

WASHINGTON AIDS PARTNERSHIP

April 27, 2010

As part of its mission to guide and promote local giving in the fight against HIV/AIDS, the Washington AIDS Partnership is pleased to present **“The Profiles Project: How the Washington, DC Suburbs Respond to HIV/AIDS.”** This first comprehensive examination of seven inner suburbs, commissioned and funded by the Partnership, looks at education, prevention, testing, and care and identifies action steps for enhanced collaboration and public policy work to improve the regional response to HIV/AIDS.

A funding collaborative of the Washington Regional Association of Grantmakers, the Partnership is the largest private funder of HIV/AIDS prevention, education, and advocacy services in the metropolitan region, awarding more than \$1 million annually.

“The Profiles Project” consists of a collection of focused analyses describing how seven suburban Washington counties and health districts are responding to HIV/AIDS. The jurisdictions include Montgomery and Prince George’s Counties in Maryland and the City of Alexandria, Arlington County, the Fairfax Health District (including Fairfax County and the Cities of Fairfax and Falls Church), Loudoun County, and the Prince William Health District (including Prince William County and the Cities of Manassas and Manassas Park) in Northern Virginia.

This new research and resulting profiles are the groundbreaking work of Mosaica: The Center for Nonprofit Development and Pluralism, under the leadership of Emily Gantz McKay, with the support of the Regional Primary Care Coalition. Throughout 2009, Mosaica collected data from more than 120 individuals and organizations, consulted with regional advisory bodies, and examined HIV/AIDS statistics and funding information from state HIV/AIDS officials.

We are grateful for the generous support of our funding partner Kaiser Permanente, the dedicated Partnership Steering Committee, and the leadership of the Washington Regional Association of Grantmakers.

“The Profiles Project” serves as a companion to “HIV/AIDS in the Nation’s Capital,” the 2005 Partnership-funded report on the District by the DC Appleseed Center. Through these and other initiatives we hope that together—as funders, policymakers, health officials, and community-based organizations—we can improve our region’s response to one of the most urgent health problems facing our region and the country.

Sincerely,



J. Channing Wickham
Executive Director

A project of the Washington Regional Association of Grantmakers

1400 16th Street, NW, Suite 740, Washington, DC 20036

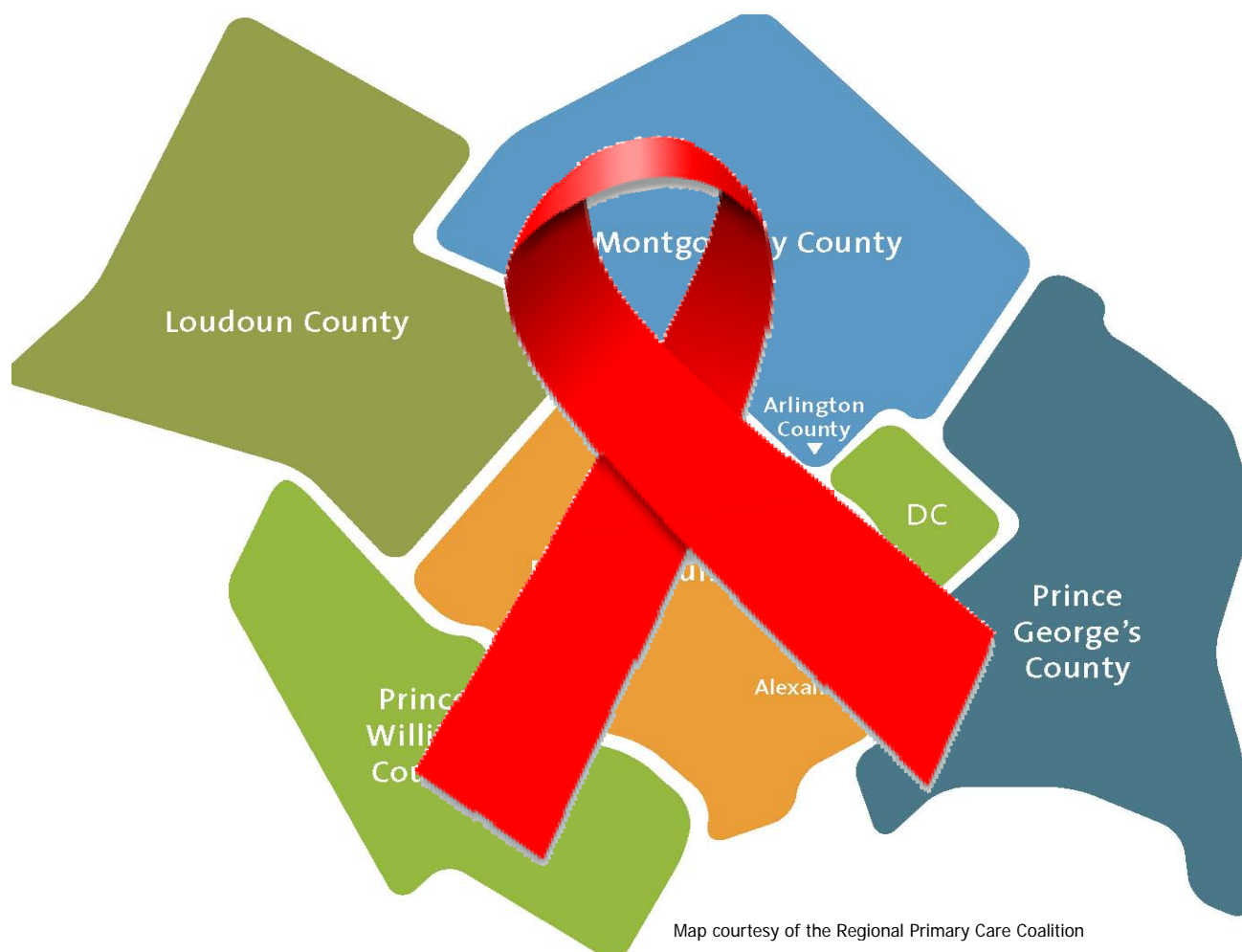
202-939-3379 FAX 202-939-3442 www.washingtonaidspartnership.org E-MAIL wap@washingtongrantmakers.org

AmeriCorps
Diane and Norman
Bernstein Foundation
Morris and Gwendolyn
Cafritz Foundation
Naomi and Nehemiah
Cohen Foundation
Community Foundation
for the National Capital Region
Consumer Health Foundation
Richard and Lois England
John Edward Fowler
Memorial Foundation
Freddie Mac Foundation
Friends of the AIDS Partnership
Gannett Foundation
Gilead Foundation
Stephen A. and Diana L.
Goldberg Foundation
Corina Higginson Trust
International Monetary Fund
Jenesis Group
Elton John AIDS Foundation
Johnson & Johnson
Kaiser Permanente
Jerry Knoll
MAC AIDS Fund
Mead Family Foundation
Meyer Foundation
Moriah Fund
Morningstar Foundation
National AIDS Fund
Open Society Institute
Prince Charitable Trusts
Rocksprings Foundation
Chris and Nalini Rogers
Smith-Evans Foundation
Syringe Access Fund
Trellis Fund
Wachovia Foundation
Washington Forrest Foundation
Weissberg Foundation
World Bank
*\$3,000 and above
J. Channing Wickham
Executive Director

The Profiles Project:

How the Washington, DC Suburbs Respond to HIV/AIDS

April 2010



Prepared for:
The Washington AIDS Partnership,
A funding collaborative of
The Washington Regional Association
of Grantmakers

Prepared by:
Mosaica: The Center for Nonprofit
Development and Pluralism,
with the assistance of
The Regional Primary Care Coalition

The Profiles Project: How the Washington, DC Suburbs Respond to HIV/AIDS

Prepared for:

WASHINGTONAIDSPARTNERSHIP

A funding collaborative of the
Washington Regional Association of Grantmakers
1400 16th Street, NW, Suite 740
Washington, DC 20036
(202) 939-3379
www.washingtonaidspartnership.org

Funded by:

The Washington AIDS Partnership
and
Kaiser Permanente

Prepared by:

MOSAICA

The Center for Nonprofit Development
and Pluralism

1522 K Street, NW, Suite 1130
Washington, DC 20005
(202) 887-0620
www.mosaica.org

With the assistance of:



RPCC

Regional Primary Care Coalition

The Regional Primary Care Coalition

www.regionalprimarycare.org

April 2010

Executive Summary

Overview of the Profiles Project

Until now, much of the discussion and research on HIV/AIDS in the Washington metropolitan area has focused on the District of Columbia, where 3% of the population is known to be living with HIV/AIDS – one of the highest rates in the nation. But the disease is also a major public health problem in the suburban jurisdictions ringing the District. The Profiles Project – the first comprehensive examination of seven inner suburban jurisdictions, commissioned and funded by the Washington AIDS Partnership with support from Kaiser Permanente – looks at education, prevention, testing, and care and identifies action steps for enhanced collaboration and public policy work to improve the regional response to HIV/AIDS.

Geographic Area Covered by the Profiles Project (Excludes the District of Columbia)

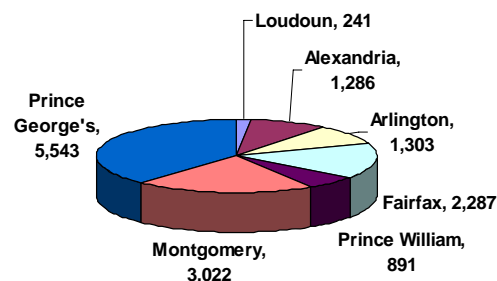


Map used with permission of the Regional Primary Care Coalition

In all, 46% of people living with AIDS in the Washington metropolitan area are thought to make their homes in one of the seven inner suburban counties and health districts in Maryland and Virginia: Montgomery and Prince George's Counties in Maryland and the City of Alexandria, Arlington County, the Fairfax Health District (including Fairfax County and the Cities of Fairfax and Falls Church), Loudoun County and the Prince William Health District (including Prince William County and the Cities of Manassas and Manassas Park) in Northern Virginia. These suburban residents with AIDS, along with those who are HIV-positive but do not have AIDS – together more than 14,500 individuals – need and deserve an array of medical and support services, regardless of where they live.

But in practice, the level of care and energy devoted to prevention and HIV care services varies from jurisdiction to jurisdiction, for a complex set of reasons, including how funding is distributed, how aggressive specific jurisdictions are in their outreach, how well the jurisdictions coordinate their efforts, how effectively area schools teach HIV prevention, how and where people living with HIV and AIDS (PLWH) feel comfortable

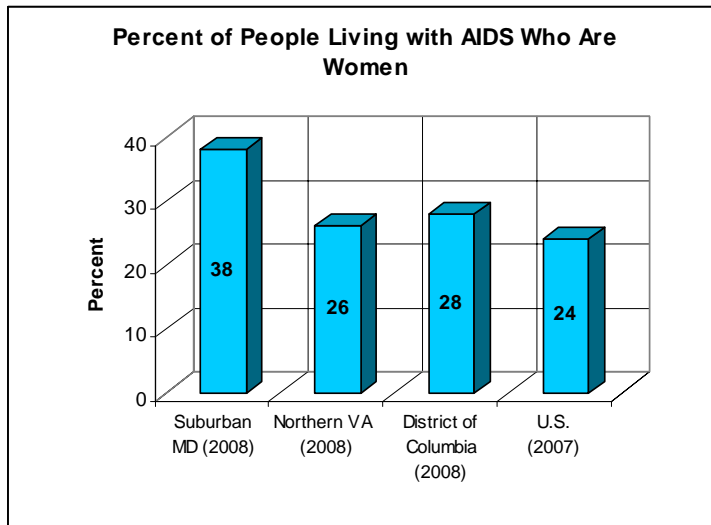
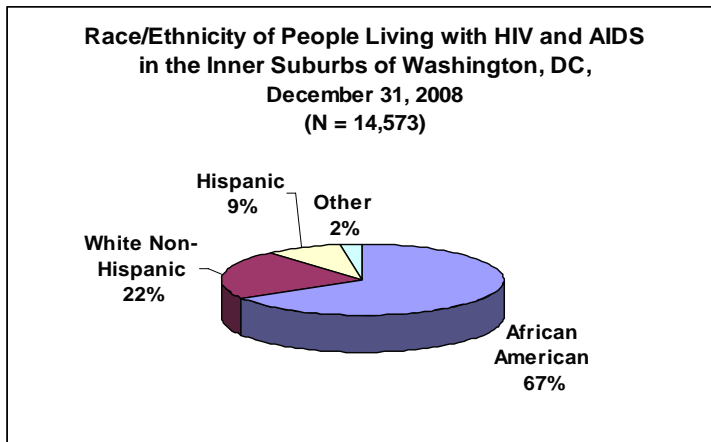
Distribution of People Living with HIV and AIDS in the Inner Suburbs of Washington, DC, December 31, 2008 (N = 14,573)



seeking care, and more. This report, and indeed the entire Profiles Project, is aimed at making sure prevention and care services are readily available, regardless of where people live.

It is not the purpose of the Profiles Project to rank the jurisdictions or point fingers of blame, particularly because the jurisdictions are laboring with undersized budgets. Rather, the Project

seeks to identify ways that the region as a whole, as well as the individual jurisdictions, can better coordinate their efforts, and make their services more effective and more readily available. In so doing, the entire region can do a better job of preventing the spread of HIV/AIDS, while providing life-saving care to more PLWH. Toward those ends, the report presents practical steps, identified by stakeholders, for improving HIV/AIDS prevention and care.



The report stresses several key elements of an improved regional system of HIV prevention and care delivery, including:

- 1. Improved planning and coordination of regional prevention efforts:** Prevention and testing dollars are in short supply. Better coordination across state and county lines would help stretch funding farther, thus improving services.
- 2. Region-wide parity, choice, and portability** (see definitions on page 7): Like other area residents, PLWH

move frequently around the region. They should be able to access the same mix of services wherever they live, should be able to cross county and state lines to get culturally appropriate and personally acceptable care, and should be able to keep the same doctor and other caregivers when they move within the metropolitan area.

- 3. Integration of HIV/AIDS into the healthcare system:** HIV/AIDS is becoming a chronic illness as opposed to a terminal one, and HIV/AIDS care needs to be linked to primary care through a client's "medical home" (see box on page 7), so that clients can benefit from improved communication and coordination among providers who share responsibility for their medical care.
- 4. Regional social marketing to encourage testing:** The District of Columbia and the suburban jurisdictions should work together on a metropolitan area-wide social marketing/media campaign to encourage people to get tested.

The report also highlights specific reforms that the various jurisdictions can and should play a lead role in implementing. They include:

- 1. Implementation of opt-out HIV screening in all healthcare settings:** The Centers for Disease Control and Prevention (CDC) has recommended routine HIV screening since 2006, allowing clients the chance to opt out. Stronger leadership from local health officials on opt-out testing would lead to increased testing and earlier diagnosis, and help slow the spread of the disease.
- 2. Access to information:** Finding information on local government websites about HIV/AIDS prevention, testing, and care can be hit or miss, and most jurisdictions lack searchable directories that identify the testing or care services they provide. Jurisdictions can improve the reach of their services by doing a better job of helping PLWH find out about them online.
- 3. Coordination meetings:** Every jurisdiction should hold regular information-sharing and problem-solving meetings of organizations providing HIV/AIDS prevention, testing, and care services, to help improve coordination, identify synergies, and use limited resources efficiently.

Funding Streams for HIV/AIDS Care

Most funding for HIV/AIDS care comes from the federal government, often directly to states or to the central cities or counties of metropolitan areas with disproportionately large numbers of PLWH. Medicaid and Medicare together provide about two-thirds of federal HIV/AIDS funding.

The main source of HIV/AIDS-specific treatment funds is the **Ryan White HIV/AIDS Treatment Extension Act**. In its city-state role, the District of Columbia receives “state” funds for HIV/AIDS care. In its metropolitan central city role, it is the grantee for **Ryan White Part A** funds for the Washington eligible metropolitan area (EMA).

The suburban jurisdictions receive Ryan White Part A funds through the District and **Ryan White Part B** funds (including funding for the AIDS Drug Assistance Program or ADAP) through their states. Jurisdictions also obtain some treatment funds through competitive grants.

The state health departments not only distribute Part B funds, but also oversee local health departments or health districts. The senior HIV/AIDS staff in the Northern Virginia health districts are state employees, except for those in Arlington and Fairfax. Similarly, the Prince George’s County health department is overseen by the state, and its health officer is a state employee.

Key Findings

Local jurisdictions operate under a variety of federal and state constraints in their battle against HIV/AIDS, limiting their autonomy and authority (see box above). Nevertheless, these jurisdictions have both the opportunity and the obligation to make the best use of available resources to help care for PLWH and to protect public health. The Profiles Project offers the following key findings:

1. Both Maryland and Virginia benefit from devoted HIV/AIDS service providers, both public and nonprofit.

In both Northern Virginia and Suburban Maryland, skilled, devoted, hardworking people are providing HIV/AIDS services. Time and again, people interviewed for this report described how program staff advocate for clients, work very long hours, find ways to ensure bridge medications

when delays occur in program eligibility determination, go to great lengths to help them obtain timely medical care, and arrange for services when systems are slow or unresponsive.

2. School-based HIV-prevention education is inconsistent and often timid.

Most area school systems do not take effective advantage of the opportunity to provide HIV prevention education to elementary, middle, and high school students, despite concern that a growing number of young people are becoming HIV-infected while still in secondary school. Some school districts provide limited sex education and only brief information on preventing HIV and other sexually transmitted infections. Some discuss the implications of sexual orientation, the importance of knowing how to prevent HIV, and the need to be supportive of people who have the disease; others do not. Only three districts provide live or video condom demonstrations to high school students; others mention condoms in varying degrees, and two systems explicitly forbid condoms to be brought into the schools.

In most public school systems, approved curriculum is not consistently implemented. Individual teachers sometimes teach what they feel prepared and comfortable covering, and exclude, minimally cover, or do not allow questions about other material. The principal may be the key decision maker. Some districts use outside experts – health department nurses and nonprofit specialists, for example – to help teach units or provide voluntary programs; others do not.

In both Maryland and Virginia, small groups of parents opposed to sex education or particular aspects of the curriculum have applied political pressure that has led to many of the gaps in the curriculum. It has also served to discourage jurisdictions from updating their curricula, to avoid an inevitably contentious process.

Most area school systems do not take effective advantage of the opportunity to provide HIV prevention education to elementary, middle, and high school students...In most public school systems, approved curriculum is not consistently implemented. Individual teachers sometimes teach what they feel prepared and comfortable covering, and exclude, minimally cover, or do not allow questions about other material.

3. Current HIV prevention and community testing are insufficient.

Efforts to prevent HIV infection are a vital but badly underfunded component of the area's fight against the disease. Research has repeatedly demonstrated that effective prevention efforts not only spare human suffering, but also save the healthcare system money, so increased investment in prevention would make sound economic, as well as moral, sense. Nevertheless, federal funding for prevention is woefully inadequate, and current economic conditions have led to cuts in state funding for prevention and testing in Maryland and Virginia. By contrast, the District is placing much greater focus on prevention and testing than its suburbs.

That said, available prevention resources in the region are sometimes not used to maximum effectiveness due to:

- **Minimal coordination across state lines:** Federal funding for prevention programs comes through the state government, and no inter-state coordination is required.

- **No health district/county or sub-state regional prevention plans:** State health departments are responsible for prevention planning. They prepare state plans only once every five years and include little or no regional information. Virginia and Maryland both have regional advisory bodies, but they produce no written regional plans or priorities.
- **Lack of flexibility in prevention models:** Both state and local HIV/AIDS experts believe prevention efforts are harmed by a requirement of the CDC that federal prevention funds be used primarily for a set of “evidence-based interventions” (EBIs) that have been documented nationally but are viewed as not addressing local needs.
- **Limited adoption of CDC-recommended opt-out routine HIV testing in all healthcare settings:** Recognizing that routine testing as part of a medical examination is relatively inexpensive and leads to earlier detection, earlier entry into care, improved medical outcomes, and reduced transmission, the CDC now recommends opt-out testing for HIV – making it routine, but giving clients an opportunity to decline testing. But that recommendation has not been widely publicized or adopted in the Washington suburbs by either safety-net clinics or individual physicians.
- **Routine emergency department HIV testing in only two suburban hospitals:** As of the end of 2009, only two hospitals in the target area – Prince George’s Hospital Center and Inova Alexandria Hospital – were doing routine HIV testing in their emergency departments.
- **Not enough rapid HIV test kits:** At least three local health departments and several nonprofits sometimes have insufficient rapid test kits. From a public health perspective, rapid testing is more effective than traditional laboratory testing for individuals who have no medical home, are concerned about a particular risky encounter, and are unlikely to check back to obtain their test results.
- **Few non-health department HIV testing sites:** County clinics or Sexually-Transmitted Infection/HIV testing sites are a convenient testing location for many people, but not for all. Some facilities are so clearly identified as HIV testing sites that many individuals concerned about confidentiality and stigma and undocumented people will not go there.
- **Limited HIV prevention and testing funds for nonprofits:** Community-based nonprofit organizations have established trust through years of work in the area and with specific populations. But state funding for HIV prevention goes largely to local health departments, which can – but usually choose not to – contract with nonprofits to provide services.

The CDC now recommends opt-out testing for HIV – making it routine, but giving clients an opportunity to decline testing. But that recommendation has not been widely publicized or adopted in the Washington suburbs by either safety-net clinics or individual physicians.

4. Health departments conduct very little outreach to find people in need of testing or care, usually due to limited resources.

City and county HIV/AIDS experts in most of the jurisdictions feel they do a good job of testing and treating people “who find us and ask for services,” but that they are not “reaching the populations that need to be reached.” They focus on two concerns: late testing because of inadequate outreach to urge people to be tested, and high proportions of people who know their status but are not in care, because they don’t know where and how to obtain affordable treatment services.

- **Outreach for prevention and testing:** Counties lack the resources to go out and find people who don't know they need to be tested. County health officials decry the lack of outreach workers, and identify the need for social marketing and media campaigns.
- **Outreach to PLWH who are not in care:** Another important target group is PLWH who know they are HIV-positive but are not receiving HIV-related medical care – an estimated 62% of PLWH in Northern Virginia and 41% of PLWH in Maryland. Yet neither region has allocated federal funding from the Ryan White Part A program, which targets support for care to metropolitan areas, for Outreach or Early Intervention Services. (Northern Virginia agencies use limited Minority AIDS Initiative funds for Outreach.)
- **Involvement of community-based nonprofit organizations:** Community-based nonprofit organizations are critical to effective outreach, given their neighborhood and population-specific links. Yet few nonprofits are actively engaged in outreach, and all have limited resources.

Community-based nonprofit organizations are critical to effective outreach, given their neighborhood and population-specific links. Yet few nonprofits are actively engaged in outreach, and all have limited resources.

5. People living with HIV/AIDS generally receive medical care immediately, but access to other services varies, depending on their neighborhood, county, and state of residence.

Access to basic treatment services (HIV-related medical care, medications, and case management) is usually immediate for low-income, uninsured PLWH in both Suburban Maryland and Northern Virginia. But other needed services can be more difficult to obtain. Some PLWH need a range of medical and supportive services to enter and remain in care.

- **Other medical-related services:** Hospitals in all jurisdictions typically accept HIV/AIDS clients without difficulty. However, most suburban PLWH sometimes have limited or delayed access to subspecialty, dental, mental health, and substance abuse services.
- **Supportive services:** Suburban jurisdictions spend a higher proportion of Ryan White funds on core medical-related services than the District – and less remains for supportive services, including help with transportation, housing, and food.

6. The region lacks parity, choice, and portability of care.

Perhaps the most complicated treatment challenge facing the Washington metropolitan area has to do with the lack of *parity*, *choice*, and *portability* of care (see box on page 7). PLWH in different parts of the metropolitan area have very different opportunities and choices in obtaining HIV/AIDS treatment. National experts indicated that in every other metropolitan area in the country, PLWH who depend on Ryan White Part A funds for care have choice and portability, allowing them to obtain services anywhere in their metropolitan service area.

Thus, people living in suburbs in other metropolitan areas have the choice to come to the central city, where more services, more anonymity, and more diversity in types of providers are typically available – even if that involves crossing a state or county line. In addition, they enjoy

portability of care, allowing them to move from one jurisdiction to another, without having to change providers.

That is not the case in Washington metropolitan area. With the exception of immigrants in the region, who are permitted to obtain care from a multilingual clinic in Washington, DC, all PLWH accessing Ryan White services are restricted to providers in the state where they live. Suburban jurisdictions have fewer provider choices than the District, and services provided by health departments are usually available only to residents of a single city or county. Suburban care providers often offer a “one-stop shop” approach that is very attractive to many PLWH and results in high quality care. However, some PLWH would prefer a smaller clinic, are afraid to go to a public clinic, or want a provider with a specific target group focus (e.g., the gay/lesbian/bisexual/transgender community or Latinos).

Parity, Choice, and Portability of HIV/AIDS Services

Parity. Equitable access to services for all PLWH regardless of who they are or where they live in the service area – in this case the Washington Ryan White Part A eligible metropolitan area (EMA). The Ryan White Part A application asks grantees to work for parity throughout their service areas with regard to “geographic location of services, quality, comprehensiveness of services, and cultural appropriateness.”

Choice. The ability to obtain services from any funded provider for which the PLWH meets eligibility criteria, regardless of where in the EMA the provider is located. Choice usually is designed to enable a PLWH to live in one jurisdiction but receive care in another due to preference for a particular provider or model of care, language or cultural issues, convenience (for example, if the PLWH works in a different jurisdiction), or confidentiality or stigma concerns (the PLWH would prefer to receive services where s/he is not known).

Portability. The ability of a PLWH to continue obtaining HIV-related services from the same provider if s/he moves across jurisdictions within the eligible metropolitan area – for example, to avoid having to change doctors or case managers.

7. Coordination is lacking between safety net clinics and HIV medical providers – HIV/AIDS is not well integrated into the healthcare system.

Medical advances have made it possible for HIV/AIDS clients to live decades longer than in the early days of the epidemic, which means that the disease is now a chronic illness rather than a

death sentence. But HIV prevention, testing, and care have not been fully integrated into the healthcare system. In the Washington suburbs, there is generally little communication or coordination between funded providers of HIV-related medical care for people without private insurance and the community health centers, other federally qualified health centers (FQHCs), free clinics, or other safety net clinics that serve as medical homes for PLWH but have no HIV-specific funding.

Considerable efforts are under way in the Washington metropolitan area to ensure that residents have a medical home. Suburban HIV/AIDS

providers and services are not yet a part of that process, even though many provide only HIV-related medical care, not primary care, and their clients are likely to receive care from other providers as well. Similarly, few safety net clinics in Northern Virginia and Montgomery County

What is a ‘Medical Home’?

A “medical home” is a health facility that provides or arranges patient-centered comprehensive health services, either providing needed services directly or arranging referrals. Usually the medical home provides primary care on-site. It is the first point of contact when a patient needs any healthcare other than emergency services – the starting point for obtaining preventive services, screening and diagnosis, and treatment. It maintains the patient’s medical records.

have either policies or a defined process for referring a person who tests positive for HIV to an HIV medical provider, while maintaining coordination of care.

8. Local governments vary in their engagement and leadership with regard to HIV/AIDS.

The seven jurisdictions profiled as part of this project vary considerably in the extent to which they take public leadership in responding to HIV/AIDS. In some jurisdictions, local leadership is significant and ongoing, with local resources (funding or in-kind) devoted to testing and care, and a belief in local responsibility to address this epidemic. In others, the only resources available to address HIV/AIDS come from the state or the federal government, and it is difficult even to find information about testing and care services on the government website.

- **Local resources:** Most jurisdictions provide little or no local funding beyond state-required matching funds for HIV/AIDS services. Some do support Sexually-Transmitted Infection/HIV clinics, and the City of Alexandria and Arlington, Fairfax, and Montgomery counties have a history of grantmaking to community-based HIV/AIDS prevention groups or other service providers. Montgomery and Fairfax counties fund primary care services for low-income and uninsured people, and several jurisdictions operate clinics, including adolescent clinics, that are partly supported through general funds. Montgomery County is the exception; it allocates substantial county funds for HIV services.
- **Barriers for nonprofits:** An effective response to HIV/AIDS requires jurisdictions to work with community-based organizations, but a special barrier has arisen in Prince George's County: a contracting structure that makes it extremely difficult for nonprofit organizations to contract with the county. The county's procurement system is complex and extremely slow-moving. A nonprofit typically waits between three and nine months to get a contract signed and the first check written – but is expected to provide services during that period. Many community-based organizations simply cannot afford to pay for services during the long delay, posing a major barrier to nonprofit engagement in prevention, testing, and treatment services.
- **Providing information about services:** The various city and county websites could serve as an effective gateway to services for someone needing an HIV test, medications, or treatment. In most cases, however, it is difficult to locate information about what HIV-related services the city or county provides. Most local government websites do not include HIV/AIDS topics on health department home pages, in Frequently Asked Questions (FAQ) sections or other search aids. The Northern Virginia Regional Commission, the Ryan White funding administrative agent for Northern Virginia, has an online resource directory that lists services and provides links to county and other provider websites. There is no equivalent online directory in Suburban Maryland or the District, although the latter has a regional resource directory in a non-searchable PDF format.

Recommended Action

A variety of interested individuals and organizations reviewed the Profile Project's key findings and helped identify needed actions, both short- and long-term. The project's detailed city and county and regional benchmarking reports provide information on specific local issues and needs. Following are specific short-term and longer-term actions that apply across jurisdictions

and that can be taken by cities and counties, nonprofit organizations, planning bodies, and other stakeholders to improve the local and regional response to HIV/AIDS. While additional public and private resources are needed, the recommendations that follow would allow jurisdictions to do more with the resources they currently have.

Short-term Actions

Following are actions that local health departments, nonprofit organizations, and planning bodies can take quickly, with minimal cash costs, to improve their response to HIV/AIDS. Health departments are often the logical leader for such actions.

- 1. Put local profiles to use.** Jurisdictions can review their profile’s assessments of the jurisdiction’s current response to HIV – prevention, testing, and care – and then identify opportunities for positive change.
- 2. Make information more readily available.** Jurisdictions can make information on HIV/AIDS testing and services more readily available on their city/county websites and through other mechanisms like 2-1-1 numbers and referral services. Website reforms include adding HIV/AIDS topics to home page search engines, FAQ sections, and “How do I” listings.
- 3. Improve coordination.** Jurisdictions could initiate periodic local-level meetings of HIV-prevention, education, and care providers, funded and unfunded. They could use the meetings to identify and resolve problems, share in-kind resources, collaborate on such activities as community testing, and improve coordination so that resources are used well.
- 4. Take the lead on opt-out HIV testing.** The CDC recommendation for opt-out testing can help diagnose HIV cases early, helping PLWH live healthier lives and reducing the chances of transmitting the disease. Opt-out testing should be the standard locally, but establishing it as such requires leadership from health officers or health department directors. Such leadership should include urging physicians, clinics, and hospitals to implement the CDC recommendations.
- 5. Ensure maximum availability of rapid HIV test kits.** Health departments and nonprofit partners would all benefit from better coordination of existing resources for rapid test kits. They could begin that effort by convening a meeting of local testing partners to explore current availability, and then work together to ensure that all partners have enough test kits to meet priority needs. That might include sharing kits in advance of planned events, using laboratory tests where appropriate, exploring ways to obtain additional test kits from public or private sources, and getting the best possible price through joint purchases.

Longer-term Actions

The following actions require longer-term efforts.

- 1. Institute rapid HIV testing in emergency rooms.** Jurisdictions could each urge one hospital in their area to serve as the pilot for rapid testing of emergency room clients – ideally a facility that serves a high proportion of people who do not have a medical home.
- 2. Develop regional HIV-prevention plans.** Existing advisory bodies could be tasked with developing a regional prevention plan, which in turn would inform the development of city/county annual prevention plans. The Northern Virginia Regional HIV Consortium and

the Suburban Washington Regional Advisory Council (RAC) could be asked to assume at least partial responsibility for preparing a concise annual or two-year prevention plan for the region based on their ongoing work.

- 3. Ensure parity, choice, and portability of care.** The region's various bodies should make a top priority of working jointly to develop a system that provides PLWH with true parity, choice, and portability. Specifically, leaders in the District of Columbia, together with officials of jurisdictions that are party to current Intergovernmental Agreements, the administrative agents managing Ryan White services in Northern Virginia and Suburban Maryland, and Ryan White planning bodies, should work jointly to develop a genuine regional system of care, refine allocation formulas, and ensure timely contracting.
- 4. Address HIV/AIDS as the chronic illness it now is.** City and county HIV/AIDS officials and health officers, along with the area's safety net clinics and their associations, need to collaborate to identify and implement immediate cooperation and collaboration, requiring communications between HIV providers and the client's medical home, engaging HIV/AIDS providers and safety net clinics in joint planning, and encouraging safety net clinics to consider becoming HIV/AIDS providers.
- 5. Overcome contracting barriers.** The most severe problem in this area is the contracting system in Prince George's County, which has become a barrier to participation by community groups. Because the county serves as the administrative agent for Ryan White Part A funds in Suburban Maryland, the situation affects services in several counties. Over the long term, county laws and regulations must be re-examined. In the meantime, alternative approaches are needed to enable nonprofits to participate fully in HIV/AIDS work, such as an intermediary organization, different types of contracting, or arrangements in which universities and nonprofits serve as lead agencies.
- 6. Mount regional social marketing campaigns and improve outreach.** Better outreach and marketing efforts will help get people tested and into care. The recent reauthorization of the Ryan White program offers new opportunities, but will require that planning councils and grantees develop and implement strategies for finding people who don't know they are HIV-infected. Ryan White programs can allocate funds for Early Intervention Services and Outreach. The region could explore a joint regional social marketing effort, with a shared theme and graphics. Nonprofits might play lead roles.
- 7. Be a voice for school-based HIV education and prevention.** The area needs strong and persuasive leadership for improved in-school HIV education and prevention efforts. That could include improvements in the curricula as well as voluntary sessions and after-school programs.

The Profiles Project: How the Washington, DC Suburbs Respond to HIV/AIDS

Prepared for:

WASHINGTON AIDS PARTNERSHIP

A funding collaborative of the
Washington Regional Association of Grantmakers
1400 16th Street, NW, Suite 740
Washington, DC 20036
(202) 939-3379
www.washingtonaidspartnership.org

Funded by:

**The Washington AIDS Partnership
and
Kaiser Permanente**

Prepared by:

MOSAICA
The Center for Nonprofit Development
and Pluralism

1522 K Street, NW, Suite 1130
Washington, DC 20005
(202) 887-0620
www.mosaica.org

With the assistance of:



The Regional Primary Care Coalition
www.regionalprimarycare.org

April 2010

Acknowledgments

Many, many people helped to make the Profiles Project possible.

The project was commissioned by the Washington AIDS Partnership, with additional funding provided by Kaiser Permanente. We are very grateful to J. Channing Wickham and Jennifer Jue at the Partnership and to Mindy R. Rubin at Kaiser Permanente. The contents of this final report and the county and regional profiles are the responsibility of Mosaica and do not necessarily represent the views of its funders or advisors.

The Regional Primary Care Coalition (RPCC) served as an essential partner, and its Director, Phyllis E. Kaye, provided continuing and invaluable advice, contacts, document review, and expert assistance throughout the project. Princeton 55 fellow Brittany Stanley assisted, especially in reviewing the profiles reports. Margaret O'Bryon, President of the Consumer Health Foundation, which houses RPCC, provided wise counsel. Two member organizations provided special help with online surveys of safety-net clinics: the Northern Virginia Health Services Coalition and the Primary Care Coalition of Montgomery County.

The project benefited from many advisors. The Northern Virginia Advisory Group provided advice and assistance at all stages of the work. Some members changed professional positions during the project and therefore were involved for part of the project. Members included Karen Berube, Inova Juniper Program; Deborah Dimon, Alexandria Health Department; Carol Jameson, Northern Virginia AIDS Ministry (NOVAM); Patricia N. Mathews, Northern Virginia Health Foundation; Sue Rowland, Virginia Organizations Responding to AIDS (VORA), and for the early part of the project, Lyn Hainge (formerly of the Campbell-Hoffmann Foundation and now with the Arlington Department of Human Services); and Brent Minor (formerly with the Whitman Walker Clinic of Northern Virginia). Special thanks to Carol for assistance with contacts, information, and review of draft profiles reports. Advisors in Suburban Maryland included Christopher King, Washington Hospital Center Foundation, Laurence Smith, formerly Co-Chair and now Chair of the Metropolitan Washington HIV Health Services Planning Council; and Dr. Sarah Leonhard and Rachel Smith of Greater Baden Medical Services.

Senior HIV/AIDS staff in all the health districts and counties assisted with key informant meetings, provided supplemental information, and reviewed draft matrixes and reports. The project received surveillance and program data from both the Maryland Department of Health and Mental Hygiene (DHMH) and the Virginia Department of Health (VDH). More than 120 people – from HIV/AIDS program administrators to Family Life Education or sexuality education program coordinators in local public school systems – participated in key informant sessions, gave interviews, and/or provided program and funding information. We deeply appreciate their assistance.

The Mosaica project team included President Emily Gantz McKay, Senior Consultant Hila Berl, Senior Research and Evaluation Specialist Nicole Robinson, Senior Consultant Hilary Binder-Aviles, Fellow Patricia Cruz, Administrative Assistant Sara Andalibi, Office Administrator/IT Specialist Tosha Francis, and Intern Ambrose Sayes.

Table of Contents

Executive Summary [Separately bound]

Acknowledgments	xii
Introduction	1
The Profiles Project	1
The Regional HIV/AIDS Epidemic.....	2
Funding Streams for HIV/AIDS Services	3
Overview of Findings and Recommended Actions	4
Key Findings	4
Recommended Action	18
Quick Actions	18
Longer-term Actions	20
Project Background and Context	25
The Epidemic	28
The Public Response to HIV/AIDS	31
Structures and Funding Streams	31
Implementation of the Washington Metropolitan Area Ryan White Program.....	35
Conclusion	37
APPENDICES	39
A. HIV/AIDS Surveillance Profiles: Suburban Maryland	39
Northern Virginia	40
B. Ryan White A Care Services Prioritized and Funded by Jurisdiction, Program Year 2009	41
C. Demographic Profiles: Suburban Maryland	42
Northern Virginia	44
D. Benchmarks.....	46

Introduction

Following is a brief overview of the Profiles Project, the regional HIV/AIDS epidemic, and funding streams that support HIV/AIDS prevention, testing, and care. Following the key findings and recommendations, more detailed information is provided on all three topics.

The Profiles Project

The Profiles Project provides information on how each of seven suburban Washington jurisdictions is responding to the HIV/AIDS epidemic. The Washington AIDS Partnership

Geographic Areas Covered by the Profiles Project
<ul style="list-style-type: none">• Northern Virginia Health Region (5 health districts):<ul style="list-style-type: none">▪ Alexandria City▪ Arlington County▪ Fairfax (Fairfax County, Cities of Fairfax and Falls Church)▪ Loudoun County▪ Prince William (Prince William County, Cities of Manassas and Manassas Park)• Maryland's Suburban Washington Health Region<ul style="list-style-type: none">▪ Montgomery County▪ Prince George's County

commissioned this action research to provide an information base for collaboration, public policy work, and other activities to improve the regional response to HIV/AIDS outside the District of Columbia. Mosaica: The Center for Nonprofit Development and Pluralism created the profiles with the assistance of the Regional Primary Care

Coalition (RPCC). Kaiser Permanente provided additional funding. Although some comparative Census and HIV/AIDS data are provided, the District of Columbia was not a focus of this project because an extensive analysis of the DC response to HIV/AIDS was carried out in 2005 by DC Appleseed, and progress towards its recommendations is regularly updated.

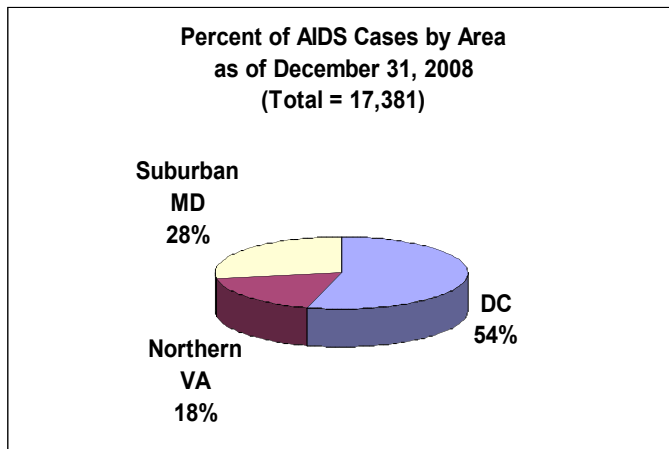
The Profiles Project collected information from secondary sources and from more than 120 individuals and entities, primarily during 2009. The project team held a series of key informant meetings, interviews, consultations with planning bodies and an advisory group, and two online surveys. State and local health departments provided extensive program information.

Principal products include seven profiles of HIV/AIDS education, prevention, testing, and care in the targeted counties and health districts, including how each meets benchmarks in seven areas (from HIV prevention education in the schools to local leadership in responding to the epidemic) as well as regional benchmarking reports for Northern Virginia and Suburban Maryland. Also provided are supplemental summaries with demographic profiles, a statistical snapshot of the HIV/AIDS epidemic in each jurisdiction and the substate region, and results of several special studies. The Profiles Project summaries were designed primarily for use by nonprofit organizations and public agencies involved with HIV/AIDS, and other individuals and entities that are already knowledgeable about HIV/AIDS.

This report provides a regional overview and summary of findings across the seven jurisdictions and recommends practical actions to improve the response to HIV/AIDS – with or without additional resources. It is designed to be of use both to HIV/AIDS specialists and health officials and to individuals and entities for whom HIV/AIDS is a concern but not a daily focus.

The Regional HIV/AIDS Epidemic

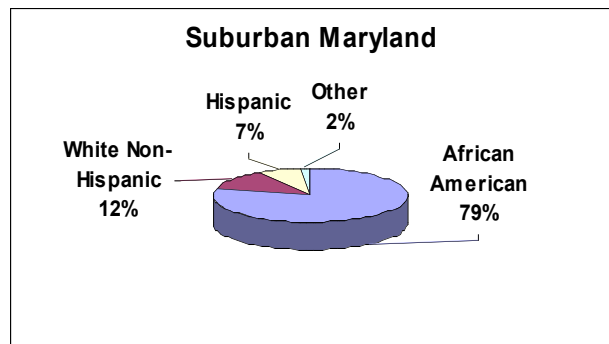
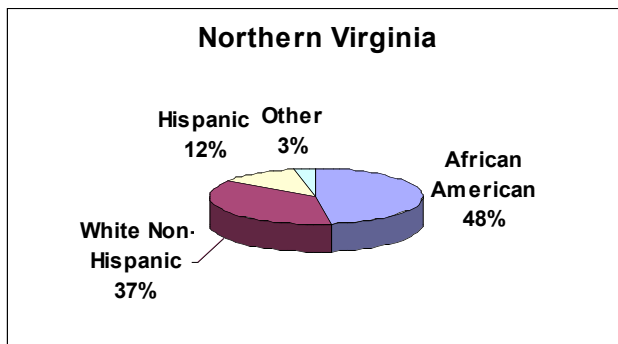
Area discussions about the HIV/AIDS epidemic tend to focus on the District of Columbia, which has one of the highest HIV/AIDS rates in the country, with 3% of residents known to be HIV-positive.¹ The District is the center of a major metropolitan area; suburban jurisdictions have much lower HIV/AIDS rates but a much larger population; the seven health districts and counties covered by this study have about 3.8 million residents, compared to the District's less than 600,000. Almost half the people *known* to be living with HIV/AIDS (PLWH) in the region were tested and are presumed to live in the suburbs; no information is available on how many have moved across jurisdictions since being tested. Far less geographically concentrated than District PLWH, people living with HIV or AIDS in the suburbs also need to be provided appropriate



medical and supportive services. As of December 31, 2008, there were an estimated 17,381 people living with AIDS in the District of Columbia and the seven suburban jurisdictions; 54% of them were in DC, 28% in the two Maryland counties, and 18% in the five Northern Virginia health districts, according to surveillance data from the states. As of the end of December 2009, the project was unable to obtain comparable data on the number of people living with HIV/non-AIDS; the District

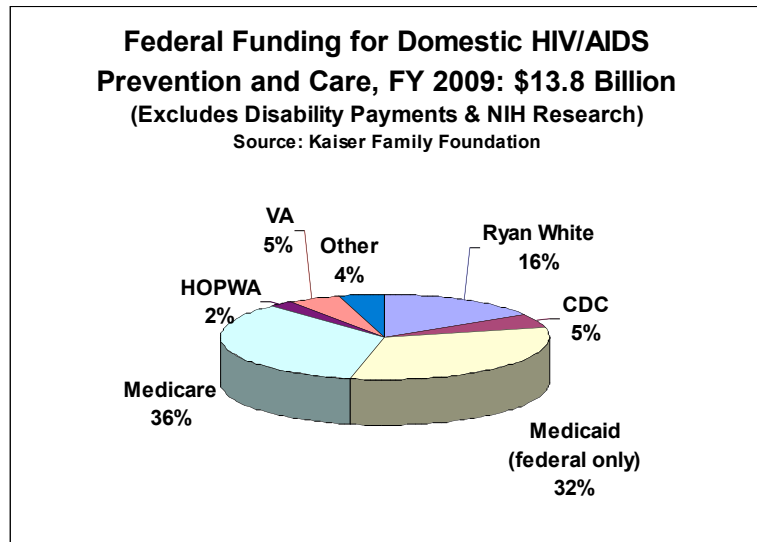
estimate includes people unaware of their status, while the Virginia and Maryland data apparently include only people aware of their status. The suburban jurisdictions had a total of 14,573 reported people living with HIV and AIDS as of December 31, 2008 – 8,565 or 59% of them living in Suburban Maryland and 6,008 or 41% living in Northern Virginia. (For additional information on the HIV/AIDS incidence [new cases] and prevalence [living cases], see the epidemiological profiles in Appendix A and the discussion in the section on “The Epidemic,” later in this report.)

Race and Ethnicity of People Living with HIV and AIDS in the Inner Suburbs of Washington, DC, December 31, 2008 (N = 14,573)



Funding Streams for HIV/AIDS Services

Federal categorical funding for HIV/AIDS prevention, testing, and care comes primarily to states and to the central cities or counties of metropolitan areas with disproportionately large numbers of PLWH. While (as the pie chart below shows) Medicaid and Medicare actually provide the most dollars for HIV services, the main HIV/AIDS-specific prevention and care programs are treatment funds authorized through the Ryan White HIV/AIDS Treatment Extension Act and HIV prevention funds awarded by the Centers for Disease Control and Prevention (CDC). The largest Ryan White programs are Part A, awarded to 56 metropolitan areas with the largest number of AIDS cases, and Part B, awarded to states. In its city-state role, the District receives “state” funds for HIV/AIDS prevention, testing, and care. In its metropolitan central city role, it is the grantee for Ryan White Part A funds for the Washington area, which is called the eligible metropolitan area (EMA).



The suburban jurisdictions highlighted in this study do receive HIV funding, but the vast majority of these funds come through the states or the District of Columbia. The five Northern Virginia health districts and two Suburban Maryland counties are not direct grantees of the federal government for major HIV/AIDS prevention, testing, and care. That funding comes through the state health departments, which also play major funding and oversight roles in the delivery of HIV/AIDS services and in the broader public health arena. Key informants reported that some jurisdictions view HIV/AIDS – and in some cases public health more broadly – as largely a state responsibility, and believe that the funding should come from the state and the federal government. Others consider HIV/AIDS and public health to involve significant local responsibility.

The findings and recommendations presented here are based on an understanding that cities and counties have significant limitations on their authority and autonomy in responding to HIV/AIDS, but also on an assumption that part of the responsibility of a local government is to make the best possible use of available resources and to take leadership in helping to protect the public health. Just as all the jurisdictions have played an active role in addressing the H1N1 virus and other threatened epidemics and have collaborated regionally, they can and should play an active, collaborative role in the response to HIV/AIDS.

Overview of Findings and Recommended Actions

Findings

- 1. Both Maryland and Virginia benefit from devoted HIV/AIDS service providers, both public and nonprofit.**
- 2. School-based HIV prevention education is varied, inconsistent, and often timid.**
- 3. HIV prevention and community testing are insufficient.**
- 4. Health departments do very little outreach to find people in need of testing or care, usually due to limited resources.**
- 5. People living with HIV and AIDS generally receive medical care immediately, but access to other services varies, depending on their neighborhood, county, and state of residence.**
- 6. The region lacks parity, choice, and portability of care.**
- 7. Coordination is lacking between safety net clinics and HIV medical providers – HIV/AIDS is not well integrated into the health care system**
- 8. Local governments vary in their engagement and leadership with regard to HIV/AIDS.**

Recommendations

Quick Actions

- 1. Review the current response to HIV – prevention, testing, and care – and identify opportunities for positive change.**
- 2. Make information on HIV/AIDS testing and services more readily available on the city/county website and through other mechanisms like 2-1-1 numbers and referral services.**
- 3. Improve coordination by initiating periodic local-level meetings of HIV prevention, education, and care providers, funded and unfunded.**
- 4. Help inform the local and regional medical community about CDC recommendations for routine opt-out testing in all healthcare settings – and encourage their adoption.**
- 5. Ensure maximum availability of rapid test kits for both the health department and nonprofit partners.**

Longer-term Actions

- 1. Work with local hospitals to initiate rapid testing in their emergency departments.**
- 2. Task existing advisory bodies with regional prevention plan development – and use the plans to develop a city/county annual prevention plan.**
- 3. Help ensure new policies to improve parity, choice, and portability of care.**
- 4. Take leadership in addressing HIV/AIDS as a chronic illness and integrating it into the public health safety net system.**
- 5. Find ways to overcome contracting barriers and inefficiencies, to increase opportunities for community-based nonprofit organizations and bring more funding for HIV/AIDS.**
- 6. Increase outreach and social marketing to get people tested and into care.**
- 7. Serve as a voice for school-based HIV education and prevention efforts – as part of the curriculum and through voluntary sessions and after-school programs.**

Key Findings

1. Both Maryland and Virginia benefit from devoted HIV/AIDS service providers, both public and nonprofit.

In both Northern Virginia and Suburban Maryland, skilled, devoted, hardworking people are providing HIV/AIDS services. In nearly every county or health district,* the vast majority of service providers, public or private, have key staff that are deeply committed to providing the best possible HIV/AIDS related education, prevention, testing, and/or care services. The Profiles Project did not assess program quality, but did obtain perspectives from over 120 people. With a very few exceptions they have great respect for the public agency and nonprofit staff managing HIV/AIDS services. Key informants including PLWH described how program staff advocate for clients, work very long hours, find ways to ensure bridge medications when delays occur in program eligibility determination, go to enormous lengths to obtain timely medical care, and manage to get services provided when systems are slow or unresponsive. At the program operational level, there appears to be competence, leadership, and professional accountability.

2. School-based HIV prevention education is varied, inconsistent, and often timid.

County officials, HIV/AIDS experts, educators, and residents frequently express concern over high rates of teen pregnancy and sexually-transmitted infections (STIs), and their belief that a growing number of young people are becoming HIV-infected while still in secondary school. Yet most area school systems are not taking effective advantage of the opportunity to provide HIV prevention education to elementary, middle, and high school students. For example, of the seven suburban school systems, only three provide live or video condom demonstrations at the high school level; the others mention condoms to varying degrees. One school system explicitly forbids condoms to be brought into the schools.

State laws: State laws provide some requirements for what Virginia calls Family Life Education and other states refer to as sex education and HIV prevention education. They do not forbid school systems from adding to the curriculum. Maryland law requires teaching of both sex education and STI/HIV prevention education; both units must cover both abstinence and contraception. Virginia law calls for Family Life Education instruction, but does not mandate inclusion of either sexuality education or HIV/STI education. When such topics are covered, both abstinence and contraception must be covered. Parents in both states can opt out of classes on behalf of their children.

Curriculum: All the school systems say they follow state mandates regarding curriculum, at least three go beyond those requirements, with a more extensive curriculum. All provide some form of HIV education, though the extent varies. Some use curriculum that provides limited sex

* The seven Profiles Project jurisdictions include one city and two counties that are also Northern Virginia health districts, two health districts that each include both a county and two small cities, and two Suburban Maryland counties. Where the report references “counties/health districts,” the term is meant to include all the various jurisdictions covered by the project.

education (Virginia uses the terminology Family Life Education instead) and brief information on HIV and other STI prevention. Others discuss the implications of sexual orientation, the importance of knowing how to prevent HIV, and the need to be supportive of people who have the disease. All at least mention condoms, but only three report condom demonstrations – and one of these uses a video. Two school systems explicitly forbid condoms to be brought into the schools. The challenges faced by school systems generally involve objections to sexuality and HIV prevention education by some parent or community groups. A legal summary prepared under the coordination of the National School Boards Association notes that “Local school districts generally have a great deal of latitude with respect to curricular content, and courts typically have rejected parental efforts to dictate or alter it. Decisions about classroom content should be based on sound education rationales, age appropriateness, relevancy to the course, and currency of the information.”² However, some counties – especially Montgomery and Fairfax – have encountered considerable community conflict. Montgomery County faced a court challenge to its proposed new sex education curriculum in 2005, including information presented about sexual orientation, and finally won the case in 2008. One point of controversy was the curriculum’s inclusion of the American Psychological Association statement that homosexuality is “not an illness, a mental disorder, or an emotional problem.”³ This information remains in the curriculum.

Implementation: In most counties, the curriculum is not consistently implemented. Frequently, individual teachers teach what they feel prepared and comfortable covering, and exclude, minimally cover, or do not allow questions about challenging material – often including use of contraceptives and sexual orientation. The problem is sometimes insufficient training, and sometimes personal beliefs that are inconsistent with the curriculum. In some school districts, the principal reportedly decides what is actually taught and whether outside experts such as a county public health nurse or a nonprofit HIV prevention specialist is invited or allowed into the schools. One school system strongly encourages the use of outside experts to help teach the core curriculum, two do not permit outsiders (not even health department personnel), and the others allow some use of outside experts – two permit them to teach just one class at the high school level. Most of the school systems allow outside groups, such as prevention program staff, to provide optional sessions or after-school programs. Prevention staff from Identity and Planned Parenthood (Maryland) and NOVAM and K.I. Services (Virginia) have ongoing programs in one or more schools.

Opt-out rates: Opt-out rates in the suburban jurisdictions are low – no school system reported levels above 2%. However, in both Maryland and Virginia, small groups of parents who oppose sex education in the schools or particular aspects of curriculum – such as its handling of sexual orientation or contraception – have tried to change what is taught, sometimes with lawsuits. One result has been a fear of public opposition, leading some jurisdictions to avoid updating their curriculum (which requires public discussion), provide limited curriculum information from their websites, avoid condom demonstrations, and refuse to allow outsiders to help deliver the curriculum.

Gay Straight Alliances: NOVAM runs intensive programs for gay, lesbian, bisexual, transgender, and questioning (GLBTQ) youth in several high schools in Northern Virginia, working with Gay Straight Alliances. Prince William does not permit these Alliances; the clubs exist in one or more high schools in each of the other four Virginia jurisdictions and in Montgomery and Prince George’s County. The Alliances sometimes face opposition. However, according to the National School Boards Association, “The Equal Access Act requires any public

secondary school that receives federal money AND has a ‘limited open forum’ to allow LGBT-oriented clubs formed by students the same access to school facilities that other student groups enjoy.”⁴

3. HIV prevention and community testing are insufficient.

There is ample research on the reduction in human suffering and deaths as well as the cost savings that can be realized through prevention. Many experts believe that prevention should be the top priority in the response to HIV/AIDS. As the CDC reports, “For every HIV infection that is prevented, an estimated \$355,000 is saved in the cost of providing lifetime HIV treatment,⁵ resulting in significant cost-savings for the health care system.”⁶ Yet throughout the region – as in most of the nation – there is far less funding for prevention and testing than for care. Prevention funds, especially funds for primary prevention for people who are not infected, have been reduced at the federal level. A 2009 report from the CDC indicated that since 2002, its “prevention budget (approximately \$750 million in FY 2009) has declined by almost 20 percent in real dollars (adjusted for inflation), and prevention currently accounts for 4 percent of all federal HIV/AIDS spending on the domestic epidemic”⁷ and more than \$20 are spent on care and treatment for every dollar spent on prevention.

Regionally, both Maryland and Virginia report reductions in state funding for prevention efforts due to the economic situation, and some counties that provide funds for HIV prevention are also making cuts. CDC recommendations for routine opt-out testing in all healthcare settings are not widely followed. There is also far less joint planning and coordination. As a result, available prevention resources are sometimes not used to maximum effectiveness.

Following are some specific prevention and testing problems and constraints:

- **Minimal coordination across state lines.** A large share of HIV/AIDS treatment funds come directly from the federal government to the central city or county of a metropolitan area. Where the metropolitan area crosses state lines, as in Washington, there is some cross-border regional planning. Prevention funds come through the state, and planning occurs at the state level, with no recognition that the Washington, DC metropolitan area encompasses parts of three states and the District of Columbia (which is funded like a state). There is no required inter-state coordination in prevention planning or implementation. People move back and forth across state lines, but prevention programs are almost all limited to a single state. The only entities regularly addressing prevention and testing issues on a multi-state regional basis are providers that work in more than one state, such as La Clinica del Pueblo and Planned Parenthood.
- **No health district/county or substate regional* prevention plans:** The states have HIV prevention plans, but there are no substate regional or local plans in the Washington, DC suburbs. Prevention and testing entities, public and private, operate largely independently, or coordinate based on individual relationships rather than any organized mechanism.

Prevention planning is a state responsibility and occurs largely at the statewide level. CDC requires HIV Prevention Community Planning Groups (CPGs), which are managed by state health departments. Both Virginia and Maryland have regional advisory bodies (which

* The term “substate region” is used in the report to refer to multi-county areas like Northern Virginia and Suburban Maryland that are within a single state – as contrasted with the multi-state metropolitan area.

include the Northern Virginia Regional HIV Consortium and Maryland’s Suburban Washington Regional Advisory Committee) that contribute to the state HIV prevention plans but do not prepare written regional plans or annual priorities. Neither the Virginia nor the Maryland plan document provides regional statistics on HIV/AIDS or on prevention and testing challenges and needs by region – only state-level data. The Virginia plan provides no regional priorities; the Maryland plan lists target population priorities for the region. These state plans are required by the CDC only every five years, and are based on data collected for several years before that – for example, the Virginia plan completed in December 2007 is based on prevention provider data from 2005. Counties or health districts within a substate region operate largely independently rather than collaborating on how best to use limited prevention dollars.

No health district or county has developed its own prevention plan. Only Arlington currently has a body (the STI Strategic Intervention Team associated with the Partnership for a Healthier Arlington) that seems likely to consider such a role. There is no regular coordination at the health district or county level between the health department and local healthcare facilities and nonprofit prevention providers, which play a critical role in prevention outreach and often have state funding and in some cases local funding.

- **Lack of flexibility in prevention models:** Both state and local HIV/AIDS experts believe prevention efforts are harmed by the CDC’s requirement that its prevention funds be used primarily for a set of “evidence-based interventions” (EBIs) that have been documented nationally. As one key informant explained, “CDC interventions do not address local needs. Therefore, the State has to develop local interventions and pay for them itself.” Very little funding is available for developing and documenting effective local models. The Washington AIDS Partnership is an important source of support for such efforts.
- **Limited adoption of CDC-recommended opt-out routine HIV screening in all healthcare settings.** People who don’t know their HIV status are more likely than those in care to infect others, and late entry into care negatively affects health status. Yet CDC recommendations for routine testing, which could greatly increase screening, have not been widely implemented in the suburbs. These revised recommendations were issued in September 2006, and urge that “In all health-care settings, screening for HIV infection should be performed routinely for all patients aged 13-64 years.” Individuals should know that they are going to be screened and should have the opportunity to refuse screening; they need not receive pre-test counseling.⁸ Risk-focused testing is becoming less effective due to changes in the demographics of the epidemic. PLWH now include more women, more people under age 20, more residents of rural areas, and more heterosexual men and women who may not be aware that they are at risk for HIV.

“Testing needs to be part of routine medical care. [Safety net] clinics and emergency departments are not doing routine testing.” – *Key Informant*

Routine screening as part of a medical examination is relatively low cost and will lead to earlier detection, earlier entry into care, improved medical outcomes, and reduced transmission. People who know their status are less likely to engage in risky behaviors. Research also suggests that PLWH whose medications have led to undetectable viral load may be less likely to infect others if they engage in risky behaviors.⁹ Despite these benefits, the CDC recommendations have not been widely publicized or adopted in the DC suburbs. A majority of safety-net clinics without specific funding for HIV/AIDS services lack policies about HIV testing, and many are unaware of the recommendations. Even some suburban

federally qualified health centers (FQHCs), which receive substantial federal funding, do not do routine testing. Many individual physicians are reportedly unaware of the recommendations, although about half of new HIV cases in some jurisdictions are identified by such physicians, according to area health officials interviewed for the project. Nationally, a majority of HIV testing is done in physicians' offices.¹⁰ The DC Department of Health's HIV/AIDS, Hepatitis, STD and TB Administration (HAHSTA) has been much more active and, according to DC Appleseed, "can now be counted among the national leaders in promoting routine testing," though "even more must be done."¹¹

- **Routine emergency department HIV testing in only two suburban hospitals:** One of the "healthcare settings" specified in the CDC recommendations is emergency departments. The CDC recommendations cite research showing that HIV screening in hospitals and emergency departments sometimes results in a higher proportion of positive tests (2-7%) than at publicly funded HIV counseling and testing sites (1.5%) and STI clinics (2%) that serve people assumed to be at high risk for HIV. Research also shows that when emergency departments refer patients who may be at risk to health department or community testing sites, they often do not go to the testing sites. As of the end of 2009, only two emergency departments in the target area – Prince George's Hospital Center and Inova Alexandria Hospital – were doing routine HIV testing in their emergency departments. One hospital in Montgomery County was reportedly considering such testing, and public funds were being sought. HIV/AIDS officials said that a number of Northern Virginia hospitals have been approached but indicated they are not interested in such a program. Even individuals with HIV-related symptoms sometimes aren't tested when they seek care. One HIV/AIDS provider described two situations in 2009 in which individuals went to the emergency department and were hospitalized more than once without being tested; another reported seeing a growing number of individuals who were not tested until they had advanced AIDS.
- **Not enough rapid test kits:** At least three local health departments and several major nonprofit groups doing HIV testing sometimes don't have enough rapid test kits to do needed testing. One health department said it does no rapid testing because of the cost of kits. This negatively affects the ability to do community testing and to ensure that an individual who is ready to be tested gets the test and results immediately. Traditional HIV tests involve drawing blood and doing laboratory analysis, with results typically available several weeks later. This works for people who have a regular source of medical care and will return for results. It is not effective for individuals who do not have a medical home, are concerned about their HIV status because of a particular situation, and are unlikely to check back in a few weeks to obtain their test results.
- **Few non-health department testing sites:** Both Maryland and Virginia report a large number of testing sites. However, the vast majority of sites in the jurisdictions studied are in health departments. Maryland's DHMH indicates 400 testing sites statewide, but sites listed in the two Suburban Washington counties include the two health departments, two Latino-focused nonprofits that are state-funded, and one church in Hyattsville. The Profiles Project identified one relatively new project that targets African American women and adolescents, four Planned Parenthood locations, and a site at the University of Maryland in College Park. The Virginia Department of Health website lists 100 sites, all associated with health departments. The Profiles Project identified three additional funded regional providers that do community testing, plus the Planned Parenthood office in Fairfax.

County clinics or STI/HIV testing sites are a convenient testing location for many people, but not for all. Some facilities are so clearly identified as HIV testing sites that individuals

concerned about confidentiality and stigma will not go there. Numerous key informants reported that undocumented immigrants are often afraid to go to a county facility because they fear arrest and deportation – though no questions about immigration status are asked at testing sites. Refugees and other legal immigrants are often concerned that being identified as HIV-positive may keep them from obtaining citizenship on the grounds that they might become a “public charge.”

- **Limited prevention and testing funds for nonprofits:** Respected Virginia and Maryland nonprofits providing community prevention and testing generally report limited resources; several indicated that they would love to work in more schools and community settings if resources were available. Federal prevention funding goes largely to the states, which can subgrant funds to local health departments and/or community-based organizations. In the suburban jurisdictions studied, a very large proportion of prevention funds go to local health departments, and only a small proportion to nonprofits. At least one nonprofit has direct CDC funding through a national grant program, but such funds are highly competitive. Community-based nonprofits are especially important because they have often developed trust through years of work in the community. For example, some Maryland Latinos are most comfortable obtaining services from Identity or CASA de Maryland.

4. Health departments do very little outreach to find people in need of testing or care, usually due to limited resources.

City/county HIV/AIDS experts in most of the jurisdictions feel that they do a good job of testing and treating people “who find us and ask for services, “ but are not “reaching the populations that need to be reached.” This concern was raised by county personnel in most of the seven jurisdictions studied. There are dual concerns: late testing because of inadequate outreach to urge people to be tested, and high proportions of people who know their status but are not in care, because they don’t know where and how to obtain affordable treatment services.

Outreach for prevention and testing: Counties lack the resources to go out and find people who don’t know they need to be tested. Health department officials identify the need for “marketing to mobilize people to get tested.” The lack of outreach through social marketing, media campaigns, or outreach workers is widely recognized. Only Prince William Health District reported a consistent HIV prevention message, and only Fairfax County reported a targeted community outreach effort. In collaboration with the Northern Virginia Clergy Council, the Fairfax County Health Department has produced a 14-minute educational video on HIV for the African American community that will be duplicated and disseminated to faith-based organizations and other entities. Community-based providers do outreach, but have very limited resources. Sometimes, outreach targets are determined by funding availability rather than identified priorities – and resources are too limited to do general outreach to people who don’t know they are at risk. Of particular concern: young adults, heterosexual women of color who do not fit other risk categories, African American adult males, and African immigrants.

Outreach to PLWH who are not in care: Another type of needed outreach is to PLWH who are not receiving needed services because they are uninsured and don’t know where to go for care. The estimated “unmet need” – the percent of all PLWH who know their HIV status but are not receiving HIV-related medical care – is high in both Virginia in Maryland. State HIV/AIDS

officials have estimated that about 62%* of PLWH in Northern Virginia and 41% in Maryland are out of care (no separate data are available for the Suburban Washington region of Maryland). Yet little funding has been allocated to finding people with unmet need and linking them to care. Neither Northern Virginia nor Suburban Maryland has allocated regular Ryan White Part A funds for Outreach or Early Intervention Services; limited Minority AIDS Initiative funds were being used for Outreach in Northern Virginia.

Involvement of community-based nonprofit organizations: Community-based nonprofit organizations with special knowledge of particular target populations are a key ingredient in effective outreach. However, only a few nonprofit organizations have funding for HIV prevention and outreach activities. Just three nonprofits in Northern Virginia are actively engaged in outreach, and all have limited resources. The nonprofit sector in Prince George's County is relatively small, and most nonprofits have small budgets. Few are engaged in prevention and outreach activities. Two Latino organizations are providing prevention and testing in Suburban Maryland, and one African American nonprofit.

5. People living with HIV and AIDS generally receive medical care immediately, but access to other services varies, depending on their neighborhood, county, and state of residence.

Access to basic treatment services – HIV-related medical care, medications, and medical case management – is usually immediate for a low-income, uninsured PLWH in both suburban Maryland and Northern Virginia. Other needed services can be more difficult to obtain. Some PLWH need a whole range of medical and supportive services to enter and remain in care.

Medical care and medications: A PLWH who requests *HIV-related medical care* is usually connected quickly to a clinic or a contract physician. There are some exceptions. In the summer of 2009, some PLWH had to wait six weeks for a first medical appointment in Prince George's County, unless referred through a hospital emergency department. *Medications* are generally provided promptly, through the state-run AIDS Drug Assistance Program (ADAP), funded through Ryan White Part B, often with state funds added. A PLWH who appears eligible for ADAP usually receives bridge medications while eligibility for ADAP and Medicaid are being determined. Neither Maryland nor Virginia has a waiting list for ADAP enrollment (as of the end of 2009, nine states did). Both have relatively generous eligibility, recognizing that paying for HIV/AIDS medications is well beyond the capacity of even moderate-income people. Like the District of Columbia, Maryland has an ADAP income limit of 500% of the federal poverty line; Virginia eligibility is 400%.[†] In Maryland, PLWH who are eligible for Medicare are required to apply at the same time for a drug discount card. The program is not locally administered, and sometimes delays in determining eligibility mean that the bridge medications period ends before a decision has been reached. Staff in both counties report intensive efforts to ensure that no one is left without needed medications during the interim period. In Northern Virginia, changes in the process of obtaining medications are a concern. The state is closing its regional pharmacies, probably including one in Alexandria. All PLWH are likely to be expected to get their ADAP

* The 2008 estimate was 63%, the 2009 estimate 62%. However, Virginia reportedly does not adjust its estimate to account for PLWH in private care or those receiving care through the Department of Veteran's Affairs, so this is probably an overestimate of unmet need.

[†] The 2009 federal poverty level is \$10,830 for a single person and \$22,050 for a family of four. See <http://aspe.hhs.gov/poverty/09poverty.shtml>.

medications through a single central pharmacy in Richmond. As of the end of the year, plans and options were not fully determined.

Other medical-related services: In addition to medical care, medications, and medical case management, PLWH often need other medical-related services, for which funding and availability varies considerably by region and by county. Hospitals in all jurisdictions typically accept HIV/AIDS patients without difficulty. However, in most jurisdictions, PLWH sometimes have limited access to, or delays in obtaining, dental, mental health, and substance abuse services, and some other services are not fully available when needed. For example:

- Several county health departments report great challenges in arranging *subspecialty care* for HIV/AIDS patients without private insurance.
- *Dental care* funds reportedly can run out before the end of the funding year, there are no dental schools in the suburbs, dental services for low-income people are insufficient, and it can be hard to find contract dentists. In an effort to expand services, Prince George's County initiated a dental program in cooperation with Howard University (which does have a dental school), largely with private funding.
- Several counties report long waits for *mental health and substance abuse services*, including a wait of up to six months for non-crisis mental health counseling. Virginia's Community Services Boards (CSBs), which are a major source of mental health and substance abuse services, normally have limited resources and have faced severe budget cuts, and Ryan White resources are limited. Comprehensive care facilities like Inova Juniper in Northern Virginia provide mental health and substance abuse services, and Inova sometimes arranges for a counselor to go to a county health department to see PLWH. There is no mental health center in Suburban Maryland, and the county clinics provide services, often with large caseloads. Montgomery County uses non-HIV funds to provide mental health services to PLWH.

Supportive services: Given the need to provide HIV-related medical care and other medical-related services, the suburban jurisdictions spend a high proportion of Ryan White funds on core medical-related services – and less remains for supportive services such as transportation and food. This makes it very important for PLWH and their case managers to identify providers that are part of the general human services safety net.

- Lack of *transportation* is a significant barrier to care in some suburban areas. Most of the suburban counties include some rural areas, and few have the same level of public transportation as the District. Transportation assistance to get to medical and other appointments is available but limited; there is no transportation assistance available to get to a testing facility. Transportation gaps make it hard for PLWH to obtain services that are not located near their homes, reduce choice, and complicate efforts to retain PLWH in care. Both Suburban Maryland and Northern Virginia spend less than 2% of their Ryan White Part A funds on transportation.
- *Housing* is a major issue. Housing costs are high throughout the region, Ryan White provides only limited short-term housing assistance, and no Ryan White Part A funds are allocated to housing in the Washington EMA. Limited funds are available through the special HIV/AIDS housing program, Housing Opportunities for Persons With AIDS (HOPWA). PLWH can sometimes obtain access to housing for the disabled or mentally ill, but the supply is very limited. There is only one HIV-specific housing facility in Northern Virginia, the 12-unit Agape House in Fairfax. Housing assistance most often comes in the form of rental vouchers.

Often there is a long wait for a voucher, and sometimes PLWH have difficulty finding a landlord who will accept the voucher.

- *Food* is another challenge for low-income PLWH, particularly in Northern Virginia. Some Ryan White funding is used for home-delivered meals and food; the District spends 8.2% of its regular Ryan White Part A dollars on food and home-delivered meals, compared to 5.9% in Suburban Maryland and just 2.4% in Northern Virginia. Several Virginia counties report that even with the funding provided, eligibility is strictly limited and sometimes services are unavailable, especially outside the Beltway. Non-HIV-specific food banks and meal programs, many of them faith-based, provide help in most jurisdictions.

6. The region lacks parity, choice, and portability of care.

PLWH in different parts of the metropolitan area have very different opportunities and choices in obtaining HIV/AIDS treatment due to limitations related to *parity*, *choice*, and *portability* of care. This is perhaps the most complicated treatment challenge facing the metro area.

Parity, Choice, and Portability of HIV/AIDS Services

Parity = Equitable access to services for all PLWH regardless of who they are or where they live in the service area – in this case the Washington Ryan White Part A eligible metropolitan area (EMA). The Health Resources and Services Administration’s HIV/AIDS Bureau (HRSA/HAB), which oversees Ryan White programs, asks grantees to work for parity throughout their service areas with regard to “geographic location of services, quality, comprehensiveness of services, and cultural appropriateness.”

Choice = The ability to obtain services from any funded provider for which the PLWH meets eligibility criteria, regardless of where in the EMA the provider is located. Choice usually is designed to enable a PLWH to live in one jurisdiction but receive care in another due to preference for a particular provider or model of care, language or cultural issues, convenience (for example, if the PLWH works in a different jurisdiction), or confidentiality or stigma concerns (the PLWH would prefer to receive services where s/he is not known).

Portability = The ability of a PLWH to continue obtaining HIV-related services from the same provider if s/he moves across jurisdictions within the eligible metropolitan area – for example, to avoid having to change doctors or case managers.

In most metropolitan areas, low-income uninsured and underinsured people living with HIV/AIDS who depend on Ryan White Part A funds for care have choice and portability. They can obtain services from any Ryan White-funded provider in the Part A service area. People from the suburbs are permitted to come to the central city, where there are usually more services, more anonymity, and more diversity in types of providers – even if the suburbs are across a state or county line. Individuals who are worried about stigma and confidentiality may seek care at some distance from their own neighborhood. PLWH who live in one jurisdiction and work in another may choose to obtain care in either location. If they move from one jurisdiction to another, they have the option of continuing to see the same physician and case manager. Client utilization data are used to ensure that PLWH from all parts of the service area are obtaining services, and action is taken when disparities are identified.

The Washington metropolitan area is probably the most complex Ryan White Part A eligible metropolitan area in the country, encompassing the District plus counties in Maryland, Virginia, and West Virginia – each with its own Medicaid system and its own ADAP. The Memphis Part A program covers parts of three states, and quite a few Part A programs (among them Boston, Kansas City, Philadelphia, and St. Louis) include counties in two states. Having a multistate service area presents challenges, but does not require that Ryan White clients be barred from obtaining services in a different jurisdiction; this is a choice that has been made in the Washington EMA. In other multi-state Ryan White Part A programs, PLWH receiving care through Medicaid may be required to obtain those services in their own state, because Medicaid is a state-run program – although some providers do operate in one state and receive Medicaid reimbursements from another. PLWH needing medications through ADAP also need to obtain them through their own state, though multi-state Part A programs sometimes use a common intake system, and a medical case manager can help a client access the appropriate ADAP. But the basic assumption is that in the absence of legislative limitations, the focus should be on choice and portability. This is not currently the case in the Washington EMA.

In metropolitan Washington, the “system of care” for PLWH is not regional. PLWH receiving services through Ryan White funds face limits on parity, choice, and portability.

- **Parity in access to services:** Except for immigrants, who are permitted to cross state lines to obtain care from La Clinica del Pueblo in Washington, DC, PLWH must receive services in the state where they live. The EMA is divided into largely autonomous mini-service regions, so a PLWH has access to a different mix of types and providers of services depending on where s/he lives. Service priorities and allocations are different in the District, Maryland, and Northern Virginia. For example, residents of Suburban Maryland have no Ryan White-funded legal services, and PLWH living in Northern Virginia have no medical nutrition therapy. Only PLWH in the District have access to Ryan White funded child care services or treatment adherence counseling. (Appendix B lists Part A-funded service categories funded in each jurisdiction and shows the differences in service availability.) Available services are often a considerable distance from their homes, so they may need transportation assistance to obtain care – and limited transportation funds are available. PLWH living in suburban Maryland may live a few blocks from a DC-based clinic, but they are not allowed to get HIV-related care at a clinic located across the state line. Federally qualified health centers, which receive considerable federal funding, are required to provide medical care regardless of a patient’s residence. An FQHC with Ryan White funding for HIV-related medical care must serve clients regardless of residence but will not be reimbursed by Part A for serving a PLWH who lives across the state line.
- **Choice:** Since PLWH are not allowed to cross state lines for services, their choices are limited to the services in their substate area. The suburban jurisdictions have less funding and fewer provider choices than the District. Some services are available only to residents of a single county; most (though not all) local health departments say they can provide services only to county residents. Some only provide testing to their own residents.

Suburban care providers often offer a “one-stop shop” approach that is very attractive to many PLWH and provide high quality care. However, some PLWH would prefer a smaller clinic, are afraid to go to a public clinic, or want a provider with a specific target group focus (e.g., Latinos, gays). Similarly, some PLWH in the District might prefer to receive services in the suburbs for a variety of reasons, such as a desire to receive comprehensive care from a

single location or obtain services where they are not known. Several key informants who work for large providers emphasized the importance of choice – in location, size, type of entity, and population focus – in getting PLWH into care and keeping them in care. Research indicates that the patient-provider relationship is an important factor in treatment adherence for PLWH.¹² Yet these factors are largely ignored by the current service system.

The regional administrative agents for Ryan White can contract with providers across state lines, but with few exceptions (primarily for home-delivered meals and groceries), funds go only to agencies headquartered in their state. When Whitman Walker closed its Arlington clinic in early 2009, area health officers and HIV/AIDS officials decided not to maintain the contract with Whitman Walker and pay for clients to go to a Washington, DC facility for services, even from close-in suburbs. Inova Juniper, the largest HIV/AIDS medical provider in Northern Virginia, received additional funds to open another clinic in Arlington. Inova Juniper has an exceptional reputation for providing high quality, comprehensive services. But former Whitman Walker clients in Northern Virginia ended up with reduced choice and had to adjust to different care providers.

- **Portability:** A PLWH who moves from one jurisdiction to another – for example, from Washington, DC to Prince George’s County or from Alexandria to Washington, DC – will almost certainly have to change medical, case management, and support service providers. Only immigrants are permitted to obtain services from the immigrant-focused clinic regardless of where they live. Since there is considerable movement across jurisdictions, often based on financial issues such as access to affordable housing, this lack of portability disrupts continuity of care for many PLWH.

The project asked federal HIV/AIDS specialists if they were aware of any other Ryan White Part A program that does not allow PLWH to obtain federally funded care in any part of the EMA, and they said no. It was also noted that HIV/AIDS data are based on where people were *tested*, not where they currently *live*, and many people move across county or state lines after diagnosis.

7. Coordination is lacking between safety net clinics and HIV medical providers – HIV/AIDS is not well integrated into the health care system.

HIV/AIDS is becoming a chronic illness, yet its treatment is still largely provided by specialized providers. HIV prevention, testing, and care have not yet become an integral part of the health care system, or even the safety net system for uninsured people. In the Washington suburbs, there is little communication and no regular coordination between funded providers of HIV-related medical care for people without private insurance and the community health centers, other FQHCs, free clinics, or other safety net clinics that serve as medical homes for PLWH but do not have HIV-specific funding.

Considerable efforts are under way in the Washington area to ensure that residents have a medical home. In the suburbs, HIV/AIDS providers and services are not yet a part of that process. Community health centers and other FQHCs almost always serve as medical homes, as do some free clinics. For example, the Arlington Free Clinic has adopted a patient-centered medical home model that “focuses on physicians building partnerships with their patients to find the best path to effective and efficient medical care.” Other safety net clinics sometimes provide regular, ongoing care to individuals or families. Individual physicians also serve as medical homes.

What is a “Medical Home”?

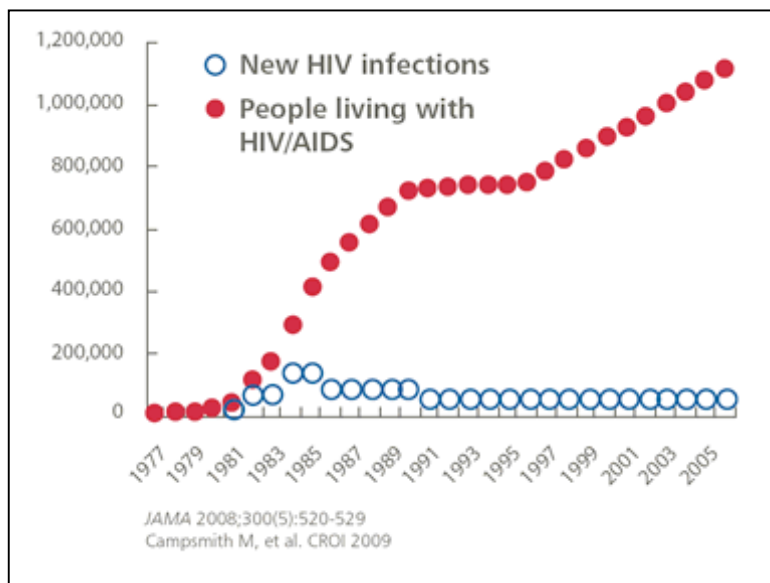
A “medical home” is a health facility that provides or arranges patient-centered comprehensive health services, either providing needed services directly or arranging referrals. Usually the medical home provides primary care on-site. It is the first point of contact when a patient needs any health care other than emergency services – the starting point for obtaining preventive services, screening and diagnosis, and treatment. It maintains the patient’s medical records.

While HIV/AIDS medical providers often are not set up to serve as the PLWH’s medical homes, some are also medical homes – for example, Greater Baden Medical Services (GBMS) in Prince George’s County is a community health center that provides both primary care and HIV care. As a result, PLWH can receive both their general and their HIV-related medical care from the same source. However, Ryan White funds are not designed to pay for comprehensive health care, only for HIV-related medical care. Public HIV/AIDS clinics typically do not have funding to provide general medical care, so their clients need another medical home.

Where a PLWH obtains medical care from two different providers, communication between them is important to avoid problems with medications and ensure coordinated care. The Profiles Project determined through online surveys and discussions that most safety net clinics in Northern Virginia and Montgomery County do not have policies around HIV testing or a defined process for referring a person who tests positive to an HIV medical provider while maintaining coordination of care. Following meetings held in both regions as part of the project, there is interest in changing this situation. In Montgomery County, there is not yet a system for coordination between the Montgomery Cares clinics, funded by the county through the Primary Care Coalition of Montgomery County to provide care to medically underserved residents, and Dennis Avenue Clinic, the only Ryan White funded HIV/AIDS provider in the county – but interest in coordination has been expressed by both entities. In Northern Virginia, the Northern Virginia Health Services Coalition, a coalition of safety net clinics, has prioritized the development of policies and procedures to address HIV testing and referrals, in cooperation with HIV-related prevention and medical providers. The Profiles Project has thus encouraged safety net providers and HIV/AIDS providers to begin working together, but there is no policy-level commitment to communication and collaboration.

Coordination is particularly important since treatments have improved to the point that HIV/AIDS is increasingly

recognized as a chronic illness, and as the number of living PLWH increases. Nationally, an estimated 56,000 people become infected with HIV/AIDS every year, and about 14,000 to 15,000 die. This means each year there are about 42,500 new people who will eventually need



HIV/AIDS services.¹³ To maintain care for this growing population, HIV/AIDS care needs to be closely linked to the broader healthcare system and PLWH need a “medical home.” Over time, HIV-specific providers are likely to focus on providing intensive services to the newly diagnosed and those with co-occurring conditions, ensuring appropriate treatments and helping PLWH learn to navigate the healthcare system. Many PLWH will have their condition stabilized, receive appropriate medications, learn disease self-management, and then be referred back to the general healthcare system – where their medical home will need to know when to refer them to an infectious disease specialist and how to arrange other needed services. HIV/AIDS specialty providers will focus their efforts on individuals with the most complicated medical and support service needs. This is already occurring with Medicaid and Medicare clients. To ensure positive medical outcomes, coordination of care is necessary.

8. Local governments vary in their engagement and leadership with regard to HIV/AIDS.

The seven jurisdictions profiled vary considerably in the extent to which they take a leadership role in responding to HIV/AIDS:

- The extent to which they view HIV/AIDS as a city or county responsibility
- Whether they visibly address HIV/AIDS and attempt to make it a public priority
- How their HIV/AIDS services are structured
- What information their websites provide and how easy it is to find that information
- What if any local funds they contribute to HIV services
- Whether they take leadership in HIV/AIDS planning and service coordination.

In some jurisdictions, local leadership is significant and ongoing, with local resources (cash or in-kind) devoted to testing and care, leaders who periodically speak out about the epidemic, and a belief in local responsibility to address this epidemic. In others, the only resources available to address HIV/AIDS come from the state or the federal government, and it is difficult even to find information about testing and care services on the government website. For example:

- **State versus local responsibility for addressing HIV/AIDS:** City and county governments included in the study play very different roles in the response to HIV/AIDS. The individuals staffing health district HIV/AIDS programs in Prince William, Loudoun, and Alexandria are Virginia Department of Health employees; Arlington and Fairfax sought special permission from VDH to make them county employees. In Prince William, officials emphasized that HIV/AIDS services are provided by the health district, under VDH supervision, not by the county. One key informant explained that providing HIV/AIDS services is controversial, so everyone benefits by having these services viewed as a state responsibility. Local health departments in Maryland are overseen by the state, and most health officers are paid by the Department of Health and Mental Hygiene. This is true in Prince George’s County but not in Montgomery County, which negotiated a different arrangement. At least four cities/counties – Alexandria, Arlington, Fairfax, and Montgomery – appear to view HIV/AIDS as part of a broader local responsibility to protect and promote public health.
- **County leadership:** In several counties, both the health officer and senior county officials are available to play a leadership role on HIV/AIDS when needed. According to HIV/AIDS staff, most health officers speak out publicly on HIV/AIDS and participate in visible events during World AIDS Day and/or Testing Day. Several are also part of ongoing efforts to build links with the faith community.

County leaders, including health officers and health department directors, have many responsibilities and concerns; HIV/AIDS is seldom among the most visible. In most jurisdictions, the responsibility for responding to HIV/AIDS lies largely with the operational staff responsible for managing clinics and funds. These individuals are in most cases both competent and committed to their work. They often serve as the primary advocates with senior officials and the general public. They are most effective when they have the continuing support of senior officials.

- **Local resources for HIV/AIDS:** Other than Montgomery County, which devotes significant general funds to HIV testing and care, most jurisdictions provide little or no local funding for HIV/AIDS services beyond state-required matching funds for HIV/AIDS services. Some do support STI/HIV clinics, and several – including Alexandria City and Arlington, Fairfax, and Montgomery counties – have a history of awarding grants to community-based HIV/AIDS prevention groups or to service providers that serve as medical homes to PLWH. Montgomery and Fairfax counties also provide considerable funding to ensure that low-income and uninsured people have access to medical care, and several other jurisdictions operate clinics, including adolescent clinics, that are partly funded through general funds. There are great variations in the availability of free or low-cost primary health care. Some of the differences in local financial support for HIV/AIDS services are resource-related, especially at present. During good economic times, the decision to provide minimal local funding for HIV/AIDS presumably reflects jurisdictional priorities. Of the seven jurisdictions profiled, all but Prince George’s County are among the 250 wealthiest counties in the U.S. based on 2007 per capita income. Four – Alexandria City, Arlington County, Fairfax County, and Montgomery County – rank 12th through 15th in those ratings, with Loudoun number 92 and Prince William at number 244.¹⁴
- **Barriers for nonprofits:** Some of the jurisdictions work closely with community-based organizations to respond to HIV/AIDS and to meet other health and human service needs. Some have a long history of funding nonprofits as providers of health and human services, and have both large and small nonprofits as grantees and contractors. A special barrier exists in Prince George’s County, which has a contracting structure that makes it extremely difficult for nonprofit organizations to contract with the county – a limitation that has negative implications for HIV/AIDS services. The county’s procurement system is complex and extremely slow-moving. A nonprofit typically waits at least 3 months and sometimes 7-9 months to get a contract signed and begin getting paid – and is expected to provide services during this period. Community-based organizations generally cannot afford to seek county or pass-through funding, because they do not have the reserves needed to pay for services during the long delay. Numerous key informants identified this situation as a major barrier to nonprofit engagement in prevention and testing as well as treatment services. Several also noted that the county’s relatively small nonprofit sector consists mostly of small nonprofits, and there have been few strong advocates to urge changes in county policies and procedures.
- **HIV/AIDS commission or advisory body:** One way to bring visibility to the problem of HIV/AIDS, and perhaps encourage planning and coordination, is to maintain a city or county commission or advisory body responsible for advising the council and senior officials about HIV/AIDS. Of the seven jurisdictions, only Alexandria has an HIV/AIDS commission. As part of the Partnership for a Healthier Arlington, an STI Strategic Intervention Team has been established to focus on prevention of STIs including HIV. It has the potential to take on a planning and advisory role. Neither of these bodies has required PLWH membership.

- **Regular meetings of HIV-related providers:** Of the seven health districts and counties, only Loudoun County holds a somewhat regular meeting of providers of HIV-related prevention, testing, and care service providers, both with and without federal or state funding for HIV services, to share information and problem solve. The Profiles Project team was told that Prince William County has agreed to host such meetings in collaboration with a nonprofit provider.
- **Providing information about services:** City and county websites provide an important source of information about HIV/AIDS testing and care services offered in each jurisdiction. A person in need of an HIV test, medications, or treatment might well use the city or county website as an information source – and find the task quite challenging. The jurisdictions vary tremendously in the ease with which a searcher not starting at the NVRC online directory can find out what HIV testing or care services are available and where to go for them. Most websites have needed information, but finding it can be time consuming and difficult. Most counties do not include HIV/AIDS topics on health department home pages or include them in frequently asked questions or other search aids.

There are also great differences in access to resource directories listing and describing providers and their services and contact information. The website of the administrative agent for Northern Virginia, the Northern Virginia Regional Commission (NVRC), has a user-friendly online resource directory with a separate page for each provides that lists service providers along with information about the services offered by each provider, along with contact information and links to county and other provider websites. There is no equivalent resource directory in Suburban Maryland. The District has a regional resource directory that covers all jurisdictions but provides very limited information. It is posted on the DC Health Department website but is in a PDF format rather than a more flexible and searchable online format.

Recommended Action

The intent of the Profiles Project was to provide information leading to action to improve HIV education, prevention, testing, and care services. A variety of interested individuals and entities reviewed and discussed the project’s preliminary findings, and helped identify needed actions, both short- and long-term. The project’s detailed city/county and regional benchmarking reports provide information on specific local issues and needs. Summarized below are specific short-term and longer-range actions that apply across jurisdictions and can be taken by cities and counties, nonprofit organizations, planning bodies, and other stakeholders to improve the local and regional response to HIV/AIDS. While additional public and private resources are needed, many of these actions are needed to help ensure the best possible use of available resources, both cash and in-kind.

Quick Actions

Following are actions that local health departments, nonprofit organizations, and planning bodies can take quickly, with minimal cash costs, to improve their response to HIV/AIDS. Health departments are often the logical leader for such actions.

- 1. Review the current response to HIV – prevention, testing, and care – and identify opportunities for positive change.** Review current funding and operations, and use the Profiles county/health district report and the regional report to review current structures and programs, and see how they compare with those of other jurisdictions. Involve the health officer, the person coordinating the city/county HIV/AIDS response, other local staff, PLWH leaders, and key provider partners. The Profiles Project team is happy to present and discuss findings on request.

- 2. Make information on HIV/AIDS testing and services more readily available on the city/county website and through other mechanisms like 2-1-1 numbers and referral services.** Health departments can improve websites by borrowing approaches from user-friendly websites and seeking advice from IT staff. Have someone take the role of a person who needs testing or care, begin at the city/county homepage, and see how long it takes to find information about HIV testing and about obtaining HIV-related medical care and medications. Some suggestions:
 - For a model of an easy to use and informative website approach to HIV/AIDS services, check out the Seattle-King County joint health website homepage at (<http://www.kingcounty.gov/healthservices/health.aspx>) and the individual websites of King County (<http://www.kingcounty.gov/>) and Seattle (<http://www.seattle.gov/>).
 - Reduce the number of “clicks” required to find information by putting HIV/AIDS onto the topics list on the health department homepage.
 - Put HIV/AIDS topics – HIV/AIDS testing, HIV/AIDS medical care, HIV/AIDS medications – into search engines, Frequently Asked Questions (FAQs), and “How do I” listings.
 - Structure search engines so that results of a search based on a topic (such as HIV/AIDS) always begin with a listing of service descriptions, not an alphabetized or chronological list of press releases and events.
 - Ensure that locations, hours, and testing/services descriptions on the website are accurate and in plain language.
 - For Northern Virginia cities/counties, provide the Northern Virginia Regional Commission (which has an online resource directory) with a direct link to the page on your website that provides the quickest access to HIV/AIDS information. For suburban Maryland counties, explore how to initiate a similar online resource directory.
 - Explore other ways of making HIV/AIDS services known, such as providing more complete and updated information and training to 2-1-1 services in both states. Nationally, 2-1-1 numbers provide free, confidential information and referral on a wide range of health and human service topics, and are staffed by professionals. Both states have such services, but it does not appear that Montgomery County is included in the service area of the current Maryland providers.¹⁵

- 3. Improve coordination by initiating periodic local-level meetings of HIV prevention, education, and care providers, funded and unfunded.** County HIV/AIDS program managers can work with key partners to identify the groups that should be included, send out invitations, and host meetings in a county facility, and agree with the group on sharing other tasks. Use these meetings to identify and resolve problems, share in-kind resources, collaborate on activities such as community testing, and improve coordination so available resources are used well.

- 4. Help inform the local and regional medical community about CDC recommendations for routine opt-out testing in all healthcare settings – and encourage their adoption.** This is a natural leadership role for the health officer or health department director. Review the CDC recommendations (available at <http://www.cdc.gov/mmWR/PDF/rr/rr5514.pdf>), and explore to ensure that private physicians, hospitals, and safety-net clinics are familiar with the recommendations. Inform medical societies and other clinical groups that the city/county follows and supports full implementation of these guidelines. Possible actions:
- Send a letter or email, attend a medical society meeting, or otherwise educate local physicians and healthcare facilities about the CDC recommendations and why the city/county health department supports their implementation.
 - Help remove barriers to compliance. For example, where special consent forms are required (as has been the case in Maryland), explain how state requirements can be met and the recommendations implemented – and support appropriate changes in laws and policies.
 - To reach and educate providers, enlist the help of area AIDS Education and Training Centers (AETCs), located at Inova Juniper in Northern Virginia, Johns Hopkins, the University of Maryland – Baltimore, and Howard University. AETCs exist to train clinical personnel.
 - Work with safety net clinics to implement the recommendations. Consider requesting free technical assistance from federally funded capacity-building providers, such as HealthHIV, which assists non-HIV-funded primary care providers in addressing HIV/AIDS.*
- 5. Ensure maximum availability of rapid test kits for both the health department and nonprofit partners.** The health department or a nonprofit prevention provider can use a coordination meeting (see above) or a special meeting with testing partners to explore current availability of test kits, and work together to ensure that all partners have enough test kits to meet priority needs. This may mean sharing kits based on planned events, using laboratory tests where appropriate, and exploring ways to obtain additional test kits from public or private sources. If entities are purchasing test kits separately, better prices may be available through joint purchases. See if private health systems can help.

Longer-term Actions

The following actions require longer-term efforts, but required resource investments are sometimes small.

- 6. Work with local hospitals to initiate rapid testing in their emergency departments.** Health department leaders or the HIV/AIDS leadership group should identify one hospital in each health district or county willing to serve as the pilot for such testing – ideally a facility that serves a high proportion of people who do not have a medical home. It can take advantage of the wait time to offer testing to everyone who comes in, including people accompanying the patient (as is done at Prince George’s Hospital Center). Ask area

* See the HealthHIV capacity-building program, Supporting Networks of HIV Care by Enhancing Primary Medical Care (SNHC by EPMC), described on the website at <http://www.healthhiv.org/index.php>.

hospitals with current programs to share their experiences and models, or take advantage of well documented models from entities like the federal Agency for Healthcare Research and Quality (AHRQ) or a recently developed, CDC-supported practical guide to emergency department HIV testing.¹⁶ Explore funding opportunities. Health insurance, public and private, can be billed for tests. Some funding is available for pilot efforts, salary costs can sometimes be covered through in-kind arrangements and through the use of nursing or other students, and nonprofit hospitals can often obtain corporate or foundation support for such programs. Currently, both Virginia and Maryland have earmarked CDC funding under the Expanded Testing Initiative (ETI) to provide expanded testing in African American communities; those funds support emergency department testing in Prince George's County.

- 7. Task existing advisory bodies with regional prevention plan development – and use the plans to develop a city/county annual prevention plan.** Work with the Northern Virginia Regional HIV Consortium and the Suburban Washington Regional Advisory Council (RAC) to enable them to take on responsibility for helping to prepare a concise, specific annual or two-year prevention plan for the region based on their ongoing work in advising the state's prevention planning group. When these bodies review data on new HIV/AIDS cases, identify disproportionately affected populations, inventory or review prevention provider information and ask the state to put the data – not just the minutes – on its website. Ask the advisory groups to agree on a small number of data-based priorities to guide prevention and testing and recommend joint action on these priorities. Since the plan will be used to encourage collaboration but not to meet any legislative requirements, it can be structured to meet regional needs. Ask the representatives from each county to add another step and identify what they see as the most important priorities for their county, then share this information with the district or county HIV/AIDS program manager (likely to be an active member or leader of the advisory group). Making this happen will require some redefinition of roles and an individual or entity to take leadership and ensure coordination, but little or no additional funding for the advisory bodies. Most important is a commitment from HIV/AIDS managers and health officers to use the recommendations in their own prevention planning and to collaborate on regional priorities.
- 8. Help ensure new policies to improve parity, choice, and portability of care.** This is among the most important and multi-faceted areas for action. It requires a commitment to action and joint decision making by the chief elected officials that are part of current Intergovernmental Agreements (IGAs) and the District of Columbia's HAHSTA, the administrative agents managing Ryan White services in Northern Virginia and Suburban Maryland, and the Ryan White Planning Council. Several actions are relatively quick, while others will require some experimentation and refinement.
 - **Refine criteria for dividing funds among the District, Suburban Maryland, and Northern Virginia,** so they include both living AIDS cases and new HIV cases. (Living HIV and AIDS cases would be preferable once Maryland and the District have reliable data on the number of people living with HIV/non-AIDS and officially reported to the CDC.) Encourage the Planning Council, which is already working on this issue, to explore other criteria that can be added to provide a more inclusive formula (perhaps based on the formula used in Los Angeles County to allocate funds across its service planning areas, which also considers factors like poverty and HIV/AIDS trends). Encourage the Planning Council to request no-cost peer technical assistance from HRSA/HAB to address issues of parity, choice, and portability.

- **Move towards eliminating the policy that PLWH cannot cross state lines for services.** At a minimum:
 - Allow PLWH that depend on Ryan White funds to continue with their current providers when they move to another jurisdiction
 - Allow PLWH with special needs (as determined by a medical case manager or outreach worker) to seek services outside their jurisdiction from a provider that fits those needs and is likely to maintain them in care.
 - Develop and implement a time-limited test or pilot in which either all PLWH or a subset – such as PLWH new to care or PLWH who have fallen out of care – are allowed to identify their preferred medical provider regardless of location. Establish a pool of “off the top” funds to reimburse the three administrative agents if they have more PLWH coming into their jurisdiction for services than going out. Implement requirements that providers document the number of people who seek services across state lines, and require all providers to maintain service data that identify non-resident PLWH. Review data quarterly. Use the results of the pilot to expand flexibility and eventually eliminate geographic barriers to care.
- **Engage the administrative agents and senior HIV/AIDS managers from the District, Suburban Maryland, and Northern Virginia to work towards a regional system of care.** This should involve exploring ways to maintain shared responsibility for services while developing a genuine regional system of care and ensuring timely contracting. This might involve changing procurement, monitoring, and other roles, or dividing the responsibility in different ways.

9. Take leadership in addressing HIV/AIDS as a chronic illness and integrating it into the public health safety net system. Both city/county HIV/AIDS officials and health officers and the safety net clinics and their associations need to collaborate on this effort. First steps should include the following:

- **Holding regular discussions between the health departments and the associations of safety net clinics** to identify and implement immediate cooperation and collaboration, in such areas as helping clinics to establish testing and referral policies and procedures, providing test kits, helping address the costs of laboratory testing, and arranging AETC or other HIV-related training for clinicians in safety net clinics.
- **Require communications between HIV providers and the client’s medical home.** For example, build into HIV-related medical care contracts (and into standards of care for funded service providers) a responsibility for the HIV provider to communicate regularly with each client’s medical home.
- **Include both HIV/AIDS providers and non-HIV-funded safety net clinics in health planning efforts,** including invitations to participate in city/county health planning efforts.
- **Encourage safety net clinics to consider seeking funds as HIV/AIDS providers** – for example, community health centers can provide oral health services to PLWH.

10. Find ways to overcome contracting barriers and inefficiencies, to increase opportunities for community-based nonprofit organizations and bring more funding for HIV/AIDS. A number of counties and health districts have slow procurement processes. The most severe problem is the contracting system in Prince George’s County, which minimizes opportunities for area community-based nonprofit organizations to be service providers because they are expected to deliver services for months before receiving a

contract and payment. Because the county serves as the administrative agent for Ryan White Part A funds in Suburban Maryland, the situation affects services in several counties. Where barriers make it hard to spend public funds and to engage qualified subcontractors, they need to be addressed. Changing county laws and regulations is a needed but long-term effort that should be undertaken. While such barriers remain, alternative approaches need to be used to enable nonprofits to participate fully in HIV/AIDS work. This could be accomplished by:

- **Finding an intermediary organization** to handle HIV/AIDS related procurement on behalf of the county or health district. Other Ryan White programs have used United Way agencies, groups like the Northern Virginia Regional Commission, and other large nonprofits that have very strong fiscal management and contracting capacity and experience.
- **Exploring different types of contracting.** Maricopa County has used a kind of multi-year basic ordering agreement, asking potential providers to provide capacity information that covers multiple service categories and is evaluated by external reviewers. The highly rated providers receive indefinite quantity contracts. The county issues quick response task orders for annual funding for its various service categories. It can also add a new project or pilot a new service model with a very quick response time.
- **Seeking partnerships that can bring more public and private HIV/AIDS funding to the city/county and the region.** Partnerships with universities and nonprofits can increase both public resources obtained through competitive grants and private funding from foundations and corporations. Explore partnerships with university departments – as Prince George’s County has done with the University of Maryland’s School of Public Health. A university can serve as a lead agency where there is a need for quick-response contracting, access pilot funding from research-focused agencies, and bring valuable student and faculty resources.

11. Increase outreach and social marketing to get people tested and into care.

This can be approached in many ways. For example:

- Explore new funding opportunities that may occur as a result of the Ryan White reauthorization passed in October 2009, which requires Ryan White planning councils and grantees to develop and implement strategies for finding people who don’t know they are HIV-infected and get them tested and into care.
- Allocate funds for Outreach and Early Intervention Services under Ryan White Part A and additional funds under the Minority AIDS Initiative.
- Ask administrative agents to work with local providers and PLWH to explore innovative approaches for finding PLWH and getting them into care, and encourage allocating funds for Early Intervention Services and Outreach.
- Explore a joint social marketing effort for the region, with a shared theme and graphics but the flexibility to target different populations with appropriate messages.
- Explore funding opportunities that would enable nonprofits to play a lead role in social marketing and other outreach.

12. Serve as a voice for school-based HIV education and prevention efforts – as part of the curriculum and through voluntary sessions and after-school programs.

Because schools offer one of the most efficient methods of reaching young people with an HIV prevention message, health departments and nonprofits need to encourage and support curriculum with a strong HIV education and prevention focus and consistent implementation of that curriculum.

- Arrange meetings between health department HIV specialists and school personnel to offer help in teaching HIV education units, doing condom demonstrations, and assisting with other components of the curriculum with which teachers are least comfortable.
- Work with nonprofits to explore opportunities within the schools, then recommend trusted nonprofits to school personnel and provide introductions, so they can help teach specific units and arrange supplemental voluntary classes and after-school programs.
- Offer training for teachers to improve preparation to teach units on HIV prevention.
- Join community advisory bodies that advise school systems on their Family Life Education/sex education curriculum to provide an informed voice on HIV education.
- Invite school nurses and other school system personnel to HIV/AIDS coordination meetings.
- Consult with MetroTeen AIDS, which has played a key role in strengthening school-based HIV education and prevention in the District of Columbia schools, for advice on ways to organize a systematic effort targeting the public schools.

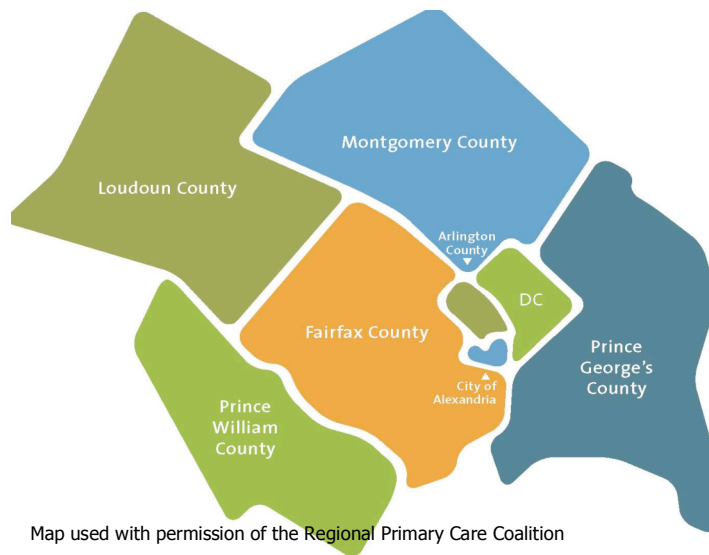
Project Background and Context

Purpose: The Profiles Project is an action research project that has generated county- and health district-based profiles of how seven suburban Washington, DC jurisdictions are responding to the HIV/AIDS epidemic, as a basis for local and regional action to improve that response. The profiles review local responses against a set of benchmarks for sound practices covering the range of HIV-related efforts: education, prevention, testing, and care. This report summarizes key cross-jurisdictional findings and recommendations. Other reports provide county/health district and substate regional reports on the public-sector response to HIV/AIDS, offering detailed descriptions of how these jurisdictions – primarily their health departments and senior officials – are addressing HIV/AIDS. Because the project was designed to encourage collaboration and problem solving, the project team consulted frequently with key stakeholders to identify action needs, some of which they were already beginning to address as of the end of 2009, through collaboration, planning, and changes in systems and processes.

Need for the Project: The Profiles Project helps to fill a knowledge gap, providing information that can be used by health departments, HIV/AIDS program providers, safety net clinics, and others to strengthen the suburban Washington response to HIV/AIDS. Discussion of HIV/AIDS in the Washington, DC metropolitan area tends to focus on the District of Columbia, which has one of the highest HIV/AIDS rates in the United States – 3% of all residents and 7% of African American men are known to be HIV-positive, and others are unaware of their status.¹⁷ The counties and cities that surround the District have varied but generally much lower HIV/AIDS rates, but a much larger combined population. As of the end of 2007, almost half the people living with HIV/AIDS (PLWH) and aware of their status in the metropolitan area were tested (and are presumed to live) in the seven suburban jurisdictions covered by the Profiles Project. An unknown percentage – national estimates are from 20% to 25% – have not been tested and are unaware of their status. Far less geographically concentrated than District PLWH, they need to be tested if unaware of their status and provided appropriate medical and supportive services. The Washington AIDS Partnership requested this study in order to establish an information base about HIV/AIDS in the suburbs, to guide collaboration, public policy work, and other action by nonprofit organizations, local health departments, and other entities concerned about HIV/AIDS. The study was carried out by Mosaica: The Center for Nonprofit Development and Pluralism with the assistance of the Regional Primary Care Coalition (RPCC), and was also supported by a grant from Kaiser Permanente.

The Geographic Area: Washington, DC is a city-state tucked between Virginia and Maryland. It is both the center of government for the nation and the center of commerce for the region. The primary metropolitan statistical area (PMSA) as defined by the Bureau of the Census – the Washington-Alexandria-Arlington PMSA – is geographically large and very diverse. It includes the District of Columbia, five counties in Maryland (Charles, Calvert, Frederick, Montgomery, and Prince George's), 11 counties (Arlington, Clarke, Culpeper, Fairfax, Fauquier, King George, Loudon, Prince William, Spotsylvania, Stafford, and Warren) and six cities (Alexandria, Fairfax, Falls Church, Fredericksburg, Manassas, and Manassas Park) in Northern Virginia, and two counties in West Virginia (Berkeley and Jefferson).

The Profiles Project focused more narrowly, on the inner suburbs around Washington, DC, including the four counties and five cities that make up the five health districts in the Northern Virginia Health Region, and the two counties that comprise Maryland's Suburban Washington Health Region – as shown in the map.



Map used with permission of the Regional Primary Care Coalition

Study Products: This report summarizes key findings for both Suburban Maryland and Northern Virginia. The project also generated detailed profiles describing how the seven counties and health districts of suburban Maryland and Virginia and the two substate regions respond to HIV/AIDS – in terms of education, prevention, testing, and care. The two regional reports and the health

district/county-specific reports have been made available to key stakeholders and will be available online.¹⁸ Other project products available on the web include a demographic summary for each of the jurisdictions and comparable information about the District, a snapshot of HIV/AIDS as of the end of 2008, and data on programs and funding for HIV/AIDS in 2009. The surveillance and demographic summaries are also attached to this report (See Appendices A and C).

Scope of Inquiry: Mosaica, with assistance and advice from RPCC, gathered the following information on each health district and county:

- Population characteristics
- HIV/AIDS cases and trends
- HIV-related education, prevention, testing, and care programs, providers, and public funding (sources and amounts)
- Family life, sexuality, and HIV education in the public schools
- The HIV/AIDS-related services available and accessible to residents
- The extent to which each health district and county and regional area meets benchmarks for sound practice around education, prevention, testing, a continuum of care, population-appropriate services, coordination, and health district/county leadership in responding to HIV/AIDS
- Involvement in HIV prevention, testing, and care by safety net clinics in Northern Virginia and in Montgomery County

Methods: The Profiles Project collected primary information through a series of structured key informant meetings, structured and semi-structured interviews, consultations with planning bodies and an advisory group, and two online surveys that together reached more than 120 organizations and individuals. Secondary information came from sources including the state health departments, various HIV-related planning and administrative entities, planning bodies, the Bureau of the Census, and various Internet sites, and included Census and surveillance data, information on service providers, prevention plans, needs assessments, comprehensive (care) plans, research reports, and dozens of other documents. Preliminary information was collected in

the summer and fall of 2008, and primary data from February through December 2009, including fact checking with HIV/AIDS program managers in all seven jurisdictions and at regional and state levels. Funding data is for 2009, but includes programs that have different funding years beginning at various points during the fiscal year.

Staffing: The work was done primarily by a Mosaica team, with assistance from the RPCC Director and 2009-2010 Princeton Project 55 Fellow. Some initial work on Medicaid was done by a group of George Washington University graduate students in public health.

Tasks: The project included the following major tasks:

- Formation of an advisory group for Northern Virginia, which offered advice throughout the process
- Implementation of seven key informant meetings in each county, six of them at health departments, with county health personnel, providers of HIV/AIDS-related services, and other knowledgeable individuals including PLWH, to develop matrices of services and identify key issues (total of 56 participants)
- Development and refinement of benchmarks reflecting sound practices (See Appendix D).

Topics for Benchmarking
1. Health & sexuality/family life education in the schools
2. Community-based education and prevention
3. HIV counseling, testing, and referral (CTR)
4. Comprehensive continuum of prevention, testing, and care services
5. Population-appropriate services
6. People living with HIV/AIDS (PLWH) and other community involvement
7. Public leadership in responding to HIV/AIDS

- Interviews with the individuals responsible for Family Life or Sexuality Education in the schools (5 officials) and with other knowledgeable individuals where school officials did not agree to be interviewed
- Two online surveys of a total of 20 safety net clinics, one conducted with members of the Northern Virginia Health Services Coalition (NVHSC) and the other with clinics that are part of the Montgomery Cares network, coordinated by the

Primary Care Coalition of Montgomery County (PCC) – both NVHSC and PCC are members of the Regional Primary Care Coalition.

- Interviews with about 35 key informants who were not part of the county/health district sessions – prevention and care providers, state officials, Ryan White administrative agency personnel, PLWH leaders, and other individuals with specific relevant knowledge
- Requests to state officials to obtain HIV/AIDS statistics and funding information
- Presentations and discussions at the Northern Virginia HIV Consortium and Northern Virginia Health Services Coalition
- Extensive Internet research to document county/city council deliberations and HIV/AIDS funding, provider services, funding from various public sources, additional HIV/ADS statistics, Census data, relevant research and best practices, the Northern Virginia Regional Commission (NVRC) online resource directory, etc.
- Searches for HIV/AIDS testing and care information on the local government websites of all seven suburban jurisdictions and Washington, DC
- Review of a wide range of documents, from Ryan White Part A needs assessment data and the 2009 Service Directory to HIV prevention and care plans for Virginia, Maryland, and the Washington, DC Part A eligible metropolitan area (EMA)

- Consultation with the Northern Virginia Advisory Group and with individual experts in Suburban Maryland regarding key findings
- Preparation of this summary report as well as benchmarking reports for each region (Northern Virginia and Suburban Maryland) and for each health district or county, as well as Census summaries, HIV/AIDS profiles, Program charts, and Funding charts for the counties/health districts and regions – all of which will be available online
- Fact checking with officials in all 7 jurisdictions
- Presentations of preliminary findings and discussion of action needs with the Northern Virginia Health Services Coalition, Regional Primary Care Coalition, Washington AIDS Partnership Steering Committee, Northern Virginia Regional HIV Consortium, and Health Officials Committee of the Metropolitan Washington Council of Governments

Project Limitations: Mosaica was able to obtain most of the information needed for the project with the assistance of state and local HIV/AIDS officials and extensive use of grant announcements and federal funding websites. It was not possible to obtain all funding data as of a specified date, since the major programs have different start and end dates and sometimes the most updated information was not available. The data are generally accurate as of fall, 2009, but some programs were being refunded around that time, so data may have been from a funding year just ending or just beginning.

Information gathering was especially challenging with regard to understanding how Family Life Education/Sex Education and HIV prevention are taught in the public schools. Efforts were made to interview the officials who run the health education/FLE programs in all jurisdictions; the team was successful in five of the seven jurisdictions. The Prince William official received and agreed to review project materials, but did not respond to multiple phone and email requests for an interview. Montgomery County requires an extremely extensive research clearance process before staff can provide even basic information about the curriculum and program – information that is considered public information by many school systems. Key informants say this is because the Montgomery County Public Schools recently experienced a lawsuit opposing the adoption of its new curriculum. The county prevailed, but the process was lengthy and difficult. The Profiles Project was able to obtain information from individuals with extensive knowledge of the curriculum and the school system, but it did not come directly and officially from the school system. Key informants in all locations provided perspectives on what is taught in the schools, but Mosaica could not officially verify information in those two school systems.

The Epidemic

The District of Columbia has an extremely high rate of HIV/AIDS. Rates are lower in the suburbs, but the “donut” areas surrounding Washington, DC had 14,573 residents diagnosed with HIV or AIDS as of December 31, 2008, according to the two state health departments. As of the end of 2007, the District had 15,120 people diagnosed with HIV or AIDS. (The District’s 2008 estimates include people living with HIV/non-AIDS who are not aware of their status, while the suburban data include only individuals aware of their status, so the 2008 data are not

comparable. *) The pie chart shows the distribution of people living with HIV and AIDS across the seven suburban jurisdictions. Prince George's and

Montgomery counties have the largest number of residents living with HIV/AIDS. Figure 1 below shows the number of PLWH and the HIV/AIDS case rates per 100,000 population. Among the suburban jurisdictions, case rates are highest in Prince George's County, Maryland, and in Alexandria, and

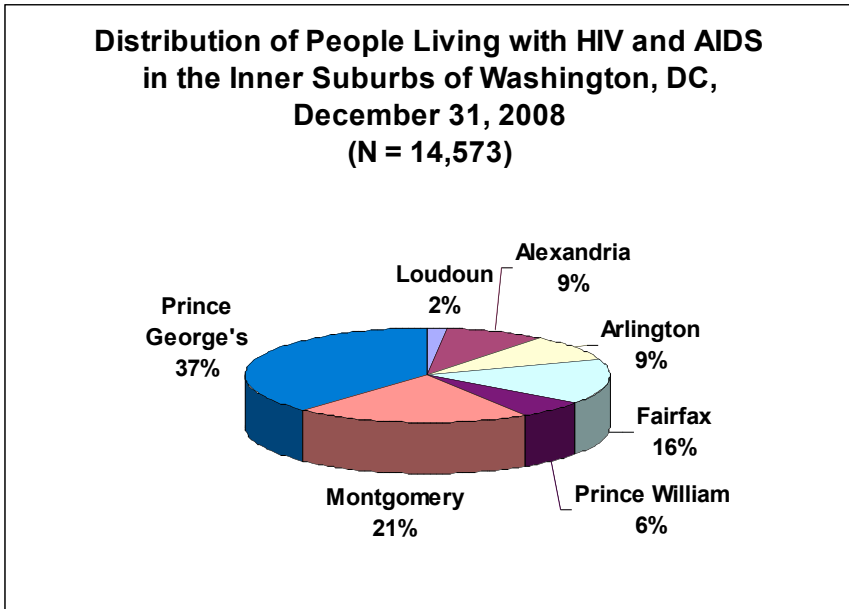
Arlington, the most urbanized parts of Northern Virginia.

They have both the highest HIV/AIDS incidence (new case) rates and HIV/AIDS prevalence (living case) rates.

Figure 2 provides AIDS case rates for the suburban jurisdictions and the District of Columbia. It shows that the number of new AIDS cases in the District was almost the same as the number in the inner suburbs (526 versus 525), but DC's population is less than one-sixth as large.

DC accounts for about 54% of

the living AIDS cases in the area. The highest suburban AIDS prevalence rates are in Alexandria Prince George's County, and Arlington; the highest AIDS incidence rates are in Prince George's County and Alexandria.



All these surveillance data should be reviewed with one important caveat in mind: *HIV/AIDS prevalence data are reported based on the residence of the individual at the time s/he first tested positive for HIV or AIDS.* A PLWH not known to have died is assumed to be living in the same location. Ryan White formula funding (which is two-thirds of total national Part A grant funds) is based on data reported to the CDC as individuals are diagnosed with HIV or AIDS. Because these are the only comprehensive data available, they are used to describe the distribution of the PLWH population. Though some people have moved, it is generally assumed that in-migration equals out-migration. There has been no statistical study of how many PLWH have moved across state lines within the Washington metro area or left the area – or how many people diagnosed elsewhere are now living and receiving services in the Washington metro area.

* DC HIV/AIDS data are as of December 31, 2007; AIDS incidence and prevalence data are as of December 31, 2008.

Figure 1
HIV/AIDS Incidence and Prevalence, Suburban Washington, DC - (2008 Data)

Health Region and County/Health District (H.D.)	Population (2006-2008 Average) [†]	Number of New HIV/AIDS Cases, 2008	2008 HIV/AIDS Incidence Rate (per 100,000)	Number of People Living with HIV/AIDS 12-31-08	2008 HIV/AIDS Prevalence (per 100,000)
Suburban Washington Region, MD	1,768,671	1,003	56.7	8,565	484.3
Montgomery County	942,747	365	38.4	3,022	317.9
Prince George's County	825,924	638	77.7	5,543	675.3
Northern Virginia Health Region, VA	2,023,885	329	15.2	6,008	296.9
Alexandria H.D.	143,885	41	33.4	1,286	893.8
Arlington H.D.	209,969	61	26.2	1,303	620.6
Fairfax H.D.	1,015,302	143	12.6	2,287	225.3
Loudoun H.D.	289,995	20	7.6	241	83.1
Prince William H.D.	364,734	64	15.1	891	244.3

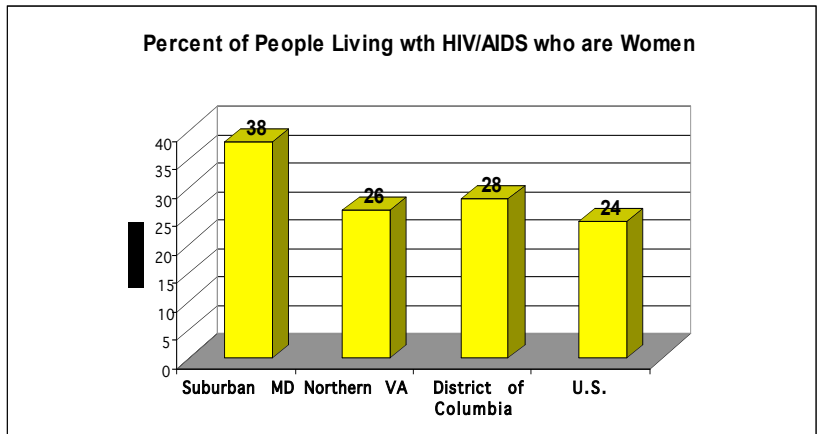
Sources: Population data as provided by Virginia Department of Health and the U.S. Bureau of the Census American Community Survey 2006-2008 averages used for Maryland counties. Surveillance data provided by Health Informatics & Integrated Surveillance Systems within the Virginia Department of Health and the Infectious Disease & Environmental Health Administration of the Maryland Department of Health and Mental Hygiene.

Figure 2
AIDS Incidence and Prevalence, Washington, DC and Suburban Washington - (2008 Data)

Health Region and County/Health District (H.D.)	Population 2008 or 2008-2008 Average [†]	Number of New AIDS Cases, 2008	2008 AIDS Incidence Rate (per 100,000)	Number of People Living with AIDS 12-31-08	2008 AIDS Prevalence (per 100,000)
Suburban Washington Region, MD	1,768,671	354	20.0	4,813	271.7
Montgomery County	942,747	120	12.6	1,701	178.9
Prince George's County	825,924	234	28.5	3,112	379.1
Northern Virginia Health Region, VA	2,023,885	171	8.45	3,110	153.66
Alexandria H.D.	143,885	31	21.54	666	462.9
Arlington H.D.	209,969	29	13.81	717	341.5
Fairfax H.D.	1,015,302	66	6.50	1,159	114.2
Loudoun H.D.	289,995	12	4.14	114	39.3
Prince William H.D.	364,734	33	9.05	454	124.5
Washington, DC	591,833	526	88.9	9,458	1,598.1

Sources: Population data as provided by Virginia Department of Health and DC Department of Health; U.S. Bureau of the Census American Community Survey 2006-2008 Averages used for Maryland counties. Surveillance data from the Virginia Department of Health, Maryland Department of Health and Mental Hygiene, and DC Department of Health.

The face of HIV/AIDS in the Washington suburbs is changing – it includes more women, more people under 30, and more individuals infected through heterosexual relations. These trends are especially clear in Suburban Maryland, where 38% of PLWH are women, compared to 24% in Northern Virginia and 28% in the District of Columbia.¹⁹ In Suburban Maryland, nearly 42% of people living with HIV/non-AIDS (who tend to be more recently diagnosed) are women, compared to 35% of people living with AIDS.²⁰ About 12% of PLWH in



Suburban Maryland are under 30, compared to 7% in Northern Virginia. However, about one-third of people with HIV/non-AIDS in Suburban Maryland were under 30 when diagnosed, compared to about one-fourth of people living with AIDS. Age at diagnosis is going down in Northern Virginia as well, but was already lower. In Suburban Maryland, the most common risk factor for newly diagnosed cases, especially for people diagnosed with HIV/non-AIDS, is heterosexual sex. In Northern Virginia, men having sex with men (MSM) is the risk factor for about half of new infections, and MSM make up about half the current population of PLWH.²¹ Injection drug use is still an important risk factor, but accounts for a lower proportion of total cases in both jurisdictions among newly diagnosed than among the overall PLWH population. The epidemic continues to disproportionately affect African Americans; about 79% of Suburban Maryland PLWH and 48% of Northern Virginia PLWH are African American, as are 76% of DC PLWH. Hispanics are a growing HIV/AIDS population in Northern Virginia, where they make up 12% of all PLWH but 17% of recent cases. Appendix A provides a profile of people living with HIV and AIDS in Suburban Maryland and Northern Virginia as of December 31, 2008, including information by county/health district, region, and state.²²

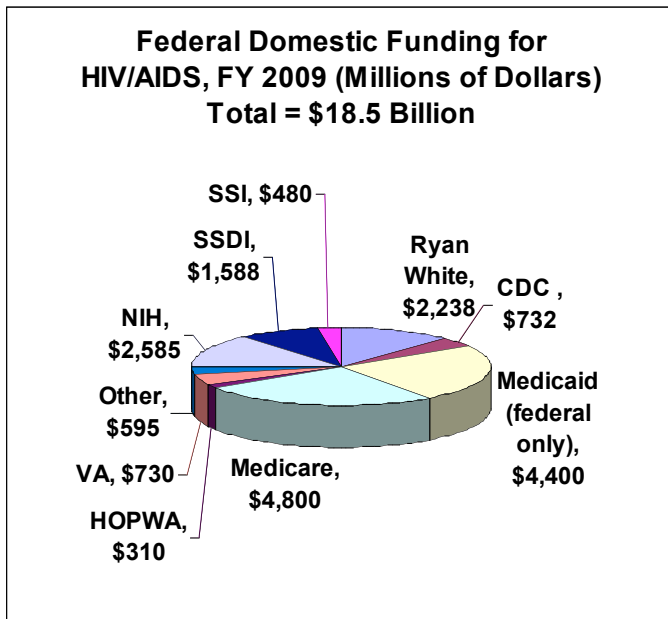
The Public Response to HIV/AIDS

Structures and Funding Streams

The structure and public funding for HIV/AIDS are extremely complex.

The pie chart that follows shows all federal domestic funding for HIV/AIDS – a total of \$18.5 billion in FY 2009 for HIV/AIDS research, prevention, care, and disability payments.²³ Medicaid (federal share only) and Medicare provide the largest financial contributions to HIV/AIDS care – more than \$9.2 billion. However, many low-income PLWH are not eligible for Medicaid, and those without disability status are ineligible for Medicare. Some needed services may not be covered by Medicaid. These PLWH often depend on HIV/AIDS-specific funding for some or all of their care.

HIV/AIDS-specific funding is largely federal, and comes primarily from several sources within the U.S. Department of Health and Human Services (HHS), through different and not always coordinated channels. Ryan White is the largest source of HIV/AIDS-specific funding, providing more than \$2.2 billion in FY 2009.



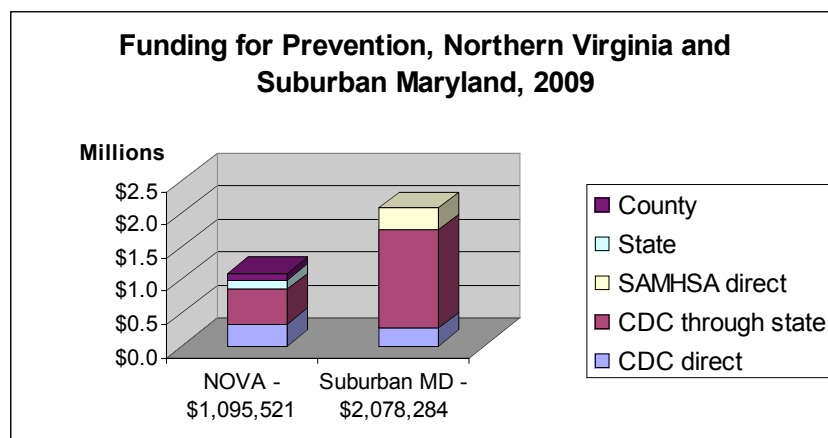
Funds for Prevention and Testing:

These funds come primarily from the Centers for Disease Control and Prevention (CDC). Most prevention funding comes in a block grant to each state. The state then allocates funds to various programs and parts of the state. Virginia has established health regions and health districts within those regions; much of the prevention funding goes from the Virginia Department of Health to the health districts and is managed at the local

level by state employees. In Maryland, the Department of Health and Mental Hygiene oversees local health departments, and most local health officers are state employees; it too provides most of its HIV prevention funding to these health departments. Both states provide rapid test kits to health departments and – directly or through the health departments – to nonprofit groups that do testing. The states also provide some federal HIV prevention funds to community-based providers, and health districts or departments have the option of subgranting some of their prevention funds. Maryland typically provides most prevention funding to local health departments; only in Baltimore are nonprofit organizations major recipients of such funds. The CDC also has some competitive prevention programs through which community-based nonprofit groups, hospitals, and universities can apply for direct funding, though funds are limited and the competition is heavy. States also provide some state funds to local health departments or their own health districts for prevention and testing, and to nonprofit organizations.

Several other HHS agencies provide some funding for HIV prevention. The Substance Abuse HIV Prevention Initiative from the Center for Substance Abuse Prevention (CSAP) of the Substance Abuse and Mental Health Services

Administration (SAMHSA) provides some funds for HIV prevention. Maryland receives this funding, but Virginia lost it in 2008 because its AIDS incidence rate for the state as a whole went below 10 per 100,000.



The bar chart shows public prevention funding in

Northern Virginia and Suburban Maryland in 2009. Northern Suburban Maryland had about \$2 million in prevention funds, Northern Virginia a little over \$1 million.*

Funds for Care: Funds for care and treatment are provided through a variety of sources. While Medicaid and Medicare provide the most funding for HIV/AIDS care, the Ryan White program is the principal source of HIV/AIDS-specific treatment funds. Most recently reauthorized in October of 2009 as the Ryan White HIV/AIDS Treatment Extension Act of 2009, it provides funding through multiple “parts”:

- *Part A* funds go to metropolitan areas with large numbers of living AIDS cases and new AIDS cases. The grantee is the chief elected official (CEO) of the jurisdiction within the metropolitan area that provides the most HIV/AIDS care. In the DC Part A eligible metropolitan area (EMA) – a geographic area that is the same as the Census-determined metropolitan area (PMSA) – the CEO is the Mayor of Washington, DC. The grantee is required to have an intergovernmental agreement (IGA) with any other jurisdiction in the EMA with at least 10% or more of PLWH. The Ryan White Part A HIV Services Planning Council – which includes members from many different categories and various parts of the EMA – has legislative responsibility for setting service priorities and allocating funds to priority services.
- *Part B* funds go to the states, and then are allocated regionally or subcontracted directly by the state to providers.²⁴ Maryland provides funding directly to the two county health departments in the Suburban Washington health region; Northern Virginia contracts with the Northern Virginia Regional Commission (NVRC), which manages the Ryan White Part B consortium and subcontracts funds. Part B funds cover a variety of services, including the AIDS Drug Abuse Program (ADAP).
- *Part C* funds are awarded competitively, and are used for medical care and related services; many of the grantees are community health centers or public clinics. In suburban Virginia, Inova Juniper has Part C funding. In the Maryland suburbs, Greater Baden Medical Services, Inc. (GBMS) has a relatively small Part C grant.
- *Part D* funding is also competitive. There are two components: funding for services to women, infants, children, and youth and funding for youth/adolescents. Inova Juniper runs a Part D program for women, infants, children, and youth. The only Maryland Part D grantee is the State Department of Health and Mental Hygiene, which has funding for both types of services. Children’s National Medical Center in the District of Columbia has Part D funding, and youth from both jurisdictions are eligible for services.
- *Part F* includes Minority AIDS Initiative (MAI) funds, which have been competitive for the past several years, but as of FY 2010 will again be awarded on a formula basis along with Part A and Part B grants. Part F includes AIDS Education and Training Centers (AETCs), which operate in the metro area, as well as several other special projects. Inova Healthcare Systems in Northern Virginia serves as a site for the Mid-Atlantic AETC. Another site is at Johns Hopkins University in Baltimore. In some locations, Part F funding supports oral health programs associated with dental schools, Howard University has a dental school, but there are no dental schools in the Washington suburbs.

* Funding periods vary, with grants awarded between late 2008 and fall 2009.

Funds for Housing: Ryan White considers housing a support service, and current policies allow only temporary housing support. Most funds for HIV/AIDS housing come through Housing Opportunities for Persons with AIDS (HOPWA), a program run nationally out of the U.S. Department of Housing and Urban Development (HUD). Most of the HOPWA funds for the region are awarded to the District of Columbia as the central city of the metropolitan area. The District manages HOPWA funds out of the HIV/AIDS, Hepatitis, STDs, and TB Administration (HAHSTA), the same Health Department division that manages other HIV/AIDS services, and subcontracts with the Northern Virginia Regional Commission to provide services in Northern Virginia. NVRC subcontracts with Northern Virginia Housing Service and with several county housing departments. Prince George’s County also receives its HOPWA funds through the District of Columbia, but Montgomery County gets separate HOPWA funding through the city of Gaithersburg, a direct HUD grantee that receives funds for Montgomery and Frederick counties.

Medicaid: Ryan White is by law supposed to be the “payer of last resort,” used when other funds are not available to cover medical and support services. The use of Ryan White funds depends, therefore, on other funding streams. A key regional variable is Medicaid. As Figure 3 shows, compared to the District of Columbia, fewer PLWH in Maryland and many fewer in Virginia are eligible for Medicaid due to lower income limits, and services are more limited. Although partly federally funded, Medicaid is state-run. It requires categorical as well as income eligibility. Disabled PLWH are eligible for Medicaid based on federal requirements – and Medicaid now can pay Medicare premiums for PLWH receiving federal disability payments. PLWH who are also parents or pregnant women are eligible because of that status, not their illness, and with different income limits, as the table below shows. Maryland has no specific HIV/AIDS waiver to make PLWH categorically eligible regardless of their family status, and Virginia’s waiver is not HIV-specific and extremely limited; officials described it as covering only a very few PLWH in nursing homes.

**Figure 3:
Overview of Medicaid Coverage, District of Columbia, Maryland, and Virginia**

Eligibility Category	Eligibility – Percent of Federal Poverty Level*		
	District of Columbia	Maryland	Virginia
Parents	207%	116%	29%
Pregnant Women	300%	250%	200%
Individuals Receiving Supplemental Security Income	74%	74%	74%
Childless Adults ²⁵	211% (DC funded)	116% (limited)	N/A
HIV/AIDS Waiver	Yes	No	Yes – very limited

Note: Federal poverty level for FY 1009-2019 is \$10,830 for a single individual and \$22,050 for a family of four.

HIV/AIDS and Broader Healthcare Options: The District, Maryland, and Virginia have very different HIV/AIDS and overall health care systems for medically underserved residents.

- The District has both the most generous Medicaid program and the DC Healthcare Alliance, a locally funded program that pays for medical including HIV/AIDS care for low-income uninsured residents who don’t qualify for Medicaid or Medicare, have incomes below 200% of the federal poverty level, and have countable resources of less than \$4,000 (\$6,000 if there is a spouse or child in the home). It covers many single adults and single non-citizens.

- Maryland has a more restrictive Medicaid program with no HIV/AIDS waiver, but it also has the Maryland Health Insurance Plan (MHIP), a high-risk insurance pool for residents who are denied private health insurance because of a chronic illness. It covers health care costs for some PLWH. Residents with incomes below 300% of the federal poverty level are eligible for MHIP+, with reduced premiums and cost sharing.
- Virginia has the most restrictive Medicaid program and lacks other state-funded safety nets.

Because of these differences, PLWH living in Northern Virginia or Maryland are more likely than those living in the District to depend on Ryan White funding for HIV/AIDS care. Part A funding is designed to help address such service gaps. Two-thirds of federal Part A funds are awarded through formula funding based on living HIV and AIDS cases, but the other third is awarded competitively, based on unmet and demonstrated need.

Implementation of the Washington Metropolitan Area Ryan White Program

The Washington, DC eligible metropolitan area includes parts of four states, and the substate regions of Maryland and Virginia each have over 6,000 residents living with HIV and AIDS. While the District is the epicenter of the epidemic, the suburbs also have significant case rates and service needs. Ryan White programs are allowed to use Part A funds for 13 specified core medical-related services and 16 support services. In the Washington EMA, each substate region plays a major role in determining what services to prioritize and fund, with the final decisions made (as legislatively required) by the Metropolitan Washington Regional Health Services Planning Council, which includes representatives from all parts of the EMA. Decisions about services are expected to be based on documented need and the availability of services supported by other funding streams.

Some care planning for the metropolitan area occurs through the Ryan White Planning Council, but its work covers only Part A funds, which are provided to Washington, DC as the core of the metropolitan area, not Part B funds, which go to each state, or HIV housing funds. The lack of coordinated planning ignores the reality of an interdependent region where people move across jurisdictions and often work in one while living in another.

In addition, the Washington Ryan White Part A program is so decentralized that it lacks a single regional system of care – instead, there are separate service systems in each substate region. Unlike most Part A programs, the District does little region-wide contracting. Instead, funds are allocated to each of the substate areas and they do their own contracting for services. This was a choice made by the District of Columbia some years ago. The District is required to have an intergovernmental agreement only with a jurisdiction that has at least 10% of the reported AIDS cases. The only jurisdiction that meets that criterion is Prince George’s County – though Montgomery County is close to 10%. The EMA has chosen to sign IGAs with additional jurisdictions in Maryland, Virginia, and West Virginia. Funds for Northern Virginia are subcontracted to the Northern Virginia Regional Commission (NVRC), while funds for Suburban Maryland go to Prince George’s County. These administrative agents subcontract for services with county health departments or health districts and with nonprofit organizations (or with for-profit entities only where no qualified nonprofits are available).

A major factor in the suburbs is ensuring that enough Ryan White funds are available to ensure that all PLWH in need of care are able to access top-priority services like HIV-related medical care and medical case management. Northern Virginia currently allocates 90% of its Part A funds to core medical-related services, Suburban Maryland 87%, and the District of Columbia 81%.

The Part A program has several policies and practices that complicate efforts to ensure parity in access to care throughout the EMA:

- **A policy that prevents PLWH from obtaining Ryan White services outside their state of residence.** PLWH who live in one state do not meet eligibility criteria for receiving services from a provider in another state, even if that is the nearest provider or the one most suited to engaging and keeping them in care. Provider contracts and intake procedures require clients to be residents of the substate region where they seek care – unless they are immigrants.
- **The method used to decide how much Part A funding goes to Northern Virginia and Suburban Maryland: living AIDS cases.** Part A funds are currently divided among the jurisdictions based on the number of living AIDS cases in each area; this is expected to change soon to the number of HIV and AIDS cases. There is no consideration of other factors. Yet Section 2602(a)(2)(A) of the Ryan White legislation states that the Chief Elected Official (CEO) of an EMA (in this case the Mayor of the District of Columbia) is expected to “establish through intergovernmental agreements an administrative mechanism to allocate funds and services” that is based on the number of AIDS cases, severity of need for outpatient and ambulatory care services, and health and support services personnel needs of the other governmental subdivisions. Washington currently uses only the first, the number of AIDS cases in each region. The allocations from the EMA to Virginia and Maryland do not take into account other factors such as differences in the availability of other funding streams like Medicaid to support HIV/AIDS care. Since Medicaid covers less of the costs of HIV/AIDS care in these jurisdictions, the suburbs need to use more of their Ryan White funding for HIV-related medical care and other services that are partially covered by Medicaid in the District. For example, Suburban Maryland spends 63% of its Part A allocation for primary and specialty medical care and medical case management, Northern Virginia spends 60%, and the District of Columbia spends 53%.
- **Development of three independently prepared substate regional recommendations for service categories to be funded and funding allocations:** Although the Planning Council is legislatively responsible for setting priorities and allocating funds for the EMA, in Washington each substate region carries out a separate priority setting and resource allocations process. The Planning Council now sets clear direction for how the process works, and it reviews the recommendations of Suburban Maryland and Northern Virginia (as well as West Virginia) along with those for the District, but it rarely changes allocations. The Planning Council can choose to provide directives to the grantee on how best to meet its priorities, which provides an opportunity to require some EMA-wide service models and other parity efforts. It is considering such approaches – but as of the end of 2009 the decisions about services and allocations were decentralized and not necessarily based on shared assumptions or priorities.
- **Separate provider selection and oversight:** The District and the administrative agents for Northern Virginia and Suburban Maryland each separately contract for services, handle

eligibility and intake, and monitor their funded providers. This results in three unlinked mini-systems of care. A provider's location near a state line is irrelevant to the process, since the contract requires that clients live on a specified side of that border.

- **Multiple funding streams and decision makers:** Further complicating efforts to establish a coordinated and accessible system of care are the many funding streams and decision makers. The states (including the District in its city-state role) are the recipients of Ryan White Part B funds and prevention funds; the District receives HOPWA housing funds on behalf of most of the suburban jurisdictions. Part C and Part D funds are competitive, and may go to community health centers, children's hospitals, or public healthcare facilities. Mental health, substance abuse, and other services are often funded by non-HIV sources. Coordination among all the grantees and subgrantees within and across state borders is an enormous challenge. The better the coordination of funds and services, the more likely the metropolitan area is to approach parity in care.

Conclusion

The Profiles Project was responsible for documenting how seven Washington, DC suburban jurisdictions respond to HIV/AIDS. It found individuals, public agencies, and nonprofits that are working tirelessly to ensure the best possible HIV prevention and care for PLWH. It also found missed opportunities, lack of prevention planning and coordination, and important inequalities in access to care and treatment based on where a PLWH lives. In most of these jurisdictions – including those with high and those with relatively low HIV/AIDS incidence and prevalence rates – HIV/AIDS is a concern but not a highly visible ongoing priority for health and other senior city/county officials. They have many other challenges to address. However, even a relatively small increase in attention and leadership could contribute to improved prevention planning, more efficient use of resources, and the beginnings of a regional system of prevention and care.

As an action research effort, the Profiles Project collected information and at the same time consulted with some 120 individuals and organizational representatives. Based on those discussions, some changes had already begun by the end of 2009. For example, safety net clinics and HIV/AIDS medical providers in both Montgomery County and Northern Virginia agreed they need to begin talking and collaborating. An analysis of barriers to nonprofit contracting in Prince George's County was under way. At least one jurisdiction agreed to begin periodic information-sharing and problem-solving meetings. Respected nonprofits in both Northern Virginia and Suburban Maryland decided to seek funding to address issues of prevention planning and service delivery in their substate region or county. The success of the project will be determined by the extent to which the information gathered provides an information base for collaborative planning and problem solving.

Endnotes

¹ "District of Columbia HIV/AIDS Epidemiology Update: 2008." DC Department of Health, February 2009. See Major Findings, p 11. Available online at http://dchealth.dc.gov/DOH/frames.asp?doc=/doh/lib/doh/pdf/dc_hiv-aids_2008_updatereport.pdf.

² "Dealing with Legal Matters Surrounding Students' Sexual Orientation and Gender Identity." National School Boards Association, 2004.

³ See "Sexual Orientation and Homosexuality" on the American Psychological Association's webpage, at

<http://www.apa.org/helpcenter/sexual-orientation.aspx>.

⁴ “Dealing with Legal Matters,” *op. cit.*

⁵ Schackman BR, Gebo KA, Walensky RP, et al. The lifetime cost of current human immunodeficiency virus care in the United States. *Med Care* 2006 Nov 44(11):990-97.

⁶ Holgate David R. Written testimony on HIV/AIDS incidence and prevention for the U.S. House of Representatives Committee on Oversight and Governance reform, September 16, 2008.

⁷ “HIV Prevention in the United States at a Critical Crossroads.” CDC, August 2009. Available online at http://cdc.gov/hiv/resources/reports/pdf/hiv_prev_us.pdf

⁸ Centers for Disease Control and Prevention, “Revised Recommendations for HIV Testing of Adults, Adolescents, and Pregnant Women in Health-Care Settings.” Issued September 22, 2006 as part of Morbidity and Mortality Weekly Report (MMWR), Vol. 55, NO. RR-14. Available at <http://www.cdc.gov/mmWR/PDF/rr/rr5514.pdf>.

⁹ Kevin M. DeCock, et al., “Preventing HIV transmission with antiretrovirals,” *Bulletin of the World Health Organization* 2009;87:488-488. Available at <http://www.who.int/bulletin/volumes/87/7/09-067330/en/index.html>.

¹⁰ CDC Revised Recommendations, *op. cit.*

¹¹ DC Appleseed, “HIV/AIDS in the Nation’s Capital, Report Card No. 5, October 2008 – September 2009. Available online at <http://www.dcappleseed.org/projects/publications/5th%20Report%20Card%20Final.pdf>.

¹² See, for example, E Abel, L Painte, “Factors that influence adherence to HIV medications, perceptions of women and health care,” *Journal of Association of Nurses in AIDS Care*, 2003, and S. Bakken, W. Holzemer, M. Brown, G. Powell-Cope, J. Turner, J. Inouye, K. Nokes, I. Corless, “Relationships Between Perception of Engagement with Health Care Provider and Demographic Characteristics, Health Status, and Adherence to Therapeutic Regimen in Persons with HIV/AIDS,” *AIDS Patient Care and STDs*, April 2000, 14(4): 189-197.

¹³ Centers for Disease Control and Prevention, “Act Against AIDS Leadership Initiative,” at http://www.cdc.gov/hiv/aaa/pdf/leadership_initiative.pdf.

¹⁴ See Bureau of Economic Analysis, “250 Highest Per Capita Personal Incomes (PCPI) of the 3111 Counties in the United States: 2007.” Available at <http://www.bea.gov/regional/reis/pepihigh.cfm>.

¹⁵ A search engine to locate the local 2-1-1 provider is available at <http://www.211.org>. General information and a state-by-state listing of services is available at <http://211us.org>.

¹⁶ A documented model for a successful emergency department HIV testing program at Metropolitan Hospital Center in Ne York is available from the Agency for Healthcare Research and Quality Innovations Exchange, posted in October 2009. Available at: <http://www.innovations.ahrq.gov/content.aspx?id=2426>. Also see “HIV Testing in Emergency Departments: A Practical Guide,” developed through a cooperative agreement between the Centers for Disease Control and Prevention (CDC) and the Association for Prevention Teaching and Research (APTR). Available online at <http://www.edhivtestguide.org/EDHIEsHeal-4055.html>.

¹⁷ “District of Columbia HIV/AIDS Epidemiology Update: 2008,” *op. cit.*

¹⁸ Reports will be available on the Mosaica website (www.mosaica.org) with links from the RPCC website (www.regionalprimarycare.org) and the Washington AIDS Partnership website (www.washingtonaidspartnership.org).

¹⁹ Data for Northern Virginia and Maryland are for 2008; DC and U.S. data are for 2007.

²⁰ Surveillance data included in the Washington Part A program year 2010 application, Attachment 3. These data include several additional Maryland counties, but they account for less than 6% of the HIV/AIDS population.

²¹ “The Scope of HIV/AIDS in Virginia DC EMA Communities,” PowerPoint presentation to the Metropolitan Washington Ryan White planning council by Khalil Kheirallah, Virginia Department of Health, May 2009. Available online at <http://www.vdh.state.va.us/epidemiology/DiseasePrevention/DAta/#RegionalStats>.

²² All state data in this section come from the surveillance sections of the Virginia Department of Health, Maryland Department of Health and Mental Hygiene, DC Department of Health, or – for national data – the Centers for Disease Control and Prevention. DC data come from the materials and data presentations from the DC Department of Health.

²³ Federal data are summarized annually for the *most recent fiscal year* in the Kaiser Family Foundation’s HIV/AIDS Policy Fact Sheet: “U.S. Federal Funding for HIV/AIDS: The President’s Budget Request.” The 2009 data are provided in the Fy 2010 Budget Request fact sheet, in November 2009. Available online at <http://www.kff.org/hivaids/upload/7029-05.pdf>.

²⁴ The 2006 Ryan White legislation [Section 2613(f), *Allocation of Funds; Treatment as Support Services*] specified that if states subcontract with regional consortia rather than contracting directly for services, the funds would be considered support rather than core medical services. Only 25% of the state’s Part B funds can be spent for support services. However, this legislative provision has not yet been enforced, and Virginia continues to subcontract to NVRC, which then uses a procurement process to choose providers.

²⁵ See Kaiser Family Foundation State Health Facts, KFF Fact Sheet, “Where are States today? Medicaid and State-Funded Coverage Eligibility Levels for Low-Income Adults” (December 2009) and Center for Medicaid and Medicare Services (searched December 2009).

Appendix A: HIV/AIDS Surveillance Profiles

Suburban Maryland

HIV/AIDS in the Suburban Washington Region of Maryland, by County, 2008								
	Maryland		Montgomery County		Prince George's County		Suburban Maryland Region	
	N	%	N	%	N	%	N	%
Number of People Living with HIV/non-AIDS as of Dec. 31, 2008	12,766	43.6	1,321	43.7	2,431	43.9	3,752	43.8%
Number of People Living with AIDS as of Dec. 31, 2008	16,514	56.4	1,701	56.3	3,112	56.1	4,813	56.2%
Total Number of People Living HIV/AIDS as of Dec. 31, 2008	29,280	100.0	3,022	100.0	5,543	100.0	8,565	100.0%
		Rate		Rate		Rate		Rate
Prevalence rate - HIV/non-AIDS		226.6		139.0		296.2		211.8
Prevalence rate - AIDS		293.1		178.9		379.1		271.7
Prevalence rate - HIV/AIDS		519.7		317.9		675.3		483.5
	N	%	N	%	N	%	N	%
2008 New Cases: HIV/non-AIDS	1,531	59.3	245	67.1	404	63.3	649	64.7
2008 New Cases: AIDS	1,050	40.7	120	32.9	234	36.7	354	35.3
2008 New Cases: HIV/AIDS	2,581	100.0	365	100.0	638	100.0	1003	100.0
		Rate		Rate		Rate		Rate
Incidence Rate - HIV/non-AIDS		27.2		25.8		49.2		36.6
Incidence Rate - AIDS		18.6		12.6		28.5		20.0
Incidence rate - HIV/AIDS		45.8		38.4		77.7		56.7
Total Number of People out of Care (Unmet Need)	12,151		N/A		N/A		N/A	
Unmet Need Percent (Estimate %)	41.5		N/A		N/A		N/A	
2008 Prevalence HIV/AIDS Gender (%)	N	%	N	%	N	%	N	%
Female	10,550	36.0	1,160	38.4	2,109	38	3269	38.2%
Male	18,729	24.0	1,862	61.6	3,434	62	5296	61.8%
2008 Prevalence HIV/AIDS Age (%)	N	%	N	%	N	%	N	%
0-12	102	0.4	15	0.5	27	0.5	42	0.5
13-19	388	1.3	18	0.6	92	1.7	110	1.3
20-29	2,428	8.3	271	9	586	10.6	857	10.0
30-39	5,465	18.7	751	24.9	1,294	23.3	2,045	23.9
40-49	11,104	37.9	1,073	35.5	1,981	35.7	3,054	35.7
50-59	7,445	25.4	669	22.1	1,152	20.8	1,821	21.3
60+	2,346	8.0	224	7.4	411	7.4	635	7.4
Missing	2		1				1	0.0
2008 Prevalence HIV/AIDS Ethnicity/Race (%)	N	%	N	%	N	%	N	%
Black not Hispanic	23,024	78.6	1,952	64.6	4,847	87.4	6,799	79.4
White not Hispanic	4,828	16.5	662	21.9	367	6.6	1,029	12.0
Hispanic	992	3.4	325	10.8	258	4.7	583	6.8
Other	436	1.5	83	2.7	71	1.3	154	1.8
2008 Prevalence HIV/AIDS Risk Factors (%)	N	%	N	%	N	%	N	%
Heterosexual Sex	7,055	24.1	1,010	33.4	1,621	29.2	2,631	30.7
MSM	6,090	20.8	704	23.3	1,338	24.1	2,042	23.8
IDU	8,263	28.2	206	6.8	536	9.7	742	8.7
MSM/IDU	783	2.7	49	1.6	86	1.5	135	1.6
Other	491	1.7	51	1.7	91	1.7	142	1.7
Risk not specified	6,598	22.5	1,002	33.2	1,871	33.8	2,873	33.5
<i>Data provided by the Maryland Department of Health and Mental Hygiene, Infectious Disease and Environmental Health Administration, November 2009.</i>								

Northern Virginia

HIV/AIDS in the Northern Region of Virginia, by Health District, 2008

	Virginia		Health District											
			Alexandria	Arlington	Fairfax	Loudoun	Prince William	N VA Health Regional Total						
Total Population, 2008	7,769,089		143,885	209,969	1,015,302	289,995	364,734	2,023,885						
Number of People Living with HIV/non-AIDS as of 12/31/08	10,905		620	586	1,128	127	437	2,898						
Number of People Living with AIDS as of 12/31/08	9,513		666	717	1,159	114	454	3,110						
Total Number of People Living with HIV/AIDS as of 12/31/08	20,418		1,286	1,303	2,287	241	891	6,008						
Prevalence rate - HIV/non-AIDS (per 100,000)	140.36		430.90	279.09	111.10	43.79	119.81	143.19						
Prevalence rate - AIDS (per 100,000)	122.45		462.87	341.48	114.15	39.31	124.47	153.66						
Prevalence rate - HIV/AIDS (per 100,000)	262.81		893.77	620.57	225.25	83.10	244.29	296.85						
Diagnosed Cases of HIV/non-AIDS, 2008	646		17	26	62	10	22	137						
Diagnosed Cases of AIDS, 2008	492		31	29	66	12	33	171						
Diagnosed Cases of HIV/AIDS, 2008	1138		48	55	128	22	55	308						
Reported Cases of HIV/AIDS, 2008	1156		41	61	143	20	64	329						
Incidence rate - HIV/non-AIDS	8.32		11.81	12.38	6.11	3.45	6.03	6.77						
Incidence rate - AIDS, 2008 (per 100,000)	6.33		21.54	13.81	6.50	4.14	9.05	8.45						
Incidence rate - HIV/AIDS, 2008 (per 100,000)	14.65		33.36	26.19	12.61	7.59	15.08	15.22						
Number HIV/AIDS cases that were out of Care (Unmet Need)	11,058		844	892	1,446	118	497	3,797						
Unmet Need Percent	54%		66%	68%	63%	49%	56%	63%						
2008 Prevalence HIV/AIDS Gender (%)														
Male	73.4%		73.8%	82.4%	75.3%	74.7%	68.9%	75.1%						
Female	26.6%		26.2%	17.6%	24.7%	25.3%	31.1%	24.9%						
2008 Prevalence HIV/AIDS by Current Age count (%)														
	N	%	N	%	N	%	N	%	N	%	N	%	N	%
0-12	57	0.3%	2	0.2%	1	0.1%	4	0.2%	1	0.4%	5	0.6%	13	0.2%
13-19	192	0.9%	3	0.2%	3	0.2%	14	0.6%	0	0.0%	6	0.7%	26	0.4%
20-29	1767	8.7%	63	4.9%	68	5.2%	148	6.5%	23	9.5%	88	9.9%	390	6.5%
30-39	4106	20.1%	245	19.1%	255	19.6%	492	21.5%	68	28.2%	209	23.5%	1269	21.1%
40-49	7946	38.9%	544	42.3%	516	39.6%	891	39.0%	78	32.4%	345	38.7%	2374	39.5%
50-59	4794	23.5%	314	24.4%	337	25.9%	548	24.0%	54	22.4%	180	20.2%	1433	23.9%
60+	1554	7.6%	115	8.9%	123	9.4%	190	8.3%	17	7.1%	57	6.4%	502	8.4%
Unknown	2	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	1	0.1%	1	0.0%
2008 Prevalence HIV/AIDS by race/ethnicity count (%)														
	N	%	N	%	N	%	N	%	N	%	N	%	N	%
Black, not Hispanic	12,538	61.4%	730	56.8%	560	43.0%	967	42.3%	108	44.8%	500	56.1%	2865	47.7%
White, not Hispanic	6,255	30.6%	400	31.1%	539	41.4%	924	40.4%	95	39.4%	271	30.4%	2229	37.1%
Hispanic	1,236	6.1%	137	10.7%	165	12.7%	290	12.7%	28	11.6%	99	11.1%	719	12.0%
Other	398	2.0%	19	1.5%	39	3.0%	106	4.6%	10	4.2%	21	2.4%	195	3.2%
2008 Prevalence HIV/AIDS by transmission category count (%)														
	N	%	N	%	N	%	N	%	N	%	N	%	N	%
Heterosexual Sex	4,661	22.8%	332	25.8%	209	16.0%	491	21.5%	43	17.8%	240	26.9%	1315	21.9%
MSM	8,053	39.4%	591	46.0%	706	54.2%	1052	46.0%	115	47.7%	313	35.1%	2777	46.2%
IDU	2,426	11.9%	120	9.3%	141	10.8%	208	9.1%	19	7.9%	109	12.2%	597	9.9%
MSM/IDU	777	3.8%	43	3.3%	55	4.2%	53	2.3%	7	2.9%	30	3.4%	188	3.1%
Other	4,510	22.1%	200	15.6%	192	14.7%	483	21.1%	57	23.7%	199	22.3%	1131	18.8%
HIV/AIDS or HIV Infection: A case of HIV, regardless of the stage of the disease (either HIV (not AIDS) or AIDS). Persons first diagnosed with HIV and later progressing to AIDS are only counted once.														
Data for 2008 is preliminary and may be incomplete due to reporting delays.														
Data provided by the Division of Disease Prevention, Health Informatics and Integrated Surveillance Systems														
11/16/2009														

**Appendix B:
Ryan White Part A Care Services Prioritized and Funded
by Jurisdiction, Program Year 2009 (Excludes Minority AIDS Initiative)**

Service Category	District of Columbia	Northern Virginia	Suburban Maryland	EMA-Wide
Core Medical Services				
Primary and Specialty Medical Care	✓	✓	✓	✓**
AIDS Drug Assistance Program (ADAP)	[Provided through Part B Funds]			
AIDS Pharmaceutical Assistance (Local)		✓	✓	
Oral Health Care	✓	✓	✓	
Early Intervention Services	✓			
Health Insurance Premium & Cost Sharing		✓	✓*	
Home & community Based Health Services	✓			
Mental Health Services	✓	✓	✓	
Medical Nutrition Therapy	✓		✓	
Medical Case Management	✓	✓	✓	
Substance Abuse Services – Outpatient	✓	✓	✓	
Support Services				
Case Management – Non Medical			✓	
Child Care Services	✓			
Emergency Financial Assistance	✓	✓	✓	
Food Bank/Home Delivered Meals	✓	✓	✓	
Legal Services	✓	✓		
Linguistic Services	✓	✓	✓*	
Medical Transportation Services	✓	✓	✓	
Outreach Services				✓
Psychosocial Support Services	✓	✓	✓	
Referral for Health Care or Supportive Services				✓***
Treatment Adherence Counseling	✓			

* Funding of less than \$2,000

** Used for a contract with a clinic for medical care for immigrants from throughout the EMA

***Used for an EMA-wide contract for client advocacy and referrals

**Appendix C: Demographic Profiles
Washington, DC and Suburban Maryland
Population Size and Characteristics
(2006-2008 3-year average unless otherwise indicated)**

Category	Characteristic	Washington, DC	Maryland	Montgomery County	Prince George's County
Population	Total population (2006-2008 Average)	588,373	5,618,250	942,747	825,924
	Total population (2000)	572,059	5,296,486	873,341	801,515
	Population increase since 2000	2.9%	6.1%	7.9%	3.0%
	Median age (years)	35.0	37.4	38.8	35.2
	Population 16 years and over in labor force	67.4%	69.4%	72.1%	73.7%
Economic Characteristics	Unemployment rate, September 2009*	11.7%	7.2%	5.3%	7.3%
	Median family income	\$67,308	\$84,126	\$112,564	\$81,908
	Per capita income	\$41,144	\$34,508	\$46,947	\$31,352
	Individuals living in poverty	17.8%	8.0%	5.2%	7.4%
	Hispanic or Latino (of any race)	8.5%	6.4%	14.4%	12.2%
Race and Ethnicity	White, non-Hispanic	32.3%	58.0%	54.3%	18.2%
	Black or African American, non-Hispanic	53.9%	28.5%	15.6%	63.3%

Category	Characteristic	Washington, DC	Maryland	Montgomery County	Prince George's County
Race and Ethnicity, cont.	Asian	3.2%	4.9%	13.1%	3.9%
	Other	2.2%	2.2%	2.7%	2.4%
	Less than 9th grade	5.7%	4.3%	4.7%	6.2%
Educational Attainment (Population 25 years and over)	High school graduate or higher	85.3%	87.5%	91.1%	86.2%
	Bachelor's degree or higher	47.2%	35.1%	56.4%	30.1%
	Native born citizen	87.2%	87.7%	70.3%	81.3%
U.S. Citizenship Status	Total foreign born	12.8%	12.3%	29.7%	18.7%
	Naturalized U.S. citizen	4.4%	5.6%	13.8%	7.0%
	Not a U.S. citizen	8.4%	6.7%	15.9%	11.7%
	Asia	18.4%	32.9%	37.6%	16.0%
Nativity of Population Born Outside the U.S.	Africa	14.3%	15.8%	14.0%	27.1%
	Latin America	47.7%	36.5%	35.0%	52.2%
	Language other than English spoken at home	14.6%	14.9%	36.0%	18.9%
Language Spoken (Population 5 years and over)	Spanish spoken at home	7.4%	5.7%	13.2%	9.5%
	Speak English less than "very well"	4.8%	5.9%	14.6%	7.9%

Data Set: Bureau of the Census, 2006-2008 American Community Survey 3-Year Estimates.

**Northern Virginia Population Size and Characteristics
(2006-2008 3-year average unless otherwise indicated)**

Category	Characteristic	Virginia	Alexandria	Arlington County	Fairfax County	Fairfax	Falls Church**	Loudoun County	Prince William County	Manassas	Manassas Park**
Population					<i>Fairfax Health District</i>				<i>Prince William Health District</i>		
	Total population (2006-2008 Average)	7,698,738	140,657	204,889	1,005,980	23,281	N/A	277,433	358,719	35,533	N/A
	Total population (2000)	7,078,515	128,283	189,453	969,749	21,498	10,377	169,599	280,813	35,135	10,290
	Population increase since 2000	8.8%	9.6%	8.1%	3.7%	8.3%	N/A	63.6%	27.7%	1.1%	N/A
	Median age (years)	37.1	37.7	37.6	39.1	40.5	39.7%	32.8	32.6	34.7	30.3
Economic Characteristics	Population 16 years and over in labor force	67.6%	76.3%	77.9%	73.1%	67.0%	73.5%	77.1%	77.3%	71.2%	77.2%
	Unemployment rate, September 2009*	6.7%	4.8%	4.2%	4.7%	5.4%	7.3%	4.7%	5.3%	6.8%	5.4%
	Median family income	\$72,733	\$106,985	\$128,132	\$127,085	\$111,555	\$97,225	\$131,673	\$95,614	\$84,104	\$61,075
	Per capita income	\$32,224	\$53,908	\$58,282	\$49,990	\$44,504	\$41,051	\$44,533	\$35,854	\$28,352	\$21,048
	Individuals living in poverty	9.9%	6.7%	6.8%	5.0%	3.5%	4.2%	3.1%	4.9%	14.0%	5.2%
Race/Ethnicity	Hispanic or Latino (of any race)	6.6%	13.1%	15.9%	13.5%	13.2%	8.4%	10.1%	19.0%	27.7%	15.0%
	White, non-Hispanic	67.1%	58.4%	64.4%	59.1%	63.7%	79.6%	67.5%	52.3%	53.8%	67.2%
	Black or African American, non-Hispanic	19.3%	20.5%	8.1%	9.1%	5.4%	N/A	7.6%	18.7%	11.2%	N/A

Category	Characteristic	Virginia	Alexandria	Arlington County	Fairfax County	Fairfax	Falls Church**	Loudoun County	Prince William County	Manassas	Manassas Park**
	Asian	4.8%	5.5%	8.8%	15.8%	15.6%	N/A	12.3%	7.0%	3.8%	N/A
	Other	2.2%	2.6%	2.8%	2.4%	2.1%	N/A	2.5%	3.1%	3.5%	N/A
Educational Attainment (Population 25 years and over)	Less than 9th grade	5.6%	5.6%	5.6%	4.1%	3.9%	1.8%	3.1%	5.5%	13.8%	7.3%
	High school graduate or higher	85.7%	90.8%	90.8%	92.3%	91.2%	95.9%	93.4%	88.5%	76.7%	76.4%
	Bachelor's degree or higher	33.2%	59.9%	68.0%	58.8%	51.7%	63.7%	56.3%	37.1%	26.5%	20.3%
U.S. Citizenship Status	Native born citizen	89.8%	76.4%	76.0%	72.3%	72.3%	83.9%	80.5%	79.2%	76.1%	85.0%
	Total foreign born	10.2%	23.6%	24.0%	27.7%	27.7%	16.1%	19.5%	20.8%	23.9%	15.0%
	Naturalized U.S. citizen	4.4%	8.9%	8.5%	13.3%	10.9%	6.8%	8.9%	8.0%	6.7%	4.1%
	Not a U.S. citizen	5.8%	14.7%	15.5%	14.3%	16.8%	9.3%	10.7%	12.8%	17.2%	10.9%
Nativity of Population Born Outside the U.S.	Asia	40.2%	6.4%	7.2%	14.0%	N/A	6.1%	10.1%	5.9%	N/A	4.3%
	Africa	9.1%	6.9%	2.7%	2.7%	N/A	1.1%	0.9%	2.6%	N/A	0.2%
	Latin America	36.1%	7.9%	10.7%	8.3%	N/A	4.9%	5.8%	11.0%	N/A	9.9%
Language Spoken (Population 5 years and over)	Language other than English spoken at home	13.2%	29.1%	30.8%	34.2%	65.7%	18.7%	25.0%	28.2%	N/A	20.0%
	Spanish spoken at home	5.9%	11.8%	16.0%	12.1%	34.3%	7.3%	8.8%	16.6%	N/A	13.6%
	Speak English less than "very well"	5.5%	13.5%	9.2%	14.7%	14.3%	7.3%	10.6%	13.1%	N/A	10.6%

Data Set: Bureau of the Census, 2006-2008 American Community Survey 3-Year Estimates

* Bureau of Labor Statistics

** 2006-2008 data not available for this geographic area because population is below 20,000; available data is from the 2000 Census.

N/A = Data not available because cell size is too small to be reliable

Appendix D: Benchmarks

Components of the Local Response to HIV/AIDS	Benchmarks: Sound Practices
#1- HIV Education and Prevention in the Public Schools	<ul style="list-style-type: none"> • Age-appropriate curriculum in <ul style="list-style-type: none"> ▪ Elementary school ▪ Middle school ▪ High school • Curriculum that covers: <ul style="list-style-type: none"> ▪ Reproductive health ▪ What HIV is and how it is transmitted ▪ Safe sex/HIV prevention methods [up to and including condom demonstration] • Opt-out procedures for parents who do not want their children to participate in reproductive health or HIV education/prevention sessions [Not “opt-in”] • Curriculum used consistently in all schools, with full curriculum covered • Teachers trained to use curriculum and observed to ensure appropriate skills and comfort level, plus periodic monitoring or quality assurance activities • Arrangements that allow Department of Health and/or nonprofit HIV-focused organizations with appropriate skills and programs to run programs during the school day • After-school peer training or other HIV awareness, education, and prevention programs by external entities encouraged in the schools
#2 - Community-based Education and Prevention	<ul style="list-style-type: none"> • County prevention plan or planning process • Community-based and community-accessible programs, including primary prevention programs, that target and are appropriate for: <ul style="list-style-type: none"> ▪ Specific behavioral risk populations ▪ Populations with disproportionately high rates of HIV/AIDS ▪ General public • Department of Health-run or –supported outreach and awareness efforts • Use of varied media and communications methods, including Internet/new media, to do outreach, prevention, and education
#3 - Counseling, Testing, and Referral (CTR)	<ul style="list-style-type: none"> • Adoption of CDC recommendations for routine opt-out screening in all healthcare settings, and initiatives to encourage such screening by healthcare providers • Rapid testing in at least one Emergency Department • Testing, with counseling and referral services, regularly available in health departments and in community settings outside health departments – including high-incidence communities

Components of the Local Response to HIV/AIDS	Benchmarks: Sound Practices
	<ul style="list-style-type: none"> • Rapid testing designed to reach: <ul style="list-style-type: none"> ▪ Specific behavioral risk populations ▪ Populations with disproportionately high rates of HIV/AIDS ▪ Individuals who lack medical homes and may not return for result if regular test is used • Sufficient rapid test kits to meet needs – including arrangements for bulk purchases and negotiations to obtain best prices • Collaborative efforts to ensure that non-HIV/AIDS focused clinics, public clinics, FQHCs, and other safety net clinics have and consistently follow clear policies on HIV testing and referral
<p>#4 - Comprehensive Continuum of HIV/AIDS Prevention, Testing, and Care Services</p>	<ul style="list-style-type: none"> • PLWH access to a comprehensive and integrated system of prevention, testing, and care, with treatment including critical core medical services such as primary medical care, medications, medical case management, mental health services, oral health services, substance abuse outpatient services, as well as support services such as transportation • Linkages and clear division of responsibility between clinics providing a medical home and HIV doctors • PLWH choice (public and private entities) in service providers/models, including primary care • Portability of care if a PLWH moves to another county or health district within the State • Continuum including non-Ryan White HIV/AIDS providers and non-AIDS-specific providers, such as community-based organizations and community of color providers • Immediate access to medications after diagnosis, change in insurance status, release from a correctional facility, or entry into county/health district -- including a bridge program if needed while eligibility for Medicaid, Medicare, or ADAP is being determined
<p>#5 - Population-appropriate Services</p>	<ul style="list-style-type: none"> • Culturally and linguistically appropriate services available to diverse HIV/AIDS populations based on race/ethnicity, gender, sexual orientation, age, behavioral risk factors, and immigration status • Flexibility and portability of care to ensure access to population-appropriate services -- includes access to care where the individual lives or works, outside of community of residence where stigma and confidentiality are concerns, and across jurisdictional borders as needed to reach a population-appropriate provider

Components of the Local Response to HIV/AIDS	Benchmarks: Sound Practices
#6 - PLWH and Other Community Involvement	<ul style="list-style-type: none"> • PLWH groups and individuals, including consumers of care, with a formal role in community planning and decision making • If jurisdiction has an HIV/AIDS advisory group, membership includes strong and diverse PLWH and community-based provider representation
#7 – Leadership in Responding to HIV/AIDS	<ul style="list-style-type: none"> • Attention to HIV/AIDS by senior elected and appointed officials (e.g., statements, advisory body, engagement in key activities) • Agency structure that facilitates internal coordination of education, prevention, counseling and testing, and treatment services • Operational staff leadership demonstrating both skills and commitment to HIV/AIDS services • Procedures for timely contracting, effective program monitoring, and prompt payment of providers [where applicable] • Collaboration with other counties/health districts within the region as well as metro area jurisdictions • Local public funding provided for HIV/AIDS and efforts to maximize public and private resources for addressing HIV/AIDS • Efforts to publicize the availability of HIV/AIDS services and help residents find needed services through website and other means