NATIONAL HIV/AIDS STRATEGY

Federal Implementation Plan

JULY 2010

Introduction

President Obama committed to developing a National HIV/AIDS Strategy with three primary goals: 1) reducing the number of people who become infected with HIV, 2) increasing access to care and optimizing health outcomes for people living with HIV, and 3) reducing HIV-related health disparities. To accomplish these goals, we must undertake a more coordinated, vigorous national response to the HIV epidemic.

The President also promised that the Strategy would rely on sound science and include measurable goals, timelines, and accountability mechanisms. This document is a companion to the *National HIV/AIDS Strategy for the United States*. It presents the Administration's plan for measuring progress toward meeting the Strategy's goals, and includes immediate and short-term Federal actions (those that can be achieved in calendar years 2010 and 2011) that will move the Nation toward improving its response to HIV/AIDS.[1] Where appropriate, we have highlighted some longer-term actions, but our immediate emphasis has been on identifying initial steps for moving forward. In 2011, ONAP will consult with Federal agencies to develop specific actions for 2012, and the plan will be updated annually, thereafter. This is a living document—we will evaluate our progress and modify it as necessary as we achieve certain milestones or experience unanticipated setbacks. Additionally, as the Federal agencies do their work to implement the Strategy, we anticipate that new activities will also be developed.

The job of implementing the *National HIV/AIDS Strategy*, however, does not fall to the Federal Government alone, nor should it. The success of the Strategy will require States, tribal and local governments, communities, and other partners to work together to better coordinate their responses to HIV/AIDS at the State and local levels. Therefore, we hope that the strategy will serve as a catalyst for all levels of government and other stakeholders to develop their own implementation plans for achieving the goals of the *National HIV/AIDS Strategy*.

The vision for the National HIV/AIDS Strategy is simple:

> 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.

1. The *National HIV/AIDS Strategy for the United States and the National HIV/AIDS Strategy: Federal Implementation Plan* are available at www.WhiteHouse.gov/ONAP.

Key Steps in Implementing the Strategy

The *National HIV/AIDS Strategy* is just a collection of words on paper, unless it provides a strategic vision for the country that leads to action. This document outlines key actions to be undertaken by the Federal Government.

Since taking office, the Obama Administration has worked to engage the public to evaluate what we are doing right and identify new approaches that will strengthen our response to the domestic epidemic. The White House Office of National AIDS Policy (ONAP), a component of the Domestic Policy Council, has been tasked with leading the effort to develop a national strategy. Throughout the process, ONAP has taken steps to engage as many Americans as possible to hear their ideas for making progress in the fight against HIV. ONAP's outreach included hosting 14 HIV/AIDS Community Discussions with thousands of Americans across the United States, reviewing suggestions from the public via the White House web site, conducting a series of expert meetings on HIV-specific topics, and working with Federal and community partners who organized their own meetings to support the development of a national strategy. A report summarizing public recommendations for the Strategy, entitled *Community Ideas for Improving the Response to the Domestic HIV Epidemic*, was published in April 2010.[2]

ONAP convened an interagency working group of officials from across the Federal Government to assist in reviewing the public recommendations, assessing the scientific evidence relevant to those recommendations, and making their own recommendations for the Strategy.

This National HIV/AIDS Strategy provides a roadmap for addressing the domestic HIV epidemic. It is not intended to be a comprehensive list of all activities needed to respond to HIV/AIDS, but is intended to be a concise plan that identifies a set of priorities and strategic action steps tied to measurable outcomes. The *Federal Implementation Plan* outlines the specific steps to be taken by various Federal agencies to support the high-level priorities outlined in the Strategy. Both the *National HIV/AIDS Strategy* and the *Federal Implementation Plan* may be accessed at www.WhiteHouse.gov/ONAP.

The quantitative targets that we have set are ambitious, and success is not assured. In the area of HIV prevention, for example, research conducted at CDC shows that while reallocation of existing resources and focusing on the most effective interventions will further improve the impact of HIV prevention efforts, there is still a strong case for making new investments in prevention, which could pay for themselves by reducing costly new infections in the future. Achieving these goals, however, requires stronger partnerships between Federal, State, and local and tribal governments, as well as faith groups, businesses, foundations, and community-based organizations.

ONAP Oversight, Coordination, and Annual Reporting

ONAP will continue to serve as the lead entity for setting the Administration's HIV/AIDS policies and will remain engaged in overseeing government-wide efforts to improve the Nation's response to the HIV epidemic. This role will include working with the Departments to support and monitor the implementation of the National HIV/AIDS Strategy. Departments will prepare and submit annual reports to ONAP.

2. See www.WhiteHouse.gov/ONAP.

ONAP will use this information to advise the President and produce an annual report describing the progress toward achieving goals in the Strategy. In addition, ONAP will continue to convene a Federal Interagency Working Group to foster collaboration across the Administration. ONAP will also continue to highlight important issues by convening meetings at the White House and working with Federal and non-Federal partners.

Role of Federal Departments

To support the implementation of the Strategy, the President has issued a Presidential Memorandum instructing relevant departments to provide a report to the President within the next 150 days outlining the steps they will take to ensure that they implement the recommendations in the Strategy. Federal agencies will also be tasked with establishing a responsible entity for coordinating their Department's efforts to achieve the goals of the Strategy and report on their progress. Other Departments are instructed to review their policies and identify steps that they can take to support implementation of the *National HIV/AIDS Strategy*. A copy of the Presidential Memorandum can be found at www.WhiteHouse.gov/Presidential-AIDS-Memo.

Role of the HHS Office of the Secretary

Implementation of the Strategy requires a new level of coordination and collaboration across agencies and among the Federal Government, States, tribes, and localities. Central to this coordination is the HHS Office of the Secretary (HHS OS)[3], which includes the Office of the Assistant Secretary for Health (ASH), who will be responsible for:

- Coordinating operational and programmatic activities for the National HIV/AIDS Strategy within the Department of Health and Human Services;
- Coordinating HIV/AIDS programs with other Departments;
- Tracking Federal programs implemented in each State or territory and working with States to ensure Federal HIV/AIDS activities are coordinated with State HIV/AIDS plans; and
- Establishing regular cross-Departmental meetings to coordinate program planning and administration of HIV/AIDS-related programs and activities.

Within ASH, the Deputy Assistant Secretary for Health will play a lead role in the supporting the implementation of the Strategy by forging collaborations across HHS and with other Federal departments and coordinating Federal efforts with States.

Role of States and Local Governments

HHS will work with States to encourage the development of statewide HIV/AIDS plans. This will include encouraging the development of needs assessments and identifying specific action steps that improve coordination among State agencies, local and tribal governments, non-profits and private advocacy

3. Throughout this document, we assign responsibilities to 'HHS OS', as they are being given new responsibilities for improving coordination across the Department. As appropriate, the Secretary will delegate responsibilities to specific offices or agencies.

groups, and the activities funded by multiple Federal agencies. The purpose of State plans would be to enhance coordination between planning and resource allocation activities, which are often siloed in a way that separates prevention and care. States will also be encouraged to establish a lead entity to coordinate the development and implementation of statewide HIV/AIDS plans and be accountable for reporting regularly on progress made towards the goals of the National HIV/AIDS Strategy. **To ensure effective collaboration in developing and implementing the statewide plans, the lead entity could be made up of representatives from State and local HIV/AIDS agencies, health departments, tribal governments, private advocacy groups, community-based organizations and people living with HIV.** In developing their plans, States will also be encouraged to identify all Federal, State, and local resources, and to the extent feasible, private and nonprofit resources to ensure that all HIV/AIDS resources are allocated in the most efficient manner to address the full range of prevention, care, and social service needs.

Role of Nongovernmental Partners

Although this document outlines initial steps the Federal Government will take after the release of the *National HIV/AIDS Strategy*, the job of implementing the Strategy does not fall to the Federal, State, tribal, and local governments alone. Businesses, faith communities, philanthropy, health care providers, the scientific and medical communities, educational institutions, professional organizations, and others must also do their part to support the achievement of the Strategy's goals. As we focus more attention on high-risk communities, for example, or as we consider the need to support people in meeting basic needs such as food and housing, and as we take steps to reduce stigma and discrimination, leadership is needed by people both inside and outside of government. Individuals or institutions themselves have a better understanding how they can maximally contribute to our efforts than the Federal Government. We hope that many interested parties will step forward and work together with the Federal Government to help end the HIV epidemic.

PACHA Review

The Presidential Advisory Council on HIV/AIDS (http://www.pacha.gov) will provide, on an ongoing basis, recommendations on how to effectively implement the strategy, as well as monitor the Strategy's implementation. At least once per year, a significant focus of one of the PACHA meetings will be to review the progress of Federal agencies and non-federal stakeholders in implementing the recommendations.

Annual Reporting

Progress in achieving the goals of the National HIV/AIDS Strategy will be reported by ONAP. ONAP will use information from the departments and States to publish an annual report on the Federal Government's progress.

Summary National HIV/AIDS Strategy Targets for 2015

Reducing New HIV infections

- By 2015, lower the annual number of new infections by 25 percent (from 56,300 to 42,225).
- Reduce the HIV transmission rate, which is a measure of annual transmissions in relation to the number of people living with HIV, by 30 percent (from 5 persons infected per 100 people with HIV to 3.5 persons infected per 100 people with HIV).
- By 2015, increase from 79 percent to 90 percent 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

- 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 continuous care (at least 2 visits for routine HIV medical care in 12 months at least 3 months apart) from 73 percent to 80 percent (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 percent to 86 percent (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

While working to improve access to prevention and care services for all Americans,

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

**All numbers based on current estimates.*

Reducing New HIV Infections

Reducing the number of new HIV infections is imperative. The targets below reflect our sense of urgency. From 2010 to 2015, the United States aims to:

- **Lower the annual number of new infections by 25 percent.** This would mean that the annual number of new infections would fall from 56,300 to 42,225. *(data source: CDC surveillance data)*
- **Reduce the HIV transmission rate, which is a measure of annual transmissions in relation to the number of people living with HIV, by 30 percent.** This would result in a reduction from 5 persons infected each year per 100 people with HIV to 3.5 persons each year per 100 people with HIV. *(data source: CDC surveillance data)*
- **Increase from 79 percent to 90 percent the percentage of people living with HIV who know their serostatus.** This would represent an increase from 948,000 to 1,080,000 Americans living with HIV who know their serostatus. *(data source: CDC surveillance data)*

2008 was the first year in which the United States could estimate the number of new HIV infections each year based on a direct measure of new infections. HIV incidence provides the best measure of the current state of the epidemic. Other measures, such as HIV diagnoses or AIDS cases, are also important, as they can indirectly estimate incidence. HIV diagnoses, for example, can provide some indication of the distribution of HIV in the United States, but it can also be affected by efforts to increase HIV testing. Expanded HIV testing could lead to more people learning their HIV status even if the annual number of new infections remains stable. The number of new infections (HIV incidence) provides a more current snapshot of how many people are becoming infected. We propose to lower the number of new infections by 25 percent by 2015.[4]

No measure is perfect. While stability in new infections is one sign of progress, incidence data alone cannot quantify the amount of transmission that occurs in relation to the growing population infected with HIV. The HIV transmission rate is another measure that takes both HIV incidence and the number of people living with HIV (prevalence) into account. It provides a measure of the number of new HIV infections that are transmitted in a given year for every 100 people living with HIV. It is expressed as a percentage and provides a "worst case" estimate of the number of infections occurring in relation to the number of people living with HIV. It provides a better means to assess the effects of public health efforts to promote changes in risk behavior, as well as the preventive effects of HIV diagnosis and treatment. HIV transmission rate is a useful measure because it is more sensitive to detecting progress in HIV prevention in the face of HIV flat incidence in the United States from year to year. According to CDC estimates, the HIV transmission rate in the United States was approximately 44.4 in 1984, 11.7 in 1990, 6.6 in 1991 and 5.0 in 2006.[5] We propose to lower the HIV transmission rate by 30 percent by 2015.[6]

4. Please refer to http://cdc.gov/hiv/topics/surveillance/incidence.htm for more information on HIV incidence calculations.
5. Holtgrave DR, Hall IH, Rhodes PH, Wolitski RJ. Updated annual HIV transmission rates in the United States, 1977-2006. J Acquir Immune Defic Syndr 2009; 50 (2): 236–8.
6. For more information on the transmission rate, please refer to http://www.cdc.gov/hiv/topics/surveillance/resources/factsheets/transmission.htm.

Thirty years into the epidemic, the challenge we face is not to initiate a brand new response to HIV. As we have already acknowledged, the U.S. and the Federal Government do many things right in responding to the epidemic. To some extent, the public should hope and expect that the best ideas for prevention, care, and research are already being implemented, even if imperfectly. That does not mean, however, that the Nation cannot expect something new and better. It does mean that many of the steps we need to take may appear incremental or mundane, even if they are transformative over time.

For the first couple of years of implementing the Strategy, the focus on achieving our HIV incidence goals will be on taking the necessary steps to ensure that we have the epidemiological data we need and that we use these data to enhance efforts to ensure that resources for HIV prevention follow the epidemic. We also believe that a short-term focus needs to be on identifying and evaluating effective combinations of HIV prevention methods for specific high risk groups, as well as evaluating the success of existing programs. In future years, we expect to know more about which combinations of interventions work for which communities and then we can turn to scaling up our efforts to deploy effective prevention combinations. Specifically, our goal in the later years is to address several gaps in prevention including: 1) conducting research to improve methods for estimating the proportion of persons living with HIV who are unaware of their infections, as well as methods to reach these individuals; 2) testing and growing the portfolio of interventions that incorporate issues such as sexual networks, income insecurity, and other social factors that place some individuals and populations at greater risk for HIV infection than others; and, 3) improving methods to prevent HIV infection among women whose heightened risk for HIV is based on the risk behaviors of their male partners.

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

1.1 Allocate public funding to geographic areas consistent with the epidemic: Governments at all levels should ensure that HIV prevention funding is allocated consistent with the latest epidemiological data and is targeted to the highest prevalence populations and communities.

Timeframe	Lead Agency/ Other Agencies	Actions to be Performed
By the end of 2010	HHS OS/CDC, SAMHSA, HRSA, and HUD	HHS OS will initiate consultations with CDC, SAMHSA, HRSA, HUD, and other departments or agencies as appropriate to develop policy recommendations for revising funding formulas and policy guidance in order to ensure that Federal HIV prevention funding allocations go to the jurisdictions with the greatest need.
	CDC	CDC will continue to evaluate all existing HIV prevention programs every five years to ensure that Federal dollars support programs that are effective and have demonstrated improved health outcomes.
By the end of 2011	HHS OS	All HHS agencies, as appropriate, will report to the HHS Office of the Secretary (OS) on baseline measures for funding allocations for their programs.
	HHS OS	HHS OS and relevant agencies will consult with States and other jurisdictions prior to allocating prevention funding to targeted populations and communities to ensure coordination of efforts.

1.2 Target high risk populations: Federal agencies should develop new mechanisms for ensuring that grant funding to State and local health departments and community-based organizations is based on the epidemiological profile within the jurisdiction.

Timeframe	Lead Agency/ Other Agencies	Actions to be Performed
By the end of 2011	CDC	CDC will establish new standards for reviewing State and local prevention plans to ensure that Federal funds are used in a manner addressing people living with HIV and reflecting populations with greatest need.
	CDC/HRSA, SAMHSA, HHS OS	CDC in consultation with HRSA, SAMHSA, and HHS OS will develop and implement a plan of recommended actions for reducing the proportion of HIV-positive individuals with undiagnosed HIV infection among target populations in high prevalence and incidence.
	CDC	CDC will update and issue guidelines on the provision of HIV counseling and testing in nonclinical settings.
	CDC	CDC will work with States to ensure that the new guidelines are incorporated into State HIV/AIDS plans

1.2.1 Prevent HIV among gay and bisexual men[7] and transgender individuals: Congress and State legislatures should consider the implementation of laws that promote public health practice and underscore the existing best evidence in HIV prevention for sexual minorities.

Timeframe	Lead Agency/ Other Agencies	Actions to be Performed
By the end of 2010	HHS OS	HHS OS will initiate planning for a consultation with national Lesbian, Gay, Bisexual, and Transgender (LGBT) organizations to re-engage LGBT community leadership in health promotion.
By the end of 2011	CDC	CDC will develop recommendations for essential prevention activities and services provided to gay and bisexual men as part of the MSM initiative in the FY 2011 budget.
	CDC	CDC will work with States to increase capacity of STD surveillance systems to identify gender of sex partners and HIV infection status of men with reportable STDs.
	HHS OS	HHS OS will work with Congress to consider revising restrictions in the Public Health Service Act that hinder the implementation of scientifically validated, culturally appropriate HIV prevention services.
	CDC	CDC will expand its work evaluating adaptations of specific interventions for transgender populations and issue a fact sheet recommending HIV prevention approaches for transgender persons.

7. Throughout this document we use the terms "gay and bisexual men" and "gay men" interchangeably, and we intend these terms to be inclusive of all men who have sex with men (MSM), even those who do not identify as gay or bisexual.

Timeframe	Lead Agency/ Other Agencies	Actions to be Performed
	CDC	CDC will work with States to ensure that State plans address deficiencies in directing the needed proportion of resources to gay male and transgender populations—overall, and within racial/ethnic groups heavily impacted by the epidemic.

1.2.2 Prevent HIV among Black men and women:[8] To lower risks for all Americans, prevention efforts should acknowledge the heavy burden of HIV among Black Americans and target resources appropriately.

Timeframe	Lead Agency/ Other Agencies	Actions to be Performed
By the end of 2010	CDC	CDC will release an update of Act Against AIDS activities and an evaluation of successes and challenges.
By the end of 2011	HHS OS	HHS OS will complete an initiative to compile and collectively assess all effective programs and initiatives for reducing HIV infections among Black Americans.
	CDC	CDC will work with States and localities with implementing the best combination of approaches to address HIV and STD prevention among Black Americans.

1.2.3 Prevent HIV among Latinos and Latinas: HIV prevention efforts that target Latino communities must be culturally appropriate and available to acculturated and nonacculturated Latino populations .

Timeframe	Lead Agency/ Other Agencies	Actions to be Performed
By the end of 2011	CDC	CDC will launch an evidence-based social marketing campaign targeted to the Latino community and will collaborate with national Latino organizations on HIV prevention efforts.
	CDC	CDC will release a report on suggestions for border states to help improve HIV surveillance and prevention interventions among migrant communities.
	CDC	CDC will work States and localities with implementing the best combination of approaches to address HIV and STD prevention among Latinos.

8. Throughout this document we use the terms "Black" and "African American" interchangeably, and we intend these terms to be inclusive of all individuals from the African Diaspora who identify as Black and/or African American.

1.2.4 Prevent HIV among substance users: Substance use is associated with a greater likelihood of acquiring HIV infection. HIV screening and other comprehensive HIV prevention services should be coupled with substance treatment programs.

Timeframe	Lead Agency/ Other Agencies	Actions to be Performed
By the end of 2010	SAMHSA/HHS	SAMHSA and other relevant HHS agencies will consider guidance requiring Federally funded substance abuse and mental health treatment clinics to offer voluntary routine HIV testing to their clients.
	CDC, SAMHSA	CDC and SAMHSA will complete guidance for evidence-based comprehensive prevention, including syringe exchange and drug treatment programs, for injection drug users.
By the end of 2011	SAMHSA/HHS OS	SAMHSA will consult with the HHS OS on policy recommendations for revising funding formulas for State/Territory Substance Abuse Prevention and Treatment and Mental Health Block Grants and policy guidance in order to ensure that Federal HIV prevention funding allocations follow the epidemic at the State and local levels.
	SAMHSA/HUD, DOJ, CDC, HRSA, his, HHS OS	SAMHSA will work with relevant Federal agencies, HHS OS, States, and community-based service providers to implement ways to improve integration of substance abuse and mental health screening in programs that serve communities with high rates of new HIV infections. These should include risk reduction efforts to reduce sexual transmission of HIV among substance using populations.

1.3 Address HIV prevention in Asian American and Pacific Islander (AAPI) and American Indian and Alaska Native (AI/AN) populations: Federal and State agencies should consider efforts to support surveillance activities to better characterize HIV among smaller populations such as Asian American and Pacific Islanders (AAPI), American Indians and Alaska Natives (AI/AN).

Timeframe	Lead Agency/ Other Agencies	Actions to be Performed
By the end of 2011	CDC	CDC will provide State health departments with greater concentrations of AAPI or AI/AN populations with recommendations on effective HIV surveillance activities for these small populations.
	CDC/IHS, HHS OS	CDC and IHS will coordinate with HHS OS to consult with tribes to develop and implement scalable approaches for effective prevention interventions for AI/AN populations that reach those at greatest risk.
	CDC	CDC will work with States with the largest AAPI communities to implement the best combination of approaches to prevent HIV that reach AAPIs at greatest risk for infection.

1.4 Enhance program accountability: New tools are needed to hold recipients of public funds accountable for achieving results.

Timeframe	Lead Agency/ Other Agencies	Actions to be Performed
By the end of 2011	HHS OS/CDC, HRSA, SAMHSA, OPHS, IHS	Relevant HHS agencies will work with States, localities, tribal governments, community-based organizations, and evaluation experts to develop standard performance measures for HIV prevention programs and provide guidance on utilizing these measures.
	CDC/SAMHSA	CDC will work with SAMHSA to make recommendations for strengthening evaluation and aligning measures and benchmarks across programs.
	HHS OS	HHS OS will devise ways to provide incentives to reward high performing Federal grantees for delivering effective prevention services.
	CDC	CDC will continue to evaluate the effectiveness of all CDC-funded HIV prevention programs to assess their impact on improving health outcomes and redirect resources to the most effective programs.

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

2.1 Design and evaluate innovative prevention strategies and combination approaches for preventing HIV in high risk communities: Government agencies should fund and evaluate demonstration projects to test which combinations of effective interventions are costefficient, produce sustainable outcomes, and have the greatest impact in preventing HIV in specific communities.

Timeframe	Lead Agency/ Other Agencies	Actions to be Performed
By the end of 2010	NIH/CDC	NIH and CDC will continue to test mathematical models to explore the best combinations of behavioral and biomedical prevention activities.
By the end of 2011	CDC/HRSA, SAMHSA	CDC, HRSA, SAMHSA will collaborate with States and localities on pilot initiatives for expanding the most promising models for integrating HIV testing, outreach, linkage and retention in care in high risk communities.
	NIH/CDC	NIH will work with CDC to develop and implement a plan for evaluating promising community-generated ('homegrown') HIV prevention interventions.

2.2 Support and strengthen HIV screening and surveillance activities: There is a need to support existing surveillance methods to identify populations at greatest risk that need to be targeted for HIV prevention services.

Timeframe	Lead Agency/ Other Agencies	Actions to be Performed
By the end of 2011	FDA	FDA will prioritize review of 4th generation HIV diagnostic tests and research in developing new tests for incident infections.

2.3 Expand access to effective prevention services: Federal funds should support and State and local governments should be encouraged to expand access to effective HIV prevention services with the greatest potential for population-level impact for high-risk populations.

Timeframe	Lead Agency/ Other Agencies	Actions to be Performed
By the end of 2010	CDC/SAMHSA	CDC and SAMHSA in consultation with other agencies, will recommend necessary elements of comprehensive, evidence-based HIV prevention for injection drug using populations.
By the end of 2011	HHSOS/CDC, HRSA, SAMHSA, NIH, CMS	Relevant HHS agencies will make recommendations for scaling up access to post exposure prophylaxis (PEP), with priority given to high prevalence jurisdictions. Consideration will be given to the role of emergency departments (if any), standardized treatment guidelines, and regimen selection.
	BOP/CDC	BOP will expand access to HIV, STD, viral hepatitis screening to prisoners on entry, and CDC and BOP will promote risk reduction interventions for healthy reintegration of ex-prisoners back into community settings.
	HHS OS/CDC, HRSA, SAMHSA	Relevant HHS agencies will prioritize expanding access to combination approaches for HIV prevention, appropriate to epidemic profiles in specific localities.

2.4 Expand prevention with HIV-positive individuals: Although most people diagnosed with HIV do not transmit the virus to others, there are effective approaches that support people living with HIV from transmitting HIV to others.

Timeframe	Lead Agency/ Other Agencies	Actions to be Performed
By the end of 2010	HRSA	HRSA will work with States and localities to ensure that medical providers comply with existing HHS treatment guidelines to offer antiretroviral therapy to HIV-positive clients in care with CD4 up to 500 cells/ml.
	CDC	CDC will work with States and localities to promote and implement scalable interventions with individuals living with HIV to lower their risk of transmitting HIV.

Timeframe	Lead Agency/ Other Agencies	Actions to be Performed
By the end of 2011	CDC	CDC will develop recommendations for promoting seroadaptation strategies (strategies used by people with HIV to voluntarily adjust their behavior toward HIV-negative individuals to lower the risk of transmitting HIV).

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

3.1 Utilize social marketing and education campaigns: Outreach and engagement through traditional media (radio, television, and print) and networked media (such as online health sites, search providers, social media, and mobile applications) must be increased to educate and engage the public about how HIV is transmitted and to reduce misperceptions about HIV transmission. Efforts will be made to utilize and build upon World AIDS Day (December 1st) and National HIV Testing Day (June 27th), as well as other key dates and ongoing activities throughout the year.

Timeframe	Lead Agency/ Other Agencies	Actions to be Performed
By the end of 2010	CDC	CDC will initiate a CDC-wide review of all social marketing and education campaigns related to HIV, STI, substance abuse and risk behaviors that increase risk of HIV transmission and will work to expand evidence based efforts to achieve maximum impact.
By the end of 2011	CDC	CDC will work with States and localities to expand public-private partnerships to focus on reaching high risk communities and/or the general public to prevent HIV/STI infection.

3.2 Promote age-appropriate HIV and STI prevention education for all Americans: Too many Americans do not have the basic facts about HIV and other sexually transmitted infections. Sustained and reinforcing education is needed to effectively encourage people across the age span to take steps to reduce their risk for infection.

Timeframe	Lead Agency/ Other Agencies	Actions to be Performed
By the end of 2010	CDC	CDC will consider strategies for ensuring that school-based health education is providing scientifically sound information about HIV transmission and risk reduction strategies.
By the end of 2011	CDC	CDC will develop a toolkit and work with States, localities, and school boards to implement age-appropriate HIV health education programs.
	CDC	CDC will consider potential partnerships, such as with private businesses, to expand HIV and STI prevention education.

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

People living with HIV should receive appropriate care and treatment to manage the disease, as well as prevention services that reduce the risk they will transmit HIV. HHS treatment guidelines for treatment of HIV infection provide the rationale for our targets concerning improving access and outcomes for people living with HIV. From 2010 to 2015, the U.S. aims to:

- **Increase the proportion of newly diagnosed patients linked to clinical care within three months of their HIV diagnosis from 65 percent to 85 percent (from 26,284 to 35,079 people).** *(data source: CDC surveillance data)*
- **Increase the proportion of Ryan White HIV/AIDS Program clients who are in continuous care (at least 2 visits for routine HIV medical care in 12 months at least 3 months apart) from 73 percent to 80 percent (or 237,924 people in continuous care to 260,739 people in continuous care).** *(data source: HRSA data)*
- **Increase the percentage of Ryan White recipients with permanent housing from 82 percent to 86 percent (from 434,600 to 455,800 people).** *(data source: HRSA data)* (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.)

Our renewed national effort to improve health outcomes for people living with HIV comes at a time when several Departments of the Federal Government are working with States and private sector partners to implement the *Affordable Care Act*. Supporting a successful implementation of this law is essential to improving health outcomes for people living with HIV. This work will ensure that in the future, health care access for people with HIV is more stable, affordable, and of high quality. Until that time, we must also stay focused on bolstering our current health care safety net for people with HIV. With the economic downturn that has caused many States to reduce services and with growing numbers of people with HIV in need of services, ongoing attention will be required to bridge short-term gaps in health coverage until the *Affordable Care Act* is fully implemented.

Over the next couple of years, our attention will need to remain on filling gaps in coverage, while also expanding coordination between Federal agencies, and across levels of government to improve linkages to care. We must also step up our efforts to address workforce shortages by taking initial steps to expand the size and diversity of the clinical and nonclinical HIV workforce. Addressing workforce challenges, however, is necessarily, a long-term effort. As we recognize the extent to which individuals with HIV have other co-occurring health conditions or other challenges in meeting their basic needs, our initial focus will be on enhancing collaboration. This will encompass coordination across agencies that provide HIV services, as well as enhancing programmatic and policy linkages between HIV programs and other health care programs, mental health and substance abuse prevention and treatment programs, STI prevention and treatment programs, as well as increasing collaboration with HUD, the VA, and other departments and agencies. In addition, the *Federal Strategic Plan to End Homelessness* will focus Federal

efforts to reduce homelessness and increase housing security. Implementation of the *National HIV/AIDS Strategy* must entail integrating efforts to increase housing security for people living with HIV.

In addition to increased program collaboration, there are opportunities to use technology to improve care delivery and strengthen linkages to care. As more health information is collected electronically, it will be necessary to develop applicable standards for using electronic records systems to facilitate linkage coordination and care management for people living with HIV, in order to manage patient confidentiality while facilitating the sharing of information.

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

1.1 Facilitate linkages to care: HIV resources should be targeted to include support for linkage coordinators in a range of settings where at risk populations receive health and social services.

Timeframe	Lead Agency/ Other Agencies	Actions to be Performed
By the end of 2010	HRSA	HRSA will begin to develop information templates to enable health departments to provide customized, local information on where to access care and support services; such information could be disseminated online at community health centers and other facilities.
By the end of 2011	HRSA/CDC, VA, HUD	HRSA in collaboration with CDC, VA, HUD and other relevant agencies will develop plans that support health care providers and other staff who deliver HIV test results to conduct linkage facilitation to ensure clients access appropriate care following a positive diagnosis.
	SAMHSA	SAMHSA will issue guidance for providers to increase linkages to substance abuse treatment and mental health services for people living with HIV and offer voluntary routine HIV testing to all persons diagnosed with an STD.
	CDC, HRSA, SAMHSA	CDC, HRSA, SAMHSA and other relevant HHS agencies will work with States, tribal governments, localities, and CBOs to promote co-location of providers of HIV screening and care services as a means of facilitating linkages to care and treatment, and to enhance current referral systems within CBOs.

1.2 Promote collaboration among providers: All levels of government should increase collaboration among HIV medical care providers and agencies providing HIV counseling and testing services, substance abuse treatment, mental health treatment, housing and support services to link people with HIV to care.

Timeframe	Lead Agency/ Other Agencies	Actions to be Performed
By the end of 2011	HHS OS/HUD	HHS agencies, HUD, and other relevant Federal agencies will develop joint strategies to encourage co-location of and enhance availability of HIV-related services at housing and other nontraditional HIV care sites.

Timeframe	Lead Agency/ Other Agencies	Actions to be Performed
	HHS OS	HHS agencies will develop plans and work with States to implement training opportunities for health care providers that will highlight the importance of program collaboration and service integration to reduce missed opportunities for identifying HIV infection.
Timeframe	**Lead Agency/ Other Agencies**	**Actions to be Performed**
	CDC, SAMHSA, DOJ, HUD	HHS OS will work with CDC, SAMHSA, DOJ, and HUD to identify and develop potential programs where there can be joint grant awards.

1.3 Maintain people living with HIV in care: Clinical care providers should ensure that all eligible HIV-positive persons have access to and are maintained on a medication regimen as recommended by the HHS treatment guidelines.

Timeframe	Lead Agency/ Other Agencies	Actions to be Performed
By the end of 2010	CMS/HRSA	CMS and HRSA will initiate a dialogue on ways to support Medicaid and Medicare providers to engage marginalized populations in HIV care.
	CMS	CMS will promote and support the development and expedient review of Medicaid 1115 waivers to allow States to expand their Medicaid programs to cover pre-disabled people living with HIV.
By the end of 2011	BOP	BOP will conduct a review of current policies and procedures and issue guidance to encourage all prisons to provide discharge planning to link HIV-positive persons to appropriate services upon release from incarceration in order to reduce interruptions in HIV treatment. This will include considering ways to promote broader adoption by nonfederal systems of BOP's standards of providing a 30-day supply of HIV medications upon release.
	NIH	NIH will continue efforts to investigate new antiretroviral therapies for HIV and treatment for its associated conditions that are safer, more effective, more tolerable, and more durable, making adherence to medication regimens easier for people living with HIV.
	NIH/CDC, HRSA, VA	NIH will work with CDC, HRSA, VA, and other relevant agencies to continue to update and disseminate the HHS treatment guidelines.

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.

2.1 Increase the number of available providers of HIV care: Federal agencies should provide incentives to encourage more health care clinicians including primary care providers, reproductive health care providers and providers of sexually transmitted disease treatment, mental health providers, and substance abuse treatment providers to offer HIV services.

Timeframe	Lead Agency/ Other Agencies	Actions to be Performed
By the end of 2010	HRSA	HRSA will issue guidance encouraging medical, dental, pharmacy, physician assistant, nurse practitioner, social work, and nursing schools to implement curricula that include HIV-specific training.
By the end of 2011	HRSA	HRSA will consider opportunities to foster residency training in HIV management and care at community health centers.
Timeframe	**Lead Agency/ Other Agencies**	**Actions to be Performed**
	HRSA/NIH, OMH	HRSA, NIH and OMH will develop a proposal to fund training programs to increase interest, representation and competence of health professionals, researchers, and racial and ethnic minority students in research, public health and HIV/AIDS care.

2.2 Strengthen the current provider workforce to improve quality of HIV care and health outcomes for people living with HIV: Federal agencies should engage clinical providers and professional medical societies on the importance of routine, voluntary HIV screening and quality HIV care in clinical settings consistent with HHS and CDC guidelines.

Timeframe	Lead Agency/ Other Agencies	Actions to be Performed
By the end of 2010	HRSA	HRSA will work with its AETCs to expand training for HIV clinicians and provider organizations to address provider-associated factors (e.g., cultural competency, provider continuity) that affect treatment adherence.
	AHRQ	AHRQ will develop a plan for working with public and private insurers to develop common data collection and reporting systems across all health care provider settings to enable monitoring of clinical care utilization, quality indicators, and health outcomes for people living with HIV.
By the end of 2011	HRSA	HRSA will develop a proposal to increase the number of clinical providers who are engaged in innovative rural HIV/AIDS health care delivery systems (e.g. home healthcare, telehealth).
	HRSA	HRSA will develop and issue guidance promoting task shifting (transferring specific tasks to be performed by physician extenders, such as nurse practitioners or other health workers) and co-management (generalist physicians overseeing HIV care while under regular consultation with an HIV expert) as methods to improve HIV workforce efficiency.
	DOL, HRSA	DOL and HRSA will work with health professions associations and collaborate on workforce training efforts to increase the number of health providers who are culturally competent.

Timeframe	Lead Agency/ Other Agencies	Actions to be Performed
	HRSA, AHRQ, DOL/HHS OS	HRSA, AHRQ, and DOL will coordinate with HHS OS to work with States, local governments, and state health professions associations to implement their recommendations and guidance to strengthen the current HIV/AIDS provider workforce.

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

3.1 Enhance client assessment tools and measurement of health outcomes: Federal and State agencies should support case management and clinical services that contribute to improving health outcomes for people living with HIV and work toward increasing access to nonmedical supportive services (e.g., housing, food, transportation) as critical elements of an effective HIV care system.

Timeframe	Lead Agency/ Other Agencies	Actions to be Performed
By the end of 2011	SAMHSA/VA	SAMHSA, VA, and other relevant agencies will collaborate and develop materials for training health care providers to conduct mental health and substance use disorder assessments and treatment referrals as appropriate.
	AHRQ/HRSA, VA, CMS, HHS OS	AHRQ, HRSA, VA and CMS, in coordination with HHS OS, will work with States, localities, and CBOs to encourage the adoption of nationally accepted clinical performance measures to monitor quality of HIV care.

3.2 Address policies to promote access to housing and supportive services for people living with HIV: Federal agencies should consider additional efforts to support housing assistance and other services that enable people living with HIV to obtain and adhere to HIV treatment.

Timeframe	Lead Agency/ Other Agencies	Actions to be Performed
By the end of 2011	HUD/HHS OS	HUD will lead a process with HHS OS and relevant Federal agencies to identify ways to collaborate and increase access to nonmedical supportive services (e.g., housing, food/nutrition services, transportation) as critical elements of an effective HIV care system.

Reducing HIV-Related Health Disparities

HIV differentially affects different groups. Making progress in lowering the number of new infections and improving access to care requires making progress toward minimizing disparities across groups. From 2010 to 2015, the United States aims to:

- **Increase the proportion of HIV diagnosed gay and bisexual men with undetectable viral load by 20 percent.** *(data source: CDC data)*
- **Increase the proportion of HIV diagnosed Blacks with undetectable viral load by 20 percent.** *(data source: CDC data)*
- **Increase the proportion of HIV diagnosed Latinos with undetectable viral load by 20 percent.** *(data source: CDC data)*

One of the challenges of reducing HIV-related health disparities is that it is easier to diagnose and document the problems than it is to implement concrete, evidence-based solutions. By expanding access to prevention and care services to high-risk communities, we will lay the groundwork for reducing inequities. Our short-term focus will be on putting in place the necessary tools to lead to improvements in health indicators for underserved communities. By working to ensure that all high-risk groups have access to the same and most appropriate diagnostic tests can help us to better monitor the health outcomes we are working to improve. Further, it is easy to see that community-level interventions are needed to respond to the magnitude of the HIV epidemic in many communities, but there are too few such interventions that reduce HIV incidence or increase access to care.

Addressing ongoing stigma and discrimination is perhaps the biggest challenge we face, as this is not about what government does as much as it is about changing hearts and minds among members of the public. At the same time, three decades of experience tell us that essential starting points for addressing stigma and discrimination include maintaining a commitment to civil rights enforcement, working to ensure that public policies are grounded in best public health practices, and supporting people living with HIV to disclose their status and promote the public leadership of community members living with HIV.

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

1.1 Ensure that high risk groups have access to regular viral load and CD4 tests: All persons living with HIV should have access to tests that track their health, but more must be done to make sure that these tests are available to African Americans, Latinos, and gay and bisexual men.

Timeframe	Lead Agency/ Other Agencies	Actions to be Performed
By the end of 2011	VA, CMS, HRSA, CDC, SAMHSA, NIH	VA, CMS, HRSA, CDC, SAMHSA and NIH will jointly consider and issue a report of strategies to encourage providers to collect and report standardized viral load and CD4 data from infected individuals within populations at greatest risk for HIV infection.

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

2.1 Establish pilot programs that utilize community models: In order to reduce disparities between various groups affected by the epidemic, testing community-level approaches is needed to identify effective interventions that reduce the risk of infection in high prevalence communities.

Timeframe	Lead Agency/ Other Agencies	Actions to be Performed
By the end of 2011	HHS OS	HHS OS will collaborate with HHS agencies to engage in policy research and evaluation activities to identify effective prevention approaches to reduce disease burden in high prevalence communities.
	HHS OS	HHS OS will work with the relevant HHS agencies to consider ways to enhance the effectiveness of prevention and care services provided for high risk communities, including services provided through the Minority AIDS Initiative.
	HHS OS/HUD	HHS OS and HUD will explore potential demonstration projects of bundled/braided funding across agencies to address HIV and other issues in high prevalence communities.

2.2 Measure and utilize community viral load: Ensure that all high prevalence localities are able to collect data necessary to calculate community viral load, measure the viral load in specific communities, and reduce viral load in those communities where HIV incidence is high.

Timeframe	Lead Agency/ Other Agencies	Actions to be Performed
By the end of 2010	CDC	CDC will identify which States and localities collect CD4 and viral load data.
By the end of 2011	HRSA, CDC	HRSA and CDC will convene a consultation with clinical providers and community-based organizations to develop recommendations for gathering and reporting necessary data to calculate community viral load.
	CDC	CDC, in consultation with States, will provide technical assistance to localities, particularly those with a heavy disease burden, to collect necessary data to calculate community viral load.

2.3 Promote a more holistic approach to health: Promote a more holistic approach to health that addresses not only HIV prevention among African Americans, Latinos, gay and bisexual men, women, and substance users, but also the prevention of HIV related co-morbidities, such as STDs and hepatitis B and C.

Timeframe	Lead Agency/ Other Agencies	Actions to be Performed
By the end of 2010	HRSA/CDC, SAMHSA	HRSA, CDC, and SAMHSA will include language in grant announcements requiring the integration of prevention and care services, including referrals to clinical services.

Timeframe	Lead Agency/ Other Agencies	Actions to be Performed
By the end of 2011	HHS OS/CDC, HRSA, NIH, AHRQ	HHS OS will coordinate among HHS agencies to mine existing databases to explore associations between HIV infection and social determinants of health.

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

3.1 Engage communities to affirm support for people living with HIV: Faith communities, businesses, schools, health care providers, community-based organizations, social gathering sites, and all types of media outlets should take responsibility for affirming nonjudgmental support for people living with HIV and high risk communities.

Timeframe	Lead Agency/ Other Agencies	Actions to be Performed
By the end of 2010	HHS OS/DOJ, DOL	HHS OS, DOJ, and DOL Offices of Faith Based and Community Initiatives will develop a plan for engaging more faith leaders to promote nonjudgmental support for people living with HIV.
By the end of 2011	DOL	DOL will consider ways to increase supports for employers to hire and maintain employment of people with HIV and how to integrate them in broader employment initiatives for people with disabilities.
	HHS OS/DOL	HHS OS will coordinate with DOL to develop standardized occupational guidelines for outreach workers, health educators, hotline operators, peer counselors, and testing/counseling personnel.
	DOL/SSA, DOJ, HHS OS	DOL, SSA, DOJ, and HHS OS will develop a joint initiative to consider ways to help individuals living with HIV access income supports, including job skills and employment.

3.2 Promote public leadership of people living with HIV: Governments and other institutions (including HIV prevention community planning groups and Ryan White planning councils and consortia) should work with people with AIDS coalitions, HIV services organizations, and other institutions to actively promote public leadership by people living with HIV.

Timeframe	Lead Agency/ Other Agencies	Actions to be Performed
By the end of 2011	HRSA/CDC, HHS OS	HRSA, CDC, and HHS OS will develop recommendations for strengthening the parity, inclusion, and meaningful representation of people living with HIV on planning and priority-setting bodies.

3.3 Promote public health approaches to HIV prevention and care: State legislatures should consider reviewing HIV-specific criminal statutes to ensure that they are consistent with current knowledge of HIV transmission and support public health approaches to screening for, preventing and treating HIV.

Timeframe	Lead Agency/ Other Agencies	Actions to be Performed
By the end of 2011	HHS	The CDC/HRSA HIV/AIDS Advisory Committee will solicit public input and make recommendations for normalizing and promoting individuals' safe, voluntary disclosure of their HIV status. HRSA will publish the recommendations.
	DOJ/HHS OS	DOJ and HHS OS will identify a departmental point of contact and provide technical assistance resources to States considering changes to HIV criminal statutes in order to align laws and policies with public health principles.
	PACHA	The Presidential Advisory Council on HIV/AIDS (PACHA) will be tasked with developing recommendations for ways to promote and normalize safe and voluntary disclosure of HIV status in various contexts and circumstances.

3.4 Strengthen enforcement of civil rights laws: The Department of Justice and other Federal agencies must enhance cooperation to facilitate enforcement of Federal antidiscrimination laws.

Timeframe	Lead Agency/ Other Agencies	Actions to be Performed
By the end of 2010	DOJ/HHS OS	DOJ and HHS OS will enter into a Memorandum of Understanding deferring complaints of discrimination on the basis of HIV to the Department of Justice for investigation and prosecution.
By the end of 2011	DOJ/EEOC, DOL, HUD	DOJ, the Equal Employment Opportunity Commission, DOL's Office of Federal Contract Compliance Programs, and HUD's Fair Housing Enforcement Office will prioritize and fast track investigations of discrimination charges involving HIV, as necessary and appropriate under relevant statutes, and consider additional policies to prevent discrimination from occurring.
	DOJ	DOJ will examine and report on HIV-specific sentencing laws and implications for people living with HIV.

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

This implementation plan delineates initial steps for addressing each of the President's goals for the *National HIV/AIDS Strategy*. Progress in reaching the Strategy's goals will be publicly reported annually by ONAP. We believe that this plan is ambitious, and success at completing all of these activities is not assured. We are committed to acting with the urgency that the epidemic requires to push Federal agencies to do more and achieve better results, and regularly assess and refine our activities.

Improving coordination of HIV programs is both the simplest and hardest task ahead of us. In recent years, various Federal agencies have already taken steps to increase collaboration and coordination. The HIV Federal Interagency Working Group, which has been central to the development of the *National HIV/AIDS Strategy*, has also helped to foster a new level of collaboration across disparate agencies. These efforts will continue. The challenge, however, lies in moving beyond the mechanics of having agency leaders talk to each other on a regular basis to creating a culture where agencies are naturally more interconnected and their programs are better aligned. In the short-term, our focus will be on strengthening the mechanisms for Federal agencies to work together more closely about policy issues, as well as the operational aspects of their programs. We also intend to encourage similar efforts at the State and local levels. Longer term, we hope to get to the next level of improved coordination and tackle issues that may require years of sustained planning and effort, such as initiating joint funding initiatives and streamlining data collection and reporting requirements. Beyond government, health care providers, affected communities, businesses, philanthropy, faith communities, and others are also encouraged to increase their own level of collaboration and coordination with other partners.

Step 1: Increase the coordination of HIV programs across the federal government and between federal agencies and state, territorial, local, and tribal governments.

1.1 Ensure coordinated program administration: The Federal Government will increase its focus on coordinated planning for HIV services across agencies. States and tribal and local governments will also be encouraged to collaborate and develop coordinated planning models, including coordinated prevention and care planning and resource allocation activities.

Timeframe	Lead Agency/ Other Agencies	Actions to be Performed
By the end of 2010	HHS OS/HUD, VA, DOL, SSA, and DOJ	HHS OS will work with HUD, VA, DOL, SSA, DOJ, and other relevant Departments or agencies to establish an ongoing process to discuss coordination of planning and services delivery for domestic HIV programs.

Timeframe	Lead Agency/ Other Agencies	Actions to be Performed
	HHS OS	HHS OS will coordinate *National HIV/AIDS Strategy* efforts with Healthy People 2020, the U.S. Preventive Services Task Force, and the Task Force on Community Preventive Services in order to make sure that recommendations are aligned across groups to the maximum extent possible.
By the end of 2011	HHS OS/HUD, VA, DOL, SSA, and DOJ	HHS OS, HUD, VA, DOL, SSA and DOJ and other relevant agencies will produce a joint progress report on HIV/AIDS program collaboration. This report will highlight key deliverables, areas for consolidating grant awards, successes and current challenges, and proposed measurable outcomes
	HHS OS/HUD	. HHS OS, HUD, and other relevant agencies will consider ways to work with State and local health officials to improve coordination of Federal, state, and local programs. States will also be encouraged to submit, in consultation with localities and CBOs, to HHS OS progress reports on State HIV/AIDS plans and on efforts to improve coordination of Federal, state, and local programs.
	SAMHSA	SAMHSA will collect and report to HHS OS (and its agency partners) on how States are using Block Grant HIV set aside funding and report it annually to HHS and its agency partners.
	OGAC	OGAC will take specific actions to facilitate the exchange of best practices and lessons learned between domestic and international HIV/AIDS programs funded by the U.S. government.
	HHS	HHS agencies including CDC, HRSA, and SAMHSA will collaborate to examine the use of the same unique identifier across federal reporting to allow better coordination at the local, state, and federal levels.)

1.2 Promote equitable resource allocation: The Federal Government should review the methods used to distribute Federal formula grants or project implementation funds and take steps to ensure that resources go to the States and localities with the greatest need.

Timeframe	Lead Agency/ Other Agencies	Actions to be Performed
By the end of 2011	HUD	HUD will work with Congress to develop a plan (including seeking statutory changes if necessary) to shift to HIV/AIDS case reporting as a basis for formula grants for HOPWA funding.
	HHS OS	HHS OS will work with Congress and HHS agencies to shift from AIDS cases to HIV infections case reporting as a basis for formula grants for HIV prevention and to ensure that resources go to States and localities with the greatest need.

1.3 Streamline and standardize data collection: The Federal Government should take short-and long-term efforts to simplify grant administration activities, including work to standardize data collection and grantee reporting requirements for Federal HIV programs.

Timeframe	Lead Agency/ Other Agencies	Actions to be Performed
By the end of 2010	HHS OS/HUD, OMB	HHS OS, HUD, and OMB will convene a working group to consider recommendations for streamlining data collection requirements.
By the end of 2011	HHS OS/HUD, OMB	HHS OS, HUD, and OMB will consult with State and local health officials and consider changes to lessen grantee reporting burden.

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

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. This requires a monitoring system that evaluates the implementation of the Strategy, its progress, and the impact of the Strategy efforts. A system of regular public reporting will help to sustain public attention and support.

2.1 Provide rigorous evaluation of current programs and redirect resources to the most effective programs: Prioritize programs that are 1) scientifically proven to reduce HIV infection, increase access to care, or reduce HIV-related disparities, 2) able to demonstrate sustained and long lasting (>1 year) outcomes toward achieving any of these goals, 3) scalable to produce desired outcomes at the community-level, and 4) cost efficient.

Timeframe	Lead Agency/ Other Agencies	Actions to be Performed
By the end of 2010	HHS OS	HHS OS will task relevant agencies to assess their programs and report to ONAP and OMB, on which programs and initiatives satisfy this requirement, as well as those that both do not meet evidence-based criteria and should be phased-out and those that may require additional review.
By the end of 2011	ONAP/HHS OS	ONAP and HHS OS will work with Federal partners to establish a monitoring system to evaluate the implementation of the Strategy, its success at completing key actions, and demonstration of impact through achieving specified targets.

2.2 Provide regular public reporting: Progress in reaching Strategy goals will be reported by the Federal Government through an annual report at the end of each year.

Timeframe	Lead Agency/ Other Agencies	Actions to be Performed
By the end of 2011	HHS OS/DOJ, DOL, HUD, VA, and SSA	HHS OS, DOJ, DOL, HUD, VA, and SSA will submit data, as requested, to ONAP on successes and challenges in achieving the goals of the *National HIV/AIDS Strategy*.
Timeframe	**Lead Agency/ Other Agencies**	**Actions to be Performed**
	PACHA	PACHA will establish a mechanism to monitor progress toward achieving the *National HIV/AIDS Strategy* goals.
	ONAP/HHS OS	Relevant Federal departments and agencies will work with ONAP and HHS OS to review progress annually and identify remediation steps (if any) to achieve *National HIV/AIDS Strategy* goals. This will include considering key action steps for the coming year.

2.3 Encourage States to provide regular progress reports. The Federal Government will encourage States to provide annual reports to ONAP and HHS OS on progress made implementing their comprehensive HIV/AIDS plans. ONAP will incorporate the State reports into the national progress report at the end of each year.

Timeframe	Lead Agency/ Other Agencies	Actions to be Performed
By the end of 2011	HRSA, CDC/ HHS OS	HRSA and CDC, and other relevant Federal departments, in coordination with HHS OS, will work with States to encourage them to produce annual reports on progress made implementing their comprehensive State HIV/AIDS plans and that outline successes and challenges in achieving the goals of the *National HIV/AIDS Strategy*.
	ONAP, HHS OS	ONAP, HHS OS, and relevant Federal departments and agencies will review progress annually and identify recommended remediation steps (if any) to assist States in achieving *National HIV/AIDS Strategy* goals.

Evaluating the National HIV/AIDS Strategy

Evaluation is the systematic acquisition and assessment of information to provide useful feedback of a situation. In 2004, CDC proposed a framework for HIV/AIDS monitoring and evaluation.[9] The framework proposes three tiers for a national monitoring and evaluation plan and provides useful questions for each of these tiers:

1. Are we doing the right things?
2. Are we doing them right?
3. Are we doing them on a large enough scale?

These questions are useful guides in evaluating the U.S. response to the domestic HIV epidemic and the degree to which our national efforts align with the President's goals for the Strategy. The first evaluation step is to determine what is currently being done. The U.S. is doing many things to address the HIV epidemic, but there has not been a concerted effort across all Federal agencies to determine which activities are grounded in evidence, produce sustainable outcomes, and target those populations or areas with the greatest disease burden. Furthermore, our efforts are not always well coordinated. In recent years, key Federal leaders have taken important steps to promote collaboration. Nonetheless, individual efforts must give way to more sustained and consistent integration across programs and agencies.

The second evaluation step is to determine how evidence-based approaches are being implemented. Identifying and utilizing the right approaches to address the HIV epidemic are only useful if these approaches are being implemented correctly. An effort must be made to evaluate the application of effective behavioral and biomedical interventions, and the capacity and technical assistance required to implement these interventions. In the area of care delivery, more work is needed to measure quality of care, and assess measures such as whether individuals are being offered therapy consistent with current clinical practice standards. It is also important to evaluate whether policies that have been put in place to address the epidemic are being followed appropriately, including enforcement of civil rights laws that are such a critical part of any effort to reduce stigma and discrimination.

Last, we must ensure that enough people receive critical services to have an impact. After identifying the right approaches and implementing them correctly, these important efforts can be undermined if they are not taking place on a large enough scale to make a difference. To effectively monitor our progress, we plan to:

- By the end of 2010, release information to more clearly delineate the implementation and monitoring roles and responsibilities of ONAP, Federal agencies, the Federal HIV Interagency Working Group, and the Presidential Advisory Council on HIV/AIDS (PACHA).
- By March 2011, ONAP, in consultation with the Federal Interagency Working Group and PACHA, will prepare an evaluation plan that will include a timetable for reporting across agencies, and a framework for evaluating progress toward reaching Strategy goals.

9. Rugg D, Peersman, Carael M. Global advances in HIV/AIDS monitoring and evaluation. New Directions for Evaluation. 2004;103:36.

- By the end of 2011, ONAP will issue its first annual progress report on Federal implementation efforts and describe specific action steps for 2012.

Conclusion

HIV is a complex epidemic that requires all of us to address this critical national public health issue. This *Federal Implementation Plan* includes timelines for actions supporting the high-level priorities outlined in the strategy. This approach reflects a commitment to act with the urgency that the HIV/AIDS epidemic requires. Federal agencies will strive to take the steps described in this plan and take other steps to work with other partners to advance the goals of the *National HIV/AIDS Strategy.* The Federal Government, however, is only one of component of the broad effort needed to improve our response to the domestic epidemic. New partnerships and a commitment to better coordination and improved accountability will help us move forward.

With governments at all levels doing their parts, a committed private sector, and leadership from people living with HIV and affected communities, the United States can dramatically reduce HIV transmission and better support people living with HIV and their families.

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.

List of Acronyms

AAPI	Asian American and Pacific Islander
ADAP	AIDS Drug Assistance Program
AETC	AIDS Education and Training Center
AHRQ	Agency for Healthcare Research and Quality, http://www.ahrq.gov/
AI/AN	American Indian/Alaska Native
AIDS	Acquired Immune deficiency Syndrome
ASH	Assistant Secretary for Health, Department of Health and Human Services
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 and Medicaid Services, http://www.cms.gov/
DOJ	Department of Justice, http://www.justice.gov/
DOL	Department of Labor, http://www.dol.gov/
FDA	Food and Drug Administration, http://www.fda.gov/
HAART	Highly-Active Antiretroviral Therapy
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
IDU	Injection Drug Use/User
IHS	Indian Health Service, http://wwww.ihs.gov
LGBT	Lesbian, Gay, Bisexual, and Transgender
NIH	National Institutes of Health, http://www.nih.gov/
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, http://minorityhealth.hhs.gov

ONAP	Office of National AIDS Policy, http://www.whitehouse.gov/administration/eop/onap/
PACHA	Presidential Advisory Council on HIV/AIDS, http://www.whitehouse.gov/administration/eop/onap/pacha
SAMHSA	Substance Abuse and Mental Health Services Administration, http://samhsa.gov/
SSA	Social Security Administration, http://www.ssa.gov/
STD	Sexually Transmitted Disease
STI	Sexually Transmitted Infection
VA	Department of Veterans Affairs, http://www.va.gov/

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