ii. Project Narrative

- *INTRODUCTION*

Through Ending the HIV Epidemic (EtHE) funding, the Atlanta Eligible Metropolitan Area (EMA) will implement strategies, interventions, approaches, and core medical and support services to reduce HIV infections in Cobb, DeKalb, Fulton, and Gwinnett Counties in Georgia (further referenced as EtHE jurisdictions) by 75% (from a three year average of 1,504 down to 376) in the five-year period and to contribute to the overarching national goal for the reduction of new HIV infections in the U.S. to less than 3,000 per year by 2030. This will be achieved by expanding and refining access and retention in care, broadening treatment adherence efforts and access to antiretrovirals to help clients reach viral suppression all in support of Pillar Two (treat Persons Living with HIV [PLWH] rapidly and effectively to reach sustained viral suppression). Activities will also support Pillar Four (respond quickly to potential HIV outbreaks to get needed prevention and treatment services to people who need them) by improving surveillance systems, dedicating a Surveillance Specialist to lead a response team, and utilizing mobile clinics to provide immediate access to care in areas where outbreaks have been identified. Target populations will be African Americans (with a focus on Men who have Sex with Men [MSM]), Transgender Females and Hispanics. Integration with the RWHAP is essential in maximizing services and efficiencies but is key to improving individual-level and population-level viral suppression. In the EtHE jurisdictions, the viral suppression rate for all PLWH is 54% but the viral suppression rate for RWHAP clients is 87%. All initiative services will augment the RWHAP system of HIV care and treatment by: improving access and removing barriers to access and retention through systems improvements; expanding weekend and evening hours for all Part A services – including Rapid Entry Clinics; having Community Health Workers and Peer Navigators maintain relationships with and support clients while they are in care; broadening the availability of telehealth services for primary care, behavioral health and case management; increasing the availability of ADAP medications and access to antiretrovirals funded under Part A; expanding the availability of essential support services (such as housing and transportation); improving systems to identify and reach persons lost to care; implementing evidence-based interventions designed to improve access and retention in care; and more effectively using social media.

- *NEEDS ASSESSMENT*

The **target populations**: Black Males, Black MSM (BMSM), Black Females, Hispanics and Transgender Females were selected for the EtHE initiative. According to CDC HIV surveillance data for 2017 and released in 2019, Metropolitan Atlanta had the 2nd highest rate of new HIV diagnoses nationwide; 2nd highest rate among Males; 1st highest rate among Black Males; the 2nd highest rate among Males aged 25-34; and the 5th highest rate among Hispanic Females (Table 1). The epidemic is primarily among BMSM.

Table 1: CDC Incidence and Prevalence by Selected Characteristics, 2017	Incidence				Prevalence	
	New cases	Rate per 100,000	Rank	2016 Rank	Cases	Rate per 100,000
Males and Females	1,618	33	2	4	31,961	670
Males	1,322	57	2	3	25,319	1110
Black Males	939	128	1	3	16,561	2315
Hispanic Males	116	49	11	20	1,986	862
Females	296	12	7	10	6,642	267
Black Females	232	26	25	23	5,329	612
Hispanic Females	17	8	5	--	426	200

Transmission Category	Incidence			Prevalence		
	Black	Hispanic	White	Black	Hispanic	White
Male to Male Contact	820	97	185	13,230	1,641	4,606
Injection Drug Use	28	4	16	1,671	145	271
M to M Contact and IDU	9	2	8	814	110	373
Heterosexual Contact	315	30	44	5,952	496	493
Other	0	0	0	223	21	37

Black Males: Black Males continue to experience disproportionately high HIV incidence rates compared to their white peers.[1] The EtHE jurisdictions have an estimated 1% HIV prevalence rate, indicative of a concentrated HIV epidemic, and among Black Men in the EtHE this rate is 3.2%, indicative of a generalized HIV epidemic in this sub-population.[2] The HIV acquisition risk is similar to that documented by the CDC nationwide; where among Black Males with new HIV diagnosis, 1 in 10 acquire HIV via heterosexual contact, and 8 in 10 through male-to-male sexual contact (BMSM).[1] CDC notes that the presence of sexually transmitted infections (STIs) greatly increase the likelihood of acquiring or transmitting HIV with significantly higher rates of syphilis, gonorrhea and chlamydia documented in Black Males than White Males in 2018.[3]

BMSM: Gay and bisexual men continue to be most affected by the HIV epidemic in the United States.[4] Among PLWH in 2018, 47% were BMSM. This group carries an overwhelming burden of the HIV disease and comprised 48% of new infections in the EtHE jurisdictions in 2018.[2]

Black Females: Among Females, Blacks are by far the most affected racial or ethnic group with a lifetime HIV risk of 1 in 48 for Females (compared to 1 in 880 for White Females).[5] The number of newly diagnosed Black Females with HIV increased by 9% from 176 new diagnoses in 2016 to 193 in 2018, indicating the need for focused interventions aimed at preventing new infections in Black Females and increasing linkage to care.[2]

Hispanics: There was a 25% increase in the number of new HIV diagnoses among Hispanics in the EtHE jurisdiction from 117 newly diagnosed persons in 2016 to 156 in 2018. Despite the absolute numbers of newly diagnosed Hispanics being lower than Whites and Blacks, this percentage increase was significantly higher than that for Whites or Blacks in the same period.[2]

Transgender Females: An estimated 1 in 5 Transgender Females (individuals assigned male at birth who identify as female) in the U.S. are living with HIV.[6,7] In the EtHE jurisdictions, a significant increase of new HIV diagnoses of 27% was noted in 2018 among Transgender Females; from 25 new diagnoses in 2016 to 34 in 2018.[2] According to the CDC, a majority of Transgender Females that are newly diagnosed with HIV are aged less than 30 years, black and have unprotected sex.[8] Due to the small numbers for Transgender Females in the EtHE jurisdictions and thus limited socio-demographic information, it is postulated from the CDC findings that Transgender Females in the EtHE are most likely young, black and sexually active and are vulnerable to acquiring HIV. They should therefore be prioritized for engagement in HIV testing, prevention and care services.

Table 2: Care Continuum for Core Counties, Atlanta 2018				
4 County Aggregate	Linked	Engaged	Retained	Virally Suppressed
Overall	85%	67%	51%	54%
White	90%	66%	52%	59%
Black	79%	66%	50%	53%
Hispanic	86%	63%	52%	56%
Male	86%	67%	51%	55%
Female	79%	65%	50%	53%
Transgender	79%	68%	52%	53%
MSM	86%	68%	52%	56%
Black Females	80%	66%	50%	53%
Black Males	79%	67%	50%	53%
Black MSM	79%	69%	51%	54%
County				
Fulton	86%	65%	50%	52%
DeKalb	84%	68%	51%	56%
Cobb	85%	66%	49%	56%
Gwinnett	84%	70%	55%	60%

Table 2: Disparities are highlighted by the comparison of Care Continuum indicator rates for the overall EtHE jurisdiction with subpopulations. Linkage rates were below the overall (85%) for all target populations (Black 79%; Transgender 79%; BMSM 79%), except Hispanic (86%). Hispanics had lower rates of engagement (63%) than other groups. Hispanics (56%) and MSM (56%) had slightly higher viral load suppression rates. Approximately 36% of PLWH had no viral load reported in 2018 and are considered not suppressed in this analysis. Missing viral load measurements may lead to an underestimate of viral suppression. Subgroup analyses of EMA data highlight the following with particularly low rates: *Linkage*: BMSM ages 13-24 (76%) and ages 25-44 (77%), Hispanic Females (58%); *Viral Load Suppression*: BMSM ages 13-24 (51%) and ages 25-44 (53%). Engagement (70%), retention (55%) and viral suppression (60%) although rates in Gwinnett county were above the EtHE jurisdiction's average.

- **Service gaps, social and structural barriers, and unmet need** have been identified by the community and described in the *Georgia Integrated HIV Care and Prevention Plan 2017-2021*, and the *Strategy to End AIDS in Fulton County* (a getting to zero plan developed by the Fulton County HIV/AIDS Task Force). The following have informed development of budget

items specifically spelled out in this application (italics) while others would be eligible for funding under the allocations to RWHAP service providers:

Stigma	*There is a need for Rapid Response Teams*
Socioeconomic conditions	*Location of services*
Lack of information on availability of services	*Lack of access to healthy foods*
Reduce unmet need for affordable transportation	*Systems and technologies issues*
Provider cultural competency training and intercultural awareness curriculum.	*Access to affordable housing &/or emergency/ transitional housing.*
Lack of access to specialized providers including infectious disease specialists.	There is a need for drop-in centers available late in the evening
Untreated mental health and substance abuse issues. Implement telehealth.	*Identify clients that have fallen out of care and attempt to reengage them into care*
Create evening & weekend services hours to remove barrier for clients employed 9am-5pm.	*Eliminate barriers to patient entry at Ryan White programs – implement data sharing.*
Standardize linkage protocols across programs to ensure clients have one provider appointment within 30 days of diagnosis.	*Assess disparities in areas where HIV is most heavily concentrated to identify provider locations and services – increase mobile clinic system.*
Continue to implement Rapid Entry pathways at Ryan White clinics to ensure an initial medical visit for newly diagnosed patients within 3 days of diagnosis.	*There is a need for annual Client Satisfaction Survey and a Consumer Needs Survey to assist with service delivery monitoring and CQI.*
Additional Patient Navigators who are easily accessible to all points of entry.	*There needs to be a review of no shows and appointment processes in RW clinics. Strengthen processes to follow-up with clients.*
Provide support services to decrease barriers to care, including and translation assistance.	*There are challenges in accessing data to enhance active re-engagement by linkage staff. Implement DPH Data to Care models.*
There is a need for Emergency Financial Assistance.	Share and match prevention and treatment data.
To reduce missed appointments there should be consistent reminders. Provide reminders for medication refills & ADAP recertification using online platforms for streamlined client communications.	*Ensure that PLWH and those at highest risk for HIV are involved in substantial ways in all aspects of program planning, development, and implementation.*
Adherence coaching tools (non-medical) including the use of technology for reminders to take meds.	*How to get into care, stay into care, centralized information/intake phone line (Ryan White).*
There is a need for empowerment activities.	Expand capacity for HIV care through FQHCs & Community Health Centers
Need ability to query GA Department of Health (DPH) the DPH Health Information Exchange (HIE) to verify if a person is out of care or receiving care elsewhere.	Provide jail pre-release linkage with 30 days of medicine.
Ensure that newly diagnosed persons in vulnerable populations (youth, those with mental health or substance use disorders, those with unstable housing, and those recently released from incarceration) receive intensive linkage navigation services	*Use patient navigators to assist with retention for vulnerable populations, especially those previously lost to care. Identify patients at high risk for loss to follow up and design individualized retention plans*
Explore feasibility of ClientTrack, the Homeless Continuum of Care's chosen Homeless Management Information System (HMIS) database, interfacing with	Establish systems for in-house pharmacies & ADAP pharmacies to communicate with patient and provider immediately when a prescription is not

Ryan White CAREWare and explore the HIPAA barriers to data sharing.	picked up, and institute adherence interventions for those demonstrating poor adherence.

Barriers to track progress toward meeting the goals

The ability to track the effectiveness of interventions designed to address stigma and discrimination that create barriers to care for the target population may have limitations. New partnerships, technical assistance and robust evaluation methodologies should improve the Atlanta EMA's performance management in this area.

- There is a need to broaden our collaborations to identify, link, engage, retain, and achieve viral suppression. In the development of the *Georgia Integrated HIV Care and Prevention Plan 2017-2021*, the primary focus was on efforts to be undertaken by RWHAP and CDC supported programs. Under this initiative, we will take a whole of society approach in identifying service gaps and in planning for services. There are potential challenges in identifying stakeholders among non-RWHAP organizations whose primary focus is on services to PLWH and those who provide service to a larger group of recipients such as programs operated by faith-based organizations, community health services, housing authorities, insurance providers, and substance abuse providers.

- *METHODOLOGY*

Proposed methods will address the needs of PLWH and reduce barriers experienced with achieving optimal health outcomes. Proposed methods were formed from the input of Metropolitan Atlanta HIV Health Services Planning Council (PC), the Fulton County HIV Advisory Committee (FCHAC), community members and recommendations from the Integrated Plan, NHAS, and quality improvement projects. Through the community engagement and planning process led by DPH, additional activities will be identified in the Atlanta Target Operating Plan (ATOP) for execution in years two through five of this proposal. Activities identified in EtHE jurisdictions work plans will be incorporated into the EtHE activities. It is anticipated the first three months will be dedicated to the hiring of staff to manage EtHE activities. A baseline data analysis will support the design of the projects to ensure service gaps and barriers are being addressed by proposed activities. In the first year, an evaluation consultant will aid in the development of the evaluation tools for the measurement of project impact and in subsequent years guide and support the analytical process with EtHE staff. The proposed project will aim to **increase access to care to ensure PLWH receive treatment rapidly, improve health outcomes to effectively reach sustained viral suppression, and reduce barriers to care by responding to outbreaks and addressing disparities in the jurisdiction.** The proposed activities will address the service gaps seen among target populations. These populations disproportionally represent many who are newly diagnosed, out of care, or in care and not virally suppressed in the EtHE jurisdictions. Proposed activities may include but are not limited to:

- **Community Engagement** – *Community Planning, Focus Groups, Stakeholder Engagement*. Contractors will be hired to coordinate the planning process for implementation of EtHE activities. Planning activities will be conducted with community input. Facilitated focus groups will solicit information from community members to guide the design of EtHE activities, including provision of services and development of targeted marketing. In years

two through five, input from stakeholders will inform the development and implementation of evaluation studies, client satisfaction surveys, and needs assessments.

- **Information Dissemination and Marketing** – *Target Awareness Campaigns*. Current billboards, radio, and television advertisements in the area focus on condom usage, testing, and HIV medications. Smaller organizations rely on print or digital flyers, word-of-mouth, and community events to bring awareness of HIV services. To engage target populations, more marketing campaigns of various media platforms are needed to bring awareness of available services. Building upon the lessons learned from HRSA-19-034 Building Capacity for HIV Elimination in RWHAP Part A Jurisdiction, Fulton County's Ryan White Part A Program (RWPA) has provided funding to **expand targeted awareness campaigns** to connect BMSM to HIV services through information dissemination and community engagement. Input received from community engagement will inform which marketing strategies to utilize.
- **Infrastructure Support to Integrated Data Sharing and Use** – *Data System Enhancements.* EtHE Staff will coordinate the **design and development of a data management information system (DMIS)** by bridging existing systems to achieve data integration. The redundancy and frequency of presenting proof of status, income, and residency for service providers has become burdensome and laborious for clients, discouraging entry and retention in care. To reduce the administrative burden on the client, increase customer satisfaction, and improve efficiency of service delivery, the first two years will focus on the building and modification of a central eligibility portal. In years two through five, the DMIS will be modified to include integration with housing, employment, insurance, and surveillance data to reduce barriers to care. Contingent upon the compatibility of data systems and memorandum of agreements, RWPA will share data with HOPWA and DPH to improve care coordination of shared clients. Training modules will be developed for end users. Additional projects include building interfaces to an appointment reminder system and the Georgia Health Information Exchange. In collaboration with DPH, the creation of **Data-to-Care team** will support Pillar Four by using surveillance and care data to detect clusters, respond to outbreaks and to identify those truly out of care and/or not virally suppressed. The team will be comprised of the Data Manager, a Surveillance Specialist, who will work with Disease Intervention Specialists (DIS) in each jurisdiction to identify, notify, and engage clients into care, and a Project Analyst. The Data-to-Care initiative will address the challenges of assisting clients who are lost to follow-up due to relocation, incarceration, immobility, or other extenuating circumstances.
- **Dissemination of Evidence-Informed Interventions** – *Enhancing Peer Support and Addressing Stigma.* EtHE activities will reduce barriers to care by addressing health disparities in the jurisdiction through **implementation of evidence-based interventions.** RWPA will partner with University of California San Francisco (UCSF) to train peer staff and implement evidence-based strategies such as MI-PEERS and TXTTXT from the HRSA E2i portfolio. These strategies focus on motivational interviewing and Anti-Retroviral Treatment and Access to Services (*ARTAS*) to overcome barriers to ART adherence and using text

messaging to improve medication adherence. UCSF will utilize HRSA resources to aid in the improvement of health literacy in the jurisdiction with the "In It Together" model and address stigma through tools from the National Minority AIDS Council (NMAC).

- **Development of System Linkages and Access to Care Activities** – *Centralized Linkage/Retention teams*. RWPA will enhance and improve capacity of services and infrastructure for care by **establishing a peer-focused centralized linkage system** to provide support to new clients and clients re-entering care in accessing care quickly. The system will consist of at least 40 peer staff dedicated to assessing eligibility for HIV services, enrollment into care, and scheduling of medical appointments. The team will function from a centralized location which will operate on evenings and weekends for immediate assistance and intake. Staff will educate clients about living with HIV, assist clients in obtaining eligibility documentation, and provide community referrals. Linkage staff will also be available to existing prevention and care agencies in addition to local hospitals to connect and engage clients into care. The peer-focused centralized linkage team will also have dedicated staff to re-engage those lost to care and retain those in care, but not yet virally suppressed. Through the **expansion of peer support staff roles** such as community health workers, care coordinators, patient navigators, and/or patient advocates, a retention team will be created to provide supportive services (i.e. psychosocial support services, non-medical case management, outreach, and health education/risk reduction services) beyond the linkage to care process. The scope and role will include addressing barriers and unmet needs of clients to ensure retention in care and adherence to treatment. Year one will primarily focus on building infrastructure and training staff. In subsequent years, staff will increase to accommodate need and client caseloads. This centralized linkage and retention team will increase awareness of services and build capacity efforts that support Pillar Two through identification of points of entry into care and streamlining linkage processes for PLWH to receive treatment rapidly.
- **Provision of RHWAP core medical and/or support services –** *Expansion of non-traditional services and supportive services*. Funding will be allocated to ensure the provision of medical and support services that supplement the current infrastructure and encourages rapid treatment. RWPA will expand the availability of services through the provision of **telehealth services, mobile clinics,** and **extended or non-traditional hours** for RWHAP services. These capacity building efforts will support Pillar Two by expanding access to HIV care and treatment for PLWH in the jurisdiction. During years two through five, RWPA will **increase access to medications** by augmenting DPH Part B's ADAP and collaborate with Atlanta Harm Reduction to ensure medical services are provided to those persons who inject drugs. Housing continues to be a major factor that limits access to healthcare, with over ten thousand PLWH in Metropolitan Atlanta in need of stable and adequate housing. Toward that end, **housing assistance will be provided**. RWPA will work with subcontractors and consultants in years three through five to develop and implement a largely **automated clinic** based upon London's Dean Street Clinic, designed to improve sexual health, HIV and hepatitis diagnosis and treatment services, as well as specialist services for at-risk populations. In addition, RWPA will work closely with the TAP and SCP to develop,

implement, and evaluate EtHE activities. Each of the EtHE activities will need buy-in from the community and collaboration with non-care partners.

- **Collaboration and Coordination**

We will collaborate/coordinate with organizations to address barriers identified in the needs assessment section. Over the next 12 months, we will engage the existing HIV planning and advisory bodies, along with state and county public health staff, HIV service providers and community-based organizations, community advocates including PLWH and stakeholders in metro Atlanta in a collective impact process to review and update current strategic plans and best practices and identify gaps in services. Based on this needs assessment, we will formulate an aggressive plan to build on and expand effective existing programs and direct resources to new and innovative programs targeted to priority locations, populations, and needs for years two through five. Using an analogous approach, each of the target counties will initiate a planning process based on the collective impact model that will utilize the framework and guidelines from the metro wide master plan and translate them into detailed county level execution plans.

We will build and maintain effective partnerships with new and existing key providers in the community including key points of entry, other RWHAP funded programs, other federally funded entities, and providers and stakeholders outside of current network that serve and support the target populations. We have already begun to strengthen our partnerships and relationships with the community. In anticipation of year one, a series of community engagement sessions were held with PLWH, organizations that represent them, and HIV advocates to review the gaps and barriers identified in the *Georgia Integrated HIV Care and Prevention Plan 2017-2021*, the *Strategy to End AIDS in Fulton County* through on-going discussions among the PC and the FCHAC. The engagement sessions were used to develop recommendations for projects, programs, and initiatives to identify, link, engage, retain, and achieve viral suppression for the target populations, including capacity building and infrastructure improvements. Two engagement sessions were held with the PC's Consumer Caucus which helped inform deliberations of the PC's Priorities Committee in the development of recommendations which were subsequently approved by the PC. Two community engagement sessions were held with the Fulton County HIV Advisory Committee. RWPA also contracted with a non-elected community leader who is living with HIV and is a Same Gender Loving African American male to hold a series of five targeted focus groups – one with Black women living with HIV, three with Black gay men living with HIV, and one with Black Transgender men.

We will continue to maintain and expand our engagement with community partners as the planning for the process unfolds. Community partners, including PLWH, and members of the affected communities are fully integrated into every aspect of the process through their membership and leadership on the advisory committee and various workgroups. Additional opportunities will exist to engage our partners, share the objectives, and make necessary changes based on their input. To broaden the cross-section of partners involved and gain different perspectives, we will include partner representation from the public and private sector, academia, the faith-based community, mental health/substance abuse, education,

criminal justice, and housing providers, as well as more traditional health and public health agencies. Partnerships with The Georgia Health Policy Center, which has extensive grass roots experience in Georgia, will support efforts to ensure community members are drawn into the EtHE initiative in meaningful roles. Initial recommendations and plans will be shared broadly via multiple communication channels, including posting on the internet and open forums.

PLWH who represent the target populations/organizations will be engaged in this project in planning and in implementation. While Atlanta has a strong history of PLWH participation in our planning processes (i.e., through the PC and the Georgia Prevention and Care Council), less attention has been provided to engaging PLWH and other representatives from targeted populations in the implementation phases, including decision-making activities. To strengthen participation, this application includes funding for a **Community Engagement Specialist** (who will ideally be a member of the target population living with HIV) tasked with developing mechanisms for on-going engagement with PLWH who represent the target populations in the decision-making process and project roll-out. The Community Engagement Specialist will also regularly meet with the Community Advisory Boards from Part A funded subrecipients in the EtHE jurisdictions. Funding is also included to support regular focus groups to gain ideas and recommendations on design and implementation.

Partners and Tasks: (Attachment 4) It is anticipated that a number of partnerships will be established as part of the collective impact planning process for prevention and care efforts under EtHE as decisions are made on projects to be funded and who will lead on each project. Three partnerships have been identified thus far:

- DPH - surveillance and response efforts under Pillar Four; development of an overarching care and prevention plan with individual pans for the four target counties; support of ADAP for the provision of antiretrovirals.
- Partners for HOME is the non-profit established by the Atlanta City Council to manage the Atlanta continuum of care for homeless services and to lead the City's coordinated strategy on homelessness. In the summer of 2019, Partners for HOME assumed responsibility for administration of the HOPWA program for 26 metropolitan Atlanta counties. The partnership will include the development of a centralized client eligibility portal for RWPA and HOPWA clients; integration of client-level databases; and the identification of the most appropriate housing services to be funded under EtHE to support the HOPWA housing continuum.
- The Elton John AIDS Foundation (EJAF) and Fulton County have entered into a Memorandum of Understanding (MOU) to work together to maximize resources and to address barriers and gaps. EJAF is assigning a staff person to fully participate in the development of the EtHE regional plan. The MOU has been approved by the Board of Commissioners and will be signed by the Foundation's trustees when they are in Atlanta in late October. As such, a copy is not yet available to be included in Attachment 4.

- **Sustainability**

This initiative aligns with the *Georgia Integrated HIV Care and Prevention Plan 2017-2021* which helps guide the PC and its Priorities Committee. Evaluation data from this initiative will be provided to the Priorities Committee for consideration during the annual priority-setting and

resource allocation process to continue programmatic efforts within the EtHE jurisdictions. After the period of federal funding ends, initiatives could be continued utilizing currently funded patient navigators and community health workers. Given the primary focus on the BMSM population, the Priorities Committee could also include continuation of the RWHAP Services within this initiative utilizing Minority AIDS Initiative funding. Thus, Part A funding will need to increase to sustain treatment and care efforts once the EtHE goals and objectives are met. Additionally, five years are allotted for the planning, implementation and evaluation of the DMIS project; therefore, funding for upgrades, maintenance and additional builds, can be acquired through other funding sources, if necessary.

Planning and evaluation studies will be conducted biannually. Annual progress reports and strategies or services and interventions that have proven effective will be disseminated to all RWPA subrecipients, stakeholders and agencies funded for this initiative via Planning Council meetings and the Ryan White Website (ryanwhiteatl.org).

- *WORK PLAN* – see Attachment 1

- *RESOLUTION OF CHALLENGES*

Challenges likely to Encounter in Designing and Implementing Work Plan Activities
DMIS Integration: There are many sophisticated approaches to creating and integrating data systems. With each project, there are several risks and levels of complexity that must be considered. While the goal is to fully integrate systems at multiple locations with multiple users in order to provide one coordinated service delivery system, challenges and delays are likely and anticipated. For example, some products may not work as one solution as intended because each product is developed by different sources (HRSA, CDC and contractors) and may use different programming languages. Subsequently, CAREWare (RWPA), Enhanced HIV/AIDS Reporting System[i] (eHARS housed within DPH Surveillance), ClientTrack[ii] (HOPWA) and electronic medical records (Subrecipients) may not fully integrate and agencies may be adding another program/product to its cadre of systems to utilize for clients. Resolution: RWPA has experience with contracting out technical initiatives and now have a Technical Liaison on staff, as well as a good working relationship with the Fulton County Department of Information Technology (DoIT).

Bureaucratic Management: Hiring and procurement delays are anticipated due to the number of infrastructure projects, services and contractors needed to successfully implement work plan activities within the designated timeframes, particularly within the first year. Resolution: Several initiatives are staggered between years one and five and new staff will be on-boarded throughout the project period. RWPA will meet with Fulton County's Procurement, DoIT and

[i] eHARS is an application used throughout the U.S. for collecting, storing, and retrieving the data CDC has identified to monitor the HIV/AIDS epidemic and evaluate HIV prevention policies and programs.
[ii] ClientTrack is an electronic data collection system that stores longitudinal client-level information about persons who access a variety of services for homeless prevention and/or rapid re-housing services.

Human Resource teams, prior to the grant period start date to initiate collaborations and to develop implementation strategies.

Barriers Described in the Needs Assessment Section
Barriers to Care: Barriers related to mistrust can impact reluctance to talk about sex and drug use; awareness of HIV status; access to general HIV information, targeted prevention messages, and the benefits of early treatment; and ultimately, access to treatment for HIV and its comorbidities. Resolution: The proposed project interventions are designed to address service gaps, barriers and unmet needs that have not been exercised through the traditional treatment and care of the RWPA service delivery model. Additionally, the collaboration with UCSF will further ensure the implementation of work plan activities, innovative approaches and evidence-informed interventions models to address the target population.

Technical Assistance (TA) Needed: Many of the EtHE activities will be new to clients and the current RWHAP service delivery system. Additional support from the TAP and SCP can aid in the phases of planning, implementing, evaluating, and improving EtHE activities. TAP: There is opportunity to build capacity for project execution by facilitating and developing training workshops and materials as it relates to service delivery and data system utilization. TAP can provide support with designing project activities and evaluative methods to ensure project fidelity and data validity. TAP can provide expertise and guidance related data integration and HRSA SPNS initiatives. SCP: SCP can assist in scanning the environment for new and existing stakeholders to participate in EtHE initiatives and to maximize opportunities for non-traditional collaborations during the planning and project implementation process. SCP can further minimize duplicative efforts related to centralized linkage/retention teams and data integration systems. Essentially, SCP can assist in the planning, collaboration, and information sharing components of the initiative while the TAP support will be ongoing from initiation to completion of the five-year project.

- *EVALUATION AND TECHNICAL SUPPORT CAPACITY*

1) Program Infrastructure

- **Information System Capabilities** – *Collect, Manage, Analyze Data.* RWPA and the DoIT bring significant resources and capacities to this project. RWPA uses CAREWare (the HRSA provided client-level electronic database) as the client-level database. CAREWare data are currently stored on a Fulton County server which is fault tolerant (dual processors, mirrored drives, uninterrupted power source) and incrementally backed up daily. CAREWare will migrate to a cloud-based system in December 2019. Data management software includes Open Data through Socrata. The **proposed information system** will collect EtHE data using an integrated approach to bi-directionally interface with client level databases. Integration of CAREWare and ClientTrack will be undertaken as part of this initiative. By placing a Surveillance Specialist at DPH, RWPA will have access to eHARS and State Electronic Notifiable Disease Surveillance System (SendSS).

  The Data Manager will oversee activities of data integration, the client level database repository/application, and partnerships with DoIT, IT Vendors, and governmental partners. He has more than 25 years in computer sciences including database, application support

and implementation. In addition, the proposal for this project will result in two data management staff being hired to support the needs of the integration of the programs that utilize the centralized repository. The Database Specialist and the Information Analyst will be dedicated to the development of external data bridges and interfaces to interconnect CAREWare, eHARS and ClientTrack. They will support the customization of CAREWare, eHARS or ClientTrack to incorporate the corresponding data elements from either the housing, surveillance or HIV care system and will provide TA to subrecipients. The positions will analyze the data and generate reports from DMIS and other systems to measure productivity of system and project outcomes.

- **Systems and Processes**- *Monitoring Initiatives.* The EtHE evaluation team will be comprised of Health Program Managers (2), Project Officers (4), Project Analysts (2), CQM Coordinator, QM Specialist, Epidemiologist (2), Data Manager, Database Specialist, and Information Analyst. The team will monitor and evaluate progress toward goals and objectives on a routine basis. EtHE will utilize CAREWare for client-level data, County's Accounting Management System (AMS Advantage) for financial data, and MS Access and Excel databases to support additional tracking. EtHE will implement processes related to but not limited to: 1) Standards of Care, 2) Compliance monitoring, 3) Risk Assessments, 4) Quality assurance and improvement activities, 5) Performance Management.

  Socrata and AchieveIt! software will facilitate monitoring and reporting of performance outcomes. In addition to our current staff, RWPA will employ the use of consultants to help monitor and evaluate the program. A data analysis consultant will help establish baseline data and prepare the current epidemiologic profile. An evaluation consultant will be utilized to analyze the impact of the program. A needs assessment consultant will help facilitate assessments and generate reports. Facilitators will also be engaged to coordinate quarterly focus groups and provide reports for each. Additionally, client satisfaction consultants will be enlisted to create a survey tool to capture the responses of the clients.
- **Measures and Reports** – *Treat and Respond.* The Data Management Team and Evaluation Team will measure and report on a timely and regular basis project and performance outcomes. The QM Team will identify and define measures and work with the Data Team to ensure measures are captured in CAREWare and/or DMIS. RWHAP services will be measured based on existing and modified HAB and/or EMA measures. The progress of evidence-informed interventions, DMIS, Telehealth and mobiles services, and other initiatives that are non-RWHAP will be measured using process, outcome, and impact indicators developed by the EtHE staff, Evaluation Consultant, and TAP based on the goals and objectives of each project.

  The reporting process and outcome data collection will include periodic program assessment by collecting, analyzing, and tracking data to measure process and impact/outcomes of program activities. The Data Management Team will be responsible for collecting baseline data within the first six months of the project and process and outcome data of project initiatives. The Data Management Team will be responsible for compiling all information and data collected and preparing comprehensive reports. The Evaluation Team will review and analyze data focusing on benchmarking of progress beginning with baseline data collected in year 1 of the grant and measuring changes from

year to year. The comparison of baseline data with collected activity data will ensure accurate analysis of outcome progress, which ultimately will impact the goal of decreasing the number of new cases of HIV within the jurisdictions.

- **Pillar Two (Treat)**

The QM Specialist, Project Analysts, Health Programs Manager (Program), and Surveillance Specialist will collaborate with state/local health department colleagues, RWPA subrecipients, DPH Surveillance, HOPWA, and other public health stakeholders to identify those persons who are newly diagnosed, not engaged in care and not virally suppressed. Surveillance Specialist and the Data Manager will utilize CAREWare to measure and report client- and service-level data and compare against DPH Surveillance data.

Within CAREWare, each client's record maintains the date of their HIV diagnosis. In addition, the service encounters provide important information relative to the client's last visit to their medical provider and the result of the client's last Viral Load (VL) test. For the clients who are newly diagnosed, the criteria for the report would be all persons whose HIV diagnosis is within a timeframe (i.e., the last three to six months). To find the clients who are not engaged in care, a report will be created to list all PLWH who have not had an Outpatient Ambulatory Health Service (OAHS) visit or whose last OAHS visit is outside a timeframe (i.e., six months or one year). Additionally, to find the clients who are not virally suppressed, a report will be created to identify all PLWH whose last viral load count is greater than 200 copies per mL. These reports will be run periodically to identify clients who meet the criteria for these categories and the reports shared with the subrecipients, programs and other stakeholders so they can contact the clients, engage them, and get them back in care.

Custom performance measures and reports will be created for routine measurement, monitoring, and reporting. Data will be analyzed to evaluate disparities in care based on the needs of RWPA, programs and stakeholders. Disparities in care will be evaluated based on notable percentage changes and trends. The results of the performance measures and reports will be made available and presented to the necessary programs and stakeholders as required.

- **Pillar Four (Respond)**

1) **Cluster detection:** A community epidemiologist will act as a Surveillance Specialist housed within DPH Surveillance. The Surveillance Specialist will work with DPH, health departments, and RWPA subrecipients to detect growing clusters of HIV infections, allowing prevention and treatment services to be directed where they are needed most. Cluster detection strategies, such as partner services and monitoring for increases in HIV diagnoses, have been used by health departments for many years. Routine analyses of surveillance data can identify growing transmission clusters that would otherwise not be identified.[9]

   The Surveillance Specialist will coordinate with all stakeholders to implement a Data-to-Care model by providing all necessary data and reports to help identify clusters and trends in new HIV diagnoses. The Surveillance Specialist will have a designated point of

contact, typically DIS, at various health departments, community health centers, and AIDS service organizations to provide reports.

Within the scope of reports in our client level database includes reports of new persons who have been recently diagnosed with HIV. Such as with HIV, other increases of sexually transmitted infections (STIs) can share the same pattern of an HIV transmission cluster. Such STIs should also prompt investigation by health department and other concerned entities and stakeholders to identify other potential risks of HIV transmission. Data regarding persons with other STIs will be shared to the needed parties in addressing HIV clusters. With the proposed integration and centralized data repository, the avenue for gathering the necessary data by DPH Surveillance would be readily available to each program or requesting program.

2) **Referrals, Retention and Health Outcomes:** The Surveillance Specialist with coordinate with the QM Specialist, Project Analysts, Health Program Manager (Programs) to develop a process to ensure data on referrals, retention, and health outcomes for PLWH identified through cluster detection efforts are utilized for care coordination and improvement of services in the jurisdiction. These data will be measured and reported in aggregated form and stratified by county. For persons diagnosed with HIV, Surveillance Specialist will provide data to centralized linkage team to connect clients to services for immediate ART, which provides health benefits and decreases the possibility of further transmission. Data for those not engaged will be provided to DIS at health departments to provide outreach and partner services. For persons in care not yet virally suppressed, subrecipients will offer additional behavioral support (i.e., risk reduction interventions to further reduce transmission). Additionally, HIV program staff in health departments and other agencies are aware of the network of local HIV care providers and other services to whom they can refer persons. In response to an HIV cluster, other services besides direct medical care may be needed including medical case management, substance abuse treatment, mental health treatment and assistance procuring health care coverage. Surveillance Specialist will coordinate and provide Out of Care list and/or Watchlists to subrecipients for care coordination. Data sharing agreements will need to be in place for data exchanges.

   Within the scope of CAREWare, RWPA will look to continue to provide data to state counterparts and other stakeholders to assist in the reduction of HIV diagnoses. Performance measures and outcomes will be employed to gather details on referrals, retention and health outcomes for HIV clusters. These data will be provided to the necessary entities and presented during PC meetings to seek input and guidance from the planning body as a whole. Through gathering these data elements and analyzing the trends and source of the issues, RWPA, its subrecipients and stakeholders will work on a comprehensive plan to address these issues. The results of this data will be made available and presented to the necessary programs and stakeholders as required. Additionally, the centralized repository will be available for each program to pull relevant data on referrals, retention and health outcomes.

2) **Data Collection and Management:** The Data Management team will oversee and manage all client-level data related to funded initiative activities. CAREWare will house service-level and client-level data for the majority of EtHE program activities. Upon successful implementation of the integrated DMIS, eligibility and linkage activities will be collected in a centralized domain. Data management team will coordinate, assess, review and submit data for EtHE. Project Officers and Fiscal Manager will collect and analyze financial data related to funded initiatives in AMS Advantage and MS Excel spreadsheets.

- **Data Coordination Activities.** Subrecipients will be required to enter data into CAREWare. The Data Manager will coordinate with jProg to customize CAREWare for EtHE reporting. Requirements for reporting client level data are included in agency CAREWare contracts. Contracts are updated in CAREWare to assure accuracy for reporting. The Surveillance Specialist will coordinate with DPH Surveillance to export/import data from eHARS to identify clusters and target care coordination activities. The Surveillance Specialist will export data from CAREWare to match with eHARS. The Data Manager and Database Specialist will coordinate with vendors to develop DMIS and integrate CAREWare and/or DMIS to other governmental information systems. The Fiscal Manager will oversee the collection of financial data and coordinate the sharing of fiscal monitoring and reporting through a MOU with County's Grants Administration Division (GAD).
- **Data Quality Activities.** The Data Manager provides oversight for the process to ensure compliance with HRSA's reporting requirements. Data Management Team will monitor data quality to ensure compliance with requirements for both real-time data entry and client-level data requirements. Client-level data will be monitored to ensure completeness and quality monthly. CAREWare custom reports, performance measures, and the Ryan White HIV/AIDS Program Services Report (RSR) are utilized to identify data or program quality issues. Custom reports will be created for data validation purposes to identify any missing values, errors, or discrepancies. Data Management team will run data validation reports by the 10th day of each month to identify data quality issues. The Data Management team will share identified issues with partner sites staff and designated Project Officer for remediation during monthly calls. Ongoing data quality issues will trigger needed TA, training, or a corrective action plan as required. Data Management team will send a follow-up report to agencies noting discrepancies and include a timeline for correction. Training needs are assessed to provide relevant TA. Technical training is provided to agency staff to ensure data capture and quality using the following process: 1) updating the CAREWare user manual to align with any changes in the RSR, 2) conducting one-on-one and group training as needed, 3) providing additional TA when discrepancies are detected, 4) ensuring that data entry specialists record data elements uniformly throughout the EMA, 5) performing quality checks periodically to identify missing and/or unknown data elements.

  Information Analysts will assess and review data in the DMIS for completeness and accuracy. The Information Analyst will run reports monthly to ensure DMIS is working properly and coordinate with vendor and data management team to improve DMIS for end user and functionality. Additionally, the QM Specialist will review performance measure data quarterly of RWHAP services by comparing CAREWare performance measures data with submitted data of subrecipients. QM Specialist will coordinate with Data Management team to work with subrecipient to address any data discrepancies. Project Officers will

review financial and programmatic data on a monthly basis with submitted invoices, spend plans, and budget revisions. Project Officers will coordinate with Fiscal Manager and Departmental Accountant every two weeks to review the quality of the financial data submitted and verify with subrecipients on progress of expenditures. Project Officers will review all invoices and budget revisions prior to sending to the Fiscal team for processing.

- **Data Collection, Review, and Submissions.** The Health Program Managers will ensure all data are being collected and reviewed by designated staff and required reports are submitted in accordance with the timeline outlined in the NOA. The Data Management team will ensure that all client-level data elements are collected in CAREWare as instructed in the RSR Manual. The QM Team will ensure EtHE indicators/measures related to clients newly diagnosed, out of care, and in care but not virally suppressed are collected and reviewed. Subrecipients will enter client-level and service-level data in CAREWare within 2 weeks of service. Data Management team will collect and review data monthly using the data quality checks. Each subrecipient's RSR will be reviewed on a quarterly basis to ensure accurate data for the **Annual RSR submission** in HRSA's Electronic Handbook (EHB). Data Management team will create custom reports to capture the number of PLWH reached out to, the number of PLWH who are newly diagnosed and linked to care, and the number of PLWH re-engaged in care to inform **Aggregate Reports**. Financial data will be monitored by Fiscal Manager and designated Project Officers. Fiscal monitoring will inform the content for the **Allocation and Expenditures** and the **Federal Financial Report**. The GAD reviews data from AMS Advantage and submits both reports annually. The Data Management Team and Evaluation Team will collect all data related to program activities and project evaluations to inform **Progress Reports**. The Health Program Manager will compile and submit a progress report to HRSA on a triannual basis.

3) **Project Evaluation:** Proposed activities are many and varied in implementation requiring multi-method evaluation activities facilitated by a multidisciplinary team. Designated EtHE staff will work closely with TAP and SCP to coordinate and evaluate project activities. In addition, an Evaluation Consultant and Community Engagement Specialist will assist EtHE Evaluation team to monitor, evaluate, and improve EtHE activities. The EtHE evaluation team is comprised of CQM Coordinator, Health Program Manager (Programs), Project Officers (4), Project Analysts (2), Epidemiologist (2), and Data Manager. Each staff member will be responsible for monitoring and evaluating different aspects of implementation. Quality Management (QM) funding will be allocated to subrecipients for support of the infrastructure to measure performance and improve the quality of services and health outcomes.

- **Evaluation Plan for monitoring the development, implementation, and project outcomes.** The Health Program Manager will facilitate the process of implementing proposed RWHAP services and lead monitoring activities of Project Officers. Project Officers will closely monitor the programmatic and fiscal requirements of all contracts by reviewing agency reports for completeness; implementing corrective actions as necessary; conducting annual site visits; monitoring submission of assigned agency quarterly reports and provide updates to QM team. The QM Specialist will monitor service providers by reviewing subrecipient's QM Plans; conducting annual QM site visits or programmatic chart reviews to assure compliance with Standards of Care; and providing TA to the

subrecipients in the development of RWHAP services and QI activities. The QM Project Coordinator and Project Analysts will monitor the process for implementing proposed initiatives, such as: 1) Data to Care Models, 2) Evidence based interventions, 3) DMIS, 4) Telehealth and mobile health services, 5) Automated rapid clinic, 6) Social Media Intervention for linkage and engagement.

The Health Program Manager (Programs) and the Project Analysts will evaluate and improve project outcomes using concepts from health informatics, public health, project management, and quality improvement. Project Analysts will closely monitor project activities by implementing, monitoring, and evaluating EtHE project activities; providing ongoing data analysis of performance measurement and support for QI activities, reports, and presentations. The managers will work with TAP, SCP, consultants and contractors to plan the implementation and coordination of EtHE activities. The CQM Coordinator will work with the Epidemiologists, Health Program Manager (Services), and Health Program Manager (Programs) to develop monitoring tools to capture data for measuring performance. Proposed metrics will consist of process, outcome, and impact measures such as: 1) Incidence Rates, 2) Prevalence Rates, 3) HIV Care Continuum data, 4) Service utilization data, 5) Client satisfaction data. Subsequently, the Project Officers, Project Analysts, and the QM Specialist will monitor progress of subrecipients and project contractors on a monthly and/or quarterly basis.

- **Process for measuring impact of program.** EtHE performance measures will be developed and embedded within the QM portfolio for routine monitoring and evaluation by the quality team. The EtHE QM team establishes the measures for system-level review. The EtHE QM team may recommend monitoring existing HAB and EMA measures or creating new measures based on the Atlanta EMA Standards of Care, HAB Performance Portfolio, NHAS, HHS Common Indicators, Integrated Plan, and other strategic plans and quality forums. Once measures of interest are identified, annual target goals are set based on EMA, Regional, and National Performance. Data review and analysis of performance measures and project outcomes will occur quarterly. Performance measures are reported using CAREWare data, chart reviews or other data sources. Prior to implementation of DMIS, the Data Manager will identify all data sources of client-level and service-level data. Data Manager will initiate the exchange of data use agreements with identified parties such as DPH and City of Atlanta. The Health Program Manager (Programs) will work with the Data Manager, Database Specialist and Information Analyst to ensure data are being collected regularly and accurately. The QM Specialist and Project Analysts will work with subrecipients to interpret, analyze and improve data or program quality. The Health Program Manager (Programs) will work with the Evaluation Consultant and Community Engagement Specialist to measure impact by collecting quantitative and qualitative data from service providers and PLWH who receive services or participate in projects.
- **Plan for monitoring goals and objectives.** EtHE staff will assess the extent to which funded activities provided to clients are consistent with the project goals, objectives and protocol and aid in the development of strategies to improve access to and quality of HIV services. The following outlines the process for ongoing monitoring and evaluation of the quality of services provided to PLWH and the execution of the EtHE activities.

- ***Internal Project Evaluation****:* Evaluation activities of the EtHE is led by Health Program Manager (Programs). The Work Plan (Attachment 1) specifies project goals, objectives and strategies for project implementation. Health Program Manager (Programs) will meet monthly with EtHE evaluation team to evaluate the progress of completing stated goals and objectives, the effectiveness of project activities, and **track and report infrastructure/system development and overall health outcomes** related to EtHE activities. The Health Program Manager (Programs) will provide an electronic copy of revised work plan and meeting minutes within 30 days following QM Meetings. Health Program Manager (Programs) will provide an oral update of work plan activities during each Department for HIV Elimination Staff Meeting and RWPA PC QM meeting. Health Program Manager (Programs) will share program updates with subrecipients via email, newsletters, or updates on website. Beginning of each fiscal year, the work plan will be developed based on project goals, objectives and performance measures using tools from TargetHIV.org, CQII, and other methods such as surveys deemed appropriate by the QM Team. The evaluation will include a review of the infrastructure, evaluation of quality improvement activities and appropriateness and results of performance measures. The results will be used to plan for future EtHE and quality activities and **inform the project and/or infrastructure development.** An evaluation consultant will conduct evaluation studies of selected core medical services. The purpose of the studies is to examine the extent to which EtHE partner sites are providing care that meets approved goals, objectives, performance standards, and measures.

System-wide Monitoring and Evaluation*:* EtHE Program staff will monitor and evaluate performance using various methods throughout the 5-year period. Health Program Manager (Programs) will develop monitoring and evaluation tools for subrecipients and contractors to ensure public health methodologies are sound and activities are measurable. The QM Specialist will review and evaluate subrecipient's QM Programs through site visits and the provision of TA. The QM Specialist monitors subrecipient-level performance measure data. Project analysts will monitor and evaluate aggregate-level performance measure data with the Health Program Manager (Programs) quarterly. The Project Analysts monitors the progress of the QI projects. Feedback from stakeholders will be gathered through participation in community engagement activities, site visit reports, QI project plans, project workshops and information provided by the PC's committees and PLWH.

QI Project Implementation*:* Using available data, best practices, and input from Planning Council, Consumers, and Recipient QM team, strategies are developed to **improve service delivery and viral suppression rates** that are consistent with the guidelines for improvement in the access to and quality of HIV health services. Information Analyst and Epidemiologist will work with QM team to **identify new and/or out of care clients, health trends and disparities.** Causal analysis, workflow diagrams, and Plan-Do-Study-Act (PDSA) cycles are used to identify and implement quality improvement projects in the jurisdictions and at the subrecipient level. QI project teams are established by the QM Program to work on specific quality improvement projects. The roles, responsibilities, and composition of the teams will change based on the nature of the project, the service, or subrecipient. Opportunities for stakeholder and PLWH involvement on improvement are anticipated. Developing a similar

model to Part A, each subrecipient will have a Consumer Advisory Board as a designated avenue to hear the needs and concerns of PLWH. Community Engagement Specialist elicit feedback from PLWH to provide their perspective on the development, implementation, and evaluation of the EtHE activities. Other methods of obtaining PLWH input include needs assessment and client satisfaction surveys. Additionally, we will continue to encourage PLWH to participate in quality improvement trainings, such as Training of Consumers on Quality (TCQ) sponsored by Center for Quality Innovation and Improvement (CQII), and/or Recipient sponsored trainings.

- **Potential obstacles for implementation.** Three potential challenges are anticipated during implementation of this project include integration of systems, data collection, and dissemination of information.
  - ***Integration of Systems****:* Integration of systems will pose the greatest challenge. The integration of systems in the centralized eligibility repository will be a collaborative effort with each respective system, information technology teams, the selected vendor and other necessary parties. The scope of the project and the budget/cost associated with the project will be key to stay on task. We will anticipate TA from external partners regarding systems integration and collaboration. Additionally, we will solicit TA for jurisdictions/agencies who have undertaken a similar project. Finally, TA will be needed to ensure contractual and budget costs are within the scope of the project.
  - ***Data Collection****:* Data collection can be a challenge given the complexity on separation of the current systems. However, there is an abundance of data sources available. Data collection, analysis and reporting are necessary to meet the collection requirements. Because there is a wide variation in the systems which we plan to interface, there is a difference in the processes and systems used to collect data. We seek TA in setting up agencies in order to capture the data required. Subsequently, we will anticipate a need for TA in determining the best dataset from the available datasets to measure progress; especially as it relates to the RSR.
  - ***Dissemination of Information****:* Dissemination of information will be a challenge when groups are talking individually but have not previously come together to the table to discuss how they might work more collectively. TA also may be needed in this area to resolve separation through meetings focused on exchanging information about individual goals, and how those goals might support each other's work can maximize the shared outcome of ending the HIV epidemic.

Collaboration, partnerships, and training will be essential to overcoming obstacles in accessing, collecting, and analyzing quality data for program performance evaluation.

- *ORGANIZATIONAL INFORMATION*
- **Organizational Description and Chart:** See Attachment 5.
- **Management and Staffing Expertise:** The Atlanta EMA has been a recipient of RWPA since the first year of funding in 1991. Our mission is to provide a coordinated response to the HIV epidemic in the Metropolitan Atlanta area. To that end, our core values (Empowerment, Representation, Health Equity and Trust) coupled with specialized

expertise included in the Staffing Plan (Attachment 2) and in the biographical sketches of key personnel in Attachment 3 make EMA staff uniquely qualified for this initiative. An essential component of our qualifications comes from the expertise of our staff who will plan, lead and initiate the projects, beginning year one. Additional staff will be hired during the implementation year to sustain the initiative activities throughout the project period.

Name/Credentials	Relevant Experience
Jeff Cheek, MCP, Director	27 years HIV care and treatment service system experience.
Bridget Harris, MSW, Deputy Director	18 years public health and human services grant administration.
Jocelyn McKenzie, MPH, CQM Coordinator	5 years of experience managing quality management programs.
Warren Hendricks, MA, Data Manager	Advanced degree in Computer Science with 25 years related experience.
Troy Scott, MBA Fiscal Program Manager	Federal, state and local funded grants management experience for over 5 years.

In addition to the key positions, the program is supported by DoIT, Finance Department, the Grants Management Division, the Department of Purchasing and Contract Compliance, the County Attorney's Office, the Strategy Office and the Office of the County Manager. External partners and collaborators with relevant expertise and experience include the PC, Part A Subrecipients in the EtHE jurisdictions, HRSA TAP and SCP providers, DPH Part B and Partners for Home and others to be determined during the planning process.

As discussed in the Resolution of Challenges section, potential obstacles for hiring additional staff and contractors may include bureaucratic delays pertaining to delayed Human Resources recruitment and procurement within the Fulton County system. Subsequently, salary and fringe are requested for 9 months for the first year. Several initiatives are staggered between years one and five and new staff will be on-boarded throughout the project period. Solutions for overcoming barriers include hosting a Fulton County grant kick-off meeting, March 2020, to strategically plan for new hires and the establishment of new contracts.

- **Key Partnerships and Collaborations:** The project will be supported by the PC and Part A subrecipients who have experience engaging with the target population and providing HIV treatment and care services. The EMA will collaborate with the TAP and SCP providers to assist with building new partnerships and to determine innovative approaches and interventions for Pillar One and Pillar Two. DPH, HIV recipient of EtHE CDC funding to support Pillar One, will be actively involved in Part A's planning process to ensure that prevention programs are well-coordinated with care and treatment efforts. Partners for Home, the HOPWA program administrator for 26 metropolitan Atlanta counties, will provide technical expertise on central intake systems and assist in the identification of appropriate evidence-based housing strategies. To date, specific staff persons with relevant expertise that will engage in work plan activities have not been identified within the partner organizations (DPH and PFH). RWPA will employ tracking and monitoring strategies to

ensure our organization follows the approved work plan as outlined in the application. Plans of action include subrecipient reporting; planning and monitoring calls with subrecipients, contractors, and the HRSA Project Officer; desk audits; and, site visits.

Fiscal management: Fulton County government manages 30 federal grants at any given time. The Department for HIV Elimination currently manages the RWPA grant as well as a HRSA Capacity Building cooperative agreement. RWPA has policies, procedures, and protocols which govern fiscal accountability. RWPA separately tracks formula, supplemental, MAI, and carryover funds in AMS Advantage using unique cost centers. As charges are made against each cost center records are updated in AMS. The Fiscal Manager also audits the budget on a monthly basis to ensure that Fulton County's Finance Department has accurately applied all charges to the proper fund source. Staff funded via multiple grants will keep allocation journals which reflect the actual portion of time charged against each grant.

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