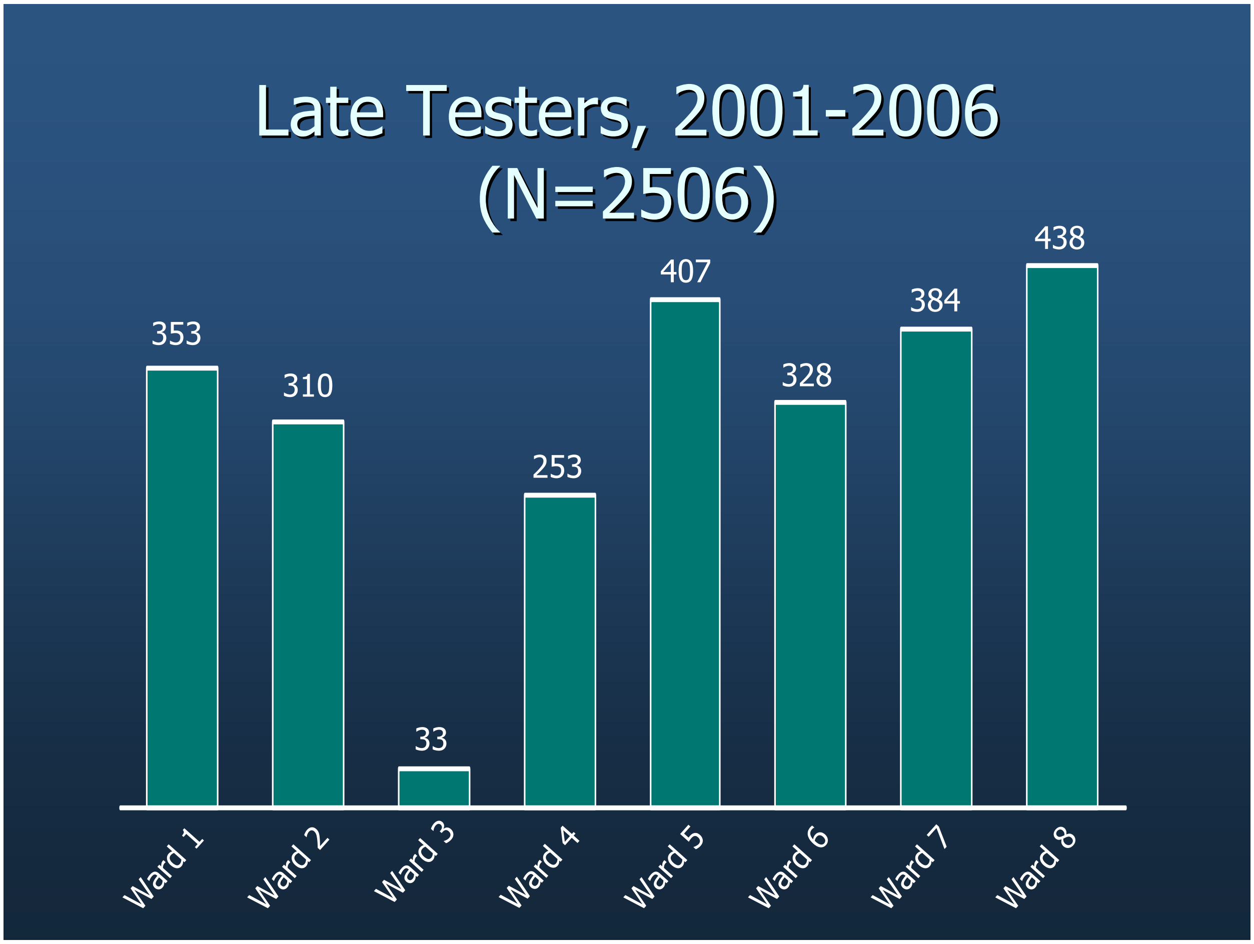


Special Issues–Late Testers (2001-2006)

Within the District, there is a persistent problem of "late testing." *Late testers* include those cases diagnosed with AIDS within 12 months of initially being diagnosed with HIV. The number is represented as a proportion of AIDS cases diagnosed with HIV 12 months or less prior to being diagnosed with AIDS. This population is a *subset* of AIDS cases and does not include HIV (non-AIDS) cases in the analysis. The total proportion of late testers in the District was 61.7% during 2001-2006. Late testers represent a segment of HIV/AIDS cases that could have been identified earlier in the course of their disease, possibly preventing the AIDS diagnosis, if routine HIV screening in health care settings was available.

The number of AIDS cases that are late testers varies by Ward. The largest number of late testers among newly diagnosed AIDS cases resided in Wards 8 and 5. These Wards also had the highest number of newly diagnosed AIDS cases during this time period with 570 and 563 cases each.

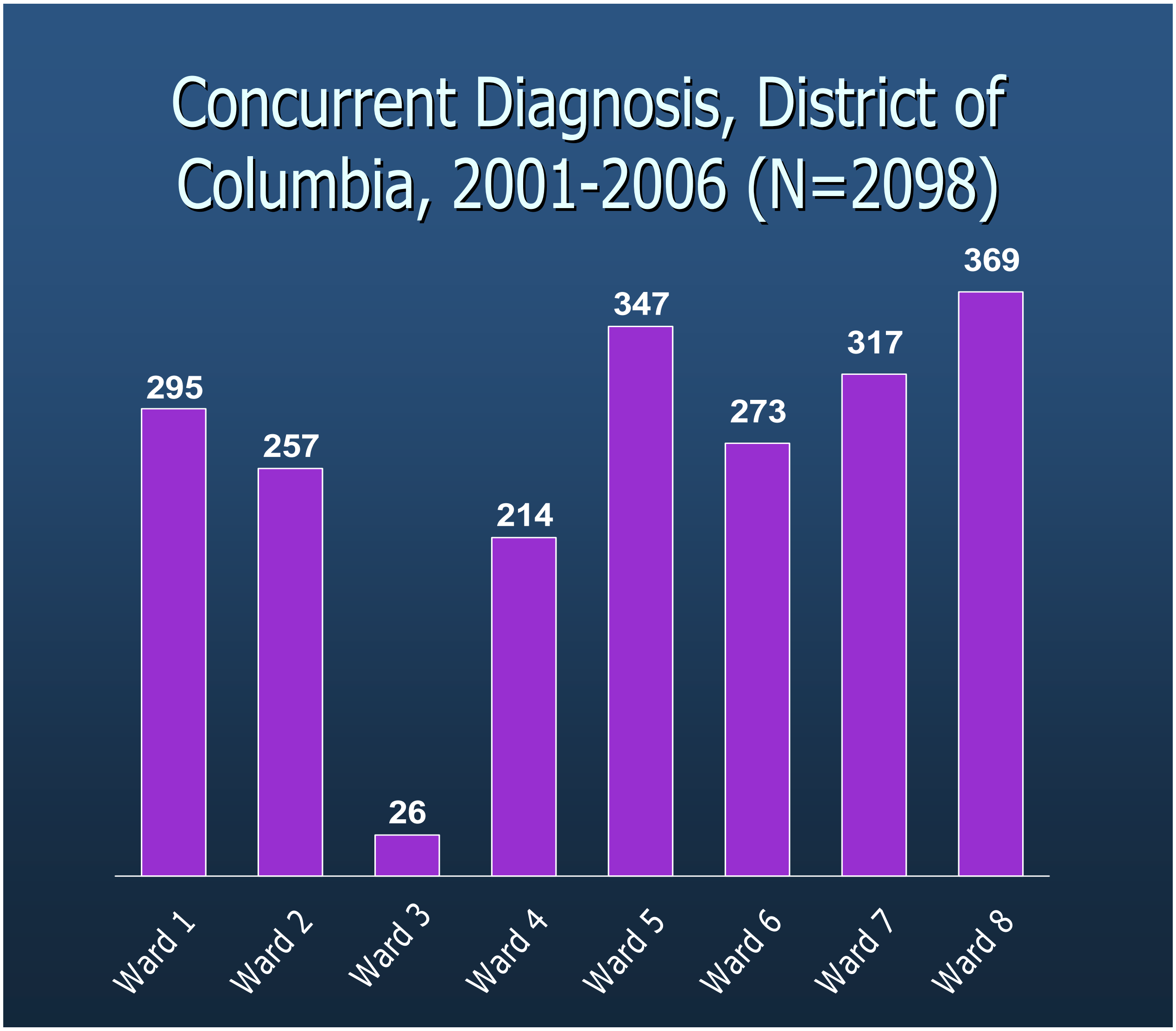
Figure 9: Late Testers by Ward (2001-2006)



Concurrent Diagnoses (2001-2006)

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 District is 51.7%. The trend by Ward here follows that of late tester data with Wards 8 and 5 reporting the highest numbers.

Figure 10: Concurrent Diagnosis, 2001-2006



Emerging and Special Populations Living with HIV/AIDS in the District of Columbia

Using epidemiological data, the unmet need framework and ongoing needs assessments, the District has identified subsets of populations that require special focus. This process 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 examining existing disparities in the health care system. The HIV/AIDS Administration utilizes this data to determine funding priorities and resource allocations to ensure that Part B funding improves access to care and targets health disparities in the District.

Prioritizing services and funding to assist those most in need will require special attention since future funding decisions must incorporate changes mandated under the 2009 reauthorization of the *Ryan White Treatment Modernization Act of 2006* and to assure consistency with the national goals established by the national health agenda, *Healthy People 2010*. Both emphasize equitable access to health care services, decreases in health care disparities and integration of disease prevention in treatment services. Ensuring optimal and effective services for hard-to-reach and disenfranchised populations in the District are valued goals of the HIV/AIDS Administration.

Minorities

Racial and ethnic minorities account for 84% of the individuals living with HIV or AIDS in Washington, D.C., yet they comprise only 61 % of the total population. A continuing trend in the District is the disproportionate impact of HIV/AIDS on Blacks, accounting for 87% of newly diagnosed AIDS cases from January 1, 2006, to December 31, 2007, and 73% of people estimated to be living with HIV (not AIDS) as of December 31, 2007. This is particularly disturbing since Blacks represent only 55% of the population of the Washington, D.C. Generally, minorities, and blacks in particular, carry a disproportionate burden of disease in Washington, D.C.

Service providers in the District report an increasing number of immigrants from Latin America, the Caribbean and Africa. As part of the priorities and funding allocation processes, the District shall be mindful of how the growing immigrant population might affect and impact the HIV care and treatment continuum and health care financing. Linguistic, cultural and clinical requirements for immigrant populations require special services and additional resources. Other challenges of serving 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, and increasing accessibility of services for uninsured individuals and families.[3]

In alignment with goals established by Healthy People 2010, the District has prioritized services and programs, which target special populations and racial/ethnic minority communities that are disproportionately impacted by HIV/AIDS. This will enable the District 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.[4] However, MSM (including MSM who inject drugs) account for 36% of the estimated number of people living with HIV/AIDS in the District and 37.2 % of the AIDS cases living in the District on December 31, 2007, demonstrating a clear disproportionate impact of HIV/AIDS on this population in the District.

Injection Drug Users (IDU)

Injection drug users (IDU), including men who have sex with men and inject drugs, make up approximately 16.3% of the estimated number of people living with HIV or AIDS in the District. But in the District, injection drug users accounted for nearly one-third of the AIDS-related deaths in the District occurring between 2001-2006.[5]

It is clear from the epidemiological data that African Americans are over-represented in this exposure category. Between 2001 and 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).[6] Therefore, the disparate rate of HIV among African American IDU in the District must be addressed when considering the treatment and prevention needs of the African American population.

Transgender Persons

Accurate data on the number of transgender people is unavailable due to the non-reporting or lack of reporting often related to generalized misperceptions and reluctant inquiry to determine gender other than male or female in addition to the lack of documentation practices and insufficient data elements other than male/female to accurately capture and report on the diverse transgender population. In the District, the transgender population is relatively large and diverse, yet frequently overlooked, misunderstood and inaccurately characterized. Every survey and focus group conducted with transgender individuals in the District indicates extraordinarily high rates of HIV risk behaviors and infection, along with a complex set of service needs.

The most comprehensive study completed in the District, *The Washington, D.C. Transgendered Needs Assessment Survey (WTNAS),* was completed in 2000. The WTNAS surveyed 263 transgender individuals in the District. Of those surveyed, 25% of participants were HIV positive and 22% did not know their HIV status. And nearly two-thirds of the male-to-female transgender individuals surveyed were HIV positive.[7]

Transgender participants of a focus group conducted in April 2006 expressed frustration at frequently being identified as men who have sex with men. They noted that transgender people frequently encounter medical and social service providers who fail to exhibit appropriate understanding, sensitivity, and respect and lack the necessary training for the effective treatment of transgender people, especially regarding the multiple issues of HIV, hormone use, silicone injections, gynecological care, and HIV prevention. One focus group participant reported pressure to live according to gender norms as a condition of receiving services.[8]
Due to discrimination and limited education, many transgender individuals have difficulty finding and keeping jobs. Of those interviewed in the WTNAS, 40% had not finished high school, 29 % reported no income, and 31 % reported annual incomes less than $10,000.[9] Focus group participants frequently cited job training as a priority, and an unmet service need. Anecdotal evidence suggests that there is substantial sharing of injection drug equipment for hormone therapy.[10] Of those surveyed in the WTNAS, 52% had taken hormones at some point yet only 34% reported that a doctor monitored their blood levels while taking hormones.[11]

The added costs of caring for this population, in addition to those related to standard HIV/AIDS care, include those related to case management, outreach, adherence, transportation, mental health, substance abuse, employment, food, housing, and basic living expenses. For example, according to the WTNAS, 47 % of those interviewed did not have health insurance, 34 % reported that their drinking was a problem, 36% felt they had a problem with drugs, and another 35% reported suicidal ideation.[12] To reach and properly provide for this population, it also is important to invest in cultural-competency training for medical and other service providers, as well as to train providers on the specific medical and other culturally specific needs of transgender people.

Formerly incarcerated PLWH/A

The criminal justice system plays a large role in the lives of many of the District residents. Although 60% of District of Columbia residents identify as African American, they comprise 89% of the inmate population who are in prison or jail or on probation, parole, or pre-trial release, according to the District of Columbia *Department of Corrections Facts & Figures 2008*.[13] This has broad reaching implications for the continued, disproportionate impact on African Americans in the District. In the District of Columbia alone, 21,000 individuals pass through local correctional facilities each year. Over 2,500 former prisoners return to the District 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 surrounding States. In the District, 15,966 incoming inmates were screened for HIV infection between June 2006 and

August 2007.[14] The screening revealed that heterosexual contact and non-injection drug use were the primary risk factors for those identified as living with HIV/AIDS.

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.[15] 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 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.[16] 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 Persons

The District 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.[17] An estimated 5,751 individuals in the District were homeless when diagnosed with HIV/AIDS.[18] Homeless individuals experience higher rates of: morbidity and mortality; increased barriers to care and prevention such as substance abuse, lack of insurance and mental illness; and challenges to adherence.[19] Because of these risks, the HAA 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 approximately 23% of living adult and adolescent AIDS cases at the end of 2006. In the District, 27.3% of living AIDS cases were women. Among newly diagnosed AIDS cases women account for 32% of AIDS cases diagnosed between January 1, 2006, and December 31, 2007. Similarly, women account for 31.8 % 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.[20]

Conclusion

When compared to the nation as a whole, Washington, D.C. is disproportionately impacted by HIV/AIDS. It was estimated that the District of Columbia living AIDS case rate was 12 times the national average (2,016.5 versus 178.6 per population of 100,000). The epidemic in Washington, D.C. is a modern epidemic with an estimated 26,704 people living with HIV/AIDS. In addition, PWLH/A in the District of Columbia experienced a very high mortality rate. HIV disproportionately impacts the minority community of the District with 84% of cases being classified as racial/ethnic minorities although the total population is only 61% minority. The greatest impact of HIV/AIDS is among persons described as Black/African American with 6% of all Blacks in the District estimated to be living with HIV/AIDS. Male-to-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 62.3% 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 District. 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 one year after learning their HIV status. As Washington, D.C. continues to develop systems to promote equal access to care, it is important to continue to conduct inquiry on affected populations and promote health care access to groups most at risk for acquiring the HIV.

Chapter 3: Description of the Local Response to the Epidemic

The Washington D.C. Department of Health has 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 the Whitman-Walker Clinic was held at the George Washington University. Eleven hundred people attended the event.

- In August 1983, the Whitman-Walker Clinic received 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 living 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 Executive 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 commissioned responsibility on matters of the emergence of HIV/AIDS to the Mayor. This authority was later delegated to the Director of the 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.

- Mayoral 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/A 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 1992-1996.

- 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 antibody 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 Title I 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[21] responsible for monitoring progress in HIV within the District, issues the first report card to chronicle achievement, or lack thereof, for HIV/AIDS in the nation's capital.

- On April 4, 2007, The Mayor convened an HIV/AIDS summit that convened 120 representatives from government, provider, faith-based, and community-based organizations to brainstorm how the HIV/AIDS Administration could improve response to the epidemic. Key stakeholders identified strengths and areas of improvement. 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. Department of Health 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".[22]

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

- 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 even though the government has made important strides in combating the disease, the HIV/AIDS epidemic poses an ominous threat to residents.

Conclusion

The history of the District of Columbia response to the HIV/AIDS epidemic reflects the dedication and perseverance of many persons. The history reflects the tackling of tough issues such as the inclusion of HIV specialty services into public health care, establishment and implementation of needle exchange programs and the advocacy for informed consent in HIV screening. For the D.C. Delegation and the HAA, understanding the historical response to HIV/AIDS keeps the commitment strong and demonstrates a continued effort to plan for and ensure equitable access to all PLWH/A, regardless of income.

Chapter 4: Assessment of Care and Prevention Needs

This chapter discusses the activities conducted to gather information on the need for services among PLWH/A.

Needs assessments play an important role in providing valuable information about the service needs and gaps of PLWH/A. A comprehensive needs assessment process includes the development of an epidemiological profile; collection of information from people living with HIV through focus groups, surveys and community forums; and the development of a resource inventory, an unmet needs determination and assessment of the service system.

In addition, the needs assessment process requires the coordination and integration of information from a variety of sources. The Statewide Coordinated Statement of Need (SCSN) process permits the various Ryan White CARE programs to work in tandem to improve services, reduce duplication of effort, and address unmet need. The outcome of the SCSN process is to identify emerging trends in HIV/AIDS health and support services, critical gaps in services and the issues that cut across service providers from all parts of the CARE Act. The SCSN includes input from consumers and providers throughout the District.

This chapter begins by looking at the SCSN process; discusses the unmet need estimate for the District, as well as summarizes other needs assessment activities conducted in the District under Part A. Collaboration between Parts A and B needs assessment activities help to conserve resources and to use Part B funds to fill service gaps.

2009 Statewide Coordinated Statement of Need (SCSN)

Since much of the planning process associated with the development of the SCSN duplicates Comprehensive Plan efforts, the HAA requested permission from the Health Resources and Services Administration (HRSA), HIV/AIDS Bureau (HAB) to combine this document with the Comprehensive Plan. The HRSA HAB granted approval, and thus, the findings of the SCSN are included in this document.

This section reviews the last SCSN and summarizes the recent SCSN conducted in November 2008, when participants from all CARE Act programs identified emerging trends, critical gaps in services and contributed to the development of broad goals across *Titles* (now *Parts*) over the next three years as efforts to provide effective HIV care in the District.

In planning for the 2009 SCSN, the HAA sent invitations to all major providers of Ryan White Care Act services in the Washington D.C. area. In preparation for the meeting, the HAA also sent a copy of the 2006 SCSN to all participants. Five providers, representing all CARE Act Parts attended the SCSN meeting. HIV/AIDS Administration staff presented an overview of the past SCSN and an epidemiological update. A brainstorming venue was used to identify trends, gaps and cross-cutting issues. The group also assisted in the development of broad goals. Tabled below is a summary of the 2009 SCSN issues.

The findings from both the 2006 and 2009 SCSN are tabled below in the tables below (Table 3).

Table 3: Summary of Statewide Coordinated Statement of Needs

2006 SCSN	2009 SCSN
Emerging Trends – "Evolving circumstances, polices, procedures or resources that affect service delivery"	**Emerging Trends – "Evolving circumstances, polices, procedures or resources that affect service delivery"**
Increasing co-morbidity of Hepatitis B and C as well as care complications caused by Hepatitis B and C	Need for District of Columbia Department of Health to advocate for HIV education in the schools. (This would be a helpful linkage with prevention efforts).
High-risk for co-infection of Tuberculosis (TB) and HIV	The nurse shortage is hampering the ability of primary care programs to hire nursing staff.
High rates of substance abuse and the difficulty of care issues for IDU substance abuse	There is increasing numbers of clients who are co-infected with Hepatitis C. The D.C. Healthcare Alliance program does not cover this treatment and this drives up the average cost of primary treatment and care.

2006 SCSN	2009 SCSN
Emerging Trends – "Evolving circumstances, polices, procedures or resources that affect service delivery"	**Emerging Trends – "Evolving circumstances, polices, procedures or resources that affect service delivery"**
Increasing use of crystal methamphetamine and the likely rise in new HIV infections	Providers reported significant numbers of persons are falling out of care and it is difficult to re-connect with them.
Increasing need for mental health services	Across CARE Act funding, there needs to be a standard definition for medical case management, especially since not every agency has on-site primary medical care.
Critical Gaps and Barriers to Service	**Critical Gaps and Barriers to Service**
Housing services	The old allocation model is not useful. Medical care is not the top need in the District and there needs to be more funding for mental health and substance abuse services.
Case Management	Key service gaps include treatment adherence, services for transgender population and growing need for food vouchers and a food bank.
Transportation	There is a need for food, especially with the recent hard economic times. Other gaps include transgender housing, effective strategies to serve increasing numbers of MSM adolescents, and funds to pay for transportation to work and job training.
Cultural sensitivity, specifically the need for interpretation services	A significant number of adolescent females are being treated for sexually transmitted infections (STI) and most report they are not referred for HIV testing. It is important to get clinic settings to encourage HIV testing. This strategy would help with the unmet need in the District.

2006 SCSN	2009 SCSN
Critical Gaps and Barriers to Service	**Critical Gaps and Barriers to Service**
Dental	There needs to be improvement in the release of information processes between the D.C. Public Schools and mental health providers around Individual Educational Plan (IEP), which have valuable school-based information necessary for effective treatment strategies with adolescents and children.
Discharge planning for the incarcerated and newly released sub-populations	The process for food stamps eligibility is long and cumbersome and is a barrier to care for families. The re-certification process can take from 45-60 days and drains Ryan White resources.
Substance abuse treatment	Stigma is a significant barrier among substance users. Most know their status, but they will not test due to stigma as many fear this knowledge will disrupt their using habits. They also fear becoming an outcast in their peer networks.
	The service system needs an effective treatment adherence model.
	Transportation for homeless clients is a barrier.
Cross Cutting Issues – "Concerns shared by a number of CARE partners"	**Cross Cutting Issues – "Concerns shared by a number of CARE partners"**
Coordination of care among CARE Act providers	With increasing numbers of transitioning adolescents into adult primary care settings, providers need effective strategies to link and retain in care this population. If not, they may potentially be lost to care as adults.
Vocational training is needed for PLWH/A due to improved health status	Community connections are very important and there needs to ongoing forums and dialogue among agencies about patient needs.

2006 SCSN	2009 SCSN
Cross Cutting Issues – "Concerns shared by a number of CARE partners"	**Cross Cutting Issues – "Concerns shared by a number of CARE partners"**
Limited housing resources allocated for special needs	Better discharge planning needs to be done in order to transition persons out of jails and into community-based HIV (services). Continuity of care is difficult, especially for those on HAART.
Communications through updating a website	There is a need to get providers to discuss customer satisfaction and quality improvement as a community.
Geographical focus-East of the Anacostia River	Need for information coordination across mental health, substance abuse, and housing services regarding client health status and outcomes.
Broad Goals	**Broad Goals**
Emergency Preparedness-Ensure the establishment of a contingency plan for the coordination and delivery of HIV services in the event of a catastrophic event such as Hurricane Katrina.	Develop and build collaborations with CARE Act program providers and non-CARE providers such as housing, substance abuse, mental health, social services in order to fully address the multiple needs of PLWH/A.
Counseling and Testing–Ensure that OraQuick rapid testing method is implemented in all testing venues	Increase the capacity of providers to work with special populations including adolescents, transgender and persons newly released from incarceration.
Special populations-Develop culturally sensitive intervention and prevention initiatives for special populations	Continue efforts to increase accountability through improved data collection systems.
Data Management–Continue to develop and conceptualize a centralized database that houses an inventory of available slots across services and providers	Continue efforts to find persons not in care and implement strategies that retain persons in care.

2006 SCSN	2009 SCSN
Broad Goals	**Broad Goals**
Clinical Trials-Educate and build trust in the community to serve as a catalyst to increase awareness of the benefits of clinical trials	Strengthen collaborations in order to provide a seamless, integrated system of care that is culturally competent.
Care and Prevention-Create a working group to identify areas where prevention and care planning groups can collaborate in order to improve the effectiveness of Ryan White care.	Collaborate with correctional systems to establish coordinated planned release.

Much of the data generated in the recent SCSN reinforces needs that were previously identified in the 2006 SCSN. Some prominent themes include the need for better coordination and collaboration in care across core medical and support services. Data and the need to focus on outcomes are re-occurring themes. The populations facing special challenges include African Americans, transitioning adolescents, newly released prisoners, homeless persons, men who have sex with men (MSM), and transgender persons.

The 2009 SCSN is both a process and a product. The process is a continual re-evaluation of the needs of PLWH/A while the product is a mechanism to inform the CARE planning process and to incorporate into the goals and objectives of the Comprehensive Plan.

Focus Interviewing Groups (FIG)

In 2008, the District also assessed consumer needs using a focus-interviewing group (FIG) format. The FIG were designed to capture the services accessed by target population and region. The FIG targeted the following populations in the District of Columbia: African Americans heterosexual women; African American MSM.; Latino/as; persons living with hepatitis C; and homeless individuals. Fifty- three individuals from the District participated in five focus groups. The members of the groups were reflective of the population represented. In addition to the FIG, the District hosted a community forum in conjunction with the local Community Prevention Group (CPG). Sixty-nine individuals participated in the community forum. These processes gleaned information on, "what services were working, what services were not working, retention in care factors and gaps." The results of these groups shed light on the barriers clients face in accessing and maintaining care in the District of Columbia.

African American Heterosexual Women

The African American heterosexual women who participated in this FIG accessed a broad range of core medical and support services including primary medical care, case management, substance abuse treatment, emergency financial assistance, and housing. The women mentioned access to vocational rehabilitation services not funded under Ryan White sources as a service gap. Participants reported that case management services were particularly helpful and most case managers showed genuine concern.

Service problems however, centered on case manager lack of knowledge about comprehensive resources, inability to properly inform clients on eligibility and referral processes for supportive services and lack of understanding about re-certification processes. The women also reported a lack of food services and food vouchers, a need for water filters, a long wait list for oral health services, limited affordable housing options, lack of physicians specializing in HIV care, and inadequate transportation as problems.

The women expressed problems with primary medical care, including not enough HIV specialists, physicians who were unaware of referral resources and limited access to pharmacies that participated with HIV programs. Furthermore, most women stated that they were not offered HIV testing during regular pre-natal visits.

Service recommendations included the need for more counseling and support on disclosure of HIV status and creation of a patient-centered newsletter detailing services so members could do more on their own to identify and secure resources.

African American MSM

The group cited mental health services as the main 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 people understand their risk for acquiring the 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 results. Participants expressed social stigma attached to being HIV-positive as a barrier for clients to access services. Participants thought that perceived stigma was an especially significant barrier to accessing substance abuse and mental health treatment services.

Reported service gaps encompassed the need for chronic care services, more complimentary/alternative care services, and more cultural competence training for providers.

HIV Positive Persons Living with Hepatitis C

Participants cited rising housing and utility costs, declining incomes, and lack of subsidized housing as 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 that severe side effects to the hepatitis treatment limited their ability to work. However, for most participants the side effects did not qualify them for disability benefits from the Social Security Administration. This creates a barrier for clients remaining on 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 providers of HIV and hepatitis C treatment. Participants felt that services could be improved with peer educators.

Latino/a

Latino/as cited access to quality medical and support services along with interpreter services as a high need. They indicated that funding for services had been reduced. Participants indicated that there is a need for more culturally competent HIV doctors. Stigma was mentioned as problematic in the provider setting and within their community. The participants felt mental health counseling services were important. Latino/a participants expressed a need for support counseling in dealing with the side effects of medication as well as more information about strategies for living with HIV. Additional needs expressed by participants were water filters and oral health services.

Homeless Persons

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 with them 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 access to HIV services, loss of prescriptions, and difficulty receiving mail. Participants cited gaps including clothing bank services, spiritual groups, transportation, and housing.

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 friends and love ones
- Experiencing a sense of responsibility to those who have died

District of Columbia Community Forum

In May 2008, the District of Columbia hosted a community forum that attracted 69 participants. PLWH/A completed a survey that asked them to identify their service needs by category, the services they had accessed within the past 12 months to address those needs, and the services they needed, but were unable to access.

Survey results are presented on the following page in Table 4 for those service categories for which at least 25% percent of respondents reported a service need, service utilization or an unmet need in the previous twelve months. The table also shows, for each service category, the number and percentage of those who needed the service and reported receiving it, and the number and percentage of those who needed the service and reported that the need remained unmet.

Table 4: 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%

Part A Consumer Survey

In 2007, the Ryan White Part A Washington, D.C. Area Health Services Planning Council conducted a survey of people living with HIV/AIDS. This survey is conducted biennially. In 2007, a total of 829 individuals participated in the survey. The survey included questions to identify services that were needed, but were not obtained by clients. The largest service gaps identified through this survey were primary medical care (60, 9%); AIDS Drug Assistance Program (ADAP) services (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

The Health Resources and Services Administration (HRSA) established a goal for HIV care services of 100% access and 0% disparity. This challenge requires communities caring for people living with HIV disease to ensure that all who need services receives them with no differences in the quality of care across populations. In order to achieve this goal, communities must have a way to assess the number of PLWH/A, who have an unmet need for HIV primary care. Toward this goal, a framework was created to calculate this number.

The HRSA defines *Unmet Need* as the total number of persons known to have HIV/AIDS who are not receiving primary medical care. Primary medical care is further defined as evidence of either CD4 count and/or viral load testing or use of anti-retroviral medications during the specified period, usually a 12-month period. The estimation consists of a single-method framework developed by the University of California in San Francisco and utilizes locally available population and care data.[23] A discussion of the framework as implemented by the HAA follows.

The District of Columbia estimates HIV cases based on a CDC-recommended methodology using AIDS counts as base. Linked service databases, Medicaid, and the HIV/AIDS Reporting System (HARS) were used to estimate unmet need.

First, the HAA worked to eliminate any duplication of clients in each dataset. This was a necessary step to avoid overestimation of the number of persons in care. The Ryan White data set was extracted from the Cross Program Reporting and Evaluation System (XPRES) and other databases used by providers independent of the XPRES. The dataset was consolidated, with duplicates eliminated, and analyzed.

The Medicaid data was extracted using a narrow-net, Statistical Analysis Software (SAS) program to identify HIV-related diagnosis, procedures and drug codes. Likewise, the HAA eliminated duplicate client information across diagnosis-based, pharmacy-based and procedure-based claims/files. Thereafter, cross-referencing (matching) was completed where possible across the datasets using a commercial analytical application, and then, analysis was conducted using the criteria for evidence of primary care visits, namely ARV orders and documentation of CD4 or viral load laboratory tests.

The final step in the estimation of unmet (or met) need is the determination of the number and proportion of cases using the Unmet Need algorithm developed under the auspices of the HRSA. Only 75% (13,493 cases) of the HIV estimate (17,991) is used to calculate the unmet need estimation. This explains the exclusion of the 4,498 of HIV-positive cases (25%) unaware of their HIV status.

Reasons for Choosing this Method

The method used to calculate unmet need was chosen because all of the data sets available to the District of Columbia at the time of this estimation were compatible with the Single Method Framework. Likewise, the HARS, a population-based HIV surveillance database, was the single source of AIDS cases. This database was used because of its availability, comprehensiveness and integrity of data. The estimation of unmet need in the District of Columbia was completed for the District.

Revisions or Updates

In the most recent two-year period, the District of Columbia transitioned from code-based to name-based reporting. However, within this validation transition, which requires a specified timeframe to ensure mature HIV case data, several projects were initiated in conjunction with the CDC, leading to appropriate adjustments to the AIDS database. First, newly reported cases were entered into the database. Secondly, duplicates of cases were eliminated and the Death Ascertainment Study was conducted to increase the integrity of the datasets.

Cross Program Collaboration

Cross- program collaboration was encouraged in order to obtain the data required to derive estimates. District of Columbia 2005 Hospital Discharge Data (with selected HIV/AIDS related diagnosis codes) was used to ascertain rates of individuals with specific payer mixes–private, other public and self. This provided valuable information on the type of payers in this population cohort. In addition, the D.C. Medical Assistance Administration, which implements two important waiver programs, provided information on client utilization and cost of care. Another important source of data was obtained through record review conducted during comprehensive quality assurance site visits. The analyses and reports served as a rich source of information from a convenient sample of providers and provided robust health information on the number of persons on ARV therapy and in care.

Limitations

HIV case counts are estimated, and may potentially overestimate or underestimate unmet need among HIV cases. Estimation of HIV case counts limits the use of the data for statistical inference (e.g. the demographic characteristics of the population). Some sources of health care data were not available, or at best, slow to access. Sources such as D.C. Alliance and private, third-party payers were not readily accessible or available. Data manipulation was challenging and technically difficult at times. Steps and foreseeable precautions were taken to uphold confidentiality of information. However, the sources of de-identified data were not easily amenable to matching.

The use of several sources of service level data in these calculations increased the chances that those in care are appropriately included. Likewise, it may potentially increase the chances of multiple inclusions across data sources because of the lack of common identifiers across different databases that may facilitate uniqueness in client counts, client matching and de-duplication across databases.

Findings

Surveillance data for 2007 indicate that an estimated 26,704 HIV/AIDS cases reside in the District of Columbia. Of these cases, about 32.6% (8,713) are confirmed AIDS cases. There are approximately 17,991 (67.3%) cases estimated to have HIV (non-AIDS). This estimate includes 25% of cases who are unaware of their status.[24] Since the unmet need framework specifies that only those who are aware are included in the estimate, the actual number of cases used in this calculation is 13,493.

In 2007, approximately 9,696 (44%) of HIV/AIDS cases in the District of Columbia were found to have an unmet need for primary medical care while 12,510 (56%) of PLWH/A have been found to have evidence that their primary medical need was met.

Of the 8,713 AIDS cases, about 33% (2,882) have an unmet need for primary medical care, while for those with HIV (non-AIDS), aware of their status, approximately 51% (6,814) have an unmet need for primary medical care.

Summary Tables

Table 5 summarizes the met needs for HIV/AIDS cases in the District of Columbia. It is estimated to be 56%. Unmet need is estimated at 44%. Taking a closer look at these estimates, the burden of need is among those cases with HIV, with 51% of total HIV (aware) cases having an unmet need for medical care. Among AIDS cases, about one-third (33%) is estimated to have an unmet for primary medical care.

Table 5: Proportionate Met and Unmet Need among Estimated HIV/AIDS Cases District of Columbia 2007

As percent of total	HIV cases N= 13,493	AIDS cases N= 8,713	Total HIV/AIDS N=22,206
Met Need	6,679 (49%)	5,831 (67%)	12,510 (56%)
Unmet Need	6,814 (51%)	2,882 (33%)	9,696 (44%)

Unmet estimates for 2007 increased by 16% compared to 2006. This is deemed to be an artificial increase due to a marked increase in the national estimates of HIV released by the CDC. A new estimate, recently issued by the CDC, indicated that there are 56,300 new HIV cases per year.[25] Since the District uses this as base, a marked increase was seen this year.

Activities the District has carried out or is planning to carry out to address unmet need

Several steps are being planned and will be undertaken by the D.C. Delegation and the HAA to improve data extraction and determine unmet need estimates. During Fiscal Year 2009, data collection methods will be revised to obtain available information from Medicaid, D.C. Alliance (third-party payer), and other sources such as the D.C. Primary Care Association (DCPCA). With new emphasis on collaborating across programs, monitoring and evaluating patient outcomes and performance, a need to transition to a linked data system is urgent. This will provide an integrated and real-time feed of data into one single database that will monitor patients across the continuum of care in the District. This will facilitate seamless access to most sources of HIV care.

Additionally, program initiatives across different sources of care have provided more focus on clinical aspects of care, with defined patient outcomes as ultimate goals. A number of programs will continue to be funded to increase access to care, retain clients in care, and re-capture clients who have fallen out of care. *Social marketing* initiatives will be enhanced to raise awareness about HIV and promote early entry to care.

Case finding and outreach to specific target populations were strengthened during FY07 and FY08. Part B funds were used to reach newly released prisoners, women and youth, using innovative approaches of integrated care to include co-located case management, treatment adherence counseling, substance abuse treatment, and early intervention services. This integration also uses a targeted response to assess needs, appropriately refer and guide high-risk populations into care.

Another innovative approach is the creation of entry points such as drop-in centers for HIV services. This is implemented in partnership with a university, faith-based initiative that includes trainings for agencies participating in the project. Families are given a focus through general support and support groups. Family-centered case management helps to retain those who are in care and to re-capture those who have fallen out of care.

Determination of the demographics and location of people who know their HIV/AIDS status and are not in care

A breakdown by specific demographic characteristics was analyzed and interpreted carefully. The sources of information did not provide uniform data sets and limited the demographic characteristics to gender, race and age. Modes of exposure and residence across the city were not available.

When distributed by gender, the data indicates that males with AIDS have a significantly higher percentage of unmet need than females, with males at 2,540 (40%) and females at 342 (14%).

Table 6: Proportionate Met and Unmet Need among AIDS Cases by Gender, District of Columbia 2007

Care Patterns	**AIDS, N= 8,713**		
	Met Need	**Unmet Need**	Total
Males	3,790 (60%)	**2,540 (40%)**	6,330 (73%)
Females	2,041 (86%)	**342 (14%)**	2,383 (27%)
Total	5,831 (67%)	**2,882 (33%)**	8,713

When distributed by gender, the data indicates that males with HIV (non-AIDS) also have a higher percentage of unmet need than females. However, the gap narrows with males at 4,861 (53%) and females at 1,953 (46%).

Table 7: Proportionate Met and Unmet Need among Estimated HIV (non AIDS) Cases by Gender, District of Columbia 2007

Care Patterns	HIV (Non-AIDS) Aware, N= 13,493		
	Met Need	**Unmet Need**	Total
Male	4,341 (47%)	**4,861 (53%)**	9,202 (68%)
Female	2,338 (54%)	**1,953 (46%)**	4,291 (32%)
Total	6,679 (49%)	**6,814 (51%)**	13,493

When distributed by gender, the data indicate that males with AIDS and HIV (non-AIDS) also have a higher percentage of unmet need than females, with males at 7,401 (48%) and females at 2,295 (34%).

Table 8: Proportionate Met and Unmet Need among Estimated HIV/AIDS Cases by Gender, District of Columbia 2007

Care Patterns	AIDS and HIV (Non-AIDS) Aware, N= 22,206		
	Met Need	**Unmet Need**	Total
Male	8,131 (52%)	**7,401 (48%)**	15,532 (70%)
Female	4,379 (66%)	**2,295 (34%)**	6,674 (30%)
Total	12,510 (56%)	**9,696 (44%)**	22,206

When distributed by race, the data indicate that out of 19 AIDS cases of unknown or unreported race (less than one percent), 19 of those cases (100%) have unmet need. The data also indicate that whereas Asian/Pacific Islanders account for 47 of reported AIDS cases (less than one percent), 46 of those cases (98%) have unmet need. Whites account for 13% of reported AIDS cases, with 613 cases (54%) having unmet need. Blacks show a disproportionate number and percentage of AIDS cases 7,064 (81.1%), with 2,108 cases (30%) having unmet need. Hispanics/Latino(a)s account for 5.1% of AIDS cases, with 96 cases (22%) having unmet need. Native Americans account for eight cases of all AIDS cases (less than one percent) and no reported cases (0%) having unmet need.

Table 9: Proportionate Met and Unmet Need among AIDS Cases by Race, District of Columbia 2007

Care Patterns	**AIDS, N= 8,713**		
	Met Need	**Unmet Need**	Total AIDS Cases
Whites	517 (46%)	**613 (54%)**	1,130 (13.0%)
Blacks	4,956 (70%)	**2,108 (30%)**	7,064 (81.1%)
Hispanics/Latino(a)s	349 (78%)	**96 (22%)**	445 (05.1%)
Asian/Pacific Islanders	1 (2%)	**46 (98%)**	47 (00.5%)
Native Americans	8 (100%)	**0 (0%)**	8 (00.1%)
Unknown/Unreported	0 (0%)	**19 (100%)**	19 (00.2%)
Total	5,831 (67%)	**2,882 (33%)**	8,713

Only 75% (13,493 cases) of the HIV estimate (17,991) is used to calculate the unmet need estimation. This explains the exclusion of the 4,498 of HIV-positive cases (25%) unaware of their HIV status (as referenced in Attachment 1 of this application).

Of the HIV (non-AIDS) cases, *aware of status*, when distributed by race, the data indicate that Whites account for 18.75% of reported HIV (non-AIDS) cases, with 2,108 cases (83%) having unmet need. The data also indicate that out of 432 HIV (non-AIDS) cases of unknown or unreported race (3.2%), 346 of those cases (80%) have unmet need. Asian/Pacific Islanders account for less than one percent of reported HIV (non-AIDS) cases, with 48 of those cases (71%) having unmet need. Native Americans account for 18 cases of all HIV (non-AIDS) cases (less than one percent), with 12 (67%) of those cases having unmet need. Blacks show a disproportionate number and percentage of HIV (non-AIDS) cases 9,810 (72.7%), with 4,066 cases (41%) having unmet need. Hispanics/Latino(a)s account for 5.0% of HIV (non-AIDS) cases, with 234 cases (37%) having unmet need.

Table 10: Proportionate Met and Unmet Need among Estimated HIV (non AIDS) Cases by Race, District of Columbia 2007

Care Patterns	**HIV (Non-AIDS) Aware, N = 13,493**		
	Met Need	**Unmet Need**	Total HIV (non-AIDS)
Whites	423 (17%)	**2,108 (83%)**	2,531 (18.75%)
Blacks	5,744 (59%)	**4,066 (41%)**	9,810 (72.70%)
Hispanics/Latino(a)s	400 (63%)	**234 (37%)**	634 (05.00%)
Asian/Pacific Islander	20 (29%)	**48 (71%)**	68 (00.50%)
Native Americans	6 (33%)	**12 (67%)**	18 (00.13%)
Unknown/Unreported	86 (20%)	**346 (80%)**	432 (03.20%)
Total	6,679 (49%)	**6,814 (51%)**	13,493

Of the total number of AIDS and HIV (non-AIDS) cases, *aware of status*, when distributed by race, the data indicate that Asian/Pacific Islanders account for 115 total HIV/AIDS cases (less than one percent), with 94 of those cases (82%) having unmet need. The data also indicate that out of 451 HIV/AIDS cases of unknown or unreported race (2.03%), 365 of those cases (81%) have unmet need. Whites account for 16.49% of all reported HIV/AIDS cases, with 2,721 cases (74%) having unmet need. Native Americans account for 26 cases of all HIV/AIDS cases (less than one percent), with 12 (46%) of those cases having unmet need. Blacks show a disproportionate number and percentage of HIV/AIDS cases 16,874 (75.99%), with 6,174 cases (37%) having unmet need. Hispanics/Latino (a) s account for 4.86% of HIV/AIDS cases, with 330 cases (31%) having unmet need.

Table 11: Proportionate Met and Unmet Need among Estimated HIV/AIDS Cases by Race, District of Columbia 2007

Care Patterns	**AIDS and HIV (Non-AIDS, Aware), N=22,206**		
	Met Need	**Unmet Need**	Total HIV (non-AIDS)
Whites	940 (26%)	**2,721 (74%)**	3,661 (16.49%)
Blacks	10,700 (63%)	**6,174 (37%)**	16,874 (75.99%)
Hispanics/Latino(a)s	749 (69%)	**330 (31%)**	1,079 (04.86%)
Asian/Pacific Islander	21 (18%)	**94 (82%)**	115 (00.52%)
Native Americans	14 (54%)	**12 (46%)**	26 (00.12%)
Unknown/Unreported	86 (19%)	**365 (81%)**	451 (02.03%)
Total	12,510 (56%)	**9,696 (44%)**	22,206

The following three tables distribute unmet need by age. The first table (Table 12) distributes unmet need for persons living with AIDS (PLWA) by age. The data indicate that PLWA under the age of 13 accounts for 93 cases (1.1%) of PLWA with 76 cases (82%) having unmet need. PLWA between the ages of 30-39 account for 3,160 cases (36.3%) with 1,687 cases (53%) having unmet need. This age group does not meet age eligibility requirements for many entitlement programs. PLWA between the ages of 40-49 represent 2,887 cases (33.1%) of PLWA with 708 cases (25%) having unmet need, closely followed by PLWA between the ages of 20-29, who account for 1,277 cases (14.7%) of PLWA with 305 cases (24%) having unmet need. PLWA between the ages of 13-19 represent 108 cases (1.2%) of PLWA with 11 cases (10%) having unmet need. PLWA ages 50 and over represent 1,188 cases (13.6%) of PLWA with 95 cases (8%) having unmet need.

Table 12: Proportionate Met and Unmet Need among AIDS Cases by Age, District of Columbia 2007

Care Patterns	AIDS N=8,713		
	Met Need	**Unmet Need**	Total AIDS
<13	17 (18%)	**76 (82%)**	93 (1.1%)
13-19	97 (90%)	**11 (10%)**	108 (1.2%)
20-29	972 (76%)	**305 (24%)**	1,277 (14.7%)
30-39	1,473 (47%)	**1,687 (53%)**	3,160 (36.3%)
40-49	2,179 (75%)	**708 (25%)**	2,887 (33.1%)
50+	1,093 (92%)	**95 (8%)**	1,188 (13.6%)
Total	5,831 (67%)	**2,882 (33%)**	8,713

The second table (Table 13) distributes unmet need for persons living with HIV (non-AIDS) or PLWH by age. The data indicate that whereas PLWA between the ages of 13-19 represent 391 cases (3%) of PLWH, they account for 281 cases (72%) having unmet need. PLWH between the ages of 20-29 represent 2,941 cases (22%) of PWLH with 1,800 cases (61%) having unmet need. PLWH between the ages of 30-39 account for 4,196 cases (31%) of PLWH with 2,468 cases (59%) having unmet need. PLWH ages 50 and over represent 1,904 cases (14%) of PLWH with 840 cases (44%) having unmet need. PLWH under the age of 13 account for 310 cases (2%) of PLWH with 135 cases (also 44%) having unmet need. PLWH between the ages of 40-49 represent 3,751 cases (28%) of PLWH with 1,290 (34%) having unmet need.

Table 13: Proportionate Met and Unmet Need among Estimated HIV (non AIDS) Cases by Age, District of Columbia 2007

Care Patterns	**HIV (aware) N=13,493**		
	Met Need	**Unmet Need**	Total AIDS
<13	175 (56%)	**135 (44%)**	310 (2%)
13-19	110 (28%)	**281 (72%)**	391 (3%)
20-29	1,141 (39%)	**1,800 (61%)**	2,941 (22%)
30-39	1,728 (41%)	**2,468 (59%)**	4,196 (31%)
40-49	2,461 (66%)	**1,290 (34%)**	3,751 (28%)
50+	1,064 (56%)	**840 (44%)**	1,904 (14%)
Total	6,679 (49%)	**6,814 (51%)**	13,493

The third table (Table 14) distributes unmet need for persons living with AIDS and HIV (non-AIDS), PLWH/A, by age. Of the total number of AIDS and HIV (non-AIDS) cases, *aware of status*, when distributed by age, the data indicate that PLWH/A between the ages of 13-19 represent 499 (02.3%) of HIV/AIDS cases with 292 cases (59.0%) having unmet need. PLWH/A between the ages of 30-39 account for 7,356 (33.1%) of HIV/AIDS cases with 4,155 cases (56%) having unmet need. PLWH/A under the age of 13 account for 403 (01.8%) of HIV/AIDS cases with 211 cases (52.0%) having unmet need. PLWH/A between the ages of 20-29 represent 4,218 (19.0%) of HIV/AIDS cases with 2,105 cases (50.0%) having unmet need. PLWH/A between the ages of 40-49 represent 6,638 (29.9%) of HIV/AIDS cases with 1,998 cases (30.0%) having unmet need. PLWH/A ages 50 and over represent 3,092 (13.9%) of HIV/AIDS cases with 935 cases (also 30.0%) having unmet need.

Table 14: Proportionate Met and Unmet Need among Estimated HIV/AIDS Cases by Age, District of Columbia 2007

Care Patterns	AIDS and HIV (Non-AIDS, Aware), N=22,206		
	Met Need	**Unmet Need**	Total HIV (non-AIDS)
<13	192 (48%)	**211 (52%)**	403 (01.81%)
13-19	207 (41%)	**292 (59%)**	499 (02.25%)
20-29	2,113 (50%)	**2,105 (50%)**	4,218 (18.99%)
30-39	3,201 (44%)	**4,155 (56%)**	7,356 (33.13%)
40-49	4,640 (70%)	**1,998 (30%)**	6,638 (29.89%)
50+	2,157 (70%)	**935 (30%)**	3,092 (13.92%)
Total	12,510 (56%)	**9,696 (44%)**	22,206

Assessment of service needs, gaps, and barriers to care for people not in care

Ryan White Part A funds most core medical services as defined by the HRSA. The principal assessment of unmet need for primary medical care and core medical services are primarily determined through Part A planning activities and priority setting. However, Ryan White Part B planning identifies and implements services to complement Part A services and bridge service gaps, thereby reducing barriers to access and care and increasing re-entry into the HIV continuum of care.

Service gaps have been identified among special populations such as women and youth and incarcerated, peri-incarcerated, transgender, substance abusers, and homeless persons. Special programs, which address the needs of such populations, are strategically located to ensure accessibility. Additionally, co-located programs for substance abuse treatment, medical case management, and treatment adherence have created points of access to care as well as points of access to recapture and retain clients in care. Specific programs with intensive follow-up (e.g. health navigation and drop-in centers) are located in target areas frequented by special populations. Access to care is ensured through payment of insurance premiums, co-insurance and co-payment fees and other subsidies implemented through the ADAP program. The D.C. ADAP program provides emergency drug assistance (within 24 hours) to facilitate emergency access to critical medications until permanent assistance can be established. In addition, the District implements treatment adherence programs to co-locate and facilitate access to medical case management, substance abuse treatment/counseling and housing services for persons with multiple diagnoses of HIV, substance abuse and homelessness.

Efforts to find people not in care and get them into primary care

Primary care services, particularly Primary Medical and Specialty Care, are funded through Ryan White Part A and other D.C. appropriated funding. However, Ryan White Part B funding is leveraged to increase and facilitate client access to medical care through the identification of those who are not aware of their status and the facilitation of HIV antibody testing. This enables persons to become aware of their status as soon as possible, and after positive diagnosis, to be immediately linked into the Ryan White continuum of HIV care. Once in care, providers use culturally competent interventions to retain them in care.

In the District, Ryan White Part B funds support five prioritized service categories to complement medical care. These are Medical Case Management, Non-Medical Case Management, Substance Abuse Treatment, Treatment Adherence Services, and Early Intervention Services. Additionally, $12,446,261 in Part B funding supports drug assistance through the ADAP. A special initiative to look at strategies to recapture clients lost to care was developed utilizing a large service provider, located east of the Anacostia River. Over a period of four months, clinic staff identified individuals who were out of care. The staff employed multiple and varied recapturing strategies (e.g. multiple follow-up calls, letters and home visits to return those clients to medical care. In some instances, clients were enrolled into primary medical care at a new site, and in other cases, clients were successfully re-enrolled into primary medical care onsite. This model successfully recaptured 77% of those individuals identified as lost to care. The HAA is considering how to use this model for other areas of the District.

Use of the results of the Unmet Need Framework in planning and decision making about priorities, resource allocations, and the adapting system of care.

Ryan White Part B programs pay special consideration to information gleaned from the estimates of unmet need. The D.C. Delegation participates in the priority setting and allocations of Part A primary care services as well as Part B services. A lengthy process of needs assessment, review of unmet need, planning, and target setting occurs throughout the year to make appropriate decisions to address service gaps and distribute resources. The unmet need framework is used to determine how many PLWH/A are not in care and to develop strategies to redirect and retain them in care.

Conclusion

The needs assessment process enables the HAA to identify common needs and gaps for Part B funding. In addition, it helps to shape recommendations for strategies to improve access to care and equally important retention in care. The greatest challenge for the future is a need to gather more comprehensive information about persons who are not in primary care.

Chapter 5: Description of 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, the HRSA defines a comprehensive continuum of care as a "coordinated delivery system, encompassing a comprehensive range of services needed by individuals or families with HIV infection to meet their health care and psychological service needs throughout all stages of illness." This includes primary medical care, HIV-related medications, mental health treatment, substance abuse treatment, oral health care, and case management services that assist PLWH in accessing treatment of HIV 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."[26] This chapter describes the continuum of care in the District and the major funding streams available.

Systems of Care in the District

Currently, 22 sub-grantees provide Ryan White Part B funded services in the District of Columbia. Under Part B, services are funded under the following service categories: medical case management (9 funded providers), family-centered case management (7 funded providers), case management for peri-incarcerated (2 funded providers), early intervention (3 funded providers), health insurance (1 funded provider), and treatment adherence counseling (6 funded providers).

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.[27] Re-connection to care is a major focus of Part B services. This change in focus from the last Part B Comprehensive Plan evolved from the many experiences of providers in keeping persons in care. The following reflects a typical experience of a large Part B agency and served as an impetus to shift focus.

The agency decided not only to outreach to new clients but also to do "in-reach" for past clients who had been lost to care. Their efforts became centered on recapturing and retaining clients in care. The approach proved to be more successful then getting new clients into care. After going through old, closed client files, the agency found that 190 clients were lost to care. Of those lost to care, the agency was able to reconnect 106 back into care at the agency, 40 were receiving care at other agencies and 44 remained *lost*. The agency used multiple phone calls to individuals with working numbers and frequent face-to-face contacts with clients in other settings, gave incentives for clients to return and restored confidence to others to care about their well-being. The HAA was impressed and now requires all Part B providers to implement similar procedures. It is a requirement of Part B funding.

Under Part A funding, there are 24 providers funded to provide a variety of core medical and support services. Core medical services include outpatient ambulatory care, AIDS drug assistance, oral health, early intervention services, home and community-based health services, hospice, mental health services, medical nutrition therapy, medical case management, and substance abuse services. Core support services include case management, child care, developmental assessment, emergency financial assistance, food bank, health education, housing, legal services, linguistic services, medical transportation, outreach, permanency planning, psychosocial support, referral to health and support, rehabilitation services, respite care, substance abuse (residential), and treatment adherence. The overall continuum of care results from the coordination through the HAA of Part A and Part B funded providers.

Washington, D.C. also 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, 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 District of Columbia. With Part A Minority AIDS Initiative (MAI) funding, the District 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 inter-related care and support services for very high-risk need clients.

Program initiatives across CARE funding sources have provided more focused clinical interventions, with defined patient outcomes as ultimate goals. Part B will continue to fund special projects that increase access to care, improve client retention in care, and recapture clients who have fallen out of care. Social marketing initiatives will also be enhanced to raise awareness about HIV and promote early entry to care.

Many individuals who are on Medicare Part D face challenges with the coverage gap ("donut hole") and co-payment fees required of enrollees. Family-centered case management enhances retention of HIV infected families in care. This project is implemented in partnership with an agency that targets women living with HIV.

In the District of Columbia, the continuum is rich with a wide array of services conveniently located in a compact urban area. Other funding streams play an important role in financing primary medical care. The District of Columbia has a combined Medicaid/SCHIP program. District of Columbia Medicaid covers many medical services, but does not pay for supportive services. Medicare coverage will not pay for supportive services. HAA and the Medical Assistance Administration (D.C. Medicaid) are lateral agencies within the Department of Health.

As a result of the close collaboration between the two agencies in the development and implementation of a Medicaid program for people living with HIV/AIDS as well as the support of the Income Maintenance Administration (within the Department of Human Services), there has been significant progress to ensure that clients receive the maximum benefits possible.

The District has taken advantage of federal flexibility to implement a Medicaid program, which allows individuals living with HIV to access Medicaid before they would traditionally be eligible. The Medicaid Expansion (HIV 1115) waiver programs have increased the number of District residents living with HIV who have comprehensive health coverage. This year, the District was not able to fund the Ticket to Work Demonstration to Maintain Independence and Employment. The program was discontinued as of December 31, 2008, due to unavailability of funding. All of the clients enrolled in the Ticket to Work program were enrolled in other programs including ADAP for medication assistance.

The District of Columbia AIDS Drug Assistance Program (ADAP) precludes client enrollment for clients eligible for Medicaid. Likewise, clients enrolled in Medicaid are immediately transitioned from the AIDS Drug Assistance Program. The D.C. ADAP is enhancing its point-of-sale system to ensure that Medicare Part D clients, when appropriate, have their prescription drug costs billed to their prescription drug plans.

Additionally, the District is working closely with the local Veteran's Administration staff to ensure that veterans living with HIV are not prevented from obtaining needed medications due to stringent co-payment rules at the District VA Hospital. The DC ADAP will be sub-contracting to make monthly payments to the VA on behalf of ADAP clients for co-payments on ADAP medications.

Table 15 summarizes other funding streams that complete the Continuum of Care in the District.

Table 15: Health Care System Eligibility
as of 01/28/09

	District of Columbia
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
Medicaid	• 100% of FPL with disability dx (AIDS). • 1115 Waiver-100% of FPL with HIV dx only but has capped no. of slots
ADAP	• 500% of the FPL • 24 hr enrollment • Pays for insurance co-payments and COBRA premiums • Pays for Medicare D co-payments • Direct Drug procurement
Part B	• Fills in gaps • Eligibility based on whether or not client qualifies for other coverage • No specific Income cap
Other	• DC Healthcare Alliance-200% of FPL • Alliance is locally funded primary care insurance. Not HIV specific • Alliance does not pay for HIV medications.

Resource Inventory

In the District of Columbia, information on HIV/AIDS services and providers can be found at the Department of Health website at http://www.dchealth.dc.gov. This resource directory was recently updated and the new directory will be available at this same web address.

Conclusion

The District's continuum of care is complex and challenging. In planning for utilization of Part B resources, special consideration must be made to ensure consistency with priorities established through the Part A planning process and to ensure that Part B funds are used to complement those priorities to fill gaps in HIV health and support services, while targeting the special needs of diverse populations.

Chapter 6: Barriers to Care

This chapter discusses barriers to care for PLWH/A in the District.

Barriers in the HIV/AIDS continuum of care can limit or prevent PLWH/A from receiving services that are essential to improving or maintaining their quality of life. They can also affect Grantee ability to ensure parity of services in the District.

The HAA continues to reassess its strategies to provide an effective continuum of HIV care that promotes recapturing and retaining individuals in care. In doing so, the HAA acknowledges that barriers to supporting this type of continuum are two-fold. There are barriers that exist from stakeholder perspectives, including PLWH/A and HIV service providers, and those that are experienced directly by the HAA.

Consistent with national trends, the ability of the government of the District of Columbia 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 living with HIV.

Case Managers continue to work hard in this volatile economic climate to locate appropriate referral sources for clients both within and outside of the Ryan White system of care. Providing appropriate services for 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 District is that decreases in other funding streams will increase the necessity for ADAP and other Part B services to complete the continuum of care.

Even though the District is characterized by higher than median income levels, housing costs continue to rise, resulting in displacement of individuals and families in need of low-income and affordable housing. Lack of housing, unstable housing, and lack of income all pose significant barriers for retaining clients in care. Clients who are unable to maintain healthcare due to unstable housing can compound costs of health care, especially when returning to care with advanced HIV disease. One of the primary goals of Part B funding is to ensure access to medications and access to treatment adherence services for clients negatively impacted by the economic downturn.

In the District, there is a critical problem of later testers, defined as persons whose AIDS diagnosis occurred within twelve months of the initial detection of HIV infection. The *2007 District of Columbia Epidemiology Report* stated, "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."[28] Late testing poses a financial burden on the continuum of care and significantly impacts the health outcomes of District residents.

As part of tracking service utilization in the District, the HAA tracks the language proficiency of clients in the Ryan White system of care. Data indicate that approximately 5% of clients may have a challenge in proficiency of spoken English. Most of those reporting English language proficiency were from the Caribbean, South America, Central America, and Africa. The most commonly spoken languages other than English were Spanish and Amharic. With a large immigrant population in the District, health literacy is an urgent need.

As part of the preparation for the update of the Statewide Coordinated Statement of Need (SCSN) there were several needs assessments conducted that identified cross-cutting barriers. PLWH/A mentioned services and stigma while providers across all Parts of Ryan White funded services cited funding, data collection and reporting and coordination as barriers to care. Common barriers identified between the two groups included lack of affordable housing options and the need to improve strategies to effectively link clients into care.

As the lead agency, HAA is often faced with barriers to care that directly impact PLWH/A. For example, the recent discontinuance of the Ticket-to-Work Medicaid Waiver program by the federal government created an increased reliance on the AIDS Drug Assistance Program (ADAP). Also, limitations are sometimes imposed by the Ryan White legislation that creates a service gap for identified client needs.

Conclusion

Although the District has a wide range of services, the challenges associated with high–risk populations and significant numbers of persons entering into care at late stages of HIV disease challenges coordination among funding streams and narrow spectrum solutions that may not work for all populations. Of particular interest to the HAA and the D.C. Delegation are the barriers caused by: the recent downturn in local, regional and national economies; the lack of accessibility to affordable housing; the large immigrant populations that present with a complex array of health care, language and cultural competency requirements; and improved data collection systems to track health outcomes.

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 chapter 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, in manners consistent with national and international methodologies.

The Comprehensive Plan process affords an opportunity to envision the ideal system and to use the planning process to move in the direction of this ideal. The HAA, through development and implementation of 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 HIV diagnosis and entry into care

2) Reduce the transmission of the HIV to others

3) Reduce progression to AIDS

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 emphasis on chronic care. Client access, enrollment, and retention in outpatient/ambulatory medical care are central to this healthcare delivery system. It is a system that is flexible, with multiple points of entry and yet ensures that the many services delivered to clients all contribute to improving health outcomes. It is a system that embraces the reality that clients receive 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, as well as care, treatment and support services.

- The continuum is designed to be flexible to model the many, varied ways in which clients experience their service needs. It is envisioned, with common expectations, to increase the likelihood that all eligible persons with HIV, including the newly diagnosed, historically underserved, disproportionately affected, and hard-to-serve will be effectively linked to and maintained in care, thereby achieving 100% access and 0% disparity. To ensure that all infected and affected persons of the District 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. As the HAA moves forward with the planning process, planning for care and prevention services will expand and be able to field complex questions unique the District, including variable access to services, and challenges to retention in care.

A critical step for the Comprehensive Care process is the formulation of a vision statement and the identification of values and guiding principles. These values and principles guide responses to barriers, gaps and emerging trends in the District of Columbia. The vision of the Washington, D.C. Part B Program is to ensure a quality continuum of care that is seamless to HIV-positive persons and is guided by the following principles.

- Facilitate, support and encourage early access into the continuum of care for newly diagnosed HIV-positive persons through access to early intervention services
- Improve health outcomes by ensuring access to existing and emerging HIV/AIDS treatments that are delivered according to established HIV related treatment guidelines and recommendations
- Emphasize the importance of retention in care, treatment adherence support and prevention for HIV positive persons
- Maintain access to the District of Columbia ADAP program to ensure availability of medications for persons living in Washington, D.C.
- Encourage optimal communication and collaboration across CARE Act-funded entities and throughout non-CARE Act systems to guarantee seamless linkage for persons with complex needs and to ensure that Ryan White funding is payor of last resort

Values

Core values are defined as those strong principles that form the basis for HIV health care in the District. The following are the core values for Part B services in the District.

Improved Care Coordination

The system will ensure that the provision of family-centered medical case management and treatment adherence services address the unmet needs of clients through efficient care coordination and equitable access to treatment services.

Measured Services for Improved Results

In order to ensure that the system of care affectively addresses the complex needs of all HIV positive residents within the District, the provision of services will be measured to improve health outcomes for all clients.

Proactive Outreach, Access to Care and Retention

Services in the District will improve equitable access to services for all patients by focusing on joint medical management, improved linkages and referrals systems that reach clients unaware of their HIV status, re-engage clients lost to care, and support clients to remain in care.

Informed Providers

In order to ensure the highest quality of care, the continuum will provide culturally competent education focusing on clinical treatments, health care and the service delivery system.

Informed Consumers

Ensure continuous support for PLWH/A to learn self-management techniques necessary for improving health and quality of life.

Conclusion

As the District moves forward, education, public awareness and other risk reduction activities will be vital to prevent new infections and enable those out of care to return to care. This ideal system will include: outreach and education activities targeted at those most at risk; linkages and coordination of services to overcome barriers, particularly for substance abuse treatment and mental health services; early intervention strategies and strategies for linking those, who know their status but are not in care, back into 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 populations, new or improved drug therapies and the changing health care environment. The ideal system will be flexible to adapt to future health care policy. Finally, the ideal system will include quality assurance mechanisms to ensure that the needs of persons are being met, and if not, generate recommendations for remedy.

The Part B Comprehensive Plan has formulated its ideal system of care with many involved and committed stakeholders. While there are many challenges and a need for coordinated efforts by many collaborators, the Comprehensive Plan develops a blueprint to guide this achievement. The goals and objectives outline critical steps to guide the District in this direction.

Chapter 8: Goals and Objectives

This chapter outlines the plan to move the District toward its ideal system of care. The following are the goals and objectives for the next three years for Washington, D.C. Part B for 2009-2011.

Table 16: Goals and Objectives for Part B Funding in Washington, D.C.

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	**Activity**	**Time Line**
Objective 1.1 Examine issues of retention in care and lost-to-care for special populations	• Review data to identify special populations out of care and use data to create a base line. • Develop a monitoring tool to guide scope of work. • Conduct pilot projects to examine out of care issues.	• Annually • Annually • 4th Qtr 2010
Objective 1.2 Continue to monitor and implement early intervention strategies targeting special populations.	• Identify special populations and non-traditional venues to ensure early access to HIV care. • Fund, through the RFP process, specialized projects that target non-traditional entry points. • Create a baseline with epidemiological, surveillance and utilization data around target populations. • Identify existing best practices. • Create monitoring tools and assess efficacy through feedback.	• Ongoing • 2nd Qtr 2010 • 2nd Qtr 2009 • Ongoing • 4th Qtr 2009
Objective 1.3 Improve coordination of care by improving the effectiveness of case management.	• Review changing case management models in other jurisdictions. • Conduct quarterly case management provider trainings. • Facilitate the certification of case managers around treatment adherence. • Review and update case management protocols.	• Quarterly • Quarterly • 2nd Qtr. 2009

Goal 2: Ensure improved health outcomes and access to medical and support services.		
Objective 2.1 Assess the changing needs of individuals who are in care.	• Review epidemiological, surveillance and utilization data to identify service utilization trends of persons in care. • Compile, analyze and interpret survey and focus group data to determine barriers to care affecting individuals in care. • Present key findings to the D.C. Delegation. • Monitor provider's response to serving specific populations. • Review focus interview groups (FIGS) to assess provider responsiveness to clients. • Prepare the Annual Progress Report for Part B Services.	• Annually • Annually • Annually • Annually • Biannually • Annually
Objective 2.2 Continue to conduct quality assurance activities to assure improved health outcomes and cost efficiency.	• Review and update existing protocols and measures. • Continue to review and update Standards of Care. • Report on primary medical care and case management outcome measures. • Provide quality assurance training and technical assistance to sub- grantees for the purpose of refining practices and identifying best practices.	• As needed • Annually • Quarterly • As needed and/or annually

Goal 3: ***Maximize resources throughout the District by increasing linkages and coordination among Ryan White programs and non Ryan White Programs (including Medicaid, Medicare, prevention, housing, District programs including APRA, Maternal and Child Health, Mental Health).***		
Objective 3.1 Increase the capacity of service providers to participate in the Ryan White continuum.	• Assess the capacity of providers for delivering quality services. • Support capacity-building activities that will strengthen provider infrastructure.	• Quarterly • Annually
Objective 3.2 Ensure that all eligible clients are enrolled in comprehensive health care programs, clients adhere to treatment and medical care appointments and providers appropriate bill third parties.	• Review ADAP rolls to make sure that people are not eligible for or currently enrolled in Medicaid. • Enhance case management systems to be sure that eligible persons are enrolled in D.C. Alliance health care. • Assess third party billing capacity of funded providers and develop recommendations to improve third party reimbursement.	• Monthly
Objective 3.3 Continue collaboration and planning with the D.C. Delegation to ensure shared goals and objectives through joint needs assessments, epidemiologic profiles, and community planning forums.	• Conduct routine and regular community wide meetings. • Work and provide training to the D.C. Delegation. • Evaluate efforts on a yearly basis.	• Monthly • Quarterly • Annually
Objective 3.4 Develop an effective monitoring system that scrutinizing program targets and expenditures.	• Develop effective monitoring tools for sub-grantees. • Annually review conditions of awards to ensure all necessary contract language for adherence to HRSA requirements.	• Annually • Annually

<table>
<tr><th colspan="3"><i>Goal 3: Maximize resources throughout the District by increasing linkages and coordination among Ryan White programs and non Ryan White Programs (including Medicaid, Medicare, prevention, housing, District programs including APRA, Maternal and Child Health, Mental Health).</i></th></tr>
<tr><td><i>Objective 3.3</i>
Increase linkages and coordinate services with other disciplines and organizations in the District of Columbia.</td><td>• Increase co-location and integration of HIV services with other organizations through the development of MOUs.</td><td>• Ongoing</td></tr>
</table>

<table>
<tr><th colspan="3"><i>Goal 4: Improve the operations of the D.C. Delegation to ensure that the system of care in the Washington D.C. addresses the needs of communities affected by the disease and fulfills the legislative requirements.</i></th></tr>
<tr><td><i>Objective 4.1</i>
Increase participation of stakeholders in the Delegation.</td><td>• Implement recruitment of participants on the belief that the opinions, experiences and expertise of individuals infected and affected by HIV are essential in the District's development of strategies to respond to the epidemic.</td><td>• 1st Qtr 2009</td></tr>
<tr><td><i>Objective 4.2</i>
Clearly define what the Delegation's role is in the District's response to HIV</td><td>• Develop a work plan calendar that will assist in guiding long range planning.
• Establish policies that provide guidance on committee eligibility, participation and governance.</td><td>• 1st Qtr 2009
• 2nd Qtr 2009</td></tr>
</table>

Goal 5: Ensure the availability of emerging and state of the art pharmaceuticals and treatments in Washington D.C.		
Objective 5.1 Integrate forecasting of program costs and service utilization into program planning across the Ryan White continuum.	- On a routine basis, develop forecasting reports for pharmaceuticals based on projected population needs. - Give regular updates to the D.C. Delegation regarding forecasting reports and assess the impact on ADAP participation.	- 3rd Qtr 2009 - Biannually
Objective 5.2 Continue modernizing the ADAP application process.	- Continue the development of the electronic filing system. - Develop a writeable PDF so clients can complete the ADAP application on line.	- Completed - 3rd Qtr 2009
Objective 5.3 Stimulate feedback loops between physicians, pharmacists and treatment adherence staff.	- Determine methods for improved data sharing around client adherence for improved health outcomes.	- 4th Qtr 2009
Objective 5.4 Increased retention of clients in ADAP and care.	- Devise strategies to outreach to clients who have not recertified or filled prescriptions. - Improve collaborations between ADAP and Medicaid to obtain accurate and meaningful data on enrollment and utilization.	- 3rd Qtr 2009 - Ongoing
Objective 5.5 Maximize appropriate utilization of antiretrovirals.	- Establish quality controls mechanisms to improve drug utilization review activities that will allow for real-time interventions on antiretroviral use.	- 4th Qtr 2009
Objective 5.6 Track ADAP client outcomes.	- Devise strategies to integrate laboratory data collected by the Surveillance Bureau with ADAP utilization data.	- 2nd Qtr 2009

Section 4: How Will We Monitor Our Progress?

Chapter 9: Monitoring

This chapter outlines the various strategies that will be used to improve quality of care and monitor progress in meeting the goals and objectives of the comprehensive Plan. These strategies encompass the following: 1) Quality Management Program, 2) Contract Monitoring, 3) Collaborative Planning between HAA and the D.C. Delegation, and 4) Community Feedback.

Of note, the HAA is currently reviewing all monitoring indicators and will be revising final core indicators, targets, and data quality processes to ensure optimal quality and results monitoring.

Quality Management Program

The HIV/AIDS Administration (HAA) has an established statewide quality management program that is responsible for the oversight and management of Part B quality assurance activities within the District of Columbia. The Part B quality management program is designed to enhance the commitment of excellence of the HIV/AIDS Administration to respond to and treat the needs of District residents. The vision of the Part B quality management program is to ensure that all District residents receive equitable access and quality HIV healthcare and related services. The program has established a mission to provide easy access to care for its sub-grantees in order to carry out the vision of the quality management program through the delivery of client-focused services to achieve improved health outcomes. There are established indicators used to assess the outcomes for services. These measures are the basis for reports to Part B committees. The indicators are presented in tables 17 and 18.

Table 17: Quality Management Indicators for Medical Case Management Services

Service Category: Medical Case Management (MCM)		
Indicator	**Measure**	**Time Frame/Method**
Clients retained in primary care	Number and percentage	12 months
New clients enrolled & linked to primary care	Number and percentage	12 months
Clients who attained needed support services	Number and percentage	12 months
New and updated client assessments	Number and percentage	Initial and Every six months

Service Category: Medical Case Management (MCM)		
Indicator	**Measure**	**Time Frame/Method**
Medication review of clients receiving HAART	Number and percentage	Medical record review (quarterly)
Eligibility assessment at intake	Number and percentage	Initial Assessment
Referrals to appropriate health benefits entitlements	Number and percentage	12 months
Face-to-face contact with case manager	Number and percentage	Minimum of 1every 6 months
Telephone contact with case manager	Number and percentage	Minimum of 1 every 3 months
Clients who dropped out of care and were returned to care	Number and percentage	12 months
Clients with documented medical visits	Number and percentage	2 or more visits over 12 months
Treatment Plan development	Number and percentage	30 days after assessment
Treatment Plan updates	Number and percentage	Minimum of 1 every 6 months

Table 18: Quality Management Indicators for Treatment Adherence Counseling Services

Service Category: Treatment Adherence Counseling (TAC)		
Indicator	**Measure**	**Time Frame/Method**
Documented assessment of barriers to adherence	Number and percentage	12 months
Clients with undetectable HIV RNA (VL) levels	Number and percentage	12 months

Service Category: Treatment Adherence Counseling (TAC)		
Indicator	**Measure**	**Time Frame/Method**
Levels of CD4 remains stable within previous 4 months	Number and percentage	Chart review
Clients continuing medical care in 3, 6 and 12 months	Number and percentage	Chart review/XPRES
Signed plan of care within 1 month of intake; updated every 6 months	Number and percentage	12 months
Clients with 3 months of pharmacy fills with consistent consumption	Number and percentage	12 months/Emdeon (ADAP pharmaceutical database)
Client record of appointments kept and appointments made	Ratio of appointments kept to appointments made	Chart review/XPRES
Recorded lab tests	Number and percentage	Every 4 months
Genotype/Phenotype Testing	Number and percentage	Initial, ARV failure and change of ARV regimen

The HIV/AIDS Administration (HAA) is currently reviewing system requirements for the collection of client level data that will be required by the HRSA in grant year 19. 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 XPRES is an electronic database system used to maintain service level and client level information, including demographics and service utilization data. This system continues to present challenges in data collection. However, sub-grantees are able to query the database to assist them in program management and services delivery. All sub-grantees have received extensive training and on-site technical assistance, but could benefit from real-time support. Sub-grantees are however able to generate simple reports to comply with data reporting requirements. During the upcoming fiscal year, the HAA will implement a new data management system to increase data collection capacity and facilitate reporting. This data collected by the sub-grantees are used to determine the number of clients served and type of services received.

Several steps are being planned and will be undertaken by the D.C. Delegation and the HAA to improve the data extraction and determine unmet need estimates. During Fiscal Year 2009, data collection methods will be revised to obtain available information from Medicaid, D.C. Alliance (third-party payer), and other sources such as the D.C. Primary Care Association (DCPCA). With new emphasis on cross-program collaboration, monitoring and evaluating patient outcomes and performance monitoring, a need to transition to a linked data system is underscored. This will provide an integrated and real-time feed of data into one single database that will monitor patients across the continuum of care in the District. This was envisioned to facilitate seamless access to most sources of HIV care.

Contract Monitoring

Program Officers and Grants Management Specialists for the District assure progress of providers in meeting program goals, client targets, expenditures, as well as providing technical assistance to help providers address barriers. Staff monitors 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 HAA keep track of services to target populations and collect utilization information on the service system.

Collaborative Planning

The Plan for 2009-2011 outlines a bold plan to move the District in the direction of the articulated vision. Each year, the HAA and the D.C. Delegation leadership will review objectives and monitor progress. This collaboration will strengthen the relationship and help all stakeholders to improve services for persons living in the District of Columbia.

Community Feedback

The HAA will continue it s commitment to the community and hold ongoing community meetings to discuss the plan, to review its progress and solidify a strong foundation for service delivery.

Conclusion

The HAA and the D.C. Delegation take very seriously the responsibility to implement the Comprehensive Plan. Over the course of the next three years, the partners will strive to achieve the following goals.

- **Goal 1: Ensure that 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 and access to medical and support services**

- **Goal 3: Maximize resources throughout the District by increasing linkages and coordination among Ryan White programs and non-Ryan White Programs (including Medicaid, Medicare, prevention, housing, District programs including APRA, Maternal and Child Health, Mental Health)**

- **Goal 4: Improve the operations of the D.C. Delegation to ensure that the system of care in Washington, D.C. addresses the needs of communities affected by the disease and fulfills legislative requirements**

- **Goal 5: Ensure the availability of emerging and state of the art pharmaceuticals and treatments in Washington, D.C.**

This plan has a system in place to ensure collaborative implementation, instituting a Quality Management Program, active monitoring of contracts, and holding community forums for feedback. As the community embarks on its journey to implement the plan, each stakeholder is ultimately committed to ensuring access to an optimal continuum of HIV services for all in need.

APPENDIX

Appendix 1

Newly Diagnosed AIDS, AIDS Prevalence and Estimated HIV (not AIDS) Prevalence by Demographic Group and Exposure Category -- Washington, DC

Demographic Group/ Exposure Category	**Newly Diagnosed AIDS**		**AIDS Prevalence**		**Estimated HIV (not AIDS) Prevalence***		**Estimated HIV/AIDS**	
	01/01/06 to 12/31/07		**as of 12/31/07**		**as of 12/31/07**		**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 %**

**Estimated HIV Prevalence based on calculations using the CDC national estimate and local surveillance data. A description of the methodology is attached*

[1] Heterosexual—Includes Male-female sexual contact and indeterminate risk

13 patients were diagnosed with AIDS as adults but have evidence of being HIV infected as children

They are counted as adults/adolescent cases in the age and race breakdown and as pediatric cases in the pediatric exposure

Demographic Group/ Exposure Category	Newly Diagnosed AIDS		AIDS Prevalence		Estimated HIV (not AIDS) Prevalence*		Estimated HIV/AIDS	
	01/01/06 to 12/31/07		as of 12/31/07		as of 12/31/07		as of 12/31/07*	
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[1]	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%**

**Estimated HIV Prevalence based on calculations using the CDC national estimate and local surveillance data. A description of the methodology is attached*

[1] *Heterosexual—Includes Male-female sexual contact and indeterminate risk*

13 patients were diagnosed with AIDS as adults but have evidence of being HIV infected as children

They are counted as adults/adolescent cases in the age and race breakdown and as pediatric cases in the pediatric exposure

Demographic Group/ Exposure Category	**Newly Diagnosed AIDS**		**AIDS Prevalence**		**Estimated HIV (not AIDS) Prevalence***		**Estimated HIV/AIDS**	
	01/01/06 to 12/31/07		**as of 12/31/07**		**as of 12/31/07**		**as of 12/31/07***	
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%**

**Estimated HIV Prevalence based on calculations using the CDC national estimate and local surveillance data. A description of the methodology is attached*

[1] *Heterosexual—Includes Male-female sexual contact and indeterminate risk*

13 patients were diagnosed with AIDS as adults but have evidence of being HIV infected as children

They are counted as adults/adolescent cases in the age and race breakdown and as pediatric cases in the pediatric exposure

Appendix 2

Methodology for Calculating HIV Prevalence in the District of Columbia

The District of Columbia estimates its HIV prevalence based on CDC data in the following manner. CDC estimates that there are between 1,039,000 and 1,185,000 people living with HIV and AIDS at the end of 2003. This number includes the estimated 25% of people who are not aware that they are HIV infected, per CDC (1). The midpoint of this range, 1,112,000, was used to calculate the estimated HIV prevalence for the District of Columbia as follows:

According to the CDC Surveillance Report 2004, Table 10, there were 388,477 persons living with AIDS through 2003 in the United States (2). Subtracting this number from the average number of people living with HIV and AIDS at the end of 2003 yields 723,523, the estimate of persons living with HIV in the United States through the end of 2003.

According to the CDC Surveillance Report 2003, Table 14, there were 965 reported AIDS cases in the District out of 44,262 reported cases nationally (2). District of Columbia cases made up 0.0218 or 2.18% of the national reported AIDS cases. Multiplying this proportion (2.18%) by 723,523 yields 15,773, an estimate of HIV prevalence in the District of Columbia, through 2003; however it does not take into account new infections and deaths for 2004 and 2007.

Estimated number of new HIV infections since 2003: CDC estimates that there are 56,300 new HIV infections per year (3). Therefore, if the District has 2.22%, 1.62%, 2.19%, and 2.01% of all AIDS cases reported in 2004 through 2007, then we can assume that there were 4,527 new HIV infections in the District since 2004. This total, added to the estimated HIV prevalence sums to 20,300 HIV cases in the District of Columbia.

Estimated number of HIV: There 2,310 reported AIDS cases in the District who had HIV diagnoses dates that occurred between 2004 and 2007 based on local surveillance data. Subtracting these cases from the above estimate for HIV prevalence provides the estimate for HIV prevalence in the District of Columbia: 17,991.

Sources:

1. Glynn M, Rhodes P. Estimated HIV prevalence in the United States at the end of 2003. National HIV Prevention Conference; June 2005; Atlanta. Abstract T1-B1101.
2. CDC Surveillance Report, Vol. 16, 2007.
3 Hall HI, Song R, Rhodes P, Prejean J, An Q, Lee LM, Karon J, Brookmeyer R, Kaplan EH, McKenna MT, Janssen RS for the HIV Incidence Surveillance Group. Estimation of HIV Incidence in the United States. *JAMA*, August 6, 2008;300(5):520

---

[1] Department of Health, District of Columbia HIV/AIDS Epidemiology Annual Report, 2007

[2] HIV/AIDS Surveillance and Epidemiology Division, HIV/AIDS Administration, Presentation for Priority Setting, April 24, 2008

[3] Washington DC EMA, FY 2009 Part A Application, September 2008.

[4] Sexual Behavior and Selected Health Measures: Men and Women 15–44 Years of Age, United States, 2002 by William D. Mosher, Ph.D.; Anjani Chandra, Ph.D.; and Jo Jones, Ph.D., Division of Vital Statistics in Advance Data from Vital and Health Statistics, Number 362, September 2005.

[5] *HIV/AIDS Among Injection Drug Users in the District of Columbia*. DC Department of Health. November 2007. Downloaded from{http://www.doh.dc.gov/doh/frames.asp?doc=/doh/lib/doh/services/administration_offices/hiv_aids/pdf/factsheets/injection_drug_users.pdf}on January 16, 2009.

[6] *HIV/AIDS Among Injection Drug Users in the District of Columbia*. DC Department of Health. November 2007. Downloaded from {http://www.doh.dc.gov/doh/frames.asp?doc=/doh/lib/doh/services/administration_offices/hiv_aids/pdf/factsheets/injection_drug_users.pdf}on December 29, 2008

[7] Xavier, J.M. *The Washington Transgender Needs Assessment Survey*. 2000. Downloaded from {http://www.glaa.org/archive/2000/tgneedsassessment1112.shtml} on January 16, 2009.

[8] FY 2007 Washington EMA Application, October 2006.

[9] Xavier, J.M. *The Washington Transgender Needs Assessment Survey*. 2000. Downloaded from {http://www.glaa.org/archive/2000/tgneedsassessment1112.shtml} on January 16, 2009, p.2.

[9] FY 2007 Washington EMA Application, October 2006.

[10] FY 2007 Washington EMA Application, October 2006.

[11] Xavier, J.M. *The Washington Transgender Needs Assessment Survey*. 2000. Downloaded from {http://www.glaa.org/archive/2000/tgneedsassessment1112.shtml} on January 16, 2009, p.2.

[12] Xavier, J.M. *The Washington Transgender Needs Assessment Survey*. 2000. Downloaded from {http://www.glaa.org/archive/2000/tgneedsassessment1112.shtml} on January 16, 2009, p.2.

[13] District of Columbia Dept. of Corrections. "DC Dept of Corrections Facts and Figures" July 2008. [Online] {http://doc.dc.gov/doc/frames.asp?doc=/doc/lib/doc/populationstats/DCDepartmentofCorrectionsFactsnFiguresJun08.pdf.}

[14] Castel, A.D., West, T., Jolaosho, T., Rowe, D., Robertson, G., et. al. "Routine HIV Screening in the District of Columbia Jail, 2006-2007". District of Columbia Dept. of Health

[15] DC Dept of Corrections Facts and Figures, July 2008.

[16] District of Columbia, Addiction Prevention and Recovery website, "Special Services for Persons with HIV/AIDS." http://app.doh.dc.gov/services/administration_offices/apr/svc_hivaids.shtm

[17] *HUD's Homeless Assistance Programs: A Guide to Counting Unsheltered Homeless People.* October 2004. http://www.hud.gov/offices/cpd/homeless/library/countinghomeless/countingguide.pdf

[18] FY 2009 Washington EMA application September 2009

[19] *NCH Fact Sheet #9: HIV/AIDS and Homelessness.* National Coalition for the Homeless, June 2008. Downloaded at {http://www.nationalhomeless.org/publications/facts/HIV.pdf} on December 29, 2008.

[20] Epidemiology Annual Report for District of Columbia, November 2007. Online at: http://www.dchealth.dc.gov/doh/cwp/view,A,1371,Q,603431.asp

[21] The DC Appleseed is a local organization that works exclusively on a broad array of public policy problems facing the national capital from health care to voting representation to education reform to jobs and housing.

[22] Kaiser Daily HIV/AIDS Report, Washington DC releases New Data on HIV/AIDS, Monday November 26, 2007.

[23] Framework for Measuring Unmet Need for HIV Primary Medical Care, prepared by the Institute for Health Policy Studies, University of California San Francisco, 2002.http:// www.hab.hrsa.gov

[24] Outreach

[25] Hall HI, Song R, Rhodes P, Prejean J, An Q, Lee LM, Karon J, Brookmeyer R, Kaplan EH, McKenna MT, Janssen RS for the HIV Incidence Surveillance Group. Estimation of HIV Incidence in the United States. *JAMA*, August 6, 2008;300(5):520.

[26] HRSA, 2006 Title I Program Guidance

[27] Department of Health, Ryan White Treatment Modernization Act Part A Request for Applications, RFA HAA_EMA 10-03-08

---

[28] District of Columbia HIV/AIDS Epidemiology Annual Report 2007, The District of Columbia Department of Health, Pg 2

[28] *District of Columbia HIV/AIDS Epidemiology Annual Report, 2007.* The District of Columbia Department of Health. Pg. 2.