

**AN AMBITIOUS AND TIMELY PLAN OF ACTION:
The implementation needed to accomplish
National HIV/AIDS Strategy goals**

September 27, 2010

The actions we take now will build upon a legacy of global leadership, national commitment, and sustained efforts on the part of Americans from all parts of the country and all walks of life to end the HIV epidemic in the United States and around the world. I am committed to renewing national leadership to fight HIV/AIDS here at home, as we continue our efforts to fight HIV/AIDS around the world.

PRESIDENT BARACK OBAMA¹

Introduction

On July 13, 2010, President Obama released the National HIV/AIDS Strategy (NHAS) and a companion Implementation Plan that describe steps to decrease annual HIV infections, increase the proportion of HIV-positive people who benefit from care services, and reduce HIV-related health disparities between 2010 and 2015. An accompanying Presidential Memorandum instructs multiple federal departments to submit operational plans for implementation of the Strategy to the White House Office of National AIDS Policy (ONAP) and the Office of Management and Budget (OMB) by December 9, 2010. In the memo the President further requires intra-departmental coordination led by the U.S. Department of Health and Human Services (HHS) and annual reporting on progress toward the Strategy's goals by ONAP.

The Strategy is a significant step forward in the response to the HIV/AIDS epidemic. America has never before had a comprehensive HIV/AIDS Strategy which aims to strengthen coordination and accountability to achieve clearly defined objectives. But to accomplish the worthy goals of the Strategy, federal officials must rapidly pursue full implementation of the plan.

Slow and incremental changes in programming and policy will not achieve NHAS targets. In fact, failure to produce bold, measurable plans risks rendering the Strategy completely obsolete. Without systems change in the near term, the federal government will fall seriously short of the success it has set out to achieve. Federal agencies cannot pursue business as usual. In some areas, operational plans will need to "break the mold."

Vigorous implementation of the NHAS can be a leading-edge of public health system improvement and can lay a foundation for full implementation of health reform legislation. Core principles in the NHAS, including effective use of resources, strategic coordination across multiple systems, and a focus on outcomes are critical across public health arenas. NHAS implementation is also the chance for everyone involved in the AIDS response to engage partners beyond the HIV/AIDS sector and establish connections with people working in other areas of health and social welfare.

¹ Implementation of the National HIV/AIDS Strategy, Presidential Memorandum for the Heads of Executive Departments and Agencies, July 13, 2010

Agency Operational Plans

Federal agencies are now preparing their NHAS operational plans. In order to establish a clear roadmap for accomplishing NHAS goals, these plans must:

- Include clear **logic models** of the inputs and outputs needed annually to reach each target goal. The July 2010 Implementation Plan identifies a variety of important actions, but these steps alone do not chart a course toward timely accomplishment of NHAS goals. Needed are step-by-step operational plans from the relevant agencies that detail what actions will be taken, and on what timeline, to realize NHAS targets on time.
- Set **clear expectations** of improved outcomes in the three priority areas—decreased incidence, increased access to care, and decreased disparities—quantified incrementally on an annual basis.
- Bring key services and activities to scale where they are most urgently needed and address the **socio-economic and societal conditions** that heighten HIV/AIDS vulnerability for certain populations.
- Be **publicly available**—either the original plans developed by agencies or as streamlined and finalized by ONAP.
- Provide specific information regarding the **services to be provided**—and corresponding resources—needed to reach targets, thereby allowing incremental monitoring of progress.
- Detail **short term actions** that will result in systems change and ramp up the most critically needed programming, as well as **longer term investments** that will yield benefits down the road.
- Set clear **deliverables, timelines, and responsibility** for each action.
- Describe specific strategies to engage **non-governmental stakeholders**, including private industry, the nonprofit/philanthropic sector, and people living with HIV/AIDS, to do their part to help achieve the nation's HIV/AIDS goals.

As an early bellwether, the operational plans are the next test of the government's commitment to the fight against HIV/AIDS domestically. As such, the operational plans must seek to do at least three critical things:

- Set clear plans for determining and communicating the Strategy's financial resource needs and the allocation of available resources;
- Prioritize activities most likely to yield tangible results toward the Strategy's goals; and
- Establish mechanisms to ensure adequate levels of coordination between and among federal agencies.

The following sections amplify how and why these are integral to the successful implementation of the NHAS.

I. Financial Resource Allocations

In order to achieve the goals established by the NHAS, operational plans must address the issue of funding, including clear articulation of needed resources, allocation and prioritization of available funds, and mechanisms to regularly monitor and publicly report on the outcome of the nation's HIV/AIDS investments. Without serious efforts to tackle thorny issues of funding, the Strategy cannot succeed.

The NHAS calls for more strategic and evidence-based policy and programming, and thus can achieve important progress against the epidemic. But even with needed policy reforms, increased and more strategic use of resources will be central to success. This will require a disciplined approach to marshal new resources, redirect resources (within and beyond HIV budgets), and pool resources so the NHAS can be fully realized. **In fact, reforms in the way resource allocations are made, prioritized, and utilized will be among the strongest indicators of the government's commitment to improve the domestic fight against HIV/AIDS.**

In an editorial published in the *Journal of Acquired Immune Deficiency Syndrome (JAIDS)*, Dr. David Holtgrave of Johns Hopkins Bloomberg School of Public Health estimates² that an additional, five-year investment of \$15 billion—which could be obtained through a combination of new and redirected appropriations and public/private partnerships—will be needed to reach NHAS goals. According to this analysis, achieving the prevention targets of the NHAS by 2015 would save nearly \$18 billion in averted public sector medical costs. A recent issue brief from the U.S. Centers for Disease Control and Prevention (CDC) makes a similar point in noting that “rapid scale up of HIV prevention efforts could save the most lives and money.”³

The Strategy's call for a concentration of effort on populations and geographic areas where the epidemic is most acute—including reform of federal and state funding distribution to better match jurisdictions' epidemiologic profiles—is an important step toward ensuring available resources are spent in ways most likely to yield the greatest results.

But better matching of spending against the epidemic is only one aspect of a more rigorous approach to resource decision-making. Federal implementers must also apply a high degree of scrutiny for every activity to assess its relative cost-effectiveness (against other funded and non-funded activities) and prioritize those initiatives most likely to make population-level impact as defined in the President's NHAS goals. Such an exercise is likely to identify worthy activities that nonetheless may not be prioritized for funding. Operational plans must reflect such difficult decisions if NHAS goals are to be realized. Some funding will no doubt be allocated differently when the NHAS is implemented, but the Strategy *cannot be about divesting* from the hardest hit communities; it must be about *making the response be maximally effective* in the hardest hit communities using a mix of public, private, and community efforts.

² Holtgrave, D, On the epidemiologic and economic importance of the National AIDS Strategy for the United States, *JAIDS*, 1 Oct 2010; vol. 55, issue 2, pp 139-142

³ CDC, Projecting possible future courses of the HIV epidemic in the United States, Atlanta, August 2010

RECOMMENDATION: *Discipline toward the NHAS goals requires there be “no sacred cows” and every cost center (intramural and extramural) be carefully scrutinized for its relative contributions in meeting the NHAS targets. To strengthen accountability and transparency, civil society must be afforded opportunities to comment on any reprioritized resource allocations.* The Strategy calls for “bundled/braided” funds from multiple funding streams (including but not limited to HIV-specific programs) to scale combination approaches and reductions in the volume, duplication and variability of different funding reporting requirements.

RECOMMENDATION: *Operational plans must specify activities to (1) combine funding from various agencies for collaborative efforts; (2) reduce reporting burdens on funded community agencies; and (3) support initiatives to leverage greater private sector, state and local government, and philanthropic investments toward Strategy activities.* The Strategy invites more transparent and accountable systems for public HIV/AIDS expenditures than have existed to date. Transparency must not be limited to what has already been awarded or spent. Credible mechanisms must be established to estimate, without prejudice, what levels of funding are needed annually to implement the Strategy, substantiate why such amounts are needed, and describe how each new investment will be strategically directed.

RECOMMENDATION: *Establish credible mechanisms for quantifying and justifying funds needed to implement the NHAS.* Agencies should establish anticipated outcomes for each incremental investment and engender confidence in federal HIV/AIDS budgeting and spending. Evaluation of federal funds awarded and spent must be integrated into regular monitoring and reporting of the Strategy. Processes must be established to quickly and nimbly make course-corrections to address changing environmental factors, unrealized and/or unanticipated outcomes, and new opportunities or challenges to advance core components of the NHAS.

RECOMMENDATION: *Operational plans delivered to OMB must inform funding levels included in President Obama’s FY12 budget request to Congress.* OMB should explicitly address NHAS implementation, resource needs, and recommended appropriations in the President’s annual budget request to Congress with as much substantiating information as possible.

II. Prioritize High Impact Activities

By committing to a limited set of high-yield activities that will be implemented immediately, operational plans can establish unequivocally the federal government’s intentions to accomplish NHAS goals.

Agency plans must reflect ambitious and rapid pursuit of NHAS targets. Below are six examples of the kinds of approaches that should be part of the NHAS operational plans.

1. Scale programming in 12 or more high-incidence areas

The President's NHAS goals can be achieved if our nation improves coverage of the prevention and treatment tools currently available. A recent analysis⁴ by academic and CDC experts presents two scenarios for scale-up of prevention services capable of accomplishing 50% reduction in HIV incidence; in one scenario over five years, in another, over ten years. In addition, emerging research, as well as experiences in San Francisco, Washington, DC⁵ and elsewhere, suggest that broader and more strategic delivery of testing, prevention, and treatment services will have synergistic effects, advancing progress on each of the NHAS incidence, care, and disparities goals. But current service coverage is inadequate and disproportionately distributed among various services and between regions and populations of greatest need to make real headway against the epidemic.^{6 7} Different federal programs are layered on top of each other with little flexibility to consolidate resources strategically.

RECOMMENDATION: *CDC, HRSA, SAMHSA, CMS and HUD should collaborate to bring HIV testing, prevention and care (including treatment) and support services to scale in 12 or more communities with the highest HIV incidence in the United States. This idea builds on the new Enhanced Comprehensive HIV Prevention Plans (ECHPP) funding announcement⁸ from CDC, but significantly expands the breadth, reach and impact of this program, and accelerates its implementation.⁹ New, reallocated and pooled funding can be used for intensified comprehensive testing, prevention, care and treatment outreach and delivery, as well as social services, in target areas. Federal government staff should work collaboratively with selected communities to develop, by mid-2011, detailed specific plans about how HIV services and resources, and non-HIV services and resources, can be brought together in maximum service of the spirit and goals of the NHAS. State and local public health staff should be involved in planning as well. Special attention must be given to identifying and addressing zones within selected jurisdictions where HIV incidence and care utilization rates are particularly concerning.¹⁰ Attention should be particularly focused on priority populations identified by the NHAS, including Black and Latino communities, and men who have sex with men of all races/ethnicities.*

As incentives to collaboration, less burdensome and less costly federal reporting and application requirements as well as heightened technical assistance on best-practice methods and approaches to improve local systems of prevention, care, planning and monitoring should be made available to local partners.

The “bring-to-scale” program approach would place a premium on combination interventions that can reach a significant portion of those in need and demonstrate population-level impact. Evidence-based

⁴ Hall, HI, et al., Estimated future HIV prevalence, incidence, and potential infections averted in the United States: a multiple scenario analysis. *J Acquir Immune Defic Syndr* 2010 July 30.

⁵ For example, see: www.hivandhepatitis.com/2010_conference/croi/docs/0312_2010_b.html

⁶ A 2006 survey found that only a relatively small share of gay men and other men who have sex with men (MSM) had participated in HIV prevention interventions in the previous 12 months (Sanchez, T., et al., Human immunodeficiency virus (HIV) risk, prevention, and testing behaviors—United States, National HIV Behavioral Surveillance System: men who have sex with men, November 2003-April 2005. *MMWR Surveill Summ*, 2006, 55(6): p. 1-16).

⁷ It is estimated that approximately one third of PLWHA in the United States are not in care (HRSA. HIV/AIDS Bureau. Outreach: Engaging People in HIV Care. August 2006. Available at <http://hab.hrsa.gov/tools/HIVoutreach>)

⁸ <http://www.grants.gov/search/search.do?mode=VIEW&oppId=56637>

⁹ In the immediate future, the 12 grantees under ECHPP should share information and lessons learned in scaling services, and help develop guidance to assist other areas scale programming.

¹⁰ For example, see San Francisco's mapping of community viral load by area of the city; page 48 of the San Francisco HIV Prevention Plan, <http://sfhiv.org/documents/Chapter1EpidemiologicProfile.pdf>

models will remain central to success, but all programs will have to be assessed to determine how well they can be cost-effectively scaled to have broad impact toward achieving the NHAS. Small scale, isolated programs alone are unlikely to advance the Strategy's goals. CDC, HRSA, and its grantees must move beyond the emphasis on individual behavior change interventions and do more to reach networks of people (including gay and straight couples, and Black and Latino communities) at elevated risk with prevention and care services.

Scaled HIV testing, prevention, and care services in the 12 or more high-incidence communities would include: routine and targeted voluntary HIV testing, linkage to care and treatment for people living with HIV/AIDS (PLWHA), HIV prevention services for PLWHA, targeted prevention for groups at elevated risk of infection, substance use and mental health, employment/vocational rehabilitation and post-imprisonment re-entry services, and housing for PLWHA (see sidebar). These would be supported by research, policy change, and planning activities. The federal government would allow greater flexibility in streamlining planning and reporting and in pooling resources among funding streams, which should include but not be limited to HIV-related programs. Support is also needed for mobilization of the communities most affected, including PLWHA. Community ownership of the response is critical to success.

Mounting evidence of the individual and community benefits of increased treatment availability and reduced community viral load underscore the importance of CDC, HRSA, and CMS working collaboratively with local stakeholders to develop strategic programs powered to achieve all three goals of the NHAS. Effective scale up of testing and care will require multiple and tailored approaches to engage individuals who, for a variety of reasons, feel estranged from or distrustful of the health care system.

In the first year of the Strategy, the federal government should concentrate on areas where the epidemic is most acute, dedicate resources and policy efforts there, establish models, and then implement them more widely in subsequent years. Jurisdictions may include states or portions of states, in addition to high incidence metropolitan areas.

Core Ingredients of a Comprehensive Response

To achieve meaningful progress against the epidemic, the availability and reach of key services and activities must be expanded to have adequate, local coverage capable of having population-level impact. Failure to achieve adequate coverage has conspired against the best laid plans to curb the epidemic. Scale, in this context, must be defined to include adequate coverage for most people in need of the following HIV-related services and activities:

1. Voluntary, informed HIV and STD testing
2. Sexual and reproductive health services
3. Linkage and case finding activities
4. HIV care and treatment
5. Stable housing
6. Support services, including mental health, substance abuse treatment, and peer support services
7. Prevention for positives and for negatives at highest risk of infection
8. Condom (male and female) and sterile syringe availability
9. Comprehensive sex education
10. Targeted prevention initiatives, including structural interventions focused on prisons and jails
11. Anti-stigma campaigns
12. Policy, public health planning, and legal reform guided by meaningful involvement of PLWHA and affected communities
13. Best-practice research in each area listed above and other areas to help reach NHAS targets

2. Encourage states to take the section 1115 waiver option

Recent health care reform legislation (the Patient Protection and Affordable Care Act) essentially eliminates rules that require PLWHA to wait until they are disabled by AIDS to be eligible for Medicaid coverage, but this change does not go into effect until 2014. Earlier implementation of the change would be a major opportunity to significantly expand health care coverage for PLWHA – *and is needed in order to accomplish NHAS care targets on time*. CMS represents approximately half of all federal HIV-related spending, yet CMS has no dedicated HIV-related initiatives to strengthen program development, evaluation, integration and other issues affecting current and future HIV-positive beneficiaries.

RECOMMENDATION: *CMS, HRSA, CDC and other agencies should launch a program to encourage and assist states in taking advantage of the section 1115 waiver option allowing them to include PLWHA who are not disabled by HIV/AIDS in state Medicaid plans.*

Specific actions could include: designing an application template to help states easily submit plans that meet CMS waiver rules; appointing a Senior Advisor on HIV to the CMS Administrator; sending a letter from the CMS Medicaid director to state officials, including state Medicaid directors and AIDS directors, welcoming HIV-related 1115 waiver applications; promoting the waiver option on the CMS website; holding conference calls for state officials including state Medicaid directors and AIDS directors and HRSA staff to discuss the waiver option; appointing designated CMS representatives to provide technical assistance to states; and facilitating data-sharing between HRSA and states to inform the waiver development process.

3. Launch anti-stigma initiative and efforts to encourage testing and care acceptance

Stigma has been shown to play a significant role in inhibiting access to and uptake of HIV testing and care. Stigma fuels HIV-related discrimination. Efforts are needed to mitigate stigma at every level from discriminatory policies and laws to stigmatizing societal attitudes and deeply held prejudices among even some care providers. Internalized HIV stigma suffered by people living with HIV is also a persistent barrier to optimal testing and care utilization and improved health outcomes.

Congressional Action Needed for Strategy Implementation

1. Direct the Congressional Budget Office (CBO) to estimate resources needed to accomplish NHAS goals.
2. Request that relevant federal agencies provide Congress with professional judgments of the resources needed to meet the NHAS targets by 2015. Congress should further request that agencies compare their professional judgments against FY10 appropriations and explain how they would invest each additional increase in their HIV budgets (in 10 percent increments) and what outcomes could reasonably be anticipated for each decile investment if it were appropriated.
3. Increase investments in HIV/AIDS prevention, care and support services adequate to accomplish NHAS targets.
4. Create an NHAS Fund resourced with a percentage tap on all HIV/AIDS programming.
5. Ensure HIV/AIDS activities are supported by Community Transformation Grants and the Prevention and Public Health Fund created through health reform.
6. Expand school interventions that address stigma and reduce isolation and marginalization of at risk youth, including LGBT, HIV-positive youth, and racial and ethnic minorities.

RECOMMENDATION: *HHS should implement an initiative focused on reducing stigma against PLWHA and groups perceived to be at elevated risk of HIV.* The initiative must include visible leadership from the President and other key leaders working closely with openly HIV-positive individuals to speak out against HIV-related discrimination. The President should also reach out to the faith community to encourage their engagement on the issue. We urge HHS to understand the inextricable link between anti-gay stigma and HIV-related stigma. Anti-gay prejudice should be challenged by federal, state and local health departments—through social marketing and other media—as a structural driver of HIV vulnerability among gay and bisexual men. The anti-stigma initiative should also include an expansion of school interventions that promote acceptance of LGBT youth and scale up of community-level interventions encouraging families to accept their LGBT children. The federal Department of Education should play a leadership role in these efforts.

An innovative, adequately funded and well-targeted social marketing campaign, informed by and focused on populations most affected by HIV, is needed to promote and to realize the benefits of HIV testing, care and treatment.

RECOMMENDATION: *HHS should launch a multi-year, multi-media social marketing campaign to promote HIV testing, prevention and care.* Leveraging corporate and philanthropic support, the multi-media initiative should aim to increase HIV awareness, decrease stigmatizing beliefs about PLWHA, and promote HIV testing and care. The effort should be sustained, evaluated, and modified, if necessary, over a 10-year period.

State and Local Action Needed for Strategy Implementation

1. Change or repeal laws and law enforcement practices that reinforce stigma, including those that criminalize the behavior of people living with HIV/AIDS, and those that result in sentencing inequities and contribute to excessive incarceration overall.
2. Change or repeal laws and policies that reinforce or amplify the economic or social marginalization of communities of color and LGBT people.
3. Expand school interventions that promote acceptance of LGBT youth and scale up of community-level interventions encouraging families to accept their LGBT children.
4. Garner meaningful involvement of PLWHA and affected communities in policy development and decision-making that affects their lives.

4. Coordinate Medicare/Medicaid and Ryan White and address capacity shortfalls

Ryan White programs funding has supported the developed of state-of-the-art programs that provide coordinated, comprehensive HIV/AIDS care. Ryan White best-practices and lessons learned must be shared with CMS to inform the planned expansion of Medicaid in 2014 and the anticipated increase in beneficiaries in Medicare in the coming decades. In addition, Ryan White providers and services will need to be integrated into public and private provider networks and services to ensure a seamless transition for people with HIV and AIDS who will finally have access to health insurance following the public and private insurance expansions. Many urban and rural areas in the United States most profoundly affected by HIV do not have the healthcare resources, infrastructure or trained staffing necessary to accommodate current or increased caseloads. Addressing these issues is critical to preparing for implementation of health care reform in 2014.

RECOMMENDATION: *HRSA and CMS should establish a joint initiative to improve and better integrate their HIV programs, and address health care capacity shortfalls. Activities should include:*

- Holding a summit of representatives from HRSA, local and state Ryan White administrators and providers, CMS, community health centers, family planning service providers and private insurers to discuss respective roles, responsibilities and benefits in HIV testing and linkage-to-care activities, and to develop a plan for coordinated service delivery.
- Collaborating on a pilot program (supported by the newly created Center for Medicare and Medicaid Innovation—CMI—or other initiative) to evaluate the coordinated, comprehensive medical home care provided by Ryan White funded programs. This project would identify key Ryan White program components that have a positive impact on health outcomes and provide cost-effective delivery of care, and would serve as a model for managing the care of low-income Medicaid and Medicare beneficiaries and minority populations. In addition to documenting the effectiveness of the Ryan White care model, the pilot would inform the development of new reimbursement mechanisms to adequately support Ryan White’s integrated, comprehensive model for care under Medicaid and Medicare.
- Collaborating on a demonstration program for leveraging the expertise of Ryan White funded programs to build HIV-related capacity in community health centers, correctional settings and clinics in areas where HIV expertise is limited.¹¹
- Ensuring that the holistic HIV/AIDS service delivery model that is the hallmark of Ryan White care is promoted in the expansion of community health centers funded by the \$11 billion in grants and support provided in the Affordable Care Act, including issuing guidance in conjunction with community health center grant requests that include HIV/AIDS services and linkages with Ryan White funded programs to expand HIV services in areas where there is a dearth of HIV expertise.
- Collaborating on research to identify personal, social, economic and other barriers to health care utilization and developing a joint plan of action for HRSA and CMS to address these barriers in their programming.
- Combining Ryan White, HOPWA, Title X and Medicaid funding streams (among others as appropriate) and establishing stronger, integrated HIV service systems to address critical health infrastructure, staff and peer training and recruitment, and other needs in communities heavily affected by HIV and struggling to meet service demands.
- Ensuring Ryan White providers and programs are included in temporary high-risk pool provider networks and services, issuing guidance to states on the use of Ryan White services as wrap-around support and technical assistance to Ryan White providers with regard to program integration, billing, and administration. This guidance can also be used to facilitate integration and continued support of Ryan White programs as other expansions of public and private insurance occur.

¹¹ This could be modeled after the successful Project ECHO program developed by the University of New Mexico.

- Encourage HRSA, CMS, the Administration on Aging, CDC and the Institute on Aging at NIH to coordinate efforts to plan for the burgeoning population of older adults living with HIV in the U.S. (half will be 50 or older by 2015) and to prevent new infections among older adults.

5. Create Health Equity Zones

In many of the communities hardest hit by HIV/AIDS, vulnerability to HIV infection and comparatively low rates of care access and utilization are linked to broader social and structural challenges including poverty, unemployment and under-employment, inadequate housing, racism, gender inequities, and homophobia.

RECOMMENDATION: *HHS, CMS, DOJ, and HUD should commit to collaborative efforts to create Health Equity Zones in 20 or more communities with high HIV incidence and suboptimal care utilization. The Zones would be designed locally with federal technical support. They would provide an array of medical, behavioral, and social (including policy and support services) interventions to address those factors that create vulnerability to HIV, STIs and other health concerns. The creation of Health Equity Zones should include careful evaluation over a five-year period using outcome measures of a variety of health and wellness markers, including, but not limited to, HIV and STI incidence, for both the individual participants and the community as a whole. As a “proof of concept” structural intervention, the Zones could be partially funded through NIH and be eligible for Community Transformation Grants established by the Patient Protection and Affordable Care Act. The Zones are an opportunity to engage the private sector in providing resources, goods, and data that can advance the goals of the NHAS, as well as overall health. As an incentive to participate, local communities must be exempted from certain burdensome reporting and re-application requirements and those that remain in force must be streamlined and coordinated.*

6. Ensure research efforts address NHAS goals directly and effectively

A more coordinated, cross-agency approach to HIV/AIDS research is needed in order to accelerate progress toward achieving the NHAS goals.

RECOMMENDATION: *NIH, CDC, HRSA, SAMHSA, HUD, and other agencies with HIV/AIDS research programs and resources should develop, by mid-2011, a coordinated research plan that 1) identifies research gaps to accomplish NHAS incidence, care and disparities targets, and 2) maps out a cross-agency strategy to address these gaps. The federal government must place a new emphasis on research that can*

PACHA’s Critical Role

The President’s Advisory Council on HIV/AIDS (PACHA) has been officially charged with monitoring implementation of the NHAS. In this role, PACHA members should consider more active involvement in identifying the specific action steps that will be necessary to realize NHAS targets on time.

Ideally, agency operational plans will detail actions steps along a timeline that shows how targets will be accomplished. But PACHA may need to identify where these plans fail to be specific, ambitious, or speedy enough to achieve Strategy targets. In these cases, PACHA should identify what specific additional policy and programmatic steps are necessary to advance the Strategy.

PACHA has a critical role in identifying the legal changes necessary to advance progress on NHAS goals.

be quickly and readily applied in the field and funded by implementation-oriented agencies including CDC, SAMHSA, HUD, and HRSA. More research is needed to evaluate combination approaches delivered at a scale that can have population-level impact. With significant percentages of people living with HIV/AIDS not in care, and increasing evidence of the prevention impact of expanded treatment and reduced community viral load, it is imperative federally funded research expand our knowledge about the best ways to reach the most at risk populations with voluntary HIV testing and to link people to care and maintain them in care.

There is also inadequate research attention to the development and testing of interventions for African-American men and women; Latinos and Latinas; gay men and other MSM of all races and ethnicities; bisexuals; and transgender populations; and survivors of violence and trauma, including the traumatic reaction to an HIV diagnosis. Expanded research on social determinants of health and HIV vulnerability as well as structural prevention and care interventions are needed. Novel, innovative mechanisms of funding must be created to enable the cross-disciplinary, multi-level, program- and policy-relevant research that is necessary to achieve the goals of the NHAS.

III. *Managing for Outcomes*

Success of the Strategy depends on improved management of the domestic HIV/AIDS effort.

Rigorous management and monitoring of implementation among various governmental and non-governmental stakeholders—with attention to efficient use of resources, development of high-yield activities, decreased duplication and greater coordination and collaboration—must be prioritized to achieve success. This requires:

1. A strong and robust federal role

An effective NHAS calls for a strengthened federal role in encouraging and supporting local and state efforts to implement strategic, ambitious and evidence-based approaches to HIV testing, prevention, and care. There is room for more technical support and direction from federal agencies in, for example, insisting that use of prevention resources at the local level is informed by epidemiological profiles and is at scale in the most at risk communities, or that plans are in place to establish a system that links HIV-infected people to care and supports them in remaining in care. The federal government must do more to encourage pooled funding streams and integration of HRSA, CMS, SAMHSA, and CDC programming on the ground.

The Presidential Memo establishing the leadership role of HHS in coordinating implementation of the Strategy is critically important. Health and Human Services Secretary Kathleen Sebelius assigned day-to-day NHAS responsibilities to the Office of the Assistant Secretary for Health (the “ASH”) at HHS. **To enable the ASH to do its job, it must be allowed to play a forceful role as a coordinator of federal agencies.**

RECOMMENDATION: *To underscore the HHS and ASH role in coordinating implementation, ranking White House officials such as the Director of the Domestic Policy Council, ONAP staff, or the President’s Chief of Staff should write relevant departmental heads to convey the President’s expectation that they fully cooperate with the ASH (including accepting adjustments to their operational plans) on matters of the NHAS.*

One lesson from the successful PEPFAR program is that budget authority at the Office of the Global AIDS Coordinator (OGAC) has been critically important to effective coordination of U.S. government's global AIDS work.

RECOMMENDATION: *Congress and/or the Executive Branch should create an NHAS Fund resourced with a percentage tap on all HIV/AIDS programming and should vest the ASH with the central authority to distribute the Fund's dollars. The ASH could allocate the Fund's resources for policy research, targeted programs, multi-agency projects, development of model programs, Health Equity Zones, capacity development, and other needs that are prioritized—through a transparent process—to meet the NHAS goals. Precedents for such a Fund exist in the Public Health Service evaluation set-aside fund and the NIH Director's Common Fund.*

RECOMMENDATION: *Annual progress reports to be issued by ONAP, as called for in the NHAS, should be released within ninety days of the end of each calendar year so that policy makers, providers, advocates and the public can have timely information about success, challenges and lessons learned in Strategy implementation. To monitor 2010 implementation indicators described in the Implementation Plan, the first report should be made publicly available no later than March 2011.*

2. Build meaningful, actionable mechanisms for accountability and transparency

American taxpayers and HIV/AIDS stakeholders deserve to know how public resources are being used to meet the goals of the NHAS. Extant federal, state, and local systems for collecting and reporting HIV/AIDS-associated data and for monitoring program spending and outcomes are not conducive to transparency and accountability.

RECOMMENDATIONS:

- *Working with federal agencies, ONAP must develop data collection and reporting mechanisms to build a workable “dashboard” to regularly monitor progress toward the Strategy's goals in a timely fashion. In some cases, this will require new models to estimate HIV incidence, prevalence, serostatus awareness, community viral load and other metrics at the local level. These models should be available for use by local planners in a timely manner. CDC needs more accurate, easier to implement, and faster-to-report methodologies that federal, state, and local officials can readily use to estimate incidence and other indicators.*
- *CDC and HRSA should play a more active role in supporting local and state health authorities in the use of federal HIV prevention, care, and planning funds. Particular attention should be placed on ensuring that resource allocation is informed by local or state epidemiologic profiles. For example, in the past, CDC staff conducted Periodic Program Reviews with local and state health authorities; these could be reinstated across multiple HIV-related funding streams.*
- *Work with health departments to develop “Statements of Alignment.” These Statements would accompany health departments' annual reports to CDC (much as departments now must provide a Statement of Concurrence from Community Planning bodies). The statements would either confirm that allocation of prevention effort reasonably matches current local epidemic conditions or explain why it does not. Such statements of alignment would need to be made publicly available.*

- *Transparency in use of prevention, care, and planning funding.* Federal agencies should annually publish reports on the use of funds – both those funds utilized by local and state authorities, and those spent by federal offices. These reports would track allocations toward different activities and target populations and communities.
- *Tracking funding alignment across and within states.* To get the greatest impact from resources, a closer look is needed at how well distribution of prevention and care dollars relates to HIV incidence and the number of PLWHA needing services. State allocation of funding to jurisdictions *within the state* should be publicly available and monitored to ensure resource allocations are informed by the service needs.
- *Identify federal and state legal reforms needed.* Alignment of reporting mechanisms to be more accountable, transparent, actionable, and efficient may require legal reforms. Federal entities should identify areas of the law that may be outmoded for a federal approach oriented around a singular, outcomes-oriented national Strategy.

3. Redefining our work

A truly effective national effort to combat HIV/AIDS requires many stakeholders to take on new roles and responsibilities and to redefine their work. For example, those who give HIV test results have a role in making sure people are linked to care; health care workers have a role in HIV prevention and treatment adherence support for those on anti-HIV medications; and government workers at every level must put a premium on cross-agency coordination to achieve shared NHAS goals. Community organizations will remain absolutely essential to an effective response, and their roles also must evolve to include what is being asked of public agencies: working within a strategic frame and being accountable for results.

RECOMMENDATION: *Federal contracts and reporting requirements should reflect new and broadened roles and expectations for providers.*

RECOMMENDATION: *As the frontlines of the nation’s fight against HIV/AIDS, community-based groups must be supported with adequate funding and be charged with report requirements that maximize impact and minimize administrative burdens. Meaningful training and technical assistance must also be prioritized.*

RECOMMENDATION: *HRSA and CDC must work with community representatives to redesign and streamline community planning activities. There is a critical role for community engagement in local level planning. These efforts should be focused on creating local and state plans that are strategically designed to have population-level impact on incidence, care access and disparities, in line with the NHAS. In many cases, the planning processes can be less time intensive and more transparent, and their results can be more widely shared with the community.*

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