IMPLEMENTING THE NATIONAL HIV/AIDS STRATEGY: OVERVIEW OF AGENCY OPERATIONAL PLANS

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Office of National AIDS Policy
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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"

Reducing New HIV infections

Action Steps:

- Intensify HIV prevention efforts in 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.

Targets:

- By 2015, lower the annual number of new infections by 25% (from 56,300 to 42,225).
- By 2015, 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 people with HIV).
- By 2015, increase from 79% to 90% the percentage of people living with HIV who know their serostatus (from 948,000 to 1,080,000 people).

Increasing Access to Care and Improving Health Outcomes for People Living with HIV

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.

Targets:

- By 2015, increase the proportion of newly diagnosed patients linked to clinical care within three months of their HIV diagnosis from 65% to 85% (from 26,824 to 35,078 people).
- By 2015,increase the proportion of Ryan White HIV/AIDS Program clients who are in care (at least 2 visits for routine HIV medical care in 12 months at least 3 months apart) from 73% to 80% (or 237,924 people in continuous care to 260,739 people in continuous care).
- By 2015, increase the number of Ryan White clients with permanent housing from 82% to 86% (from 434,000 to 455,800 people). (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.)

Reducing HIV-Related Health Disparities and Health Inequities

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.

Targets:

- By 2015, increase the proportion of HIV diagnosed gay and bisexual men with undetectable viral load by 20%.
- By 2015, increase the proportion of HIV diagnosed Black Americans with undetectable viral load by 20%.
- By 2015, increase the proportion of HIV diagnosed Latinos with undetectable viral load by 20%.

Achieving a More Coordinated National Response to the HIV Epidemic in the United States

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

I. Background

This report provides an overview of the operational plans submitted by the lead Federal agencies for implementing the *National HIV/AIDS Strategy for the United States* (the Strategy). This report and individual agency plans may be accessed at www.AIDS.gov. AIDS.gov will continue to be a source for information on the implementation of the Strategy.

On July 13, 2010, President Obama fulfilled a public commitment by releasing the nation's first comprehensive national plan for responding to the domestic HIV epidemic. The purpose of the Strategy is to provide a roadmap for public and private stakeholders to better address the serious ongoing HIV epidemic in the United States. It identifies a limited set of priorities and strategic action steps that we believe will have the biggest, measurable impact on the domestic epidemic. A *Federal Implementation Plan* released with the Strategy outlines specific short-term steps to be taken by various Federal agencies to support the high-level priorities outlined in the Strategy. These documents are available at www.aids.gov/federal-resources/policies/national-hiv-aids-strategy/whats-next/agency-operational-plans.html.

To support the implementation of the Strategy, the President issued a Presidential Memorandum identifying lead agencies and instructing these agencies to take specific actions to support the implementation of the Strategy. Lead agencies are the departments of Health and Human Services (HHS), Housing and Urban Development (HUD), Justice (DOJ), Labor (DOL), and Veterans Affairs (VA), as well as the Social Security Administration (SSA). The memorandum called for the head of each lead agency to submit within 150 days to the Office of National AIDS Policy (ONAP) and the Office of Management and Budget (OMB) operational plans for implementing the Strategy within their agencies. Lead agencies were also directed to designate an official responsible for coordinating the agency's ongoing efforts to implement the Strategy, develop a process for sharing progress reports with ONAP and other agencies, and in consultation with the OMB, use the budget development process to prioritize programs and activities most critical to meeting the goals of the Strategy.

Additionally, within 150 days, the memorandum directed the following:

- The Secretary of Defense to submit a plan for aligning the health care services provided by the Department of Defense with the Strategy to the extent feasible and permitted by law;
- The Secretary of State to submit recommendations for improving the government-wide response to the domestic HIV/AIDS epidemic, based on lessons learned in implementing the President's Emergency Plan for AIDS Relief (PEPFAR) program; and
- The Chair of the Equal Employment Opportunity Commission (EEOC) to submit recommendations for increasing employment opportunities for people living with HIV and a plan for addressing employment-related discrimination against people living with HIV, consistent with the Commission's authorities and other applicable law.

Though not an implementing agency, the White House Office of National Drug Control Policy (ONDCP) is working closely with ONAP to harmonize our anti-drug policies with our national HIV/AIDS policy. In doing so, ONDCP has pledged to support ONAP and other AIDS-related agencies to raise awareness about the twin epidemics of drug addiction and HIV/AIDS.

II. Designated Lead Agency Officials

As stipulated in the Presidential Memorandum, specific individuals at each agency were identified as leads for Strategy implementation activities.

Office of National AIDS Policy (ONAP)	Jeffrey S. Crowley, Director
Office of Management and Budget (OMB)	Jacob J. Lew, Director

Department of Health and Human Services (HHS	Howard K. Koh, M.D., M.P.H., Assistant Secretary for Health
Department of Housing and Urban Development (HUD)	Mercedes M. Márquez, J.D., LL.M., Assistant Secretary, Community Planning and Development
Department of Labor (DOL)	William E. Spriggs, Ph.D., Assistant Secretary for Policy
Department of Justice (DOJ)	Thomas E. Perez, J.D., M.P.P, Assistant Attorney General for Civil Rights
Department of Veterans Affairs (VA)	Robert A. Petzel, M.D., Under Secretary for Health
Social Security Administration (SSA)	David A. Rust, Deputy Commissioner, Retirement and Disability Policy

III. Key FY 2011 Agency Activities to Implement The National HIV/AIDS Strategy

This report is intended to provide an overview of selected top line activities or initiatives from various individual operational plans. The collective result of individual agency planning will lead to synergistic results when agencies are aligning their efforts around the same set of action steps as outlined in the Strategy. Throughout this report, we highlight selected initiatives or activities that can be found in the agency plans. Since it is not feasible to include all of the details of the plans in a short summary, highlighted activities are intended to be illustrative only. Readers are encouraged to review the individual agency plans at www.aids.gov/federal-resources/policies/national-hiv-aids-strategy/whats-next/agency-operational-plans.html. It should be noted that responsibility for implementing the Strategy is a government-wide task with critically important responsibilities for all lead agencies. Nonetheless, the Department of Health and Human Services (HHS) has a larger role than other agencies in funding HIV services and operating HIV programs. The Presidential Memorandum also delegated specific responsibilities for improving program-level coordination across Federal agencies to the Secretary of HHS. Throughout this report, prominence is given to HHS activities given the scope of the Department's activities for HIV prevention, care, and research. Despite the significant role HHS plays, however, it should not diminish the important contributions of the other Federal agencies, without which the Strategy could not be successfully implemented.

It is also important to note that this report is focused on the efforts by the Federal agencies to implement the Strategy. As the Strategy states, however, "[implementing the Strategy] does not fall to the Federal government alone, nor should it. Success will require the commitment of all parts of society, including State, Tribal and local governments, businesses, faith communities, philanthropy, the scientific and medical communities, educational institutions, people living with HIV, and others." ONAP and the individual lead agencies are committed to engaging the private sector and other external stakeholders as an essential component of nearly all of the activities described in this report. While the lead agencies will be monitored and held accountable for the actions they take to complete the objectives described here, we can only be successful if State, Tribal, and local governments, as well as private sector partners also hold themselves accountable for taking bold new steps to achieve the vision of the Strategy.

This report is intended to complement, but not duplicate the *Federal Implementation Plan* that was released in July 2010. The *Federal Implementation Plan* details specific action steps that agencies will undertake to further the goals of the Strategy in 2010 and 2011. The development of lead agency operational plans provided an opportunity for individual agencies to conduct their own processes for organizing their programs and activities to further the Strategy. In addition to planning to implement the very granular actions identified in the *Federal Implementation Plan*, the operational plans identify additional initiatives or activities that will lead to more systemic change in order to ensure that the Federal resources are leveraged to maximum effect.

Reducing New HIV Infections

The United States continues to have a very serious HIV epidemic with more than 56,300 new infections each year. This number represents the evolution of HIV and AIDS in our country. Within a few short years in the 1980s, HIV went from an unknown condition to an epidemic that was infecting more than 130,000 people annually. We have lowered the annual infection rate by more than half, but this rate has remained steady for several years. This high number of new infections imposes costs on the country, as HIV remains a serious, life-threatening condition.

The Strategy identifies three action steps for reducing incidence:

- Step 1: Intensify HIV prevention efforts in communities where HIV is most heavily concentrated;
- Step 2: Expand targeted efforts to prevent HIV infection using a combination of effective, evidence-based approaches; and
- Step 3: Educate all Americans about the threat of HIV and how to prevent it.

Step 1: Intensify HIV prevention efforts in communities where HIV is most heavily concentrated.

As stated in the Strategy, "Not every person or group has an equal chance of becoming infected with HIV. Yet, for many years, too much of our nation's response has been conducted as though everyone is equally at risk for HIV infection. Stopping HIV transmission requires that we focus more intently on the groups and communities where the most cases of new infections are occurring."

Key FY 2011 Activities

To focus on the populations and communities at greatest risk, the Federal agencies are undertaking a number of important activities. Of critical importance are the following:

- **HHS has produced a new baseline of information on how its resources are currently being allocated.**

  In developing its Operational Plan, HHS conducted an unprecedented inventory of HIV/AIDS spending across the department (See the Appendix and read the HHS operational plan for additional information). What these new data tell us is that most resources are multi-targeted and intended either for the general population or multiple target populations, although this does not necessarily mean that most of these resources are devoted to populations at little to no risk of HIV infection. These data have caveats. It is not possible to describe fully how HHS resources are specifically utilized at the client-level for a number of reasons, including: lack of a common system of reporting on the specific uses of HIV funding across HHS agencies and offices; confidentiality of client HIV status and client data; distribution of HHS resources to State, Tribal, and local governments which, in turn, distribute resources based on State, Tribal, or local-level planning processes; allocation of funding to support research that will broadly benefit all populations at risk for or infected with HIV. Moreover, there are data limitations that inhibit our ability to assess the level of resources provided to many populations. Nonetheless, these data do give us an important indication of whether our existing resource allocation is

consistent with the Strategy goal of intensifying prevention efforts in communities where the epidemic is most heavily concentrated.

When agencies do target their efforts, they generally identify populations that the Strategy identifies as being high risk, but the proportion of funds do not always align well with the share of the epidemic that specific populations comprise. Of particular note, despite representing the greatest number of new cases of HIV infection among all populations each year, gay and bisexual men received an inadequate share of targeted resources across HHS agencies that collected risk data. In addition, very little funding was directed toward transgender populations, despite high HIV prevalence in these populations.

On a more positive note, over the past decade, increasing attempts to respond to HIV in Black America are reflected in funding data. Seventy percent of CDC/SAMHSA/OS (OS refers to the HHS Office of the Secretary) targeted resources and 47% of HRSA targeted resources were directed towards Black Americans. Success in targeting funds is only as important as the impact that these resources make in changing the epidemic. Black Americans remain disproportionately at risk for HIV infection compared to other racial/ethnic groups despite this concentration of resources. Therefore, as we strategically invest resources in high risk communities, we must also demonstrate an unflinching commitment to prioritizing investments to the interventions that will have the biggest impact.

These data are the first comprehensive review of HIV/AIDS resources from all HHS agencies and will provide a useful tool for agencies in making funding decisions. These data are also useful for policy makers and the public to track progress. To increase their effectiveness, we would expect that a growing share of resources for HIV services and programs will be allocated consistent with CDC surveillance data and the level of funding targeted to specific groups or communities will bear a relationship to their share of the epidemic.

- **CDC has developed a concrete plan and timeline for updating its funding formula to ensure that Federal HIV prevention allocations are based on the latest HIV/AIDS data.**

  Targeting populations at greatest risk must also include concentrating on those localities that carry the greatest burden of the HIV/AIDS epidemic in the US. Over many years, most reporting systems have transitioned from reporting names-based AIDS cases to reporting names-based HIV cases, as well as AIDS cases. These more recent data provide a more complete and accurate picture of the HIV epidemic in State, Tribal, and local jurisdictions across the country. HHS's operational plan includes plans for CDC to finalize and publish a new formula to be used for allocating core prevention funding for State and local health departments (the single largest portion of CDC's HIV prevention budget) that is based on the latest available HIV and AIDS cases.

- **CDC has committed to reviewing its HIV Prevention Community Planning process for allocating Federal HIV prevention resources at the local level to ensure that funds follow the epidemic.**

  CDC will undertake an extensive evaluation of the community planning process to determine whether and to what degree prevention resources are following the epidemic. Most Federal

HIV prevention funding is awarded to State, Tribal, and local health departments and is allocated at the local level following a community planning process. Funding allocations are intended to be based on the epidemiological profile in the community and set priorities for targeting resources to serve the populations that comprise the greatest proportion of infections and fund the interventions that are most effective. CDC's review will consider whether HIV prevention planning processes should be streamlined and where feasible, combined with Ryan White HIV/AIDS Program planning efforts. The review will also consider ways to connect with other Federal, State, Tribal, and local planning efforts, such as related housing plans. Policy changes will be incorporated into the upcoming revision of guidance to State, Tribal, and local health departments receiving HIV prevention funds.

- **HUD will propose a new funding formula to better target resources to people living with HIV/AIDS.**

  In FY 2011, HUD will work with Congress to develop a plan to shift HIV/AIDS case reporting as a basis for formula grants for Housing Opportunities for People with AIDS (HOPWA) funding. The provisions of the HOPWA statute reflected the nature of the AIDS surveillance information available in 1990. As changes have occurred to HIV/AIDS surveillance tools over time, the method used for allocating HOPWA formula funds has become increasingly dated. Basing the formula funding on cumulative AIDS data fails to reflect the present state of the domestic epidemic. Cumulative data includes information on over one half million Americans who have died due to AIDS. Instead, the HOPWA formula could be based on the number of individuals currently living with HIV/AIDS. This surveillance data is collected by CDC and is used as the standard for tracking and monitoring the epidemic. Revising the HOPWA formula based on current people living with HIV/AIDS would better target the distribution of housing assistance resources to communities based on a more relevant data set reflecting present need as part of enhanced community plans for HIV housing and service delivery.

- **Selected other critical agency activities for FY 2011 include:**
  - OGAC will share its experiences with HHS in its ongoing work to support countries to complete rapid assessments, mapping, and size estimation activities for most-at-risk populations (MARPs) and other vulnerable populations. These activities help determine the amount of coverage needed, identify locations where interventions can reach the targeted groups, and tailor services for the local context.
  - SAMHSA will work with HHS OS, Assistant Secretary for Legislation (ASL), and Office of the General Counsel (OGC) to develop a legislative Strategy for updating the criteria that allow States to use Substance Abuse Prevention and Treatment Block Grants funds for HIV/AIDS services to drug users.
  - The Bureau of Prisons at DOJ (BOP) will expand current HIV/STD and viral hepatitis screening to prisoners on entry.

- HUD will work to utilize HUD assistance to improve health outcomes, including efforts to improve linkage with HIV prevention and care programs.
- BOP and CDC will implement risk reduction interventions for HIV-positive and high risk HIV-negative individuals released from prison.
- VA will increase the proportion of all Veterans in health care that are tested for HIV at least once in their lifetime, especially among target populations identified in the Strategy.

Significance of FY2011 Activities Toward Reaching 2015 Goal

In order to meaningfully reduce HIV incidence, we must concentrate energies and resources on those populations and geographic areas that are most heavily impacted. Each of the FY2011 activities is geared toward focusing efforts where the epidemic is concentrated. As underscored by the data on Black Americans, however, targeted funding alone is not sufficient to alter the epidemic. There must be an equal emphasis on funding a combination of effective interventions that are proven to reduce HIV transmission at the individual and the population-level.

Step 2: Expand targeted efforts to prevent HIV infection using a combination of effective, evidence-based approaches.

The Strategy states, "our prevention efforts have been hampered by not deploying adequate overlapping, combination approaches to HIV prevention. Further, we have not consistently utilized the most effective, cost-efficient tools to prevent HIV or tools that will have a sustainable impact over the long term. Evaluating and employing multiple, scientifically proven methods will have a greater impact to keep people from becoming infected. Additional research can also help identify new prevention strategies and the most effective combination approaches to prevent new HIV infections."

Key FY 2011 Activities

To identify which interventions and practices are effective and how to deploy them in the most scalable way to have the largest impact on lowering HIV incidence, the Federal agencies are undertaking a number of important activities. Of critical importance are the following:

- **HHS is planning a comprehensive package of efforts in the 12 highest prevalence jurisdictions in the United States.**

  A significant component of the HHS Operational Plan is the "HHS Twelve Cities Project," an effort to support comprehensive HIV/AIDS planning and cross -agency response in 12 communities hit hard by HIV/AIDS. The project is anchored by and builds on a CDC funding announcement to undertake Enhanced Comprehensive HIV Prevention Planning (ECHPP). The ECHPP initiative will help jurisdictions identify and address gaps in scope and reach of HIV prevention interventions and strategies among high risk populations, especially gay and bisexual men and transgender persons, Black Americans, Latino Americans, and substance users. These 12 metropolitan statistical areas account for 44% of the total estimated persons living with AIDS in the United States.

Twelve Jurisdictions with the Highest AIDS Prevalence in the United States

2007 Rank	MSA/MD	2007 Estimated AIDS Prevalence
1	New York Division	66,426
2	Los Angeles Division	24,727
3	Washington, D.C. Division	15,696
4	Chicago Division	14,175
5	Atlanta-Sandy Springs-Marietta, GA	13,105
6	Miami Division	12,732
7	Philadelphia Division	12,469
8	Houston-Baytown-Sugar Land, TX	11,277
9	San Francisco Division	11,026
10	Baltimore-Towson, MD	10,301
11	Dallas Division	7,993
12	San Juan-Caguas-Guaynabo, PR	7,858

The jurisdictions targeted by CDC's Enhanced Comprehensive HIV Prevention Planning (ECHPP) initiative had the highest AIDS prevalence in the United States in 2007. The surveillance data that formed the basis for this list can be found at http://www.cdc.gov/hiv/surveillance/resources/reports/2008report/index.htm. HHS's Twelve Cities Project is focused on these same communities. Please note that while the project refers to "cities" the selection criteria were based on data for the surrounding metropolitan statistical area (MSA) or metropolitan division (MD) .

The HHS 12-city initiative actively engages CDC, HRSA, SAMHSA, NIH, IHS, CMS, and other federal partners. This cross departmental effort will support innovation and evaluation in a number of areas, including:

- support coordinated planning for HIV prevention, care and treatment in each of the 12 jurisdictions, including a complete mapping of federally-funded HIV/AIDS resources in each jurisdiction;
- assess the current distribution of HIV prevention, care, and treatment resources in each of the 12 jurisdictions with special emphasis on program coverage, scale and effectiveness;
- identify and address local barriers to coordination across HHS grantees;
- develop cross-agency strategies for addressing gaps in coverage and scale of necessary HIV prevention, care and treatment services;
- coordinate the implementation of strategies and interventions addressing HIV prevention, care and treatment;

- develop the capacity to deliver strategies and interventions addressing HIV prevention, care, and treatment;
- develop common measures and evaluation strategies to assess process and impact outcomes as they relate to the goals of the Strategy;
- actively promote opportunities to blend services and, where appropriate, funding streams across Federal programs; and,
- develop and apply lessons learned in these 12 jurisdictions to federally funded activities in other jurisdictions, including creating technical guidance on the development of statewide plans, as called for in the Strategy.

- **NIH and CDC will pilot the evaluation of effective combination prevention strategies.**

  Scientists will continue to strive to develop effective biomedical and behavioral prevention strategies, including vaccines, microbicides, and the use of treatment as prevention. While research on prevention strategies has made important advances, we have incomplete knowledge about how to synergistically combine proven interventions to magnify both individual effectiveness and community-level impact. The diversity of high risk populations and the differences in prevention needs and other issues mean that the most effective combinations of interventions will vary by population group. In other words, the best combination of effective interventions for heterosexual injection drug users may not be the same set of interventions to prevent HIV among gay and bisexual men.

  In FY 2011, NIH and CDC will pilot the evaluation of combinations of effective strategies for preventing HIV acquisition, encouraging testing for HIV, and ensuring access to treatment and appropriate care—especially for vulnerable populations. This project will add to the knowledge gained in the HHS Twelve Cities Project and CDC's ECHPP initiative to move us forward.

- **Selected other critical agency activities for FY 2011**

  A. Improving the effectiveness of current programs

  - In FY 2011, HHS OASH/OHAP will begin to restructure how the Minority HIV/AIDS Initiative (MAI) Fund is used by targeting MAI Fund dollars within minority communities disproportionately impacted by the HIV epidemic in order to more effectively support activities outlined by the Strategy that reduce HIV incidence.
  - CDC will prioritize those Diffusion of Effective Behavioral Interventions (DEBI) targeting high-risk HIV-negative individuals that have demonstrated biologic outcomes (e.g. reduced rates of HIV/STD acquisition) or have reduced risk behaviors at the community-level. All available and effective behavioral interventions that reduce risk behaviors among previously diagnosed positives in clinical and non-clinical settings will be prioritized.
  - OGAC will share data from mathematical modeling activities and demonstration projects that are investigating successful combination HIV prevention methods.

B. Integrating HIV testing into existing programs

- SAMHSA will conduct a needs assessment of the HIV testing capacity and frequency in SAMHSA funded drug-treatment and appropriate mental health centers and will use the results from the assessment to determine areas for expanding HIV testing capacity in SAMHSA funded drug-treatment and appropriate mental health centers.
- VA will encourage mental health and substance use disorder clinics to offer voluntary HIV testing to all Veterans in health care.
- HRSA will support an assessment of HIV testing capacity and frequency in community health centers across the United States. Results from this assessment will be presented to the HHS OASH along with specific, time-phased recommendations for expanding HIV testing capacity in federally-funded community health centers.

Significance of FY2011 Activities Toward Reaching 2015 Goal

Significant resources are devoted to HIV prevention and care in the United States each year. Although our Nation funds multiple efforts each year to prevent HIV infection, some funded activities have little or no effect on the epidemic. In order to effectively combat the epidemic, we must ensure that resources are devoted to those activities that will reduce HIV incidence. This requires a Federal-wide shift from non- or less successful programs to successful programs that are scaleable and will meaningfully reduce HIV infection.

Step 3: Educate all Americans about the threat of HIV and how to prevent it.

One of the key tenets of the Strategy is to focus public investments to achieve maximal response. Many people believe that HIV is no longer a priority or an issue that will affect them personally; however, we must ensure that all Americans are provided with clear information about how to avoid HIV infection. Recent data underscore the need for education activities for the general public. A 2009 Kaiser Family Foundation survey reported that 30% of Americans believed that HIV could be transmitted from sharing a glass of water, swimming in a pool with a person with HIV, or from a toilet. Shockingly, the percentage of Americans with these misperceptions has not changed since 1987. As the Strategy acknowledges, some people living with HIV still face discrimination in many areas of life including employment, housing, provision of health care services, and access to public accommodations. These experiences perpetuate HIV-related stigma which hinders our education efforts. All Americans must have access to a common baseline of information about the current HIV epidemic. This baseline includes knowing how HIV is and is not transmitted, knowing which behaviors place individuals at the highest risk, and promoting a compassionate response that upholds the rights and dignity of people living with HIV.

Key FY 2011 Activities

In order to better educate Americans about the threat of HIV/AIDS and how to prevent it, the Federal agencies have initiated key strategies, including the following:

- **Agencies will actively prioritize education efforts—emphasizing that HIV prevention is everyone's responsibility.**
  - The VA will expand its social marketing and educational campaign to better target high-risk veteran populations. The VA will also hold focus groups in high-risk communities to ensure

that social marketing messaging is geared towards these communities of interest and to maximize the impact.

- The HHS OASH/OWH will launch a national STD awareness social marketing campaign to empower teen girls to make informed decisions about sexual activity so as to reduce sexually transmitted diseases, including HIV, and minimize their serious health consequences, including cancer and infertility.
- CDC will continue to implement the *Act Against AIDS* campaign to provide all Americans with information about the threat of HIV and how to prevent it, and to improve the ability of health care providers to provide appropriate HIV screening and prevention services. Emphasis will be placed on efforts that reach communities most heavily affected (i.e., Black Americans, Latinos, gay and bisexual men). Existing and new campaigns will include effective communication, mobilization, and outreach activities.

Significance of FY2011 Actions Toward Reaching 2015 Goal

The emphasis on HIV education efforts have waned over the past decade. It is important to provide Americans with the necessary knowledge and tools to prevent HIV transmission. Federal efforts are only a part of the national response. Businesses, foundations, and other private sector and community partners have important roles in helping to ensure that all Americans are knowledgeable about HIV and how to lower their risk of becoming infected and support their communities in responding to the epidemic.

Increasing Access to Care

The implementation of the Strategy is intended to complement the implementation of the *Affordable Care Act*, which will greatly expand access to insurance coverage for people living with HIV and provide a platform for improvements in health care coverage and quality. As the new law takes effect, Federal agencies and State, Tribal, local and community partners will need to ensure that people living with HIV and HIV health care providers are included in the various initiatives that seek to improve the quality of care and integration of services. Implementation is beginning at a time that has witnessed several significant research advances that create new and expanded opportunities for preventing HIV infection and improving access to care. While research has already brought us a long way, continued and sustained research is needed to develop safer, less expensive, and more effective treatments and drug regimens for HIV and its co-infections, co-morbidities and clinical complications, including those related to AIDS and aging, as well as to evaluate new approaches to meeting HIV treatment needs as well as HIV-treatment related needs (e.g. housing, transportation).

To take advantage of the current opportunities, the Strategy identifies three action steps related to increasing access to care:

- Step 1: Establish a seamless system to immediately link people to continuous and coordinated quality care when they are diagnosed with HIV;
- Step 2: Take deliberate steps to increase the number and diversity of available providers of clinical care and related services for people living with HIV; and

- Step 3: Support people living with HIV with co-occurring health conditions and those who have challenges meeting their basic needs, such as housing

Step 1: Establish a seamless system to immediately link people to continuous and coordinated quality care when they are diagnosed with HIV.

The Strategy says, "While a decision about when to start treatment must remain voluntary and require an individual to be ready to start a long-term regimen, growing evidence suggests that early initiation of treatment leads to improved outcomes. To achieve this clinical goal requires that people are identified soon after their infection and systems are put in place to link them to care." In recent years, the Nation has implemented a number of policies and initiatives to expand access to HIV testing and screening. This investment must continue with a renewed emphasis on identifying undiagnosed HIV-positive individuals. Our system has often fallen short in ensuring immediate access to culturally-relevant, quality care. We must recognize that some individuals need a variety of supports to get them into care and help them to remain in care and adherent to their treatment regimens.

Key FY2011 Activities

To strengthen the capacity of our health system to link and maintain people living with HIV in quality care, the following are especially significant activities:

- **CMS will support States trying to maximize opportunities for using Medicaid to effectively serve people living with HIV/AIDS.**

  Medicaid is the cornerstone of the health care system for people living with HIV and is the single largest source of care for this population. Before enactment of the Affordable Care Act, most people with HIV were only eligible for Medicaid because they had low incomes and were permanently disabled due to an AIDS diagnosis, with limited exceptions. Under the Affordable Care, beginning in 2014 all people with income under 133 percent of the Federal poverty level will have access to Medicaid, providing a significant expansion of insurance coverage for people living with HIV. The Affordable Care Act also includes key provisions that provide States with immediate options to extend coverage (at current Medicaid Federal matching levels) to low-income adults without a disability. While not all States are likely to take advantage of this flexibility, it provides an important new pathway before 2014 for States to extend Medicaid coverage to people living with HIV who do not yet have an AIDS diagnosis.

  In FY 2011, CMS will publish a tool kit letter reminding States and stakeholders about various Medicaid options available to increase access and improve care coordination for people with HIV/AIDS. Some of these options include Medicaid 1115 waivers, 1915(c) home and community based services waivers and the Affordable Care Act's health home option (under which certain Medicaid beneficiaries participate in a coordinated and comprehensive health care partnership with physicians). To help States pursue these options, CMS will provide guidance on simplifying the submission of waivers to provide Medicaid coverage to people living with HIV/AIDS; expediting the application review process; and providing technical assistance opportunities for State Medicaid directors and their staff. In addition, CMS will collaborate with HRSA to explore options for evaluating the key components of comprehensive, coordinated Ryan White HIV/

AIDS program-funded care to determine if these elements can be identified and replicated within Medicare and Medicaid.

- **DOJ, VA, and HHS will implement activities to improve community re-entry for people living with HIV leaving correctional institutions and take other steps to improve care quality in correctional settings.**

  Currently, nearly 80% of HIV-positive prisoners under BOP care are have undetectable viral loads. Unfortunately, there is no guarantee that parolees will continue to have access to care once released from Federal facilities. In FY 2011, BOP will issue guidance for all prisons to provide discharge planning to effectively link HIV-positive persons to care after release from prison. BOP is hiring Re-entry Affairs Coordinators (RACs), whose primary duty is to coordinate efforts and develop resources to assist inmates' reintegration back into the community.

  The VA, through its incarcerated Veterans program, will expand HIV testing to Veterans being re-integrated into the community and ensure they are linked to health care in a timely manner. A particular area of focus is provision of care for HIV-positive persons cycling in and out of jail (rather than prison) settings. The relatively short period of time that jailed individuals are in custody make the provision of care during incarceration and after release particularly challenging. In FY 2011, HRSA will disseminate findings of a four year project ("Enhancing Linkages to HIV Primary Care and Services in Jail Settings"), which will aid in the development of "best practices" to link persons with HIV/AIDS in jail settings to care, as well as linking newly released HIV-positive persons into care. These findings will be reviewed by BOP and the agency will share these and other findings with the National Commission on Correctional Healthcare as well as the American Correctional Association.

  HHS OASH/OMH will continue to support the HIV/AIDS Health Improvement for Re-Entering Ex-Offenders (HIRE) programs. HIRE funds community networks designed to bridge healthcare gaps and improve HIV/AIDS health outcomes for ex-offenders re-entering the mainstream population. To improve collaboration and program efficiency, BOP and HRSA will partner with OASH/OMH to coordinate re-entry efforts that each agency is implementing in similar jurisdictions.

- **Selected other critical agency activities for FY 2011 include:**
  - HRSA and CDC will continue to support a six-clinic, multi-year evaluation of interventions designed to increase HIV-positive client appointment attendance among patients at risk of missing scheduled appointments. The current phase of this project is a randomized controlled trial which compares two interventions designed to increase retention in HIV care to standard HIV clinical care.
  - HRSA will develop a guide with lessons learned on model practices for engaging and retaining underserved, hard-to-reach, HIV-positive persons in medical care. The content of this guidance will derive from the "Targeted Outreach and Intervention Model Development Initiative", a six-year, multi-site evaluation conducted in community and clinical settings. Training curricula will be developed and disseminated to grantees and other HHS agencies.

- HHS OASH/OPA will facilitate linkages to HIV care for clients who test positive in Title X Family Planning Clinics through staff training, formalizing referral agreements, and improving data and surveillance systems.
- VA will continue to use technology opportunities such as telehealth to improve HIV health care in remote locations. VA will consider supporting pilot programs to improve health care to rural Veterans with HIV.
- HUD will share information on model HIV housing efforts that support re-entry efforts through planning and coordination to promote stable housing outcomes.

Significance of FY2011 Activities Toward Reaching 2015 Goal

Each of the listed agency activities are directly related to providing continuous and quality care for people living with HIV. Engaging people living with HIV in continuous and quality care not only improves their health outcomes, but provides opportunities to counsel people living with HIV about starting and adhering to therapy regimens, as well as reducing risk behaviors with sexual partners.

Step 2: Take deliberate steps to increase the number and diversity of available providers of clinical care and related services for people living with HIV.

As the Strategy indicates, in order to improve health outcomes, "we need to adopt policies that will produce a workforce that is large enough to care for all people living with HIV, is diverse, has the appropriate training and technical expertise to provide high-quality care consistent with the latest treatment guidelines, and has the capacity, through shared experiences or training, to provide care in a non-stigmatizing manner and create relationships of trust with their patients."

Key FY2011 Activities

In an effort to expand the HIV workforce and to increase cultural competency, the lead Federal agencies will undertake the following steps:

- **HRSA will actively work toward developing specific strategies to strengthen the current provider workforce to improve quality of care for people with HIV/AIDS.**
  - HRSA's Bureau of Health Care Professions, will provide training on the Strategy and the Federal Implementation Plan to all project officers and subsequently develop an action plan to work with schools of medicine, dentistry, nursing, pharmacy, and other allied health professions to implement changes that will improve the quality and content of HIV-related curricula with special emphasis on health disparities and evolving co-morbidities of various U.S. populations living with HIV/AIDS.
  - HRSA's HIV/AIDS Bureau will fund eight regional AIDS Education Training Centers (AETCs) to provide specific training, technical assistance, and ongoing consultation to providers who are caring for American Indian/Alaska Native populations. AETCs will collaborate with the IHS to achieve the following goals: improve/enhance HIV diagnostic opportunities; establish and maintain robust linkages to care and treatment; and help ensure high-quality, culturally competent treatment.

  - HRSA's HIV/AIDS Bureau will identify and disseminate "best practices" in caring for male and female Hispanic/Latino clients obtained from a qualitative assessment of "exemplary" HIV service providers in six states serving substantial populations of Hispanics/Latinos. These best practices will encompass clinical strategies, administrative actions, and organizational practices.

- **The VA will take steps to increase the HIV-competency of its providers.**

  The VA will continue to train primary care providers, women's health care providers, mental health providers, and substance use providers to provide HIV related services such as routine HIV testing to all Veterans in health care at least once in a lifetime, and at least annually for those with on-going risk factors. In addition, VA will provide educational opportunities about updates in HIV treatment and co-morbid health care to these VA health providers.

- **OGAC is using effective strategies to expand the health care workforce.**

  OGAC will share lessons learned to expand healthcare providers in resource poor settings and rural areas through various activities (e.g. task shifting). Through these efforts, health care workers are trained to engage in targeted tasks that alleviate the burden on doctors and nurses, thus expending the reach of the health care system.

Significance of FY2011 Activities Toward Reaching 2015 Goal

Having access to care does not guarantee quality care for people living with HIV. As people living with HIV have more options for the provision of their care through health care reform, it is more important than ever to educate providers about HIV care. These FY 2011 actions outlined by agencies are initial steps toward educating and improving the provider base for people living with HIV. We intend to build upon these actions in ensuing years.

Step 3: Support people living with HIV with co-occurring health conditions and those who have challenges meeting their basic needs, such as housing.

HIV care is more than health care. The Strategy explains that "access to housing is an important precursor to getting many people into a stable regimen that will improve their health. Individuals with HIV who lack stable housing are more likely to delay HIV care, have poorer access to regular care, are less likely to receive optimal antiretroviral therapy, and are less likely to adhere to therapy." Besides housing, the Strategy recognizes that transportation, food and nutrition, a sustainable income, childcare, mental health services and substance use treatment, safety from intimate partner violence, and other factors influence health outcomes for people living with HIV.

Key FY2011 Activities

- **In order to provide important ancillary services to support people living with HIV/AIDS, Federal agencies will engage in the following activities in FY 2011:**
  - HUD will continue efforts with other Federal HIV programs and providers to improve HIV housing and service integration by identifying models of coordinated service delivery and expanding the use of the Homeless Management Information Systems (HMIS) client-level

data elements, as currently used by HUD and SAMHSA homeless programs, and as proposed for use by Veterans Affairs.

- HRSA will develop and disseminate technical guidance on how to integrate buprenorphine treatment, for opioid abuse, into HIV primary care settings.
- SSA will continue to promote various initiatives that support beneficiaries with disabilities (including qualified people living with HIV), such as the Ticket to Work program , the Work Incentives Planning and Assistance program, and the Protection and Advocacy Beneficiaries of Social Security program. SSA will also update its medical listing for HIV infection based on an Institute of Medicine review. The medical listings are used to expedite a determination of disability for applicants for Social Security disability benefits. Listings for HIV infection, as with other conditions, are intended to be updated periodically to ensure that disability determinations are made in accordance with clinical advances.
- HHS OASH/OMH will evaluate the "Linkage to Life" (L2L) program to assess its effectiveness in addressing gaps in healthcare, social and supportive services for high-risk minority families living with HIV/AIDS (or at high risk for HIV) who are in transition from incarceration, domestic violence situations and/or substance abuse treatment.
- EEOC's Office of Federal Operations will meet with Office of Personnel Management to explore ways to increase federal employment opportunities for people living with HIV.

Significance of FY2011 Activities Toward Reaching 2015 Goal

Supporting people living with HIV with essential services is paramount and providing non-medical services can be critical in order to improve individual health outcomes and meet public health goals. One of the distinguishing aspects of the Strategy is the importance of bringing together agencies across the Federal level to partner with HHS to address the various needs of people living with HIV. The FY2011 actions of HUD, HHS, SSA, and EEOC are important steps toward providing a safety net for people living with HIV that spans across Federal agencies.

Reducing HIV-Related Disparities

HIV exists within a health care system where different groups have varying access to services—and achieve varying health outcomes. Significant disparities in access to prevention and care services, clinical outcomes, and knowledge of health protective behaviors have been well documented on the basis of race/ethnicity, gender, socio-economic status, sexual orientation, homelessness, and other characteristics across the field of medicine. The transmission of HIV has long been concentrated in groups that have been marginalized or underserved, and we also know that some groups are far less likely to know their HIV-positive serostatus or have appropriate access to quality care consistent with the latest clinical practice standards. These inequities are manifested by people coming into care late in the course of their illness, poorer clinical outcomes, and earlier death. We know that Black Americans and Latinos are more likely to die from HIV compared to whites, and that the majority of all AIDS deaths in the U.S. have occurred among gay and bisexual men. The Strategy calls for a concerted national effort to

increase engagement and service delivery capacity of whole communities to prevent HIV and support community members living with HIV.

The Strategy identifies three actions steps for reducing HIV-related disparities:

- Step 1: Reduce HIV-related mortality in communities at high risk for HIV infection;
- Step 2: Adopt community-level approaches to reduce HIV infection in high-risk communities; and,
- Step 3: Reduce stigma and discrimination against people living with HIV.

Step 1: Reduce HIV-related mortality in communities at high risk for HIV infection.

The Strategy highlights that in addition to health outcomes research and combination prevention strategies, there needs to be community level approaches to "altering the conditions in which HIV is transmitted and addressing factors that influence disparate health outcomes among people living with HIV, including lessening stigma and discrimination."

Key FY2011 Activities

- **HHS and VA will take a variety of steps to reduce HIV-related mortality in communities at highest risk, including the following:**
  - NIH will initiate new programs to support a comprehensive therapeutics research program to design, develop, and test drugs and drug regimens to maintain long-term undetectable viral load, overcome drug resistance and treatment failure and eradicate persistent viral reservoirs that may lead to a potential or functional cure for HIV disease.
  - CDC will review and assess the quality of data measuring community viral load (CVL); following this process, technical guidance on the collection and use of CVL data will be developed and disseminated to health departments. Working with health department and other public health leadership, collaborative strategies will be developed to leverage resources so as to increase capacity to measure CVL. These strategies will include targeted training and technical assistance to health department grantees supporting the implementation and adoption of high-quality CVL monitoring.
  - VA will continue to routinely collect data on viral load and CD4 counts for all Veterans with HIV receiving VA health care.
  - HRSA will develop a guide with lessons learned on model practices for engaging and retaining underserved, hard-to-reach, HIV-positive persons in medical care. The content of this guidance will derive from the "Targeted Outreach and Intervention Model Development Initiative", a six-year, multi-site evaluation conducted in community and clinical settings. Training curricula will be developed and disseminated as a component of the guidance document.

Significance of FY2011 Activities Toward Reaching 2015 Goal

Over the past 30 years, an HIV diagnosis has changed from a poor prognosis to the possibility of many additional years of life. These advances are, in large part, due to investments in research that led to the development of an array of effective medications designed for people living with HIV. The Strategy unequivocally supports biomedical research and these activities will continue in FY2011. The past year has witnessed extraordinary advances in our ability to monitor population-level measures, such as CVL. Viral load is associated with clinical outcomes for people living with HIV and predicts new HIV cases in particular localities. We can monitor CVL and when we lower it, it is likely that we are reducing the number of new infections. Ensuring that all viral load values, including undetectable, are reportable across localities will provide important information that can improve care for people living with HIV and reduce HIV-related mortality.

Step 2: Adopt community-level approaches to reduce HIV infection in high-risk communities.

As the Strategy emphasizes, "in order to reduce disparities [in infection rates] among groups, we need effective approaches to reduce the risk of HIV transmission not only at the individual level but at the community level. "Unfortunately, there are very few community models that have made demonstrable impact on the domestic HIV epidemic. Part of the failure of existing community models is the unilateral nature of their approach and the lack of a coordinated effort across various agencies at the Federal and local level. Coordination across agencies and levels of government, along with participation of local communities, is crucial to make a community impact. It is also crucial to use HIV surveillance data to gauge progress in combating HIV and to help pinpoint which communities need more intensive HIV prevention efforts. Last, it is imperative that we continue to fund studies to help us better understand the various social drivers of HIV risk in particular communities.

Key FY 2011 Activities

- **Federal agencies will take numerous actions that may have public health impact, including the following:**
  - The HHS Twelve Cities Project will support comprehensive HIV/AIDS planning and cross-agency response in the 12 communities most impacted by the epidemic in our nation. A hallmark of this initiative is the inclusion of all HHS agencies working toward common goals. New and existing resources, including funds from the Minority AIDS Initiative will be used to supplement these efforts.
  - NIH will continue with existing and undertake new collaborations with other Federal partners to support studies defining social processes (e.g., mobility, migration, resilience, etc.) and structural factors (e.g. housing, employment, access to substance use treatment, access to health care, etc.) that mediate risk of HIV infection.
  - HHS and CDC will publicize opportunities for communities to procure important resources that can have a public health impact (for example, Community Transformation Grants authorized by the Affordable Care Act).

- VA will develop a process to share de-identified HIV viral load information by region with CDC or other lead Federal agencies in an attempt to measure community viral load.

Significance of FY2011 Activities Toward Reaching 2015 Goal

In addition to important potential prevention strategies such as vaccines and microbicides and other interventions for individuals at risk of HIV infection, prevention interventions are also needed to address interpersonal, community, and structural factors that affect HIV transmission. An important component to realizing the goals of the Strategy is to incorporate more HIV prevention interventions that have a community-level impact. The FY2011 actions are important steps toward combining individual-level approaches to HIV prevention with those that embrace a broad social context recognizing the importance of structural and community-level interventions.

Step 3: Reduce stigma and discrimination against people living with HIV.

People with HIV/AIDS still face stigma and discrimination, which as the Strategy indicates, "undermines efforts to encourage all people to learn their HIV status, and it makes it harder for people to disclose their HIV status to their medical providers, their sex partners, and even clergy and others from whom they may seek understanding and support."

Key FY 2011 Activities

- **DOJ will enforce civil rights laws that outlaw HIV/AIDS-related discrimination:**

  DOJ will increase outreach to affected communities to educate them about their rights and to uncover discrimination. In addition, DOJ will proactively open all investigations of discrimination charges involving HIV as *priority* investigations, meaning that claims of discrimination on the basis of HIV will be actively reviewed. Just recently, DOJ reached a settlement with Wales West LLC, owner and operator of Wales West RV resort in Alabama, resolving a case of HIV discrimination in Alabama. In the complaint, DOJ alleged that Wales West violated Title III of the Americans with Disabilities Act (ADA) when it unlawfully denied full and equal services to a child and his family because the child has HIV.

  DOJ will provide technical assistance to States reassessing HIV criminal statutes in order to align more closely with public health. DOJ will also convene other Federal partners to explore possible actions to address HIV criminalization laws.

- **DOL and EEOC will enforce civil rights laws that outlaw HIV/AIDS-related discrimination in employment and work to ensure that people with HIV/AIDS are not subject to discriminatory, stigmatizing treatment based on unfounded fears and stereotypes:**

  DOL's Office of Federal Contract Compliance Programs will develop a memorandum to its field offices regarding prioritizing and tracking investigations of employment discrimination complaints involving HIV/AIDS. In addition, compliance evaluations will include the investigation of possible employment discrimination involving HIV/AIDS discrimination.

  EEOC enforces Title I of the ADA, which prohibits employers from discriminating against qualified individuals with disabilities in job application procedures, hiring, firing, advancement, compensation, job training, and other terms, conditions, and privileges of employment. An

employer is also required to make reasonable accommodations to afford equal opportunities to qualified applicants or employees with disabilities if it would not impose an "undue hardship" on the operation of the employer's business. In FY 2010 EEOC received 250 charges of HIV/AIDS-related disability discrimination. In the first quarter of FY 2011 EEOC has settled three lawsuits concerning HIV/AIDS-related discrimination and filed one new suit seeking redress for a person who experienced such discrimination.

- **DOL and EEOC will educate employers and employees about employee's rights:**

  DOL and EEOC will continue to develop public education materials on employee rights and will post educational materials on their website and send these materials to field offices to be used during compliance assistance seminars, investigations and outreach. In addition, DOL and EEOC will develop outreach and educational materials regarding the employment rights of individuals with HIV/AIDS. This will include incorporation of HIV/AIDS discrimination into staff training related to disability complaints, and hosting of webinars related to this issue.

  EEOC will increase outreach to both employers and the public to educate them about their rights and responsibilities under the law. EEOC will also task each of their 25 field outreach program coordinators to enhance their partnerships with organizations that educate and provide services to persons with HIV/AIDS to ensure that these organizations know about the prohibitions against employment discrimination.

  DOL will provide targeted HIV/AIDS resources to employers and employees through the Job Accommodation Network and work with HIV/AIDS partner agencies, stakeholders and other organizations to ensure that this resource is utilized in an efficient and effective manner.

  DOL will continue to engage and educate employers and employees about employees' rights under the Family and Medical Leave Act (FMLA). Under FMLA, eligible employees would be entitled to leave for absences due to HIV/AIDS. DOL will ensure that needs of people with HIV/AIDS are fully considered as it develops and implements its workplace flexibility initiative.

- **HHS will take the following actions:**

  NIH will continue to support a series of ongoing studies investigating how stigma and discrimination may prevent at-risk populations, including racial/ethnic minorities, gay and bisexual men, prisoners, formerly incarcerated individuals, and high-risk heterosexual men and women (e.g., men and women who use drugs or have been incarcerated or have incarcerated partners, and women in sexual and social networks with elevated viral load) from accessing HIV testing and treatment. The goal of these efforts is to develop culturally appropriate HIV prevention and treatment interventions to overcome these barriers.

  The HHS Office for Civil Rights, will continue to provide information to the public (via web, brochures, national meetings, and other outreach events) on the civil rights and the health information privacy rights of people living with HIV/AIDS and will continue to investigate and take action on complaints alleging discrimination against people living with HIV/AIDS by health care providers and human service agencies and on complaints alleging violations of the health

information privacy rights of people living with HIV/AIDS by health care providers and health plans.

- **Selected other critical agency activities for FY 2011 include:**
  - HHS Office for Civil Rights and DOJ will continue to closely coordinate on investigation and prosecution of HIV/AIDS-related discrimination complaints and HHS Office for Civil Rights will, when appropriate, defer complaint investigations and prosecutions to DOJ.
  - HUD will provide guidance to Federal agencies promote equal access to housing and to address issues of stigma as seen in housing discrimination facing lesbian, gay, bisexual, and transgender (LGBT) persons.
  - OGAC will provide information on HIV stigma reduction initiatives from international settings that may be applicable to the US context.

Significance of FY2011 Activities Toward Reaching 2015 Goal

Realizing the goals of the Strategy will not be possible unless there are serious efforts to reduce HIV stigma. These are the first of several steps that will be taken in the next few years to address HIV-related stigma.

Achieving a More Coordinated National Response

Across the Federal agencies and among other partners, there is a strong sense that the Strategy presents an opportunity to make major progress at improving our national efforts to end the HIV epidemic. We have never had more tools or a better understanding of what works effectively in fighting HIV. Further, the past year has been among the more fruitful in the history of the epidemic in producing research discoveries that have furthered our knowledge about how to prevent and treat HIV. As we enter our fourth decade of living with HIV/AIDS, and as we focus on maintaining and bolstering our national response, maximizing collaboration and synergies across Federal agencies and through community partnerships has never been more important. Since our ultimate success at ending the domestic HIV epidemic depends on the American people understanding the urgency of the challenge and remaining supportive of our prevention and treatment investments, a priority must be placed on communicating to the public the progress we are making.

The Strategy identifies two actions steps for coordinating the national response to the HIV epidemic:

- Step 1: Increase the coordination of HIV programs across the Federal government and between Federal agencies and State, Territorial, Tribal, and local governments.
- Step 2: Develop improved mechanisms to monitor and report on progress toward achieving national goals.

Step 1: Increase the coordination of HIV programs across the Federal government and between Federal agencies and State, Territorial, Tribal, and local governments.

The Strategy emphasizes that "we need to integrate services and reduce redundancy, encourage collaboration across different levels of government and with nongovernment partners, and ensure accountability for achieving positive results."

Key FY2011 Activities

- **ONAP is undertaking projects to improve interagency coordination and collaboration:**
  - *IOM Data Project:* In October 2010, ONAP announced that it had partnered with the Institute of Medicine to address gaps in data collection, analysis and integration of the care and treatment experiences of people living with HIV. The implementation of the Affordable Care Act and the development of the Strategy create a unique opportunity to dramatically improve access to insurance coverage and the quality of care, and the clinical outcomes achieved by people living with HIV. As we work toward full implementation of the Affordable Care Act in 2014, it will be useful to establish baseline measures and consider monitoring strategies to ensure that people living with HIV are receiving high quality, clinically necessary services designed to achieve optimal clinical outcomes. Over the next two years, IOM will convene a Study Committee to consider questions such as: what are the best sources of data (and which core data elements should be standardized) across public and private HIV care databases that track continuous care (and related services such as housing) for people living with HIV?; How can Federal agencies efficiently analyze data that are already being collected in order to improve HIV care quality?; and, What models or best practices in data system integration can be gleaned from Federal agencies or private industry to make existing data systems and core indicators interoperable? The IOM also will investigate and provide suggestions on how to obtain meaningful national level estimates of access to care and services utilization by people living with HIV. This new project will significantly support our collective efforts to implement and effectively measure our progress toward achieving the established metrics in the National HIV/AIDS Strategy and will support broader efforts to integrate people living with HIV in the implementation of the Affordable Care Act.

- **HUD is reviewing its funding formula to better target resources for people living with HIV/AIDS to where it is most needed.**

  As discussed earlier in this report, HUD will work with Congress to develop a plan to shift HIV/AIDS case reporting as a basis for formula grants for HOPWA funding. The provisions of the HOPWA statute reflected the nature of the AIDS surveillance information available in 1990. Revising the HOPWA formula based on current people living with HIV/AIDS would better target the distribution of housing assistance resources to communities based on a more targeted data set reflecting present need.

- **Several coordination activities were identified in the Agency plans, a few of which are highlighted below:**

A. Research and Surveillance

– In FY 2011, CDC, IHS, and NIH will convene one or more multi-disciplinary technical consultations to identify surveillance strategies and a research agenda to better characterize the extent and burden of HIV/AIDS among populations that represent a small share, nationally, of the U.S. epidemic, including: American Indians, Alaska Natives, Asian Americans, and Pacific Islanders.

– Based on new and emerging findings, NIH and CDC will collaborate in FY 2011 to develop research opportunities to investigate the social and behavioral factors that are likely to influence the roll-out, uptake, effectiveness and long-term impact of biomedical interventions like pre-exposure prophylaxis (PrEP), microbicides, and Test, Linkage to care and promotion of adherence ("Test and Treat").

– BOP will continue to collaborate with the Veteran's Administration for provision of viral load and CD4 cell lab testing.

B. Policy Actions

– In FY 2011, HHS OS, including ASL, will work with HRSA and senior Department leadership to develop a detailed Strategy—including legislative options, policy guidance, and programmatic steps-- to support states and jurisdictions in better managing AIDS Drug Assistance Program (ADAP) and pharmacy access programs.

– Building on current coordination efforts, EEOC will confer with DOL and DOJ to explore joint enforcement and education efforts to eliminate employment discrimination directed against people living with HIV/AIDS.

C. Education and Community Mobilization Efforts

– DOJ and EEOC will work together to create fact sheets on the rights of HIV-positive persons and the responsibilities of employers in the workplace.

– The HHS Center for Faith-Based and Neighborhood Partnerships and OASH, in partnership with counterparts from the Departments of Labor, Justice, Housing and Urban Development, Veterans Affairs, and Education, will develop a national outreach effort to engage faith and community-based leaders, organizations and members in promoting routine screening for HIV, with the primary goal of encouraging early diagnosis of HIV and a secondary goal of de-stigmatizing HIV and people living with HIV/AIDS, in order to promote early entry into care and support ongoing prevention efforts.

D. Improving Access to Care

– HUD will identify and disseminate successful models developed by HOPWA and other HUD grantees that enhance linkages to care, local provider collaboration and integrated service delivery.

- HUD will partner with other Federal agencies to promote the development of integrative, place-based approaches in community planning efforts.
- VA will collaborate with HRSA, CDC, HUD, and other relevant agencies to develop plans that support health care providers and other staff who deliver HIV-positive test results to Veterans, and to provide linkage to healthcare to all eligible Veterans at a VA medical facility.

Significance of FY2011 Activities Toward Reaching 2015 Goal

The individual agencies, at their core, are responsible for implementing programs or achieving policy objectives established by the Congress. For example, the Department of Justice is responsible for protecting the civil rights of Americans, including individuals living with HIV. The VA is responsible for protecting the health of Veterans, including the health of Veterans living with HIV. HUD's mission is to create strong, sustainable, inclusive communities and affordable quality homes for all. And, HHS is responsible for improving the health of the American people. Overly prescriptive coordination could serve to create new barriers to effective HIV programs and limit the ability of HIV experts to innovate effectively. Therefore, the focus of Federal efforts is to identify a manageable number of strategic areas where collaboration across agencies can have a big impact.

Step 2: Develop improved mechanisms to monitor and report on progress toward achieving national goals.

The Strategy says that "we need to measure the results of our efforts to reduce incidence and improve health outcomes to chart our progress in fighting HIV and AIDS nationally, and refine our response to this public health problem over time."

Key FY 2011 Activities

- **Several activities to monitor and report on progress were identified in the Agency plans, a few of which are highlighted below:**
  - In FY 2011 and beyond, OASH within HHS will serve as the central focus for coordination and monitoring of the HHS operational plan. In order to monitor and gauge progress toward achieving the Strategy goals, OASH will develop metrics to measure progress at various levels (i.e., Federal, State, Tribal, and local); develop standardized tools that can help agencies/staff offices conduct rigorous program evaluation; develop processes that will provide accurate information about how federal HIV/AIDS resources are being used at state, Tribal, and local levels; and convene a department wide retreat, in the 3rd quarter of 2011, to assess and critically review progress made and gaps remaining.
  - HUD will implement HUDStat, which is a new tool by which the agency promotes accountability, to monitor and evaluate each Office's contributions to achieving the Department's Strategic goals and activities, including those in the Strategy, in utilizing housing as a platform to improve health outcomes, increase economic security, and provide housing stability for vulnerable populations. The performance measures within HUDStat will be analyzed at the national, regional, community and grantee level and information will be shared with communities. HUD programs, including HOPWA, are working on data-driven

assessments allowing grantees to profile and assess their results, share insights, and identify where actions are needed to refine their programs.

- In FY 2011, VA will submit a progress report to ONAP on successes and challenges in achieving the goals of the Strategy. In addition, the VA will work with other relevant agencies to review progress annually and identify challenges and potential barriers to achieve Strategy goals.

HHS has produced a new baseline of information on how its resources are currently being allocated. These data are the first comprehensive review of HIV/AIDS resources from all HHS agencies and will provide a useful tool for agencies in making funding decisions. These data are also useful for policy makers and the public to track progress. HHS will compile these data again for FY2011 and each successive year to help gauge progress toward targeting populations most impacted by the epidemic and activities that will have the greatest impact.

Significance of FY2011 Activities Toward Reaching 2015 Goal

The President directed that we report annually on our national progress at meeting the goals of the Strategy. The Strategy identified a small number of metrics that we believe are aggressive, yet realistic. Further, we have committed to developing a small number of process measures over the next year to further measure whether the agencies are taking the steps needed to meet the outcome goals. The steps identified here lay the ground work for a new level of reporting and accountability.

IV. Timeline

The development and implementation of the Strategy is intended to be an ongoing process of evaluation and modification to ensure that the Nation is fully utilizing the tools, resources and opportunities for meeting the goals of the Strategy. Although every activity may not be completed at the outset and there may be barriers to coordination that must be solved creatively, the Federal government is committed to making the goals of the Strategy a reality across all agencies and all levels of government. We must ensure that we are putting in place flexible processes that allow for new ideas and creative thinking. Implementation is an iterative process where Federal and other stakeholders are constantly assessing and refining their efforts to achieve stable and constant goals and action steps laid out in the Strategy.

Implementing the National HIV/AIDS Strategy: Key Milestones and 2011 Priorities

2009

- **Public Input:** Engaged in an extensive information gathering and public engagement process. This included the White House holding 14 HIV/AIDS Community Discussions and HHS holding an additional 5 HIV/AIDS Community Discussions in locations across the United States and the territories.
- **HIV Federal Interagency Working Group:** Convened the Federal HIV Interagency Working Group of senior HIV leaders across the government to assist ONAP in reviewing public recommendations and developing the Strategy.

2010

- **Strategy Release:** Developed and released the *National HIV/AIDS Strategy* and the *Federal Implementation Plan*.
- **Ongoing Implementation:** President Obama issued a Presidential Memorandum designating lead Federal agencies and directing specific ongoing activities take place to implement the Strategy.
- **Agency Operational Plans:** Lead agencies developed and submitted agency operational plans. Departments of Defense and State and the EEOC submitted recommendations.

2011

- **HIV Federal Interagency Working Group:** ONAP will convene quarterly meetings of the Federal HIV Interagency Working Group to coordinate on Administration policy priorities and goals. Per Presidential directive, HHS will convene Federal agencies on a regular basis to identify and implement high impact collaborations across agencies.
- **Annual Reporting:** ONAP will work with OMB on a model for evaluating efforts and reporting annually to the President on progress in implementing the Strategy.
- **Process Measures:** ONAP will work with the Federal HIV Interagency Working Group to identify a small number of meaningful process measures to track progress of lead agencies in implementing the Strategy.
- **2012 Implementation Plan:** ONAP and HHS will coordinate efforts to work with Federal agencies on developing *Federal Implementation Plan* goals for 2012.
- **High Impact Collaborations:** HHS will work with other lead agencies on additional high impact collaborations.

V. Appendix

Agency Key Contacts

Department of Defense (DOD, OASD)	Lynn Pahland
Department of Housing and Urban Development	David Vos
Department of Labor	Maria Enchautegui
Department of Justice (DOJ)	Allison Nichols, John Wodatch, David Knight
Bureau of Prisons (BOP)	Christopher Bina
Department of Veterans Affairs (VA)	Maggie Czargonoski
Equal Employment Opportunity Commission (EEOC)	Brett Brenner, Jennifer Mathis
Department of State (OGAC)	Ann Gavaghan
Social Security Administration (SSA)	David Rust
White House, Office of Management and Budget (OMB)	Aaron M. Lopata, Tricia A. Smith
White House, Office of National AIDS Policy (ONAP)	James Albino, Chantelle Britton, Natalie R. Pojman, Gannet Tseggai

HHS Agency	Lead(s)
HHS ONAP Liaison	Greg Millett
Office of the Assistant Secretary for Health (OASH)	Ronald Valdiserri, Christopher Bates
Centers for Disease Control and Prevention (CDC)	Kevin Fenton, Jonathan Mermin
Centers for Medicare & Medicaid Services (CMS)	Caya Lewis
Health Resources and Services Administration (HRSA)	
HIV/AIDS Bureau (HAB)	Deborah Parham Hopson, Laura Cheever
Bureau of Primary Health Care (BPC)	Seiji Hayashi, Angela Powell
Indian Health Services (IHS)	Scott Giberson
National Institutes of Health (NIH)	Carl Dieffenbach, Tony Fauci, Wendy Wertheimer, Jack Whitescarve
Substance Abuse and Mental Health Services Administration (SAMHSA)	Gretchen Stiers

Budget Information for Federal HIV/AIDS Activities

Few agencies submitted budgets related to their HIV/AIDS activities in large part because HIV/AIDS activities are part of broader initiatives that include HIV/AIDS rather than dedicated funding for HIV/AIDS activities. BOP does not break down all of its spending on population groups, for example, but it does know that for FY 2010, HIV-related pharmaceutical costs were greater than $16 million, out of a total pharmaceutical budget of slightly more than $64 million.

Of the operational plans, HUD and HHS provided FY 2010 budgetary information that is described below. Please note that these numbers are only estimates that must be corroborated by the Office of Management and Budget and are not considered final until such review.

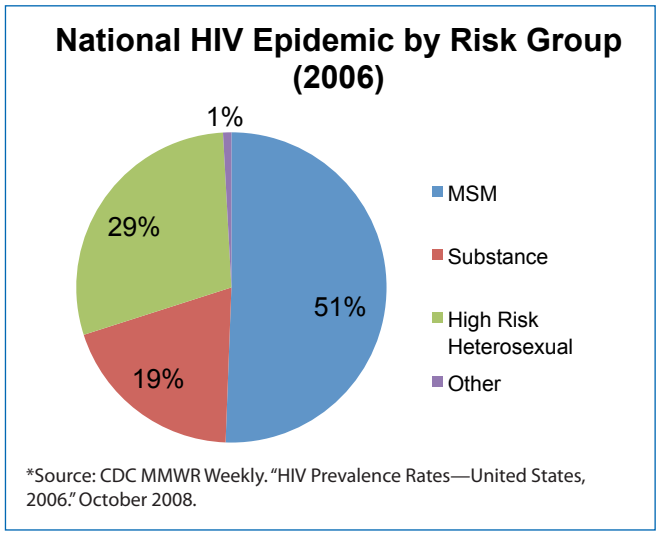
HUD reports that the Housing Opportunities for Persons with AIDS (HOPWA) program was allocated $335 million in FY2010: $298.5 million allocated per formula based on cumulative AIDS cases to 133 locales; $33 million funded continuing competitive grants with model approaches to housing PWAs or projects not covered under formula allocations; and, $3.35 million supported technical assistance and project management activities. People living with HIV/AIDS who are homeless and low income are not only served by the HOPWA program. People living with HIV/AIDS who qualify may also be eligible for various other HUD programs other than HOPWA.

HHS estimated that domestic FY 2010 HIV/AIDS funding totaled approximately $15.9 billion, the majority of which (77%) was devoted to HIV/AIDS care and treatment (62% through CMS and 15% through the HRSA Ryan White HIV/AIDS Program). Approximately 17% of total HIV/AIDS expenditures in FY2010 were devoted to research activities undertaken by the NIH, 5% were devoted to CDC, 1% was devoted to SAMHSA, and the remainder was shared among Food and Drug Administration, Indian Health Services, Agency for Healthcare Research and Quality (AHRQ) and HHS offices. A breakdown of how these funds were targeted by various demographic categories is detailed in the following pages.

FY 2010 HHS HIV/AIDS Resource Allocation by Risk Group

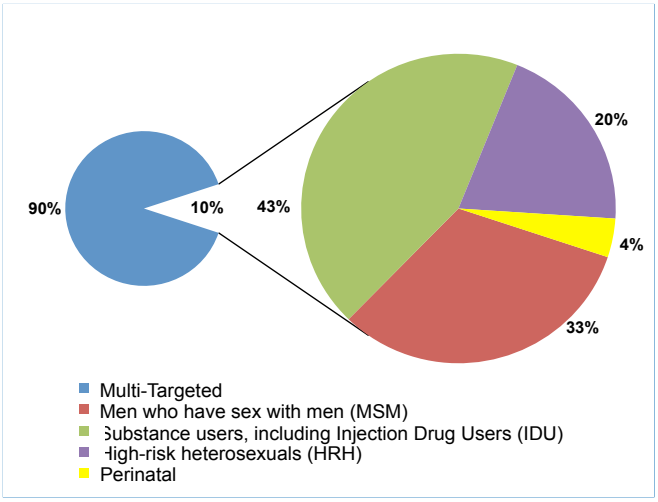
HHS FY 2010 Resource Allocation Baseline

- Approximately $910,000,000 was spent on HHS discretionary extramural activities in FY 2010 for HIV/AIDS activities funded by **CDC, SAMHSA, IHS** and **OS** Offices.
- Most (90%) of the **CDC, SAMHSA, IHS** and **OS** Office funding was multi-targeted. Of the remaining funds, 43% went to programs for substance users, 33% for men who have sex with men **(MSM)**, 20% for high-risk heterosexuals, and 4% to reduce perinatal transmission.
- **HRSA** data is presented in terms of number of Ryan White HIV/AIDS Program services visits in FY 2010. Please note that the **HRSA** data is representative of program beneficiaries (i.e., people with HIV/AIDS) and does not distinguish between targeted and multi-targeted funding.
- For **NIH**-funded intramural and extra mural behavioral and social science research, well over half (61%) of the research was multi-targeted.

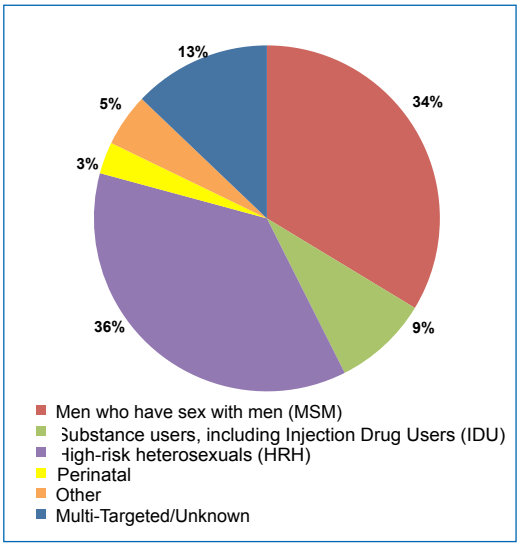


*Source: CDC MMWR Weekly. "HIV Prevalence Rates—United States, 2006." October 2008.

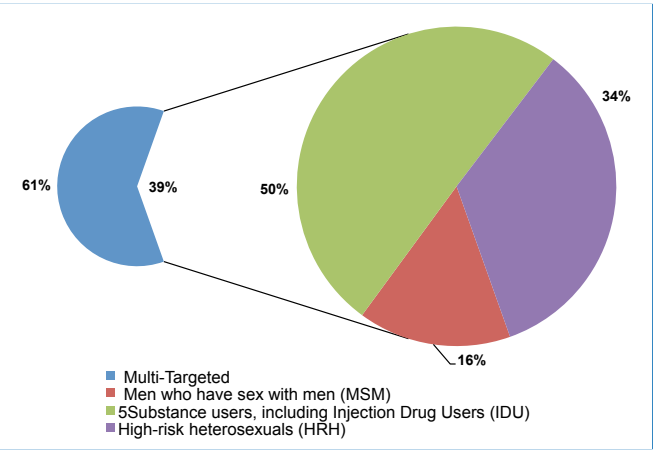
CDC, SAMHSA, IHS, OS, HIV/AIDS Funding,



HRSA, HIV/AIDS Funding



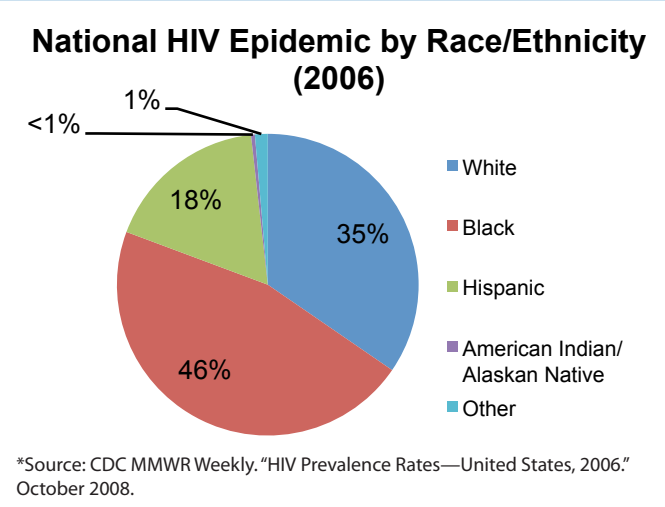
NIH, HIV/AIDS Funding



FY 2010 HHS HIV/AIDS Resource Allocation by Race

HHS FY 2010 Resource Allocation Baseline

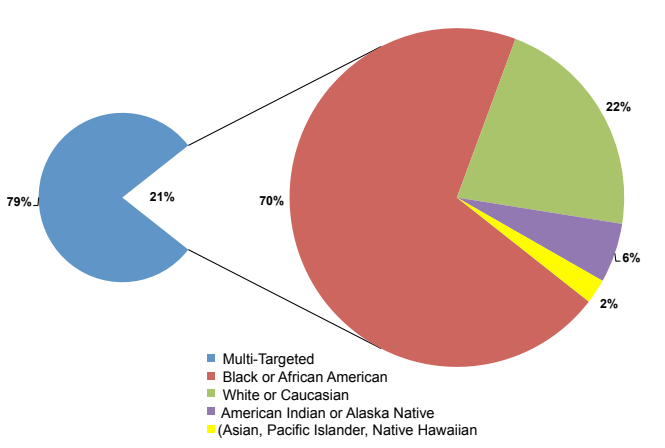
- Most of the HHS FY 2010 discretionary extramural funding for **CDC/SAMHSA/IHS/OS** ($910,000,000) was categorized as multi-targeted in terms of race and ethnicity.
- **HRSA** Ryan White HIV/AIDS Program service visits by race/ethnicity (Figure 4c) were distributed as follows: 47% Blacks, 27% Whites, 23% Latinos, 2% Asian/Pacific Islanders, and 1% American Indian/Native Alaskans. Please note that the **HRSA** data is representative of program beneficiaries (i.e., people with HIV/AIDS) and does not distinguish between targeted and multi-targeted funding.
- **CMS** data are presented in terms of number of HIV/AIDS beneficiaries (including approximately 76,000 dual beneficiaries in 2007) separately for **Medicare** (114,041 in CY2008, the most recent data available) and **Medicaid** (172,541 in CY2007, the most recent data available).



*Source: CDC MMWR Weekly. "HIV Prevalence Rates—United States, 2006." October 2008.

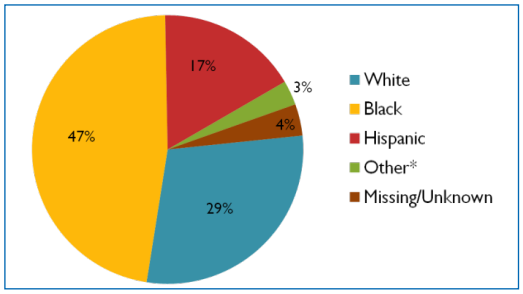
CDC, SAMHSA, IHS, OS

(FY 2010 HIV/AIDS Funding: Discretionary Extramural by Race)



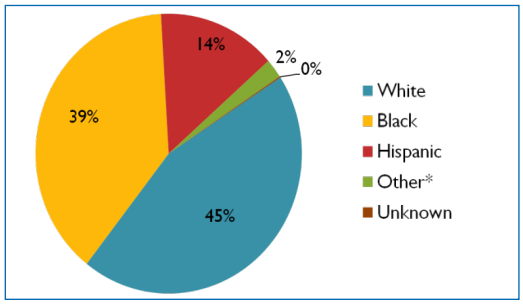
CMS/Medicare

(CY 2008 Number of HIV/AIDS Beneficiaries by Race/Ethnicity within Program, n=114,041)



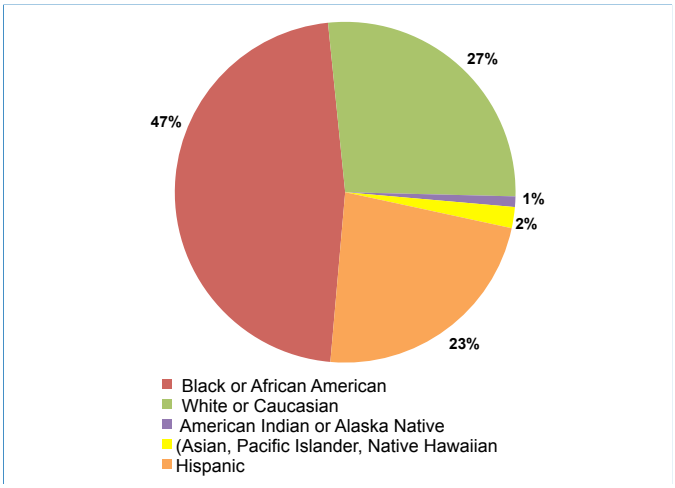
CMS/Medicaid

(CY 2007 Number of HIV/AIDS Beneficiaries by Race/Ethnicity within Program, n=172,541)



HRSA

(FY 2010 HIV/AIDS Service Visits by Race/Ethnicity, n=855,230 visits)

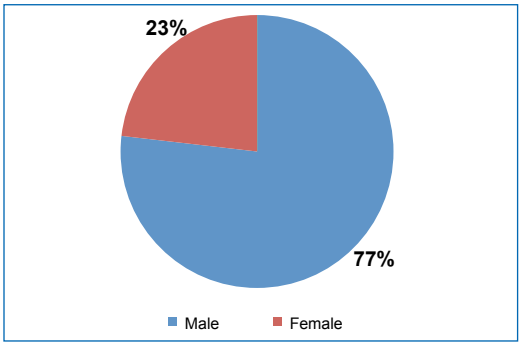


FY 2010 HHS HIV/AIDS Resource Allocation by Gender

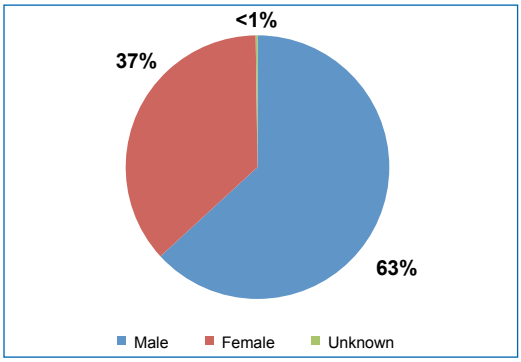
HHS FY 2010 Resource Allocation Baseline

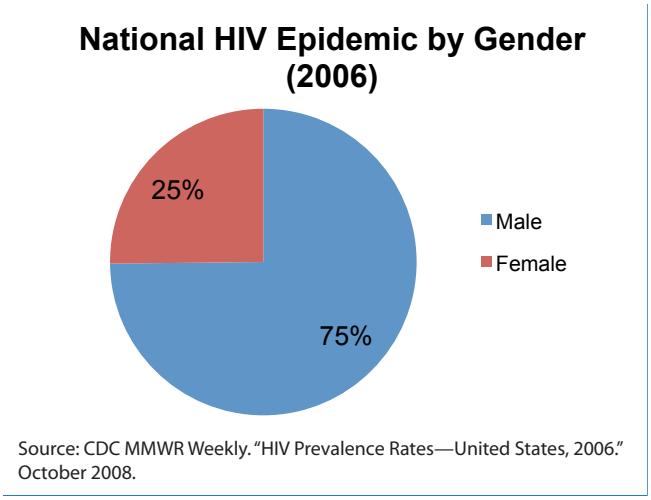
- The majority of activities for **CDC/SAMHSA/IHS/OS** Offices were multi-targeted for gender. Among the remaining 19% of extra-mural funding, 61% was for males, 38% for females, and 1% for transgender individuals.
- Two thirds of **HRSA** Ryan White HIV/AIDS Program service visits were for males (67%), nearly one third (32%) for females, and 1% for transgender persons. Please note that the **HRSA** data is representative of program beneficiaries (i.e., people with HIV/AIDS) and does not distinguish between targeted and multi-targeted funding.
- **CMS** HIV/AIDS Medicare beneficiaries (CY2008) were 77% male and 23% female (Figure 5c). **CMS** HIV/AIDS **Medicaid** beneficiaries (CY2007) were 63% male, 37% female, and <1% transgender persons.

CMS/Medicare
(CY 2008 Number of HIV/AIDS Beneficiaries Gender within Program, n=114,041)



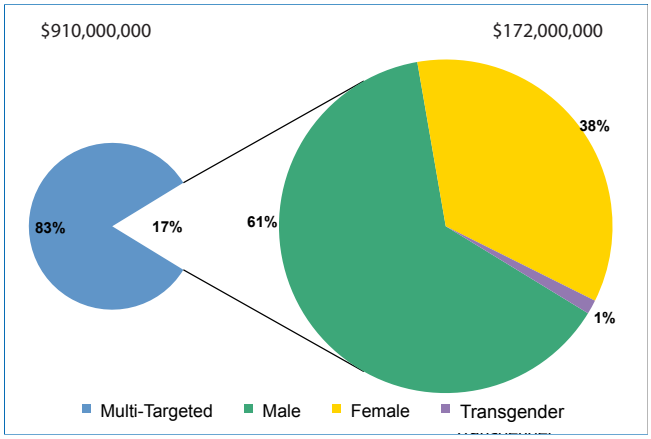
CMS/Medicaid
(CY 2007 Number of HIV/AIDS Beneficiaries by Gender within Program, n=172,541)



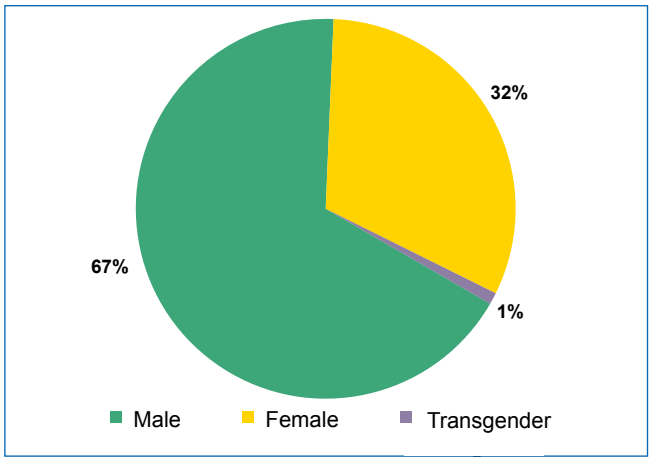


Source: CDC MMWR Weekly. "HIV Prevalence Rates—United States, 2006." October 2008.

CDC, SAMHSA, IHS, OS
(FY 2010 HIV/AIDS Funding: Discretionary Extramural by Gender)



HRSA
(FY 2010 HIV/AIDS Service Visits by Gender, n=876,987 visits)

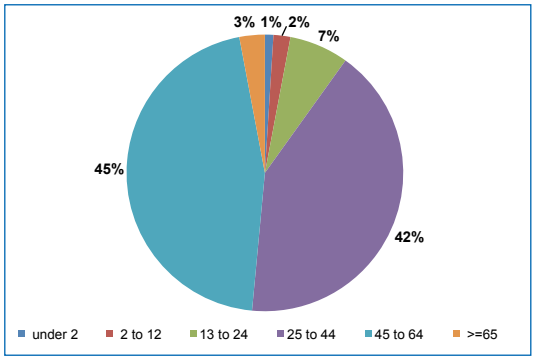


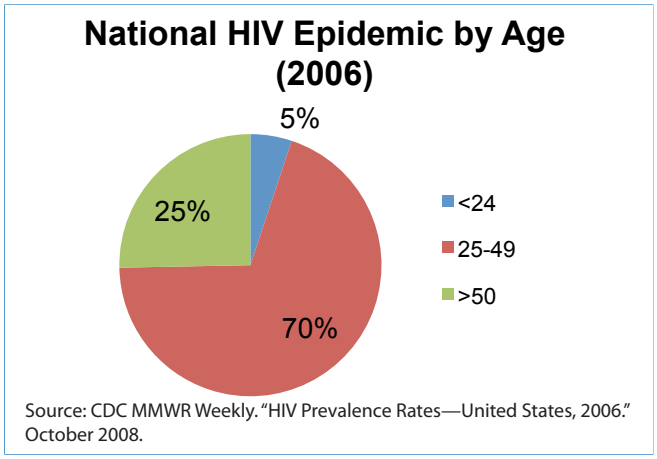
FY 2010 HHS HIV/AIDS Resource Allocation by Age

HHS FY 2010 Resource Allocation Baseline

- Approximately $910,000,000 was spent on HHS discretionary extramural activities in FY 2010 for HIV/AIDS activities funded by **CDC, SAMHSA, IHS and OS** Offices. Of that amount, 17% was intended for specific age groups.
- For **HRSA**, 45% of Ryan White HIV/AIDS Program services visits were for adults 45 to 64; 42% of visits were for adults age 25-44; 7% of visits were for youth and young adults age 13-24. Please note that the **HRSA** data is representative of program beneficiaries (i.e., people with HIV/AIDS) and does not distinguish between targeted and multi-targeted funding.
- Over half (59%) of **CMS** HIV/AIDS funds for **Medicare** in CY 2008 was for beneficiaries were aged 45-64, 26% were aged 21-44, 11% were aged 65-74, and 4% were 75 years or older (Figure 6c).
- The age breakdown of **CMS** HIV/AIDS **Medicaid** (CY 2007) beneficiaries was distributed as follows: 51% were aged 45-64, 39% were 21-44, 5% were under 21, 4% were 65-74, and 1% were 75 years or older.

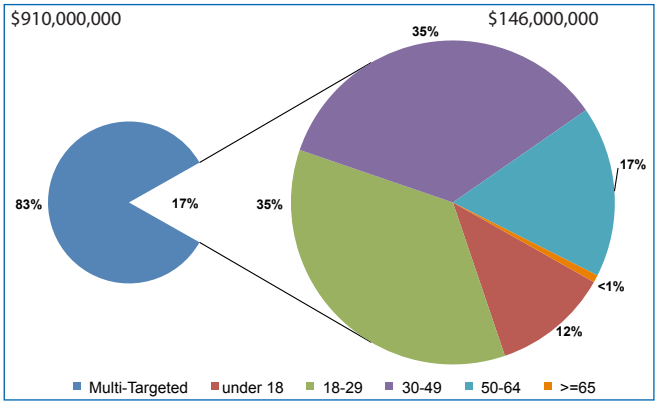
HRSA
FY 2010 HIV/AIDS Service Visits by Age Group, n=876,552



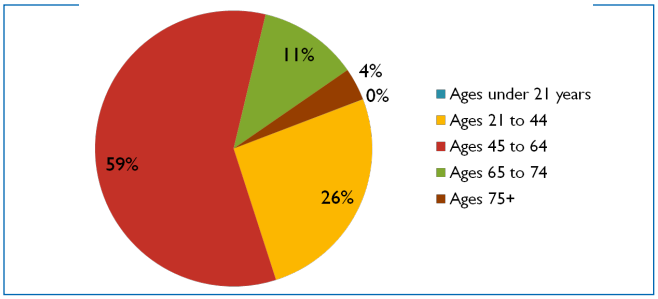


Source: CDC MMWR Weekly. "HIV Prevalence Rates—United States, 2006." October 2008.

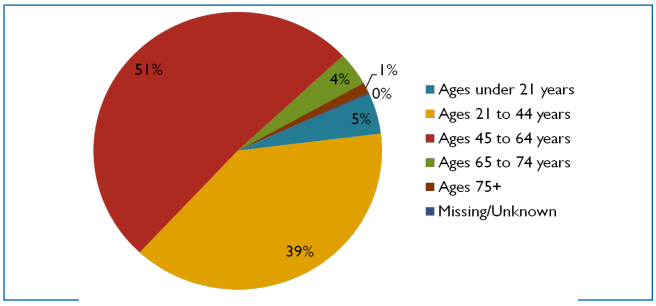
CDC, SAMHSA, IHS, OS
(FY 2010 Discretionary Extramural by Age Group)



CMS/Medicare (CY 2008 Number of HIV/AIDS) Beneficiaries by Age Group within Program, n=114,041



CMS/Medicaid (CY 2007 Number of HIV/AIDS Beneficiaries by Age Group within Program, n=172,541)



List of Commonly Used Acronyms

ADAP AIDS Drug Assistance Program

AETC AIDS Education and Training Center

AHRQ Agency for Healthcare Research and Quality, http://www.ahrq.gov/

AIDS Acquired Immune deficiency Syndrome

BOP Bureau of Prisons, Department of Justice, http://www.bop.gov/

CBO Community-based organization(s)

CDC Centers for Disease Control and Prevention, http://www.cdc.gov/

CMS Centers for Medicare & Medicaid Services, http://www.cms.gov/

CVL Community viral load

DOD Department of Defense, http://www.defense.gov

DOJ Department of Justice, http://www.justice.gov/

DOL Department of Labor, http://www.dol.gov/

EEOC Equal Employment Opportunity Commission, http://www.eeoc.gov

ECHPP Enhanced Comprehensive HIV Prevention Planning

HIV Human Immunodeficiency Virus

HHS Department of Health and Human Services, http://www.hhs.gov/

HOPWA Housing Opportunities for Persons with AIDS
http://www.hud.gov/offices/cpd/aidshousing/programs/

HRSA Health Resources and Services Administration, http://www.hrsa.gov/

HUD Department of Housing and Urban Development,
http://portal.hud.gov/portal/page/portal/HUD

IHS Indian Health Service, http://www.ihs.gov

LGBT Lesbian, Gay, Bisexual, and Transgender

NIH National Institutes of Health, http://www.nih.gov/

OASH Office of the Assistant Secretary for Health, Department of Health and Human Services,
http://www.hhs.gov/ash/

OGAC Office of the Global AIDS Coordinator, Department of State, http://www.state.gov/ogac/

OMB Office of Management and Budget, http://www.whitehouse.gov/omb/

OMH Office of Minority Health, Department of Health and Human Services,
http://minorityhealth.hhs.gov

ONAP Office of National AIDS Policy, http://www.whitehouse.gov/administration/eop/onap/

OWH Office Women's Health, Department of Health and Human Services, http://www.womenshealth.gov/about-us

SAMHSA Substance Abuse and Mental Health Services Administration, http://samhsa.gov/

SSA Social Security Administration, http://www.ssa.gov/

STD Sexually Transmitted Disease

VA Department of Veterans Affairs, http://www.va.gov

The White House Office of National AIDS Policy
202-456-4533
AIDSpolicy@who.eop.gov
http://www.whitehouse.gov/onap/