

**Determination and Findings  
for a  
Sole Source Contract**

**Requisition No.:** RQ926306  
**Caption:** HIV Surveillance Black Box Project  
**Proposed Contractor:** Georgetown University  
**Program:** Department of Health, HIV/AIDS, Hepatitis, STD & TB Administration (HAHSTA)

**FINDINGS**

**1. AUTHORIZATION:**

D.C. Official Code §2-354.04, 27 DCMR 1304, 1700, 1701, and 2005.2 (b)

**2. MINIMUM NEED:**

The Government of the District of Columbia, Office of Contracting and Procurement (OCP) on behalf of DOH/HAHSTA seeks to enhance the efficiency and effectiveness of HIV surveillance case reporting through the development and implementation of a novel technology system for cross-jurisdictional HIV data sharing. The contract will implement a privacy device (known as “Black Box”) for receiving, analyzing and returning results to source personally identifiable information of HIV case records. The “Black Box” shall be an isolated computer that is secured a facility that provides no direct user access. The device will contain an algorithm for matching personal identifying information. The system will interface with the DOH and other health departments surveillance systems. The device will match identifiable data and report back to the health departments while not retaining the data.

The period of performance shall be 12 months from date of award with two option years.

**3. ESTIMATED REASONABLE PRICE:**

The estimated fair and reasonable price for a sole source of this contract is not to exceed \$174,915.00 annually.

**4. FACTS WHICH JUSTIFY SOLE SOURCE PROCUREMENT:**

The DOH/HAHSTA is proposing to enter into a sole source contract with Georgetown University to develop and implement a new technology to enhance HIV and potentially other disease reporting surveillance activities.

Public health surveillance is the ongoing systematic collection, analysis, and interpretation of data, closely integrated with the timely dissemination of these data to those responsible for preventing and controlling disease and injury. Such surveillance can serve as an early warning system for impending public health emergencies; document the impact of an intervention, or track progress towards specified goals; and monitor and clarify the epidemiology of health problems, to allow priorities to be set and to inform

public health policy and strategies. States and jurisdictions define the diseases that are reportable, which can include select health practices, such as laboratory tests, to enhance the context of the disease. In the District of Columbia, HIV is a reportable disease. Through the advances of medication and treatment, the condition has transitioned from an emergency and too often cause of death to a chronic condition. To better understand HIV disease, the District has also required laboratories to report select tests that measure the condition. This combination of information contributes to the life cycle of persons living with HIV now known as the HIV care continuum. Through research studies, persons living with HIV who are successful through the steps of the continuum – diagnosis, initiation and retention on medication and viral load suppression – not only accrue personal positive health outcomes, but also reduce transmission. An effective HIV care continuum is essential for the District to accomplish the Mayor’s goals of ending the epidemic.

The U.S. Centers for Disease Control and Prevention (CDC) established the guidelines for HIV surveillance. It includes the basic definition that a HIV case is recorded by the jurisdiction where the infection was diagnosed. That jurisdiction then maintains that case as part of its reported, diagnosed and living case count in perpetuity until there is a confirmation the individual is deceased. For example, a medical provider in the District of Columbia diagnoses an individual with HIV and reports the case in 2006. In 2010, the individual moves to Maryland. The case, however, is still counted in the District. Due to this practice, when a jurisdiction receives a report of a new HIV diagnosis, it has to verify that it is a new report and not one previously reported in another jurisdiction.

While CDC has a protocol for checking if a diagnosis is truly a new case or migration, it is not conducting regularly resulting in delays in case identification.

The cross-jurisdictional DC metropolitan region, including areas in District of Columbia, the State of Maryland, and the Commonwealth of Virginia, experiences some of the highest prevalence rates among key population groups in the country, and is therefore critical to the national response to HIV. Public health departments and clinical providers in this region have long observed that persons have historically migrated from one jurisdiction to another for HIV care. In January 2013, representatives from these public health departments, alongside federal colleagues from the CDC and the National Institutes of Health joined at Georgetown University with others to discuss sharing of HIV data in the DC metropolitan region. At this initial conference, they identified the need for a novel real-time and automated approach to data sharing in this cross-jurisdictional area, and specified that the process of reaching such a milestone should simultaneously account for the highly private and sensitive nature of HIV data.

After about two years of collaborative planning work, including brainstorming sessions, conference calls, and in-person meetings, Georgetown University developed a proof of concept and experiment using a novel privacy and data sharing technology called “the Black Box”. Georgetown tested the device initially with trial data and subsequently with the real data from the three jurisdictions. The demonstration identified 21,472 person matches in HIV surveillance data across the District, Maryland and Virginia. After the test, Georgetown destroyed the prototype device in accordance with the experiment.

The HIV community faces a new era of engagement in HIV care, in which persons living with live longer and where mobility and technology are becoming increasingly more common in everyday life. Effectively adapting to this new era of engagement in HIV care requires re-examining traditional, current, and brainstorming new HIV surveillance data sharing models and technology. Developing the organizational processes that facilitate such activities are quintessential to ultimately improving HIV surveillance and its related care and outreach services.

### **Market Research**

DOH/HAHSTA has assessed the available technology for a similar type system and none exists. This is novel and original technology.

The only current available mechanism for matching HIV surveillance records is the CDC instituted Routine Interstate Duplicate Review (RIDR) system. All states participate in RIDR. As part of routine reporting of cases to CDC, SOUNDEX (a code devised from the letters of the case name) and date of birth are transmitted to CDC along with other demographic, clinical, and behavioral information. CDC detects cases with the same SOUNDEX and date of birth. Since the SOUNDEX is not highly specific it is possible for cases with different names to have the same SOUNDEX. Periodically, CDC transmits lists to states of cases that are reported in more than one state with the same SOUNDEX and date of birth (potential duplicates). Individual states then communicate by telephone to resolve potential duplicates by discussing specific case information. Outcomes can include: no match (they are different people) or match. If they match, the states decide which state should retain the case based on where the case was first diagnosed with HIV and then again if the person is diagnosed with AIDS. The state that retains the case will have that case included in analysis of HIV/AIDS surveillance data. CDC utilizes this system approximately twice per year, which is not timely for the identification of HIV cases.

RIDR does not meet the expectation of a real-time surveillance matching system.

### **5. CERTIFICATION BY AGENCY HEAD:**

I hereby certify that the above findings are true, correct and complete.

6/15/16  
Date

LaQuandra S. Nesbitt  
LaQuandra Nesbitt, MD, MPH  
Director, Department of Health

**6. CERTIFICATION BY CONTRACTING OFFICER:**

I have reviewed the above findings and certify that they are sufficient to justify the use of the sole source method of procurement under the cited authority. I certify that the notice of intent to award a sole source contract was published in accordance with Section 404(c) of the District of Columbia Procurement Practices Reform Act of 2010 (D.C. Official Code §2-354.04) and that no response was received. I recommend that the Chief Procurement Officer approve the use of the sole source procurement method for this proposed contract.

\_\_\_\_\_  
Date

**DETERMINATION**

Based on the above findings and in accordance with the cited authority, I hereby determine that it is not feasible or practical to invoke the competitive solicitation process under either Section 303, 402 or 403 of the District of Columbia Procurement Practices Reform Act of 2010 (D.C. Law 18-371; D.C. Official Code § 2-354.02 or 2-354.03). According, I determine that the District is justified in the sole source extension method of procurement.

\_\_\_\_\_  
Date

\_\_\_\_\_  
George A. Schutter  
Chief Procurement Officer