



NATIONAL HIV/AIDS STRATEGY

IMPROVING OUTCOMES:
ACCELERATING PROGRESS ALONG THE
HIV CARE CONTINUUM

Office of National AIDS Policy

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Introduction

In July 2010, President Obama released the National HIV/AIDS Strategy (the Strategy) with a simple, but inspiring vision:

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

The Strategy outlined three primary HIV health outcome goals: 1) reducing new HIV infections, 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, the President declared that we must undertake a more coordinated national response to the HIV epidemic. And that’s what the key Federal agencies involved in the fight against AIDS set out to do – working with state, tribal and local governments, businesses, faith communities, philanthropy, the scientific and medical communities, educational institutions, people living with HIV, and others.

It was and remains an ambitious undertaking, but one that we must continue to prioritize. As noted later in this report, recent national and jurisdictional data indicate we are making gains against HIV. We are making progress and we cannot afford to stop now. In fact, our efforts to implement the Strategy must continue to accelerate, concentrating investments in populations most affected by HIV and with the greatest HIV-related health disparities, including gay and bisexual men, blacks, and Latinos.

Analyses conducted since the Strategy’s release show that there are significant gaps along the HIV care continuum—the sequential stages of care from being diagnosed to receiving optimal treatment—including that only 25 percent of people living with HIV in the United States have the virus under control. That is why this past July the President announced the establishment of the HIV Care Continuum Initiative to accelerate improvements in HIV prevention and care. Recent scientific discoveries have greatly enhanced our understanding of how to prevent and treat HIV. For example, treatment is now recommended for all adults and adolescents living with HIV in the United States to reduce the long-term consequences of HIV. Recent research also shows that an important benefit of earlier treatment is that it dramatically reduces the risk of HIV transmission to partners. Furthermore, HIV testing technology is faster, and more accurate than ever before, and HIV medications are less toxic and easier to administer.

In response to these compelling data, this report presents the first group of recommendations and action steps from the Federal HIV Care Continuum Working Group to help move our nation forward in meeting the goals of the Strategy by focusing on improving rates of diagnosis and care. The next stage of implementing the Strategy will be guided in large part by the HIV Care Continuum Initiative, in concert with ongoing implementation of the Affordable Care Act, which will increase healthcare coverage for thousands of persons living with HIV and millions at risk for infection.

In addition to new recommendations and actions for Federal agencies, this report provides persuasive examples of both local efforts and public-private partnerships that are already using data effectively to improve testing, services and treatment along the care continuum. By building on what we know works and implementing new ideas, we can accelerate progress toward the Strategy’s goals.

We are at a transformative time. As the President said in his 2013 State of the Union Address, “realizing the promise of an AIDS-free generation...is within our reach.” But we cannot rest as long as there are still too many Americans living with HIV who have not realized the benefits of treatment and others who are becoming infected every day. With science continuing to provide the foundation for our efforts, a strong Federal commitment to support state and local partners, and ongoing community engagement and leadership from people living with HIV, we are moving collectively, aggressively forward.

The State of the Epidemic

How are we doing with regard to HIV prevention and care in the United States? It is important to begin by reviewing the most recent data and reflect on how they inform the challenges that lie ahead.

The President has made implementing the Strategy a top priority, with the core values of the Strategy remaining just as relevant today as when it was announced. Resources have been re-allocated to better align with the geographic regions and populations bearing the greatest burden of the epidemic. Collecting, analyzing, and responding to accurate data have been prioritized. Reporting has been standardized and simplified. Our robust efforts to scale up science-based interventions targeting communities most affected by HIV and have population-level impact continue. We have enhanced efforts to confront stigma and discrimination. And we continue to strengthen and grow partnerships across all levels of government and with private stakeholders and the community to support a collective response to the epidemic.

Moreover, people living with HIV will continue to benefit from ongoing implementation of the Affordable Care Act. People living with HIV have higher rates of being uninsured, are more likely to face barriers in accessing medical care, and often experience higher rates of stigma and discrimination than other groups. The health care law expands Medicaid, in states that choose to do so, for low-income people; strengthens and improves Medicare; and expands access to affordable private insurance options. It also prohibits discrimination on the basis of HIV status while banning lifetime dollar limits and phasing out annual dollar limits on essential health benefits for most insurance plans.










As we continue implementation of the Strategy and the Affordable Care Act, it is reasonable to ask: how will we benchmark progress? Figure 1 presents the latest data on the Strategy's indicators. Because they are from either 2010 or 2011, these data cannot be used to grade the success of the Strategy, which was released in July of 2010. Instead, the value of the information is that it provides the most recently available data that give an accurate assessment of the status of the epidemic in the United States, and show changes from baseline estimates that were used to set the Strategy's targets.



Overall, this update shows progress, with eight of the nine Strategy indicators showing improvements from baseline. On the other hand, one indicator remained essentially stable, and progress towards several of the targets has been slow, especially for those in which multiple years have elapsed between the baseline and follow-up measure. To meet the targets of the Strategy, we must do better. Concerted and focused implementation efforts since the Strategy's release reflect that commitment; details can be found in prior reports on AIDS.gov.

Surveillance Data Primer

- The United States has one of the best HIV surveillance systems in the world
- National surveillance data do not reflect 'real-time' snapshot
- The lag in these data reflects time needed to report the data to health departments and confirm vital records, collect complete information, clean data, and analyze results
- National surveillance data and data from other sources, including from State and local levels, rapid assessments, studies, and program evaluation, can be used to monitor the progress of the Strategy
- CDC is working to reduce the time elapsed between data collection and reporting

Figure 1. Update on Nine Indicators of the National HIV/AIDS Strategy.

Strategy Indicator ^a	Strategy Baseline		Progress			Target
	Year ^b	Data estimate	Most current estimate ^c	Net result ^d	Progress from baseline to most current estimate	2015 Strategy target
Lower new HIV infections by 25%	2006	48,600	47,500	Decrease		36,450
Increase knowledge of HIV-positive status to 90%	2006	80.9%	84.2%	Increase		90%
Reduce HIV transmission rate by 30%	2006	4.6	4.2	Decrease		3.2
Increase linkage of newly diagnosed persons to HIV medical care within three months to 85%	2006	65%	79.8%	Increase		85%
Increase the percentage of Ryan White program clients in continuous care to 80%	2010	75.7%	75.5%	Stable		80%
Increase the percentage of Ryan White program clients with permanent housing to 86%	2009	82.0%	84.2%	Increase		86%
Increase viral suppression among MSM by 20%	2009	40.7%	41.7%	Increase		48.8%
Increase viral suppression among blacks by 20%	2009	32.7%	34.9%	Increase		39.2%
Increase viral suppression among Latinos by 20%	2009	36.6%	37.2%	Increase		43.9%

 Positive change  Stable

^a Data on seven of these nine indicators are from the Centers for Disease Control and Prevention 2013 National HIV Prevention Progress Report. The Ryan White program indicators are the most recent data from the Health Resources and Services Administration (HRSA) Ryan White program.

^b Some baselines estimates have changed due to revised and more accurate estimates, and may not be the same as the original estimate listed in the Strategy; viral load estimates were not available at the time of the Strategy's release.

^c All are 2010 data, except linkage to care and the Ryan White program data, which are 2011. HRSA changed from an aggregate-level to client-level data system in 2009-2010, and estimates are based on the more accurate client-level data system.

^d Does not use statistical tests to assess changes over time.

Additional information, including some pertinent data on specific populations with large numbers of HIV cases are described on the following pages; further details and additional data on most of the indicators can be found in the CDC's [National HIV Prevention Progress Report](#).

Target 1: Lower the annual number of new HIV infections by 25 percent

The number of new HIV infections remains unacceptably high. The decrease in the number of overall infections, while promising, was not seen in all groups.

Promising results	Between 2008 and 2010, HIV infections fell 21 percent among black women and 22 percent among male and female injection drug users (IDUs).
Challenges	Between 2008 and 2010, new HIV infections increased among men who have sex with men (MSM) by 12 percent, with the highest percentage increase among young (13-24 years) MSM (22 percent).
	Between 2006 and 2010, more HIV infections occurred among blacks than any other racial/ethnic group.

A main focus of Strategy implementation is preventing as many new infections as possible. Examples of actions include reallocation of HIV prevention funding to better align with populations and geographic regions where HIV is concentrated, and prioritizing prevention resources to focus on the most effective interventions. To reach the 2015 target, increased prevention efforts must continue to be prioritized and, through redirection of resources, brought to scale in the populations at highest risk. Effective, science-based interventions, including HIV testing; treatment combined with prevention interventions for people living with HIV; new prevention technologies such as pre-exposure prophylaxis; prevention education; condom use; and comprehensive substance abuse treatment are vital to helping us achieve the 2015 Strategy target.

Target 2: Increase the percentage of people living with HIV who know their serostatus to 90 percent

In 2010, 180,900 people were living in the United States with undiagnosed HIV infection. A key factor in reducing the number of new infections is for people to get tested so those with HIV can get care and protect their health. Moreover, knowing one's status can potentially help reduce the risk of HIV transmission.

Promising results	Between 2006 and 2010, the number of people living with undiagnosed infection decreased by 9 percent.
	Serostatus awareness was 90 percent or higher among persons 45 years of age and older, and male and female IDUs.
Challenges	Across age groups, young persons (13-24 years) are most likely to be undiagnosed, with fewer than half aware of their infection.
	Across risk groups, MSM are the most likely to be undiagnosed with HIV.

Clear progress has been made on this Strategy target. To achieve the target goal of 90 percent by 2015, testing efforts will need to reach more people with undiagnosed infections, through a combination of routine HIV screening and targeted HIV testing of groups least likely to know their HIV status, such as young gay men. Programs like the CDC's expanded HIV testing initiative and the Department of Veterans Affairs' (VA) work to increase routine testing are examples of ongoing, successful testing efforts.¹ The April 2013 grade "A" recommendation by the U.S. Preventive Services Task Force (USPSTF) to screen all adults aged 15 to 65 for HIV, should catalyze testing as part of routine medical care. Under the Affordable Care Act, new health plans will be required to cover HIV testing as recommended by the USPSTF without cost sharing.

Target 3: Reduce the HIV transmission rate by 30 percent

The HIV transmission rate measures the number of new HIV infections in a given year per 100 people living with HIV. It is an important measure of progress because it takes into account increases in the number of people living with HIV.

1. Czarnogorski, M., et al. Expanded HIV Testing in the US Department of Veterans Affairs, 2009–2011. *American Journal of Public Health*. 2013; 103(12): e40-e45.

Promising results	Between 2006 and 2010, the HIV transmission rate decreased 9 percent; this means fewer infections are being transmitted on average by people living with HIV.
Challenges	As more people continue to become infected with HIV, more people will need HIV treatment and prevention interventions to reduce the transmission rate.

To build on progress, efforts to support testing, and provision of care, treatment, and behavioral prevention services for people living with HIV will need to continue in order to achieve the 2015 target. The discovery that effective medical treatment for people living with HIV can dramatically reduce HIV transmission highlights the importance of integrating prevention and care.² This includes redoubling efforts to detect HIV as early as possible, offering timely and accessible treatment, and providing comprehensive information, education, and strategies to reduce the risk of transmitting HIV.

Target 4: Increase the percentage of persons diagnosed with HIV who are linked to HIV medical care within three months after diagnosis to 85 percent

It is essential to link people diagnosed with HIV to medical care as soon as possible to improve their health and reduce the risk of transmission to others.³

Promising results	For white Americans, the percentage linked to HIV medical care within three months of diagnosis was 85%.
Challenges	Linkage to HIV care within three months of diagnosis for black Americans remains the lowest for all racial and ethnic groups (75.9 percent).

Examples of Federal government action to improve linkage to HIV care include CDC’s support for expanding linkage services in community-based organizations, and research to develop linkage to care models for racial and ethnic groups disproportionately affected by HIV via the HRSA Special Projects of National Significance program. If not already in existence, HIV testing programs should establish protocols and implement strategies that facilitate timely linkage to HIV medical care. These strategies should include the use of laboratory, surveillance and other data as well as peer navigators to improve linkage to care and health outcomes among people who are newly diagnosed with HIV.

Target 5: Increase the percentage of Ryan White program clients in continuous care to 80 percent⁴

With recent HHS treatment guidelines now recommending that all adults and adolescents living with HIV in the United States be offered treatment, there is an even more urgent need to engage people diagnosed with HIV who have never been in care or who have subsequently fallen out of care.⁵ There is also a need for ongoing support to maintain high levels of adherence to antiretroviral treatment.⁶

Promising results	Among populations with the highest number of HIV cases, there were few differences in continuous care by race/ethnicity (75.9 percent white, 73.6 percent black, 79.3 percent Latino).
	There were also few differences by males versus females (75.0 percent vs. 76.5 percent), or by risk group (76.4 percent MSM, 76.3 percent heterosexual, 74.5 percent IDU).
Challenges	There was essentially no change in the percentage of clients in continuous care between 2010 and 2011.
	Young adults aged 19 to 24 years had that lowest percentage of continuous care (65.6 percent).

2. Cohen, M.S., et al. Prevention of HIV-1 Infection with Early Antiretroviral Therapy. *New England Journal of Medicine*. 2011; 365: 493–505.
3. White House Office of National AIDS Policy. National HIV/AIDS Strategy for the United States, July 2010.
4. In the Strategy and this report, continuous care is defined as at least two visits for routine HIV medical care in 12 months at least three months apart.
5. NIH. Guidelines for the Use of Antiretroviral Agents in HIV-1-Infected Adults and Adolescents. Available on <http://www.aidsinfo.nih.gov/guidelines>.
6. White House Office of National AIDS Policy. National HIV/AIDS Strategy for the United States, July 2010.

Within the Ryan White program, racial and ethnic disparities that are seen in the national epidemic are mitigated, and continuous care rates approach the Strategy target. Programs to determine the best interventions to keep persons living with HIV engaged in care are being implemented and evaluated, including at HRSA and the Substance Abuse and Mental Health Services Administration (SAMHSA). However, progress is still needed, especially among youth. Ryan White program grantees, Medicaid programs, CDC-funded surveillance programs, medical providers, and community-based organizations will need to strengthen coordination to support and monitor engagement in care.

Target 6: Increase Ryan White program clients with permanent housing to 86 percent

Being stably housed is an important precursor to getting people into regular care. Homeless or marginally housed people living with HIV are more likely to delay or have poorer access to care and are less likely to receive and adhere to optimal antiretroviral therapy.⁷

Promising results	Over a two-year period, the percentage of Ryan White program clients with permanent housing increased.
Challenges	In 2011, transgender and IDU clients were least likely to report stable housing (74.5 percent and 75.6 percent, respectively).

A substantial majority of Ryan White program patients are stably housed. The Department of Housing and Urban Development’s (HUD) Housing Opportunities for People with AIDS (HOPWA) program’s new emphasis on integrating housing and care services, and the Department of Labor’s (DOL) support of policies and practices to maximize employment opportunities for people living with HIV, are important steps towards increasing housing stability for people living with HIV. New models for supporting vulnerable populations may also be needed. While the Administration has prioritized the HOPWA program, sequestration has limited the amount of resources available.

Targets 7-9: Increase the percentage of HIV- diagnosed MSM, blacks and Latinos with a suppressed viral load by at least 20 percent

As noted in the Strategy, because viral suppression improves health and reduces the risk of HIV transmission, it is critical to increase viral suppression among all people living with HIV and particularly in communities that have the greatest burden of disease.⁸

Promising results	At the time of the Strategy’s release, there was no reliable national estimate for viral suppression. Today, we not only have overall national estimates, but national-level estimates for disproportionately affected populations as specified in the Strategy.
Challenges	Among populations at highest risk for HIV infection (MSM, blacks and Latinos), fewer than half are virologically suppressed.

To achieve the 2015 virologic suppression targets, there need to be improvements for MSM, blacks, and Latinos along the entire care continuum. We must also continue to strive to provide quality, effective care for all persons living with HIV in the United States. Ongoing coordination between the Ryan White program and implementation of the Affordable Care Act is vital to success, including continuing efforts by community health centers to provide HIV care. The Department of Justice’s (DOJ) ongoing work to investigate allegations of HIV-related discrimination in care is an important component of ensuring true access to care throughout the country.⁹ An example of the Federal commitment to improving treatment access is increased investment in the Ryan White program AIDS Drug Assistance Program (ADAP),

7. White House Office of National AIDS Policy. National HIV/AIDS Strategy for the United States, July 2010.

8. Ibid.

9. [Justice Department Settles Three HIV Discrimination Cases.](#)

as announced by President Obama on World AIDS Day in 2011, with corresponding reductions in persons on ADAP waitlists from over 9,000 in September 2011 to zero as of November 2013.

More Work to Be Done

While there are some early signs of progress, we still have important work to do to ensure our 2015 targets are met. In the United States, 1.1 million people are living with HIV and about 50,000 more become infected each year. Approximately one in six people with HIV do not know that they have the virus. Racial and ethnic disparities continue, and gay and bisexual men still account for the largest number of new HIV infections. In 2011 alone, gay and bisexual men accounted for 50 percent or more of all HIV diagnoses in all states except for two.¹⁰ While the drop in new infections among black women is a hopeful sign, black and Latina women continue to make up the majority of new infections among women nationally.¹¹

We must remain vigilant in implementing the Strategy with a laser focus on accelerating progress along the care continuum to meet the 2015 targets. Planning and implementing meaningful changes takes time. Collecting, evaluating, and responding to data is an iterative process. The Administration is using the following parameters to measure progress toward 2015 targets: 5 percent of the target goal would be gained in 2011; 15 percent in 2012; 20 percent in 2013; 30 percent in 2014; and 30 percent in 2015. This gradual improvement takes into account the time needed for program planning, start-up activities, and for effects of these changes to be measured. Whether these improvements are achieved will depend on an ongoing commitment and coordinated response across the nation, with a particular focus on specific populations where HIV remains stable or is increasing.

To turn around the national HIV epidemic, the Strategy necessarily focuses on those groups with the greatest number of new HIV infections each year. However, we must acknowledge that disparities continue to exist in other communities where the numbers of new infections are smaller, but no less important. Disparities in undiagnosed HIV infection and linkage to appropriate care remain issues in Asian and Pacific Islander as well as American Indian and Alaska Native communities. Comparable to national estimates, the majority of new infections in these communities continue to occur among gay and bisexual men.¹² Also of note is the fact that transgender women are at elevated risk for HIV infection in the United States and there is a need for them to receive culturally competent care.¹³ Progress on the Strategy must benefit smaller and larger communities disproportionately affected by HIV infection.

Reaching each of our quantitative targets will require that we continue to embrace the fourth goal of the Strategy: achieving a more coordinated response to the epidemic. This will require a collective response, including all partners—state, local and Tribal governments; the private sector; faith communities; philanthropic organizations; scientific and medical communities; educational institutions; and perhaps most importantly, community members including those at risk and living with HIV—to come together and do their part. On the Federal level, we need to ensure agencies are supporting the most cost-effective, quality prevention strategies available and allocating resources commensurate with observed disparities in the epidemic. At the state level, continuing implementation of the Affordable Care Act, including expansion of Medicaid among low-income populations, is vital to addressing HIV-related disparities. At the local level, ongoing work must ensure that the most affected communities are being reached with the most effective interventions.

These are dynamic and challenging times. But we will not let up on our efforts to fight HIV in the United States. Achieving the 2015 Strategy targets will require ongoing, committed engagement, accelerated progress, and adequate support from all parties across the nation.

10. CDC. MMWR. HIV Testing and Risk Behaviors among Gay, Bisexual, and Other Men Who Have Sex with Men—United States, December 2013.

11. CDC. Estimated HIV incidence in the United States, 2007–2010. HIV Surveillance Supplemental Report. 2012; 17(4). Available on http://www.cdc.gov/hiv/surveillance/resources/reports/2010supp_vol17no4/.

12. CDC. *HIV Surveillance Report, 2011*. 2013; 23: Table 3b. <http://www.cdc.gov/hiv/topics/surveillance/resources/reports/>.

13. Baral S.D., et al. Worldwide Burden of HIV in Transgender Women: A Systematic Review and Meta-analysis. *The Lancet Infectious Diseases*. 2013; 13(3): 214–22.

Accelerating Federal Action: Recommendations of the HIV Care Continuum Working Group

On July 15, 2013, the third anniversary of the release of the Strategy, President Obama issued an [Executive Order](#) establishing the HIV Care Continuum Initiative. The Initiative is designed to mobilize and coordinate Federal efforts to meet the goals of the Strategy in light of recent advances in the prevention and treatment of HIV infection.

The Strategy catalyzed efforts to better characterize the domestic epidemic to make our work more focused. Data released by the CDC as part of this effort show that there are critical gaps along the HIV care continuum—the sequential stages of care from being diagnosed to receiving optimal treatment. A high proportion of the estimated 1.1 million people living with HIV are undiagnosed; one-third are not linked to medical care; nearly two-thirds are not engaged in ongoing care; and only one-quarter have the virus effectively controlled, which is necessary to maintain long-term health and reduce the risk of transmission to others. Progress is needed along the entire continuum, not only on each end, but also in the steps between testing and virologic suppression; particularly the marked drop-off between linkage and sustained engagement in care.

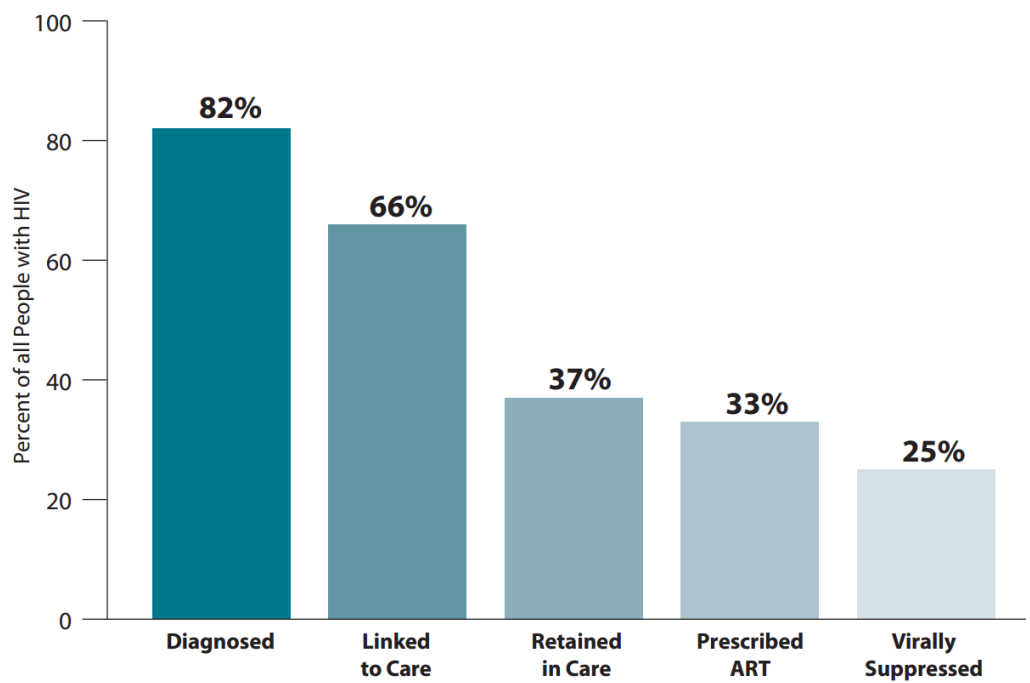
As part of the Executive Order, President Obama called for the creation of the HIV Care Continuum Working Group, co-chaired by the Director of the Office of National AIDS Policy and the HHS Assistant Secretary for Health. The purpose of the Working Group is to coordinate Federal efforts to improve outcomes nationally across the HIV care continuum. Members are from agencies across the Federal government including the DOJ, DOL, HHS, HUD, VA, the Office of Management and Budget (OMB), and the Office of National Drug Control Policy (ONDCP).

The Working Group expressed strong support for multiple recent and ongoing actions across Federal departments that are responsive to the Initiative’s charge. Highlights of this work were detailed at the Initiative’s [launch](#).

Supporting Investments in Innovation and Coordination to Improve Outcomes along the HIV Care Continuum

As part of the Care Continuum Initiative launch in July 2013, Secretary of Health and Human Services Kathleen Sebelius announced that HHS will launch “Integrating HIV Prevention and Care Services to Improve HIV Outcomes in Areas of High Unmet Need,” an estimated \$8.5-10 million new demonstration project to expand the capacity of community health centers, health departments, and their grantees to provide integrated HIV prevention and treatment services across the HIV care continuum.

Figure 2. The HIV Care Continuum in the United States, 2009.



Source: CDC. XIX International AIDS Conference, July 2012
Note: 2010 diagnosed estimate is 84.2%

The first official task of the Working Group was to submit recommendations to the President on how Federal efforts will be integrated to improve outcomes along the HIV care continuum. The Working Group's Recommendations Subcommittee worked across agencies to develop recommendations that were brought to the co-chairs for consideration. The Working Group also held two webinars with the HIV/AIDS advocacy community to ensure that all stakeholders had the opportunity to be heard as the recommendations were being developed.

Below is the first set of recommendations and actions presented by the Working Group. The action steps are not exhaustive, nor do they represent the considerable work that is already underway to make improvements along the care continuum. Rather, they are specific examples of new activities. This implementation work will be coordinated by the Office of HIV/AIDS and Infectious Disease Policy (OHADIP) at HHS, as part of their overall charge to implement the Strategy. All new activities and initiatives included in the recommendations will be conducted by agencies within existing resources.

Recommendation 1: Support, implement and assess innovative models to more effectively deliver care along the care continuum

Gaps along the care continuum highlight the importance of developing new models of care that effectively diagnose and care for people living with HIV. While examples of successful models exist, the changing healthcare environment provides greater opportunity for innovation and rigorous evaluation of new delivery models.¹⁴

Specific Agency Actions:

- 1.1** CMS and HRSA will support models of care that provide incentives for improvements along the care continuum.
- 1.2** VA will implement the use of real-time routine electronic HIV clinical reminders at all VA facilities to increase HIV testing among veterans.
- 1.3** HRSA will fund a new initiative to increase the capacity of Ryan White program grantees to increase the engagement and retention of young gay men of color in care.
- 1.4** SAMHSA, in collaboration with HRSA, CDC, and HUD, will support and rigorously evaluate the development and implementation of new integrated behavioral health models to address the intersection of substance use, mental health, and HIV.

Recommendation 2: Tackle misconceptions, stigma and discrimination to break down barriers to care

The Strategy emphasizes the need to address misconceptions and HIV-related stigma and discrimination, which remain significant barriers to accessing testing and care.¹⁵ These factors must continue to be addressed through outreach, monitoring, and changing outdated laws and policies.

LaPHIE: Using Health Information Technology to Improve Care Continuum Outcomes

The Louisiana Public Health Information Exchange (LaPHIE), funded by HRSA, provides real-time alerts to HIV primary care providers when a person living with HIV, who has not had CD4 or HIV viral load monitoring in over a year, is seen for any reason within a network of seven hospitals that provides the majority of HIV care in Louisiana. Thus, LaPHIE provides an opportunity for re-engagement in care.

Of the 344 out-of-care patients identified during the first 18 months of the program's implementation, 85 percent were re-engaged in HIV care. Even among those who had been out of care for 18 months or more, 82 percent participated in at least one healthcare visit, or had a viral load or CD4 count test.

LaPHIE shows that a simple alert can go a long way towards reengaging people in care.

14. Moore, R.D. et al. Improvement in the Health of HIV-Infected Persons in Care: Reducing Disparities. *Clinical Infectious Disease*. 2012; 55 (9): 1242-51.

15. Sayles, J.N. et al. The Association of Stigma with Self-Reported Access to Medical Care and Antiretroviral Therapy Adherence in Persons living with HIV/AIDS. *Journal of General Internal Medicine*. 2009; 24(10): 1101-8.

Specific Agency Actions:

- 2.1 CDC, in collaboration with HRSA, will develop a multimedia campaign for persons living with HIV to: 1) address myths surrounding HIV treatment; 2) reach persons who have been diagnosed, but have not been linked to care; 3) re-engage those who have dropped out of care.
- 2.2 DOJ will issue, for the first time, best practice recommendations to help ensure that Federal and state criminal laws reflect current scientific knowledge regarding HIV and avoid imposition of unique or unwarranted barriers and penalties, including criminal penalties, based on HIV status.
- 2.3 HHS, VA, HUD, and DOL, in close collaboration with DOJ, will review social marketing and education campaigns related to the care continuum and incorporate nondiscrimination and Health Information Privacy messages.
- 2.4 HHS Office for Civil Rights (OCR) will conduct compliance reviews of health care providers to ensure their compliance with relevant provisions of the Health Insurance Portability and Accountability Act (HIPAA). DOJ and OCR will provide technical assistance to health care providers with regard to requirements to care for persons living with HIV, in compliance with Federal nondiscrimination laws.

Recommendation 3: Strengthen data collection, coordination and use of data to improve health outcomes and monitor use of Federal resources

Considerable progress has been made in improving and streamlining HIV-related data collection to monitor Strategy progress. Examples include the generation of the care continuum itself, and Secretary Sebelius’ [order](#) establishing seven HIV core indicators for HHS agencies and the requirement that these same agencies reduce data collection burden by at least 25 percent.¹⁶ Further action will build on these meaningful changes, with a focus on sharing data and supporting generation of continuums at the state level.

Specific Agency Actions:

- 3.1 Federal agencies will expand upon HHS efforts outlined above and harmonize HIV data collection and increase interoperability of HIV data systems to improve care continuum outcomes.
- 3.2 CDC will increase technical assistance efforts to States and locally- funded jurisdictions to describe and monitor care continuums in their locales.
- 3.3 CDC will require that eligibility for related HIV surveillance funding be contingent on the collection and submission of data necessary to monitor the care continuum.
- 3.4 HRSA, in collaboration with CDC, will support a newly funded initiative to increase states’ use of continuum of care data to more effectively target public health interventions and care.

Recommendation 4: Prioritize and promote research to fill gaps in knowledge along the care continuum

Continuing to improve outcomes along the care continuum requires ongoing scientific inquiry. Developing and testing new approaches that are scalable, sustainable, and engage populations at greatest risk of HIV health disparities are extremely important. Supporting new basic scientific research to inform the development of more robust HIV treatments is also vital.

**HIV Resource Allocation Modeling:
A Tool to Align Resources Along the
Care Continuum**

One ongoing challenge in Strategy implementation is how to best allocate resources in the local context. This was recently addressed by the Philadelphia Department of Public Health. In collaboration with CDC, Philadelphia used a HIV Resource Allocation Model, developed by CDC health economists, to help the department identify the optimal allocation of CDC HIV prevention funds across populations and interventions. The model provided the estimated costs per HIV infection averted for a wide range of interventions, including interventions to reduce risk behavior, testing, and medication adherence. Results showed a striking 100-fold difference in the cost of each HIV infection averted, depending on the type of intervention and population prioritized. These results guided local decision making for maximizing the potential of Federal dollars for HIV prevention. OHAIDP and CDC recently worked with 3 other jurisdictions to apply this model and will continue to collaborate with other localities to scale up this approach.

16. Valdiserri, R.O., et al. Measuring What Matters: Development of Standard HIV Core Indicators Across the U.S. Department of Health and Human Services. *Public health reports (Washington, DC: 1974)*. 2013; 128(5): 354-9.

Specific Agency Actions:

- 4.1 The National Institutes of Health (NIH), CDC, and VA will support new implementation research that takes into account the complexities of the interplay of individual behavior, social, structural, and biomedical factors on care continuum outcomes.
- 4.2 NIH will support the development and study of new HIV medication formulations and delivery systems to improve treatments and rates of virologic suppression.
- 4.3 NIH will support new basic science to help advance HIV cure research.
- 4.4 An Institute of Medicine (IOM) report will be commissioned by ONAP and lead Strategy agencies to recommend how to best coordinate and strengthen implementation science research efforts across Federal agencies.

Recommendation 5: Provide information, resources, and technical assistance to strengthen the delivery of services along the care continuum, particularly at the state and local levels

Strategy implementation is taking place in a dynamic environment, with scientific advances and expanding healthcare options driving change at an increasingly accelerated pace.¹⁷ Extending assistance to state and local partners will help support and integrate care continuum efforts.

Specific Agency Actions:

- 5.1 HHS will develop a core curriculum requirement that teaches basic contemporary HIV concepts, with a focus on information relevant to the care continuum; this training will be required of certain Federal employees working in the HIV field, including project officers, and certain staff of Federal HIV care and prevention grant recipients.
- 5.2 CDC, HRSA, SAMHSA, and ONDCP will implement new training and technical assistance activities to increase the capacity of health departments and community-based organizations to leverage opportunities created by the Affordable Care Act to improve outcomes along the care continuum.
- 5.3 HHS (including CMS and the Indian Health Service), HUD, and DOL will collaboratively develop and disseminate guidance on how both the Affordable Care Act and Medicaid expansion can be used to facilitate access to care, prevention, and supportive services for people living with HIV.
- 5.4 HUD and HHS will provide technical assistance and trainings to better coordinate and align the provision of housing services with medical care for people living with HIV.
- 5.5 HRSA will place new emphasis on improving outcomes along the care continuum for AIDS Education and Training Centers.

As we work together to achieve the goals of the Strategy, we must ensure that the HIV Care Continuum Initiative is focused squarely on responding to recent advances to prevent and treat HIV infection. These recommendations and action steps complement ongoing work to reduce new HIV infections and improve the health of people living with HIV. The Working Group will continue to serve as a catalyst for Federal action to improve outcomes nationally along the care continuum. The Working Group will continue to meet on a regular basis to review progress made implementing recommended actions; identify and resolve barriers and delays; share lessons learned; and address emerging issues or concerns. To that end, as part of the annual report on Strategy implementation, ONAP will include an update on the Initiative's progress.

17. Millett, G.A. et al. A Way Forward: The National HIV/AIDS Strategy and Reducing HIV Incidence in the United States. *Journal of Acquired Immune Deficiency Syndrome*. 2010; 2: S144-7

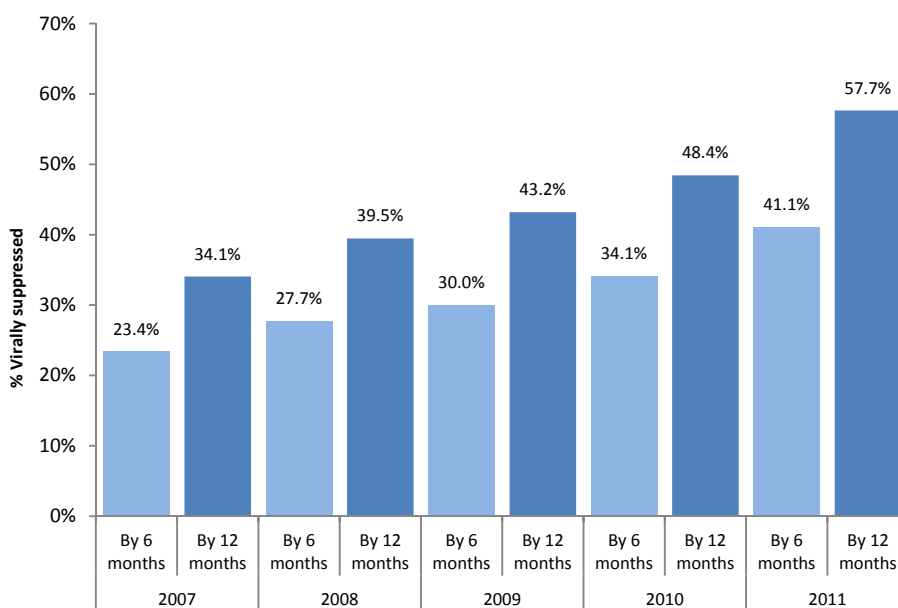
Signs of Progress Along the HIV Care Continuum in Three High Prevalence Cities

Implementing the Strategy not only requires ongoing Federal action; it requires leadership and work at the state and local levels, with strong community engagement. Across the country, we have seen localities embrace the Strategy and implement innovative approaches to improve outcomes along the care continuum and prevent infections.

In fact, applying the Strategy’s principles should not be done using a “top-down” approach. The Strategy’s principles and recommendations were grounded in what we heard was working at the local level during the fourteen ONAP-sponsored community listening sessions held during the development of the Strategy. In collaboration with Federal partners, states and local jurisdictions have worked to align efforts. Now, in several jurisdictions that have some of the highest rates of HIV in the nation, we are seeing strong indications of success emerging from such dedicated grassroots work. The following examples highlight steps that three cities have taken, through ongoing, collective mobilization at different points in the care continuum, to increase testing and diagnose people living with HIV who are unaware of their infection; link and retain people in care; increase access to antiretroviral therapy; increase viral suppression; and decrease disparities.

New York City: New York City has had the largest number of HIV cases of any U.S. city.¹⁸ In recent years, the City has made important progress in improving care along the care continuum. In 2012, nearly seven in 10 adult New Yorkers (aged 18-64) reported having ever been tested for HIV, a significant increase from five in 10 in 2002. Among people newly diagnosed with HIV, the proportion virally suppressed rose from 34.1 percent 12 months after diagnosis in 2007 to 57.7 percent in 2011 (Figure 3).¹⁹ A Health Department recommendation in 2011 that all people with HIV be offered ART may have helped accelerate the proportion of HIV patients who are virally suppressed: by the end of 2012, for the 73,573 persons known to be in care with a documented viral load test, nearly eight in 10 were virally suppressed.²⁰

Figure 3. Virologic Suppression within 6 and 12 Months of Diagnosis, New York City, 2007-2011



Source: NYC Department of Health and Mental Hygiene, June 2013

Commensurate with these improvements, new diagnoses in New York City have declined by 40 percent since 2002, and estimated new infections among all city residents have declined by 52 percent between 2006 and 2012, including by 42 percent among MSM.²¹ Officials believe that the decline in new infections may be a result of the progress New York City has made in improving outcomes along the care continuum.²²

18. Hall, H.I., et al. Epidemiology of HIV infection in large urban areas in the United States. *PLoS one*. 2010;5(9):e12756.

19. New York City Department of Health and Mental Hygiene. NYC HIV Surveillance Data, 2013.

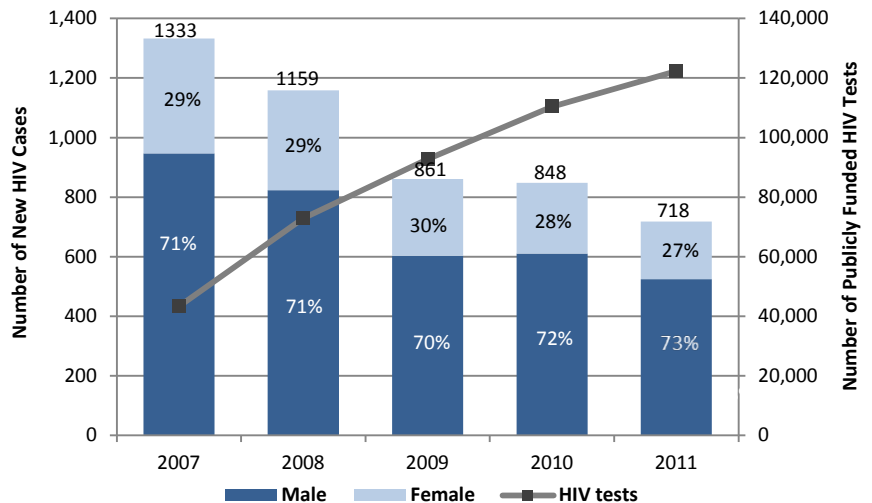
20. New York City Department of Health and Mental Hygiene. Community Health Survey, 2002 and 2012.

21. New York City Department of Health and Mental Hygiene. NYC HIV Surveillance Data, 2013.

22. Ibid.

Washington, DC: The District of Columbia has among the most severe HIV epidemics in the country, with 2.4 percent of residents living with HIV; among blacks, the rate is 3.7 percent, with the highest rate among black men at 5.4 percent.²³ In response to the ongoing HIV crisis, D.C. worked across all levels of government and collaborated with community-based organizations, medical providers, and other key stakeholders to expand testing, condom distribution, needle exchange efforts; implement a “treatment on demand” program; and prioritize an evidence-based approach to the epidemic. Data indicate that these efforts are paying off, with a 46 percent drop in newly diagnosed cases between 2007 and 2011, despite increased testing rates (Figure 4).

Figure 4. Newly Diagnosed HIV Cases and HIV Testing by Year and Sex, District of Columbia, 2007-2011



Commensurate with these drops, there were parallel improvements in serostatus awareness and viral suppression; for instance, among MSM living with HIV, awareness of infection increased from 59% in 2008 to 77% in 2011; viral suppression among blacks increased from 25% in 2009 to 40% in 2011.²⁴

San Francisco: Nearly 16,000 San Franciscans are diagnosed and living with HIV; MSM comprise 73% percent of cases.²⁵ Using a data-driven approach, San Francisco focused HIV prevention and care investments in neighborhoods with large gay populations, with an increased emphasis on providing testing and promoting early treatment for HIV. As shown in Figure 5, from 2004 to 2011, there was progress, with increases in testing and treatment correlated with decreased diagnosed cases and estimated new infections (incidence).²⁶

Figure 5. Comparison of HIV Indicators for MSM, San Francisco, 2004-2011.

	2004	2011
Unrecognized HIV infection	21.7%	7.5%
Tested for HIV in last 6 months	44.1%	57.8%
Currently on HIV treatment	Not available	88%
HIV incidence	2.6%	1.0%
Newly diagnosed cases	630	307

These changes in outcomes among MSM are paralleled by higher rates of virologic suppression in San Francisco compared with national rates; 62 percent of people living with HIV had the virus controlled, and 57 percent had suppressed viral load within 12 months of diagnosis.²⁷

With ongoing implementation of the Strategy, other jurisdictions will necessarily need to vary their approaches based on a multitude of factors, including the severity and distribution of their local epidemic, resources, and other dynamics. However, New York City, Washington, DC, and San Francisco demonstrate what can be accomplished when collective efforts and investments across communities are focused on applying evidence-based interventions in populations where HIV is most concentrated.

23. District of Columbia Department of Health Annual Epidemiology and Surveillance Report, 2013

24. District of Columbia Department of Health. 2012 Annual Epidemiology and Surveillance Report. Available at:

<http://doh.dc.gov/sites/default/files/dc/sites/doh/publication/attachments/Executive%20Summary.pdf>.

25. San Francisco Department of Public Health. HIV/AIDS Epidemiology Annual Report, 2012. Available at

<http://www.sfdph.org/dph/files/reports/RptsHIVAIDS/AnnualReport2012.pdf>.

26. Raymond, H.F., et al. A New Trend in the HIV Epidemic Among Men Who Have Sex With Men, San Francisco, 2004-2011. *JAIDS*. 2013; 62(5): 584-9.

27. San Francisco Department of Public Health. HIV/AIDS Epidemiology Annual Report, 2012.

Public-Private Partnerships: Advancing the Strategy Along the HIV Care Continuum

In launching the Strategy, President Obama made clear that the fight against HIV/AIDS must be a shared effort, and extend beyond government alone.²⁸ The following are two examples of public-private partnerships making a difference along the care continuum at the local level.

A Public-Private Partnership to Increase Access to Care

AIDS United's Access to Care (A2C) initiative was created to increase access to and retention in effective HIV healthcare and support services for people living with HIV, particularly previously diagnosed, low-income people who know their HIV status, but are not receiving care or support. A2C is designed to help bridge access to services for the most marginalized people living with HIV by serving as an innovation hub for local strategies to tackle barriers to care.



A2C kicked off on World AIDS Day 2009 with a multi-year, multi-million dollar commitment to AIDS United from Bristol-Myers Squibb's (BMS) Positive Charge initiative. In May 2010, five Positive Charge grants were awarded to Chicago, Illinois; New York, New York; Oakland and San Francisco, California; North Carolina; and Louisiana. The grants called for geographically and culturally diverse organizations within a region to combine their expertise in the development of community-driven solutions to help enable greater access to HIV care and treatment.

A2C's work was significantly expanded in July 2010 when the U.S. government's Corporation for National and Community Service (CNCS) entered into a five-year agreement with AIDS United under the Social Innovation Fund. The agreement is supporting 104 additional community-driven projects to improve individual health outcomes and strengthen local services systems to connect economically and socially marginalized people living with HIV to high quality supportive services and health care. CNCS's match requirement of AIDS United and the communities it funds ensured that every Federal dollar invested was matched once at the national level through private donors, and then matched again at the local level, resulting in \$2.2 million of Federal investment generating an additional \$6.6 million in matched funds.

The work being done by A2C's grantees is inspiring. For example, in Philadelphia, San Francisco and Los Angeles, grantees are working to help formerly incarcerated people living with HIV access care and obtain safe and affordable housing and participate in back-to-work programs. In San Diego, Christie's Place is focused on improving women's access to and retention in comprehensive HIV care, with a particular focus on women of color. In Chicago, the Connect2Care project goal is to increase access to and consistent retention in HIV care. St. Louis' BEACON Project provides access to peer advocates to help deal with barriers of stigma, disclosure and fear and assist in navigating social services resources. Montgomery, Alabama is using encrypted, high-speed data connections, clinical support, and high definition video/diagnostic tools to allow urban-based care teams to hold real-time consultations with rural consumers and providers throughout the state. And a rigorous national evaluation is documenting outcomes and identifying successful models for improving linkage to care.

28. White House Office of National AIDS Policy. National HIV/AIDS Strategy for the United States, July 2010.

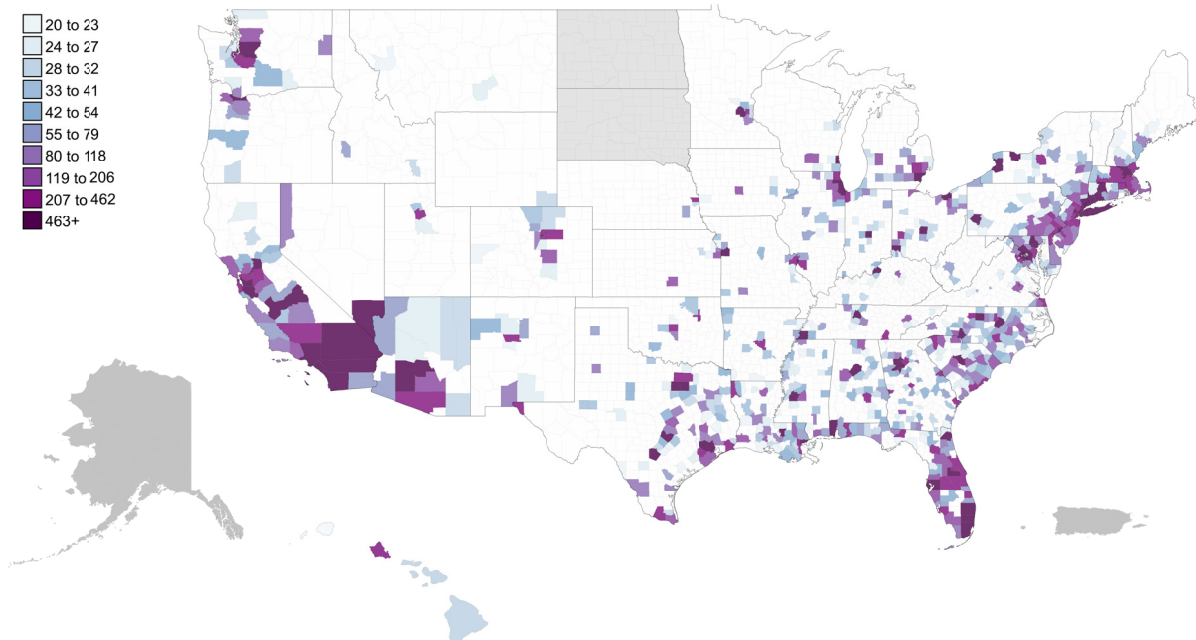
A Public-Private-Academic Partnership to Improve Targeting of HIV Resources

A major step in reducing new HIV infections is to intensify HIV prevention efforts in the communities with the highest burden. AIDSvu, a free, interactive online mapping tool, was developed through a public-private-academic partnership to provide a roadmap that highlights geographic areas where HIV is concentrated. AIDSvu is a collaborative effort in which high quality HIV surveillance data are provided by CDC and local health departments in 20 cities; financial support is provided by Gilead Sciences; and data processing and mapping are conducted by Emory University. In addition, an Advisory Committee representing multiple sectors provides guidance.

The purpose of AIDSvu is to make HIV prevalence and new diagnosis data widely available, comprehensible, and locally relevant. By displaying data at the state, county and, in some cases, zip code and census tract levels, AIDSvu allows users to visually explore the HIV epidemic in the United States alongside social determinants of health data, as well as identify critical resources nearby such as HIV testing center locations.

An example of how geographic mapping can help focus efforts, AIDSvu presented data showing that 92 percent of new HIV diagnoses between 2008 and 2011 occurred in only 25 percent of U.S. counties (Figure 6). AIDSvu's mapping of the data shows that the areas with the darkest shading represent counties where the most new HIV diagnoses are occurring. Identifying areas with high numbers of new diagnoses is particularly useful for understanding where to focus HIV prevention and care efforts.

Figure 6. Number of HIV Diagnoses Among Adults and Adolescents by County, 2008-2011.



Using Maps to Focus HIV Care Resources

While HIV remains concentrated in urban centers, accessing appropriate care in rural areas remains a challenge, particularly in the South. Medical AIDS Outreach in Montgomery, Alabama used mapping to improve delivery of HIV-related clinical care expertise via telemedicine. This was done by overlaying an AIDSvu state map of HIV cases by county with a state map of healthcare provider shortage areas by county. Medical AIDS Outreach assessed how these data overlapped to determine where rural telemedicine clinics would have most impact to fulfill unmet needs for HIV care.

The AIDSvU collaborative effort has also developed a new website with detailed visualizations of the care continuum in several major U.S. cities: HIVContinuum.org. This tool uses public health surveillance data to increase our understanding of the specific demographic groups, neighborhoods and ZIP codes where interventions should be considered to improve HIV testing, care and treatment provision. In addition to detailed maps, data can be summarized in a grid (Figure 7) that shows the distribution of each continuum indicator (columns) by demographic group (rows). The color in each box corresponds to the most frequent category of the outcome at the ZIP code level: the lighter the color, the better the indicator. This type of information is particularly useful for recognition of patterns and monitoring progress towards goals among many different groups and indicators. Once those patterns are recognized, more analyses can be performed to uncover details needed for public health and community action.

Figure 7. Heat Mapping the HIV Care Continuum, Atlanta, 2011



Note: The color within each box corresponds to the most frequent category of the outcome at the zip code level for each subgroup. The categories for new HIV diagnoses were created from the overall data, therefore no mode exists (gray box).

- 1 New HIV diagnoses 2006-2010 per 100,000 persons
- 2 Proportion with AIDS within 12 months of diagnosis
- 3 Proportion with a CD4 or viral load within 3 months of diagnosis
- 4 Proportion with a CD4 or viral load in 2011
- 5 Proportion with suppressed HIV viral load in 2011

Moving Forward

We are making steady progress in the fight against HIV/AIDS in the United States, but we must accelerate our efforts if we are to meet the Strategy's goals. Recent scientific advances have given new energy to the great potential we have to meet this charge. To capitalize on these advances, we must continue our work, including focusing on efforts along the care continuum.

We recognize that resources will always be limited. Sequestration has reduced Federal HIV/AIDS programs, and economic challenges have translated into reductions to programs in many State and local governments and community-based organizations. As noted in the Strategy, "we will have to make tough choices about the most effective use of funds. Therefore, resource allocation decisions for programs should be grounded in the latest epidemiological data about who is being most affected and other data that tells us which are the most urgent unmet needs to be addressed."²⁹ For many jurisdictions and programs, this includes re-doubling efforts to effectively prevent and treat HIV among gay and bisexual men, who comprise two-thirds of annual new infections nationwide. Emphasis is particularly needed on programs for young gay and bisexual men, especially young black gay and bisexual men.

On the Federal level, while collaboration has increased and communication across Departments and agencies has improved dramatically, we must continue this progress—ensuring that each Federal agency is sharing information, prioritizing investments and interventions in the right populations, and avoiding duplication. The HIV Care Continuum Initiative is enhancing collaboration across the Federal government and the recommendations in this report reflect the Administration's commitment to continue moving forward steadily and effectively. Ongoing implementation of the Affordable Care Act, including Medicaid expansion, will help contribute to the Strategy's success. However, at the time of this report, multiple states, including those with large populations of persons living with HIV, have not yet committed to expand Medicaid.^{30,31}

As described earlier, there are successful, innovative programs being implemented across the country to get more people tested, treated, and engaged in care. We need to scale up the best programs by redirecting funding from less effective activities. Each locality must assess how to best deal with its HIV/AIDS challenges while also adhering to science-based approaches and remaining accountable for strategies that reduce new infections and improve the health of people living with HIV. Moreover, it is critical that people living with HIV continue to provide leadership and guidance in policy and program implementation.

Achieving the goals of the Strategy is within our reach. Everyone involved in this fight must continue to commit, and we welcome others to join us to seize the moment and act.

29. White House Office of National AIDS Policy. The National HIV/AIDS Strategy for the United States, July 2010.

30. CDC. HIV Surveillance Report: Diagnoses of HIV Infection in the United States and Dependent Areas, 2011. Available at http://www.cdc.gov/hiv/pdf/statistics_2011_HIV_Surveillance_Report_vol_23.pdf#Page=68.

31. Kaiser Family Foundation. [Status of State Action on Medicaid Expansion Decision, as of October 23, 2013](#).

List of Acronyms

CDC	Centers for Disease Control and Prevention (HHS)
CMS	Centers for Medicare and Medicaid Services (HHS)
CNCS	Corporation for National and Community Service
DOJ	U.S. Department of Justice
DOL	U.S. Department of Labor
HHS	U.S. Department of Health and Human Services
HRSA	Health Resources and Services Administration (HHS)
HUD	U.S. Department of Housing and Urban Development
IOM	Institute of Medicine
NIH	National Institutes of Health (HHS)
NHAS	National HIV/AIDS Strategy
OCR	Office for Civil Rights (HHS)
OHAIDP	Office of HIV/AIDS and Infectious Disease Policy (HHS)
OMB	Office of Management and Budget
ONAP	White House Office of National AIDS Policy
ONDCP	Office of National Drug Control Policy
SAMHSA	Substance Abuse and Mental Health Services Administration (HHS)
USPSTF	United States Preventive Services Task Force
VA	U.S. Department of Veterans Affairs



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