U. S. Department of Health and Human Services

NATIONAL HIV/AIDS STRATEGY

Implementation Progress Report 2011

NATIONAL HIV/AIDS STRATEGY

This report was prepared under the direction of the Office of HIV/AIDS and Infectious Disease Policy (OHAIDP), Office of the Assistant Secretary for Health, U.S. Department of Health and Human Services (HHS). Information contained in the report was provided by HIV Leads in each of the HHS Operating Divisions and Staff Offices and assembled by Ms. Vera Yakovchenko, MPH, of OHAIDP. Mr. Steve Holman, MBA, working under contract to OHAIDP, assisted OHAIDP staff in writing and formatting the report.

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Introduction

Throughout 2011, the U.S. Department of Health and Human Services (HHS) made significant strides in implementing the National HIV/AIDS Strategy (NHAS). This progress report, prepared by the Office of HIV/AIDS and Infectious Disease Policy (OHAIDP, formerly the Office of HIV/AIDS Policy) with input from HHS agencies and offices, highlights some of the Department's key 2011 accomplishments. It is, however, just a sampling of the myriad actions taken both independently and collaboratively by the Office of the Secretary and the HHS operating divisions and staff offices to pursue the Strategy's vision and goals.

These selected highlights include many actions specifically detailed in the NHAS *Federal Implementation Plan* and the HHS NHAS *Operational Plan*. In several instances, they also reflect significant achievements that go beyond what the Strategy called for. Together, these highlights expand on those listed in the White House's July 2011 NHAS *Implementation Update* to give a broader picture of the depth and breadth of activities undertaken by the Department in 2011 to reduce the number of new HIV infections, increase access to care and improve health outcomes for people living with HIV, and reduce HIV-related health disparities.

Background

On July 13, 2010, the White House released the National HIV/AIDS Strategy for the United States. The Strategy is the nation's first-ever comprehensive, coordinated HIV/AIDS roadmap, with a clear vision for the future.

Vision for the National HIV/AIDS Strategy

> The United States will become a place where new HIV infections are rare and when they do occur, every person regardless of age, gender, race/ethnicity, sexual orientation, gender identity or socio-economic circumstance, will have unfettered access to high quality, life-extending care, free from stigma and discrimination.

The NHAS set forth three ambitious but achievable goals for the nation to work toward by 2015:

1. Reducing the number of people who become infected with HIV;
2. Increasing access to care and optimizing health outcomes for people living with HIV; and
3. Reducing HIV-related health disparities.

It also acknowledged that to accomplish the Strategy's goals, we must undertake a more coordinated national response to the epidemic involving greater coordination across all levels of government as well as more thoroughly engaging all sectors of society to build on and refocus our existing efforts to deliver better results.

Accompanying the NHAS was a *Federal Implementation Plan* that tasked specific actions to federal agencies in 2010 and 2011. Subsequently, the lead federal agencies for implementing the Strategy—the Departments of Health and Human Services, Housing and Urban Development, Justice, Labor, and Veterans Affairs, and the Social Security Administration—developed and submitted to the White House's Office of National AIDS Policy (ONAP) and Office of Management and Budget (OMB) detailed operational plans for implementing the NHAS within their agencies. The HHS NHAS *Operational Plan* was submitted in early December 2010 and served, along with the NHAS and the *Federal Implementation Plan*, as a blueprint for HHS actions throughout 2011.

Read more about the NHAS and access all the related documents at www.AIDS.gov.

Highlights of 2011 Accomplishments

Operating divisions and staff offices across the Department of Health and Human Services contributed in many ways to our progress toward achieving the NHAS goals in 2011. The following overview highlights some of the key milestones in each of the Strategy's goals.

GOAL 1 Reduce New HIV Infections

NHAS Action Steps

- Intensify HIV prevention efforts in the communities where HIV is most heavily concentrated.
- Expand targeted efforts to prevent HIV infection using a combination of effective, evidence-based approaches.
- Educate all Americans about the threat of HIV and how to prevent it.

Anticipated Results, by 2015

- Lower the annual number of new infections by 35% (from 56,300 to 42,225).*
- Reduce the HIV transmission rate, which is a measure of annual transmissions in relation to the number of people living with HIV, by 30% (from 5 persons infected per 100 people with HIV to 3.5 persons infected per 100 with HIV).*
- Increase from 79% to 90% the percentage of people living with HIV who know their serostatus (from 948,000 to 1,080,000 people).

* In August 2011, CDC published new incidence estimates using a refined methodology that allowed for a more precise 2006 incidence estimate (48,600, rather than the previous 56,300) as well as new estimates for 2007, 2008, and 2009. These new estimates showed that the annual number of new HIV infections was stable overall from 2006 through 2009. These new estimates have implications for published 2015 targets, including numbers of new infections and transmission rate.

In pursuit of the Strategy's first goal, HHS undertook numerous activities in 2011, including the following:

Improving Alignment of Funding to Achieve Maximum Impact on Reducing New HIV Infections—The Centers for Disease Control and Prevention (CDC) implemented important changes to its five-year HIV prevention funding cycle for health departments in states, territories, and select cities. The funding opportunity, Comprehensive HIV Prevention Programs for Health Departments, is CDC's single largest investment in HIV prevention and the changes announced in 2011 achieve a higher level of impact for every federal HIV prevention dollar. First among the changes was a shift in the basis of the funding formula, moving from people reported to be living with AIDS in each jurisdiction to people reported to be living with an HIV diagnosis. This better ensures that resources are allocated in proportion to the actual burden of HIV, since less than half of all Americans living with HIV have progressed to AIDS. In addition to better geographic targeting, CDC

also provided health departments with new, specific guidance for prioritizing the most effective, evidence-based prevention strategies to have the greatest impact on reducing new HIV infections. These include HIV testing; prevention with HIV-positive individuals to reduce their risk of transmitting HIV to others; condom distribution for people at high risk of acquiring HIV; and initiatives that align structures, policies, and regulations to enable optimal HIV prevention, care, and treatment. Through this program, a total of $304 million was awarded to health departments in all 50 states, eight cities, the District of Columbia, Puerto Rico, U.S. Virgin Islands, American Samoa, the Federated States of Micronesia, the Republic of Palau, the Marshall Islands, Guam, and the Northern Mariana Islands to support Core HIV Prevention Programs.

In addition, through a separate funding program, the Enhanced Comprehensive HIV Prevention Planning Program (ECHPP), CDC targeted supplemental HIV prevention funding to maximize the impact of HIV prevention in the 12 jurisdictions with the highest HIV disease burden (in 2007, these cities accounted for 44% of people living with AIDS in the U.S.), including: Atlanta, Georgia; Baltimore, Maryland; Chicago, Illinois; Washington, DC; Houston and Dallas, Texas; Los Angeles and San Francisco, California; Miami, Florida; New York City, New York; Philadelphia, Pennsylvania; and San Juan, Puerto Rico. In 2011, the jurisdictions completed situational analyses, and developed and began to implement a set of goals, strategies, and specific objectives to achieve an optimal combination of prevention activities to reach NHAS goals. As they began the second phase of the three-year demonstration project in late 2011, the jurisdictions were implementing evidence-based interventions that can be scaled and targeted based on the local epidemic, need, and resources.

Advancing HIV Prevention Science to Reduce HIV Transmission—The National Institutes of Health (NIH) continued its support of basic clinical research on HIV prevention, including research to develop vaccines, microbicides, and behavioral interventions. NIH also supported critical studies in the area of therapeutics as a method to prevent infection, including treatment to prevent HIV infection after exposure; pre-exposure prophylaxis (PrEP); a potential prevention strategy known as “test and treat” to determine whether a community-wide testing program with treatment can decrease the overall rate of new HIV infections; and improved strategies to prevent mother-to-child transmission. In 2011 the results of one of those studies, an HIV Prevention Trials Network study known as HPTN 052, demonstrated that the early initiation of combination antiretroviral therapy by an HIV-infected heterosexual individual reduced sexual transmission of HIV to their uninfected partner by 96% among serodiscordant heterosexual couples. *Science Magazine* named the pivotal findings from this phase III, randomized controlled, multisite trial “Breakthrough of the Year.” These results have critical implications for the design of future prevention strategies. NIH is continuing to support this study to assess the durability of the HIV prevention benefit. Other HHS agencies and offices are exploring how to most effectively move away from siloed approaches and bring HIV prevention and treatment into closer coordination at all levels.

Intensifying Efforts to Promote and Support HIV Testing—Across the Department, several steps were taken in 2011 to increase the number of people in the United States who are aware of their HIV status, particularly among populations disproportionately impacted by HIV/AIDS. These included:

- *Funding HIV testing efforts for disproportionately impacted populations:* CDC's revised approach to disseminating HIV prevention funding to health departments also provided $54.8 million specifically for expanded HIV testing for disproportionately affected populations. CDC also awarded funding to support prevention projects focused on increasing the number of young men who have sex with men (MSM) of color and young transgender persons of color who are aware of their HIV status and linked to care. In addition, the 2011 awards by the Secretary's Minority AIDS Initiative Fund (SMAIF) emphasized HIV testing for racial and ethnic minority populations disproportionately impacted by HIV/AIDS. For example, the SMAIF awarded funds to CDC to scale up HIV testing among African American and Hispanic MSM and to the Indian Health Service (IHS) to expand its testing initiatives in tribal and urban sites.

- *Strengthening efforts to integrate rapid HIV testing in substance abuse treatment facilities:* The Substance Abuse and Mental Health Services Administration (SAMHSA) published Rapid HIV Testing in Substance Abuse Treatment Facilities and made it available in December 2011 to its grantees, technical assistance providers, and others in the field of substance use disorders. This resource contains information about the benefits of and requirements for incorporating rapid HIV testing into substance use disorder treatment programs. In addition, SAMHSA awarded $14.2 million in new grants to provide behavioral health services in communities most impacted by HIV/AIDS through the Minority AIDS Initiative Targeted Capacity Expansion: Integrated Behavioral Health/Primary Care Network Program. Funds awarded under these agreements can be used to support rapid HIV testing and counseling located onsite at mental health and substance abuse community-based organizations. Consequently, an increasing number of SAMHSA grant recipients are able to offer and provide rapid HIV testing to their clients.

- *Including HIV testing and counseling in Women's Preventive Health Services Guidelines:* In accordance with provisions of the Affordable Care Act, the health care law enacted in 2010, and Section 2713(a)(4) of the Public Health Service Act, HHS adopted new guidelines to ensure that millions of women receive recommended preventive health services with no cost sharing, including screening and counseling for HIV, sexually transmitted infections, and domestic violence. These evidence-based guidelines were recommended by the Institute of Medicine (IOM). The requirement that new health insurance plans cover these recommended preventive services without cost sharing takes effect in August 2012. By eliminating barriers such as co-pays, co-insurance, and deductibles, these guidelines will help improve access to affordable, quality health care for women by increasing the number of women aware of their HIV status and connecting those living with HIV to care.

- *Introducing a Healthy People 2020 Leading Health Indicator on knowledge of HIV status:* Assistant Secretary for Health Howard Koh released 26 Leading Health Indicators (LHIs) in 2011, which are to be used over the coming decade to assess the health of the U.S. population, communicate high-priority health issues to the public, facilitate collaboration among diverse groups, and motivate individuals and communities to take action to improve their health. The Department's efforts to work towards the NHAS goals were strengthened and reinforced by the inclusion of an HIV-related LHI: Persons living with HIV who know their serostatus. By including HIV serostatus awareness among the LHIs, HHS is helping to ensure that HIV will remain a high priority health issue around which it and its public health partners across the nation will focus attention and actions over the next decade. The indicator echoes the NHAS goal, setting a target of 90 percent of persons aged 13 years and older living with HIV who are aware of their HIV infection, working from a baseline of 79 percent in 2006. Progress will be monitored and measured using data from CDC's HIV case surveillance system.

- *Streamlining Testing that Detects Acute HIV Infections:* Detection of acute HIV infections typically has relied on nucleic acid tests, which are not widely used. (At present there is only one HIV nucleic acid test approved by the Food and Drug Administration [FDA] for use as an aid in the diagnosis of HIV infection.) FDA has recently approved two laboratory-based tests that detect both anti-HIV antibodies and HIV p24 antigen. The presence of HIV p24 antigen is detected earlier in the course of infection than antibodies and only slightly later than HIV RNA. These so-called fourth-generation HIV tests offer testing platforms that are better suited for more widespread clinical laboratory use and are expected to facilitate detection of early HIV infection.

GOAL 2 Increase Access to Care and Improve Health Outcomes for People Living with HIV

NHAS Action Steps

- Establish a seamless system to immediately link people to continuous and coordinated quality care when they are diagnosed with HIV.
- Take deliberate steps to increase the number and diversity of available providers of clinical care and related services for people living with HIV.
- Support people living with HIV with co-occurring health conditions and those who have challenges meeting their basic needs, such as housing.

Anticipated Results, by 2015

- Increase the proportion of newly diagnosed patients linked to clinical care within 3 months of their HIV diagnosis from 65 percent to 85 percent.
- Increase the proportion of Ryan White HIV/AIDS Program clients who are in continuous care (at least 2 visits for routine HIV medical care in 12 months at least 3 months apart) from 73 percent to 80 percent.
- Increase the percentage of Ryan White HIV/AIDS Program clients with permanent housing from 82 percent to 86 percent. (This serves as a measurable proxy of our efforts to expand access to HUD and other housing supports to all needy people living with HIV.)

In pursuit of the Strategy's second goal, HHS undertook numerous activities in 2011, including the following:

Increasing Access to HIV Care—As a result of ongoing investments in research and years of clinical experience, people living with HIV can enjoy long and healthy lives. To make this a reality for everyone, it is important to get people with HIV into care early after infection to protect their health and reduce their potential of transmitting the virus to others. Efforts to improve opportunities to access HIV care were a key focus of HHS in 2011 and included:

- *Expanding availability of HIV care in community health centers:* The more than 8,100 community health center service sites across the nation serve as important providers of comprehensive, culturally competent, quality primary health care services to medically underserved communities and vulnerable populations. The Affordable Care Act recognizes this important role and invests in strengthening and expanding community health centers. HRSA took several steps to support these community health centers in expanding the availability of HIV care. In June 2011 HRSA's Bureau of Primary Health Care (BPHC) issued a Program Assistance Letter (PAL) about HIV/AIDS care and treatment to all health center grantees outlining BPHC expectations regarding the increased integration of HIV/AIDS services across the Health Center Program, reviewing key guidelines and protocols, identifying opportunities for training and technical assistance, and providing links to resources for additional information. In support of these expectations, in 2011 BPHC also held grantee technical assistance

conference calls on the NHAS and improving HIV/AIDS care in the health center community; added and raised the visibility of HIV resources on the BPHC TA website; and conducted two trainings of federal project officers to equip them with the knowledge and tools needed to engage in meaningful dialogues with grantees about HIV service delivery.

- *Increasing access to Medicaid coverage for individuals living with HIV:* In June 2011 the Centers for Medicare & Medicaid Services (CMS) issued a State Medicaid Director (SMD) letter giving guidance to states about opportunities to provide Medicaid coverage to individuals living with HIV. The six coverage and service design options detailed in the SMD letter offered states possibilities to increase access to care for individuals living with HIV and improve their care coordination. The options may also provide states with alternatives that could alleviate the burden on AIDS Drug Assistance Programs (ADAP), and help states make progress towards expanding coverage and providing access in accordance with the Affordable Care Act requirements. Following the release of the SMD letter, CMS, HRSA's BPHC and HIV/AIDS Bureau (HAB), and HHS OASH conferred with representatives of the National Association of Medicaid Directors, the National Alliance of State and Territorial AIDS Directors, and the National Association of Community Health Centers to identify technical assistance efforts around these HIV-focused Medicaid options. Subsequently, CMS provided technical assistance to states interested in exploring these options for flexibility to improve care and care coordination for individuals living with HIV. CMS continues to make technical assistance available to states interested in pursuing these options.

- *Helping people living with HIV/AIDS find—and keep—health insurance:* In 2011 HHS continued to implement provisions of the Affordable Care Act, including those that improve access to health care coverage for people living with HIV/AIDS. Under the Affordable Care Act, insurance companies can no longer deny coverage to children because of their HIV, AIDS, or any other pre-existing condition, rescind coverage for adults or children except in cases of fraud or intentional misrepresentation of a fact, or impose a lifetime dollar limit on essential health benefits. In addition, ADAP benefits are now considered as contributions toward a Medicare beneficiary's true out-of-pocket spending limit for drug coverage, a huge relief for low-income beneficiaries living with HIV infection and AIDS because it helps close the gap in Medicare's prescription drug benefit known as the "donut hole." The Affordable Care Act also created the Pre-Existing Condition Insurance Plan (PCIP), a temporary program intended to provide health care coverage to eligible uninsured individuals who are unable to access coverage in today's private insurance market due to pre-existing conditions between now and 2014, when new affordable options become available to all Americans with pre-existing conditions. In 2011 almost half of the states worked to coordinate PCIPs with their Ryan White ADAPs to help low-income people with HIV access life-saving medications and other health care services. These efforts were serving nearly 2,400 clients by year's end. These provisions help people with HIV/AIDS find and keep health insurance and serve as an important bridge to 2014, when the Affordable Care Act will take full effect and additional changes in health insurance options will be made available for many Americans, including those living with HIV/AIDS.

Strengthening Provider Capacity to Deliver HIV Care—HHS took steps in 2011 to build service provider capacity, encourage more clinicians to provide HIV services, and ensure that HIV care providers have the knowledge and training to provide quality HIV care consistent with the latest treatment guidelines. These efforts included:

- *Updating and disseminating treatment and care guidelines to providers*: During 2011 NIH facilitated the update and dissemination of three sets of federally approved HIV/AIDS medical practice guidelines (Adult and Adolescent Antiretroviral Treatment, Perinatal, and Pediatric ARV Treatment). In addition, NIH's National Library of Medicine made all the guidelines available in a new web-based format via AIDSinfo, enabling more widespread access to the information as well as enhancing the opportunity to quickly search the guidelines for specific information. HRSA also updated and disseminated the *Guide for HIV/AIDS Clinical Care for Ryan White HIV/AIDS Programs*. Presenting best practices in the clinical management of HIV disease, the Guide provides health care providers easy access to crucial facts. It incorporates new insights in response to patient needs that have expanded across a broad spectrum of medical, psychological, behavioral, and social issues that confront clinicians with complex and immediate care challenges.

- *Training clinicians:* HHS also took action to improve the supply, capacity, and distribution of primary care providers able to offer HIV prevention, care, and treatment. HRSA's Bureau of Health Professions (BHPr) announced Primary Care Training and Enhancement Grants that included awards providing practical experiences for trainees on HIV/AIDS-related prevention, care, and treatment. BHPr also worked in partnership with 11 major universities on developing teaching components for future clinicians on a host of issues, ranging from HIV in elderly patients and chronic disease management in vulnerable populations to on-site training for medical students in outreach centers for homeless people living with HIV. In addition, HAB awarded a total of $450,000 to develop residency training opportunities with a focus on HIV management and care at community health centers located in areas with high HIV prevalence and a shortage of health professionals.

- *Enhancing culturally competent HIV care capacity of community health centers:* Several initiatives were launched to expand the culturally competent HIV care capacity of the nation's community health centers. The new National Center for HIV Care in Minority Communities (NCHCMC), an AIDS Education and Training Center (AETC) supported by HRSA/HAB, began an intensive year-long capacity building program with its first cohort of 24 health centers from 12 states, and its second cohort of 30 health centers from 16 states. Collectively, these health centers serve over 4,000 patients living with HIV and over 500,000 total patients in predominantly ethnic and racial minority communities. The NCHCMC develops the clinical and organizational capacity of health centers not directly funded through the Ryan White HIV/AIDS Program to offer comprehensive HIV/AIDS care and treatment within highly impacted communities of color. In 2011 another 160 health centers in highly impacted communities participated in the Ryan White Part C program for Early Intervention Services. In addition, HRSA/BPHC also established a new national lesbian, gay, bisexual, and transgender (LGBT)

technical assistance and training center for health centers and state primary care associations as part of broader efforts to improve the health of LGBT populations, including those living with and at risk for HIV.

Improving Health Outcomes for HIV-infected Individuals through Research—NIH continued to support research to improve antiretroviral therapy (ART) to improve immune function, reduce toxicities and side effects associated with antiretroviral drugs, and delay progression of HIV disease to the development of AIDS. NIH is supporting research to prevent and treat co-infections, co-morbidities, AIDS-defining and non-AIDS-defining malignancies, and complications associated with long-term HIV disease and ART, including issues related to AIDS and aging. These include tuberculosis, hepatitis C, metabolic disorders, cardiovascular disease, and neurologic and neurocognitive disorders.

Addressing Viral Hepatitis Co-infections to Improve Health Outcomes—Among the co-occurring conditions that must be addressed to improve health outcomes for people living with HIV is viral hepatitis. Hepatitis C virus is a leading cause of morbidity and mortality among people living with HIV, and as many as one-third of people living with HIV are co-infected with hepatitis C; an estimated 10 percent are co-infected with chronic hepatitis B. In May 2011 HHS issued *Combating the Silent Epidemic of Viral Hepatitis: Action Plan for the Prevention, Care & Treatment of Viral Hepatitis* which outlines robust and dynamic steps to increase viral hepatitis awareness and knowledge among health care providers and communities, and improve access to quality prevention, care, and treatment services for viral hepatitis. In support of both the NHAS and the *Viral Hepatitis Action Plan's* goals, HRSA/HAB developed and disseminated technical assistance tools to assist HIV and other primary care providers in the diagnosis, treatment, and prevention of viral hepatitis. These included *A Guide for Evaluation and Treatment of Hepatitis C in Adults Coinfected with HIV*, a quick reference for clinicians in the diagnosis, evaluation, and treatment of HCV in the setting of HIV primary care, and *Integrating Hepatitis C Treatment In Ryan White Clinics: Models & Steps* which presents a rationale for why Ryan White clinics should play a greater role in hepatitis C treatment and steps they can take to integrate hepatitis C treatment into their HIV/AIDS primary care services. SAMHSA's Center for Substance Abuse Treatment is supporting expanded hepatitis C virus (HCV) testing and hepatitis B (HBV) vaccination of HIV/HCV co-infected individuals through the bulk purchase and distribution of HCV test kits and hepatitis B vaccine to SAMHSA-regulated opioid addiction treatment programs (OTPs).

GOAL 3 Reduce HIV-Related Disparities and Health Inequities

NHAS Action Steps

- Reduce HIV-related mortality in communities at high risk for HIV infection.
- Adopt community-level approaches to reduce HIV infection in high-risk communities.
- Reduce stigma and discrimination against people living with HIV.

Anticipated Results, by 2015

- Increase the proportion of HIV diagnosed gay and bisexual men with undetectable viral load by 20 percent.
- Increase the proportion of HIV diagnosed Blacks with undetectable viral load by 20 percent.
- Increase the proportion of HIV diagnosed Latinos with undetectable viral load by 20 percent.

In pursuit of the Strategy's third goal, HHS undertook numerous activities in 2011, including the following:

Strengthening Efforts to Measure and Utilize Community Viral Load—As outlined in the NHAS, scientific evidence shows that the average viral load among all diagnosed HIV-positive individuals in a given community who are in care is strongly associated with the number of new infections that occur in that community. Thus, efforts to reduce community viral load may help reduce the number of new HIV infections in specific communities, which may, in turn, reduce HIV-related disparities. In September 2011 CDC developed and released technical guidance for calculating viral load, including community viral load. In collaboration with HRSA/HAB, CDC sponsored a consultation on the monitoring and use of laboratory data reported to HIV surveillance. Forty external consultants joined CDC and HRSA/HAB representatives to explore scientific, programmatic, and ethical considerations for the collection and use of laboratory indicators in HIV surveillance for public health action and monitoring and to highlight a broad range of innovative examples of how state and local programs are using surveillance data at both the individual and aggregate levels.

To further support such efforts, CDC provided a total of $8.4 million in supplemental resources to funded health jurisdictions to support the implementation and maintenance of electronic lab reporting for all HIV-related test results, to collect CD4 (an important laboratory indicator of immune function) and viral load data as part of their core surveillance activities, and to improve their ability to use geocoding of HIV surveillance data to more precisely monitor and respond to their local epidemic. Some of these CDC resources also supported several demonstration projects in health jurisdictions to develop, monitor, and evaluate models for using CD4, viral load, and other surveillance data to improve the effectiveness of local HIV prevention efforts.

Restructuring the Secretary's Minority AIDS Initiative Fund—The Office of HIV/AIDS and Infectious Disease Policy (OHAIDP) restructured and transitioned the SMAIF to be in closer alignment with the goals, objectives, and priorities of the NHAS. Through program and process directives, OHAIDP worked with HHS agencies and offices to enhance the effectiveness of HIV prevention and care services provided for racial and ethnic minority communities through the SMAIF. In addition, OHAP issued guidance requiring the use of standardized HIV testing and training metrics for all SMAIF-supported projects. The SMAIF allocated $53 million among 35 awards to 10 HHS agencies and offices for a variety of activities that complemented existing efforts to address HIV/AIDS in racial and ethnic minority communities. The awards supported a range of activities from HIV prevention and testing to linkage to and retention in care. They also included capacity building, outreach and education, training and technical assistance, and planning and evaluation activities. The funded activities served diverse populations, including women of color, African immigrants, and Latino and African American MSM, among others. While some of the projects supported activities in multiple locations across the U.S., others addressed very specific geographic regions such as the U.S.-Mexico border region, rural areas, Puerto Rico, and the Pacific territories.

Heightened Efforts to Improve HIV Prevention, Care, and Treatment among Vulnerable Populations—In addition to the examples described above, HHS agencies and offices took deliberate steps to improve HIV prevention, care, and treatment among populations for whom HIV-related health disparities exist. Among these were:

- CDC worked with its health department grantees to scale up HIV testing among African American and Hispanic MSM. CDC also funded a number of community-based organizations that provide HIV testing and linkage to care for Asian American and Pacific Islander communities.
- The Office of Adolescent Health funded a new National Resource Center for HIV/AIDS Prevention among Racial and Ethnic Minority Adolescents.
- HRSA/HAB funded three AETC Telehealth Training Centers to help expand access to and improve health care and health outcomes for hard-to-reach, HIV-positive persons in medical care residing in historically underserved, mostly rural communities.
- With funds provided through the SMAIF, CDC worked with non-governmental organizations serving American Indian/Alaska Native (AI/AN) adolescents to build their capacity to provide quality HIV prevention programming, and HRSA/HAB supported a capacity development initiative for AI/AN-serving health care providers. At the same time, IHS expanded its HIV testing activities, adding eight new sites, and worked to enhance the continuity of care among HIV-infected AI/AN substance abuse patients.

- The Office on Women's Health (OWH) supported HIV prevention demonstration projects implementing gender-responsive strategies for women and girls from diverse populations across the nation.

- HRSA/HAB supported efforts to promote high quality, culturally sensitive education and capacity building programs for health care providers and agencies that provide HIV/AIDS-related prevention and clinical management services in the U.S.-Mexico border region.

- The Office of Minority Health worked to improve HIV care continuity for ex-offenders re-entering their communities from jail or prison and OWH supported HIV prevention interventions for racial and ethnic minority women whose partners are incarcerated or were recently released.

- NIH is continuing to support research to better understand the causes of HIV-related health disparities, their role in disease transmission and acquisition, and their impact on treatment access and effectiveness. These include disparities among racial and ethnic populations in the U.S., between developed and resource-constrained nations, between men and women, and between youth and older individuals, as well as disparities based on sexual identity. NIH is also continuing to support research training for new investigators from racial and ethnic communities, development of research infrastructure, community outreach, information dissemination, and research collaborations to help reduce these disparities.

- An NIH-funded study (HPTN 064) revealed that HIV infection rates among Black women in some parts of the United States are similar to the incidence in some countries in sub-Saharan Africa. This rate is five times higher than previous estimates. NIH is continuing to support research to identify the biological, behavioral, social, and economic factors related to vulnerability to infection, including issues related to drug use, stigma, and domestic violence; prevention and treatment of unique clinical complications; factors related to response to therapy; and issues related to adherence to therapy and prevention strategies.

Achieving a More Coordinated National Response to the HIV Epidemic

The Strategy also clearly states that in order to achieve the goals it established, emphasis must be placed on coordination of activities among agencies and across all levels of government. It specifically calls for:

- Increasing the coordination of HIV programs across the federal government and between federal agencies and state, territorial, local, and tribal governments.
- Developing improved mechanisms to monitor and report on progress toward achieving national goals.

Highlights of progress within HHS during 2011 on both these priorities include the following:

Improving Coordination of HIV/AIDS Programs Across HHS—Efforts to further strengthen coordination of the Department's programs continued throughout 2011 and included quarterly meetings of the HHS NHAS Implementation Group, comprised of senior officials from all of the operating divisions and staff offices with HIV/AIDS-related activities. During these meetings, participants shared updates on the implementation of activities aligned with the Strategy and the HHS NHAS *Operational Plan,* identified opportunities for cross-agency/office collaboration, and developed mechanisms for ongoing communications. Such efforts were praised and encouraged by the Secretary of Health and Human Services in a January 2011 message to HHS leadership in which she reiterated that implementation of the NHAS is a priority for HHS. Accordingly, she emphasized the importance of ensuring that all HHS funding announcements for federal HIV/AIDS dollars adhere to and are consistent with the goals of the NHAS. To help promote this consistency, she asked that all HIV/AIDS funding announcements undergo a technical review in the Office of the Assistant Secretary for Health (OASH) prior to finalization and publication.

In addition, CDC, HRSA, IHS, NIH, SAMHSA, and OASH continued to work together on the 12 Cities Project, an HHS-wide project designed to support and accelerate comprehensive HIV/AIDS planning and response in the 12 U.S. jurisdictions that bear the highest AIDS burden in the country. During 2011 a cross-agency work group met regularly to identify specific opportunities to further support and extend cross-program collaboration at the local level. As part of efforts to better leverage new and existing federal investments and more effectively coordinate federally funded HIV/AIDS activities in those jurisdictions, NIH engaged nine of its Centers for AIDS Research (CFARs) located in the jurisdictions in focused partnerships with the local health departments. SAMHSA also provided resources to 11 of these jurisdictions to develop and expand networks of primary care, HIV/AIDS, and behavioral health service providers serving racial and ethnic minorities living with or at high risk for HIV/AIDS. Within HHS, to more fully inform planning and evaluation efforts and foster closer coordination at both the federal and local levels, the participating agencies shared with one another planning, programmatic, and HIV/AIDS financial data about activities in these jurisdictions. Lastly, OHAIDP initiated an evaluation of the 12

Cities Project to assess progress toward the goal of aligning HIV resources for maximum impact on the HIV epidemic in those jurisdictions. The evaluation framework will examine individual jurisdiction and cross-site progress on program collaboration, coordination, and integration of planning, services, and funding, as well as efforts to address gaps in services. Importantly, this qualitative evaluation will also identify "lessons learned" that can be applied in other jurisdictions as well as inform future HHS planning, funding, technical assistance, and policy activities.

Streamlining and Standardizing Indicators—Throughout 2011 HHS engaged in a process to establish common core HIV indicators, streamline data collection, and identify ways to reduce reporting burden for HHS-funded HIV programs. A cross-agency workgroup inventoried all indicators currently in use by HHS HIV programs and examined guidelines and performance standards from non-federal entities such as the National Quality Forum. OHAIDP and its HHS colleagues then convened a consultation with representatives from state and local health departments, academia, community-based organizations, and national HIV organizations to further examine options for and implications of a core set of indicators. As a result of these efforts, a proposed small set of standardized common indicators that could be widely used across programs was developed. The domains for the proposed standardized HIV/AIDS prevention, treatment, and care indicators are: HIV diagnosis, early HIV diagnosis, initial linkage to care, sustained engagement in care, initiation of antiretroviral treatment, viral load suppression, and housing. These standardized indicators are an important part of government-wide efforts to improve mechanisms to monitor and report on progress toward achieving the NHAS goals. At the end of 2011, OHAIDP was preparing to make recommendations to the Secretary and OASH on the domains and the process for finalizing and implementing the common set of indicators as well as for reducing reporting requirements across HHS HIV/AIDS programs.

Epilogue

The activities outlined in this report, along with the myriad others undertaken across HHS agencies and offices, have established a solid foundation for our efforts to pursue the NHAS vision and goals. In the coming months and years, it will be essential to sustain this momentum and continue to thoughtfully assess and innovate as well as engage, more intensively, various non-federal partners in these efforts, including partners from across sectors such as state and local government, science, philanthropy, entertainment and media, education, and faith communities.

In the near term, all of the HHS agencies and offices engaged in implementing the NHAS are looking forward to gathering at the XIX International AIDS Conference in July 2012 in Washington, D.C., with our colleagues in the field of HIV, as well as policy makers, persons living with HIV/AIDS, and other stakeholders from around the world committed to ending the pandemic. This global forum affords us an opportunity to share what we have learned through our efforts to implement the Strategy as well as to learn about both new scientific developments and the experiences of others pursuing comparable goals elsewhere. All of this will better enable us to chart a clearer course forward as well as generate greater awareness among the American public about the persistence of the epidemic and the need for their support and involvement to realize the vision of the National HIV/AIDS Strategy:

The United States will become a place where new HIV infections are rare and when they do occur, every person regardless of age, gender, race/ethnicity, sexual orientation, gender identity or socio-economic circumstance, will have unfettered access to high quality, life-extending care, free from stigma and discrimination.

Appendix: List of Acronyms

ADAP	AIDS Drug Assistance Program, part of the Ryan White HIV/AIDS Program administered by HRSA
AETC	AIDS Education and Training Center, HRSA
AI/AN	American Indian/Alaska Native
AIDS	Acquired Immune Deficiency Syndrome
ART	Antiretroviral Therapy
ARV	Antiretroviral
BPHC	Bureau of Primary Health Care, HRSA
BHPr	Bureau of Health Professions, HRSA
CDC	Centers for Disease Control and Prevention
CFAR	Center(s) for AIDS Research, NIH
CMS	Centers for Medicare and Medicaid Services
ECHPP	Enhanced Comprehensive HIV Prevention Planning, CDC FOA
FDA	Food and Drug Administration
FOA	Funding Opportunity Announcement
FY	Fiscal Year (October 1 – September 30)
HAB	HIV/AIDS Bureau, HRSA
HBV	Hepatitis B Virus
HCV	Hepatitis C Virus
HHS	Department of Health and Human Services
HIV	Human Immunodeficiency Virus
HPTN	HIV Prevention Trials Network
HRSA	Health Resources and Services Administration
HUD	Department of Housing and Urban Development
IHS	Indian Health Service
IOM	Institute of Medicine
LGBT	Lesbian, Gay, Bisexual, Transgender
LHI	Leading Health Indicator
MSM	Men who have Sex with Men
NCHCMC	National Center for HIV Care in Minority Communities
NHAS	National HIV/AIDS Strategy
NIH	National Institutes of Health
OASH	Office of the Assistant Secretary for Health, HHS
OHAIDP	Office of HIV/AIDS and Infectious Disease Policy, OASH
OMB	Office of Management and Budget, The White House
ONAP	Office of National AIDS Policy, The White House
OS	Office of the Secretary, HHS
OTP	Opioid Treatment Programs
OWH	Office on Women's Health, OASH
PAL	Program Assistance Letter
PCIP	Pre-existing Condition Insurance Plan
PrEP	Pre-Exposure Prophylaxis
SAMHSA	Substance Abuse and Mental Health Services Administration
SMAIF	Secretary's Minority AIDS Initiative Fund
SMD	State Medicaid Director

Vision of the National HIV/AIDS Strategy

The United States will become a place where new HIV infections are rare and when they do occur, every person regardless of age, gender, race/ethnicity, sexual orientation, gender identity or socio-economic circumstance, will have unfettered access to high quality, life-extending care, free from stigma and discrimination.

NATIONAL HIV/AIDS STRATEGY