



ENDING *the* EPIDEMIC

NASHVILLE

A FIVE-YEAR COMMUNITY PLAN
TO END THE HIV EPIDEMIC
in DAVIDSON COUNTY, TENNESSEE

ACKNOWLEDGEMENTS

The development of this plan would not have been possible without the participation and commitment made from approximately 120 people who attended Ending the Epidemic (EtE) Action Committee meetings from June through October 2018. Too long of a list to include here, they are identified by name in Appendix ii. Their role in and importance to this process cannot be overstated.

Equally as important to the EtE planning process were the contributions of time, creativity and passion made by members of the Ending the Epidemic Coordinating Committee, most of whom also served as leaders of the six Action Committees. These individuals included the following:

- Clare Bolds, Southeast AIDS Education & Training Center
- Meredith Brantley, Tennessee Department of Health
- Gareth Butler, Metro Public Health Department
- Judith Byrd, Office of Mayor David Briley
- Amber Coyne, Metro Public Health Department
- Larry Frampton, Nashville CARES
- Ebony Gordon, Nashville CARES
- Ben Gramling, Planning Consultant
- Jessica Hoke, Nashville CARES
- Josh Love, Metro Public Health Department
- Brady Morris, Nashville Regional HIV Planning Council
- Peter Rebeiro, Vanderbilt University Medical Center
- Tarik Smith, Meharry Medical College
- Reverend Terry Terrell, Metropolitan Interdenominational Church First Response Center
- Kristen Zak, Tennessee Dept. of Health

And finally, it is important to acknowledge members of the Ending the Epidemic Task Force. This group met multiple times during 2018 and early 2019 to provide guidance on the structure of the planning process, establish the EtE goals described in this report and offer expert advice and feedback on the Plan's recommendations as they were being developed.

Members of the EtE Task Force included the following individuals:

- Dr. James Hildreth, President, Meharry Medical College (Task Force Chair)
- Dr. Stephanie Bailey, Senior Associate Dean of Public Health Practice, Meharry Medical College
- John Ray Clemons, Representative, Tennessee General Assembly
- Brian Haile, CEO, Neighborhood Health
- Kevin Hartman, Owner, Nashville Pharmacy Services
- Sharon Hurt, Executive Director, Street Works and Metro Councilmember
- Joseph Interrante, CEO, Nashville CARES
- Michele Johnson, Co-Founder and Executive Director, Tennessee Justice Center
- Julian Leggs, Community Advocate
- Dr. Bill Paul, Director, Metro Public Health Department Nashville/Davidson County
- Dr. Stephen Raffanti, CMO, Vanderbilt Comprehensive Care Center, Vanderbilt University
- Reverend Edwin Sanders, Senior Servant, Metropolitan Interdenominational Church First Response Center
- Tom Ward, Executive Director, Oasis Center
- Dr. Carolyn Wester, Medical Director-HIV/AIDS/STD, Tennessee Department of Health

The Care Foundation of America provided critical financial support for the planning process through a grant to Nashville CARES, who served as fiscal agent through a Memorandum of Understanding with the Mayor's Office of Nashville.

Design by Noelle Grimes

TABLE OF CONTENTS

List of Abbreviations and Acronyms	p. 5
Message from Mayor David Briley	p. 6
Message from Dr. James Hildreth	p. 7
Executive Summary	p. 8
CHAPTER 1 Introduction to Ending The Epidemic - Why Now?	p. 10
CHAPTER 2 Current State of The HIV Epidemic In Nashville	p. 11
CHAPTER 3 Commitment to Equity & Social Justice In Ending The Epidemic	p. 17
CHAPTER 4 The Planning Process	p. 18
CHAPTER 5 Recommendations for Ending The Epidemic In Nashville	p. 21
CHAPTER 6 Implementation - Putting This Plan into Practice	p. 42

Appendices

Appendix i. Action Committee Participants	p. 45
Appendix ii. Metrics & Data Sources to Track Progress Towards Ending The Epidemic	p. 49
Appendix iii. References	p. 50

List Of Abbreviations And Acronyms

AIDS	Acquired Immune Deficiency Syndrome
ART	Antiretroviral Therapy
CDC	Centers for Disease Control and Prevention
eHARS	Enhanced HIV/AIDS Reporting System
HIV	Human Immunodeficiency Virus
IDU	Intravenous/Injection Drug Use
MPHD	Metropolitan Health Department of Nashville/Davidson County
MSM	Men Who Have Sex with Men
NHAS	National HIV/AIDS Strategy
PEP	Post-exposure Prophylaxis
PLWH	People Living with HIV
PrEP	Pre-exposure Prophylaxis
PTBMIS	Patient Tracking Billing Management Information System
PWID	People Who Inject Drugs
STD	Sexually Transmitted Disease
STI	Sexually Transmitted Infection
TDH	Tennessee Department of Health

MESSAGE FROM MAYOR DAVID BRILEY

As Mayor, my primary focus is to promote solutions to address inequality so that all residents have the chance to prosper. Since HIV thrives in the face of stigma and discrimination, it is particularly important that we work together to break down social barriers, find equitable solutions and bring this disease into the light. It is our obligation to reach those who are at risk, undiagnosed, or lacking care, because treatments are available today that create the opportunity for us to eradicate HIV in Nashville and change many lives for the better.

With a collective goal and community-wide strategy we can drive down new transmissions to pre-epidemic levels and, at the same time, drastically improve health outcomes for people living with HIV.

This report is our city's plan to do just that. I would like to thank the members of the Ending the Epidemic Task Force for producing this work and for overseeing what has been an inspiring and inclusive process to create this true community-driven report. I am also extremely grateful to the more than 120 advocates and stakeholders who offered their expertise and their time, and I thank the members of the public who provided their feedback on the draft report.

While this is a robust and comprehensive plan, it is still a vision for our future to come. We know an incredible amount of work will be required to achieve our goals. I encourage all stakeholders – consumers, nonprofits, for-profits, health care providers, insurers, researchers, advocates, churches, businesses and government alike – to continue to engage early and often throughout this process to guarantee our success.

I look forward to working with each of you as we move to our next phase in combating HIV in Nashville. Thank you for everything you've done and will continue to do to end the epidemic.



Mayor David Briley
Nashville & Davidson County

MESSAGE FROM DR. JAMES HILDRETH

The HIV pandemic continues to be a major issue for communities around the world, especially for people of color and those in resource-constrained environments. Through the efforts of scores of biomedical scientists, physicians, community organizations and public health professionals the end of the HIV epidemic is now a real possibility. Pre-exposure prophylactic use of drugs (PrEP) can substantially reduce the risk of HIV infection in high risk populations such as young men who have sex with other men. When infected persons are appropriately treated with HIV drugs and remain compliant, the risk that they will transmit the virus to their sex partners is reduced by as much as 96%. Based on this finding The Joint United Nations Program on HIV/AIDS proposed the 90-90-90 strategy for ending the HIV epidemic. The goal is to identify 90% of all persons infected with HIV, get 90% of infected persons into care and treatment with anti-HIV drugs and achieve and sustain total HIV suppression in 90% of those in treatment. If these three goals were achieved globally, the HIV pandemic could be eradicated.

The 90-90-90 approach to ending the HIV epidemic is the strategy now being pursued in communities around the globe including major cities in the United States. Nashville's Ending the HIV Epidemic Task Force has developed a plan based on this concept specifically for Nashville. The work of the EtE Task Force was highly collaborative and involved a wide cross-section of stakeholders including persons living with HIV. This report and recommendations are the product of a community driven process that leveraged the many organizations and individuals who are committed to the fight against AIDS. The work of the Taskforce reflects the theme of the 2018 Worlds AIDS Day - "Saving Lives through Leadership and Partnership".

Implementation of the Task Force recommendations will have a tremendous impact on the HIV epidemic in Nashville. Hundreds of new infections will be prevented and many infected individuals brought into care and treatment can enjoy extended productive lives. Resources that would otherwise be needed for treating AIDS could be directed to other critical community needs. The plan addresses social determinants of health that are not only factors in HIV risk and disease but also for other conditions that beset minorities and low income communities. Implementation of the EtE recommendations could therefore have impact beyond HIV/AIDS and improve the overall health status of these communities.



Dr. James Hildreth, President
Meharry Medical College

Executive Summary

In 2017, there were 146 individuals who were newly diagnosed with HIV in Nashville and Davidson County. While the number of new HIV cases in Nashville is lower today than any year since 1989, and the number is down from its peak of 436 in 1992, there is still much work to accomplish in the fight against HIV.

The data presented in Chapter 2 of the Plan sets the charge: major progress in reducing new diagnoses has slowed and the number of Davidson County residents living with HIV today totals more than 4,100 (national modelling predicts there may be as many as 720 additional residents of Davidson County that are unaware they are living with HIV). As long as the recent trends continue, so too will the HIV epidemic.

Nashville and Davidson County are now in a position to end the HIV epidemic and this 5-Year Plan provides the roadmap for how to accomplish this aspirational, ambitious and achievable goal. The Plan is the result of a community-driven process that started with an Ending the Epidemic Summit on World AIDS Day 2017 and culminated with approval of this plan's recommendations by Mayor David Briley's Ending the Epidemic Task Force on January 31, 2019.

Between these two milestone events, more than 120 participants made massive contributions of time and energy in a total of 35 meetings held by six different Action Committees. They brought their passion, knowledge and creativity to bear on the six EtE Goals that were established at the outset of the process, which stated that, by 2024, Nashville will:

- 1. ENSURE THAT 90% OF NASHVILLE RESIDENTS LIVING WITH HIV KNOW THEIR SEROSTATUS**
- 2. DECREASE BY TWO-THIRDS THE NUMBER OF NASHVILLE RESIDENTS WITH NEWLY ACQUIRED HIV**
- 3. LINK 90% OF THOSE DIAGNOSED WITH HIV TO CARE WITHIN ONE MONTH OF DIAGNOSIS**
- 4. ENGAGE 90% OF PEOPLE DIAGNOSED WITH HIV IN CARE**
- 5. ENSURE THAT 90% OF THOSE ENGAGED IN CARE WILL ACHIEVE VIRAL SUPPRESSION**
- 6. ELIMINATE DISPARITIES IN HIV OUTCOMES: GOALS WILL BE ACHIEVED AMONG ALL POPULATIONS, REQUIRING GREATER FOCUS ON POPULATIONS DISPROPORTIONATELY IMPACTED BY HIV AND/OR UNEQUALLY REPRESENTED AMONG HEALTH OUTCOMES.**

Participants in the planning process also reflected and delivered on a commitment to health equity and social justice. Chapter 5 of the Plan outlines Objectives and Action Steps that build on great work already happening in our community and that will reach "priority populations" - communities that are disproportionately impacted by HIV and that are more likely to lack access to the resources they need to thrive. It is understood that health equity is not just an outcome but it is also a process, and as such, equity should be reflected in the way partners work with each other and with the community as they work together to implement the recommendations and achieve the goals of the Plan.

The Plan's recommendations and the prioritization among them that will need to be done will evolve as time passes. New opportunities and challenges will arise that were previously unforeseen and, most excitingly, new scientific advances, financial resources and partners will emerge to help end Nashville's HIV epidemic. Chapter 6 of the Plan lays a framework that embraces the unpredictable future and provides structure to guide and support implementation of the Plan's recommendations. It spells out the following keys to successful implementation:

- Convene a standing Oversight Body to guide implementation of the Plan's recommendations
- Create a dedicated staff position within the Nashville Metro Public Health Department to coordinate the EtE initiative
- Increase and diversify funding necessary to fully implement the Plan's recommendations
- Achieve policy changes necessary to implement fully the Plan's recommendations
- Sustain commitments from new and existing partners
- Establish a Data Monitoring Team to provide ongoing measurement and evaluation capabilities, track progress and communicate success

Finally, as stated later in the Plan, successful implementation of recommendations will need to take advantage of the momentum that has built in the community during the planning process. The intent of all participants that gave generously of their time leading up to this point, and of new partners just now coming to realize their part in this effort, should be to carry the momentum forward and sustain their commitment to Ending the Epidemic on behalf of all Nashville residents.

CHAPTER 1: INTRODUCTION TO ENDING THE EPIDEMIC - WHY NOW?

Throughout the life of the HIV epidemic, communities have consistently fought for improved treatment and supports for people living with HIV (PLWH) and better prevention tools to reduce transmission of the virus. The progress made over the course of this epidemic is astounding and could have never been achieved without the leadership of those living with HIV, some of whom are no longer with us, as well as their community allies.

Over the past decade, HIV science and medicine have created a new era. We know that HIV will not be eradicated until there is a cure for HIV, and research continues to make significant advances toward that goal. While it is critical that the broader HIV community remain committed to a cure, evidence-based tools are now available to drive down new transmissions to pre-epidemic levels and dramatically improve health outcomes for people living with HIV. These include Treatment as Prevention (TasP), Pre-Exposure Prophylaxis (PrEP) and Post-Exposure Prophylaxis (PEP) which, when combined with behavioral interventions to reduce risk, can effectively end HIV as an epidemic. That's what Ending the Epidemic is all about - amassing the collective will to end HIV as an epidemic in Nashville.

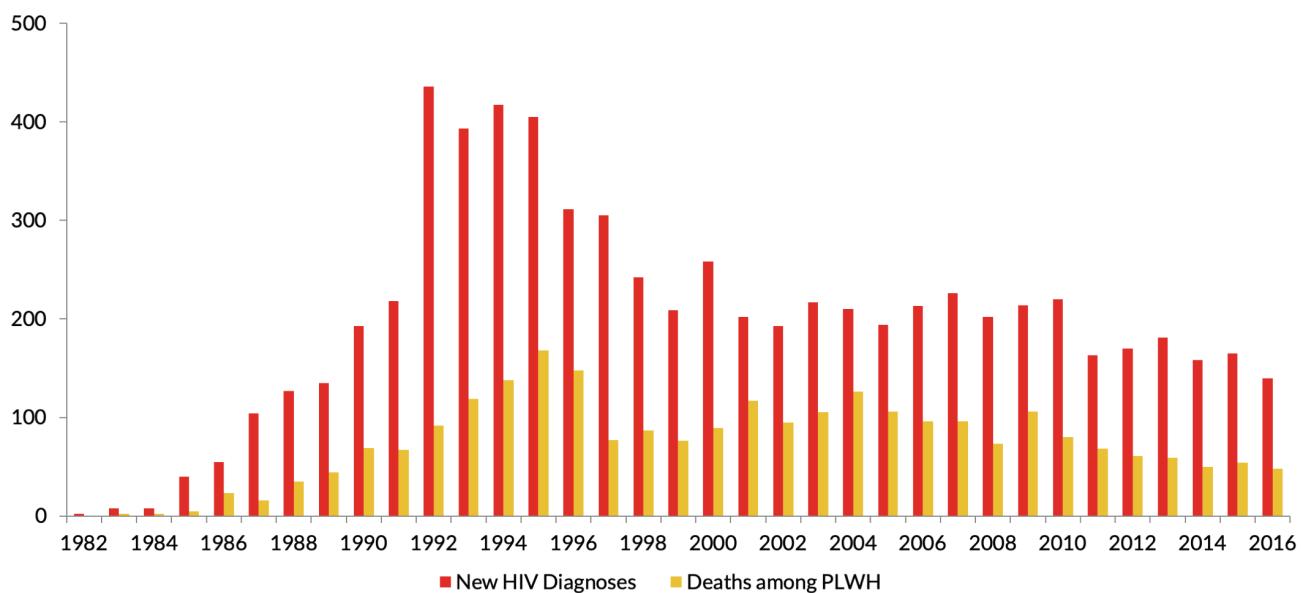
Ending the Epidemic is a national movement. Cities and states throughout the country have developed EtE Plans. The first EtE Plan was published by the State of New York in 2014 and since that time other jurisdictions have followed. In May 2017, the Treatment Action Group and the Southern AIDS Coalition convened a meeting in Atlanta with southern jurisdictions to discuss the EtE concept, identify potential barriers and opportunities and gauge interest in EtE planning. Out of that, Nashville became part of a cohort of southern communities that includes the states of Alabama and Louisiana and the city of Jackson, Mississippi that have committed to work with Treatment Action Group to organize and engage in EtE planning.

CHAPTER 2: CURRENT STATE OF THE HIV EPIDEMIC IN NASHVILLE

Historic Trends

The HIV epidemic emerged in the early 1980s and new HIV diagnoses in Nashville/Davidson County (from this point forward referred to as “Nashville”) increased each year until peaking in the mid-nineties (Figure 1). Coinciding with the introduction of antiretroviral therapy (ART) for HIV treatment in 1996, new diagnoses began to steadily decline, as did deaths among people living with HIV (PLWH) as PLWH began to live longer, healthier lives.

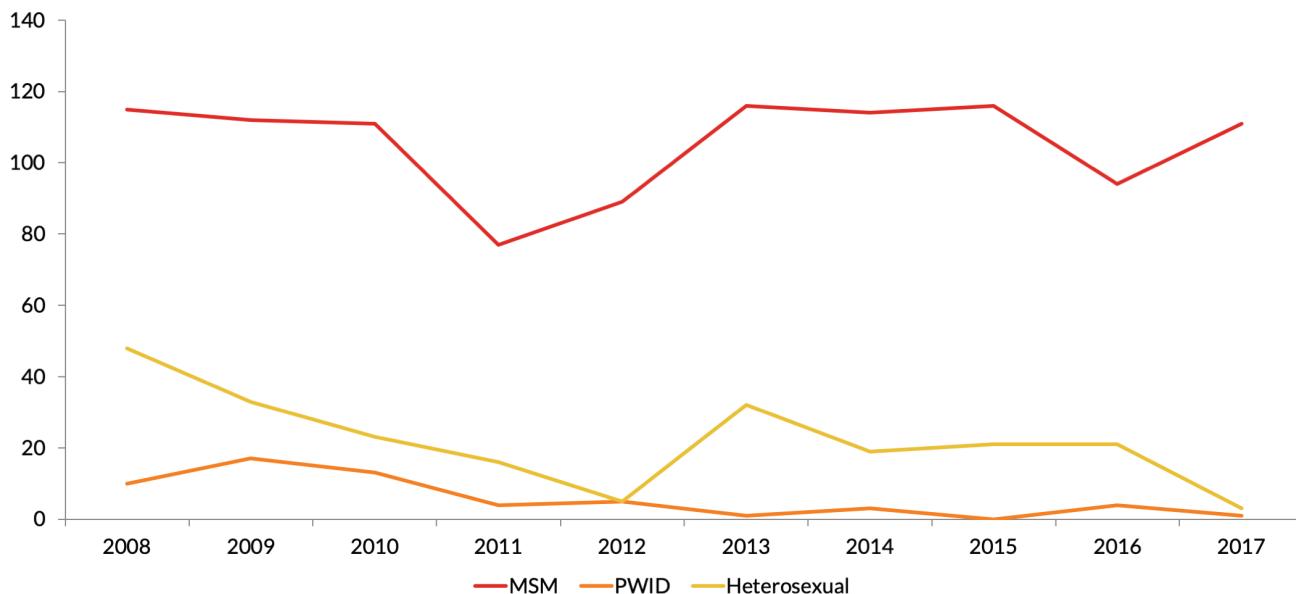
FIGURE 1. NUMBER OF NEW HIV DIAGNOSES AND DEATHS AMONG PEOPLE LIVING WITH HIV (PLWH) – NASHVILLE, 1982-2016



Source: Tennessee enhanced HIV/AIDS Reporting System (eHARS), accessed June 30, 2017.

Certain subpopulations continue to be disproportionately affected by HIV in Nashville. Over the past ten years, transmission of HIV among gay, bisexual, and other men who have sex with men (MSM) has persisted (Figure 2). While new diagnoses among people who inject drugs (PWID) declined during this period, primarily attributed to national harm reduction efforts, PWID remain a priority population for prevention in the context of a burgeoning opioid epidemic and vulnerability for rapid transmission of HIV due to injection drug use.

FIGURE 2. NUMBER OF NEW HIV DIAGNOSES BY TRANSMISSION RISK – NASHVILLE, 2008-2017



Source: Tennessee enhanced HIV/AIDS Reporting System (eHARS), accessed June 30, 2018.

Recent Trends

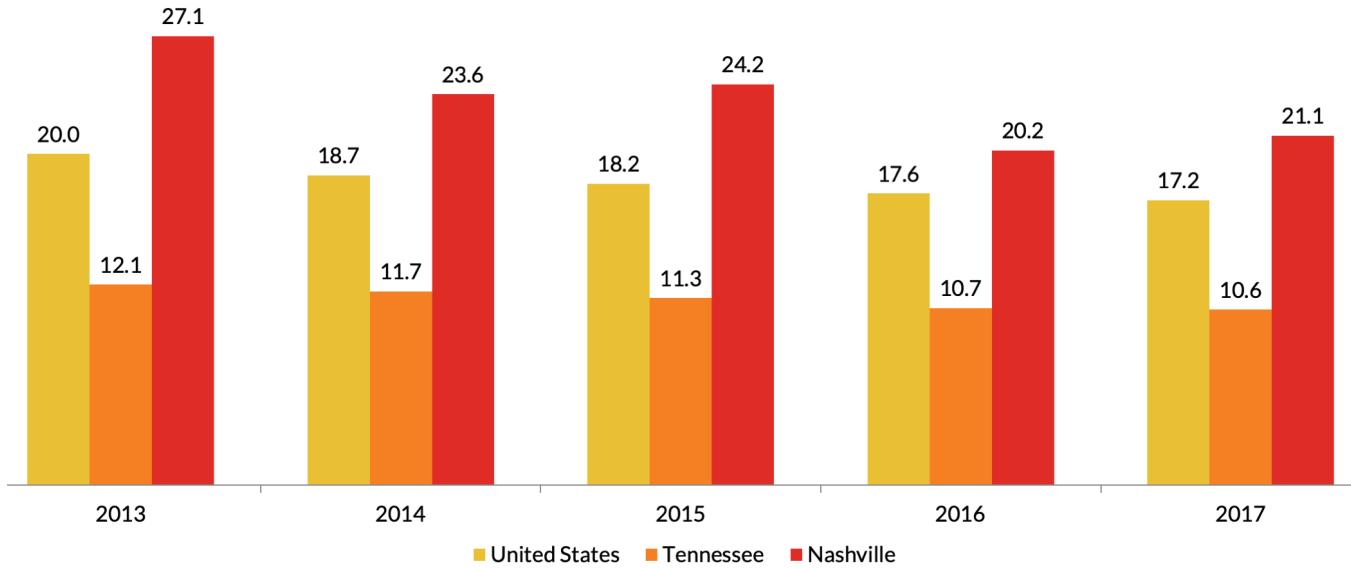
Data presented on new HIV diagnoses, persons living with diagnosed HIV, and HIV-related health outcomes highlighted in this section are shown to illustrate the current state of the HIV epidemic in Nashville.

NEW HIV DIAGNOSES

In 2017, 146 individuals were newly diagnosed with HIV, the lowest number of new diagnoses since 1989. Over 90% of new diagnoses were among males; 54% occurred among Blacks/African Americans, followed by Whites (36%) and Hispanics/Latinos (6%). Approximately six out of ten (63%) new HIV diagnoses occurred among young persons aged 15 to 34 years; 76% of newly diagnosed persons were MSM and 2% were heterosexual individuals.

While the rate of new HIV diagnoses in Nashville decreased by 22% between 2013 and 2017, the rate of new HIV diagnoses has been consistently higher than state and national levels, signifying the persistent concentration of the HIV epidemic in Nashville (Note: a rate is a way to compare numbers across groups; in Figure 3, the rate is defined as the number of people newly diagnosed with HIV per 100,000 people).

FIGURE 3. RATE OF NEW HIV DIAGNOSES – UNITED STATES, TENNESSEE, & NASHVILLE, 2013-2017



Source: Tennessee enhanced HIV/AIDS Reporting System (eHARS), accessed June 30, 2018.

Rate: number of people newly diagnosed with HIV per 100,000.

People Living with HIV (PLWH)

At the end of 2017, approximately 4,103 people were living with diagnosed HIV in Nashville, the majority (78%) of whom were male. Despite representing only 27% of the population in Nashville, more than 53% of PLWH were Black/African American. In addition, the HIV population in Nashville is aging, with 60% over the age of 45 years. Fifty-five percent of PLWH in Nashville identified as MSM and 9% were PWID.

When applying the estimate for Tennessee that approximately 15% of PLWH are unaware of their status, an estimated additional 724 individuals may be unaware that they are living with HIV^[1].

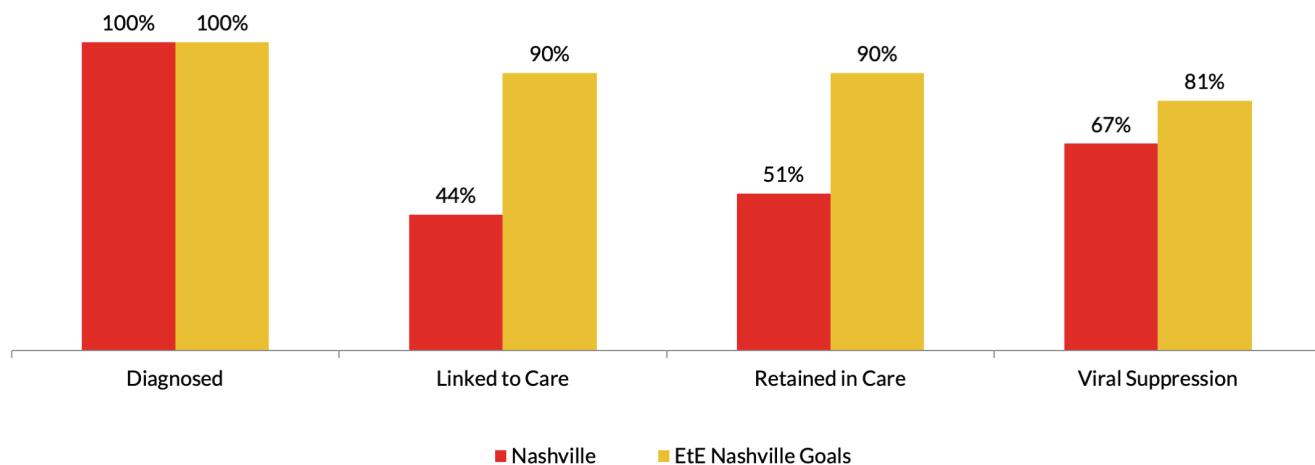
HIV-related Health Outcomes

A portion of the goals for EtE Nashville were based upon the National HIV/AIDS Strategy (NHAS) 2020^[2], which monitors several core indicators related to ending the HIV epidemic:

- Linkage to care: the percentage of people receiving a diagnosis of HIV in a given calendar year who had one or more documented viral load or CD4+ test within 30 days of diagnosis
- Engaged in care: the percentage of PLWH who received two or more viral load or CD4+ tests, performed at least three months apart during a given calendar year
- Viral suppression: the percentage of PLWH engaged in care who received a viral load test result of <200 copies/mL at the most recent viral load test during a given calendar year

In 2016, the proportion of newly diagnosed individuals linked to care within 30 days (44%) was well below the 90% goal; similarly, the proportion of PLWH engaged in care by the end of 2016 (51%) was lower than the 90% goal (Figure 4). However, among those PLWH who were engaged in care, 67% were virally suppressed (Figure 4).

FIGURE 4. HIV-RELATED HEALTH OUTCOMES – NASHVILLE, 2016



Source: Tennessee enhanced HIV/AIDS Reporting System (eHARS), accessed June 30, 2018.

Linked to care: the percentage of people receiving a diagnosis of HIV in a given calendar year who had one or more documented viral load or CD4+ test within 30 days of diagnosis.

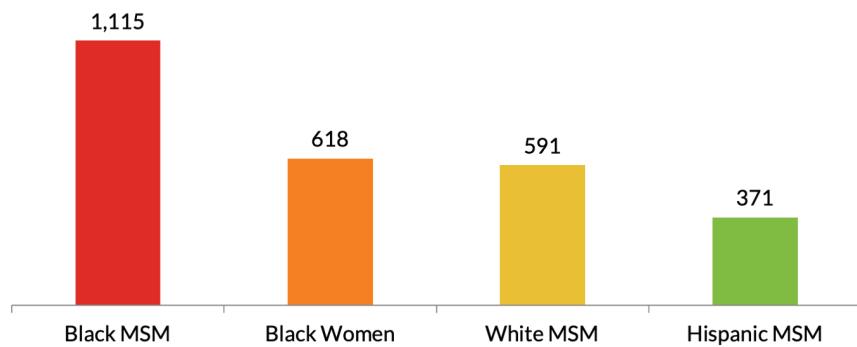
Engaged in care: the percentage of PLWH who received two or more viral load or CD4+ tests, performed at least three months apart during a given calendar year.

Viral suppression: percentage of PLWH engaged in care who received a viral load test result of <200 copies/mL at the most recent viral load test during a given calendar year.

Notable Disparities

As noted above, there are profound HIV disparities that persist across certain subpopulations in Nashville. As such, part of the EtE Plan is aimed at improving HIV-related outcomes among all populations while not being limited to only gauging success on aggregate-level measures. Blacks/African Americans and Hispanics/Latinos remained disproportionately affected by HIV. In 2017 in Nashville, 1,153 per 100,000 Black/African Americans were living with HIV and 355 per 100,000 Hispanic/Latinos were living with HIV, compared to 402 per 100,000 Whites. When examining other populations and subpopulations, MSM and Black/African American women were among the groups experiencing the highest rates of HIV (Figure 5).

FIGURE 5. RATES OF PLWH AMONG PRIORITY POPULATIONS – NASHVILLE, 2017

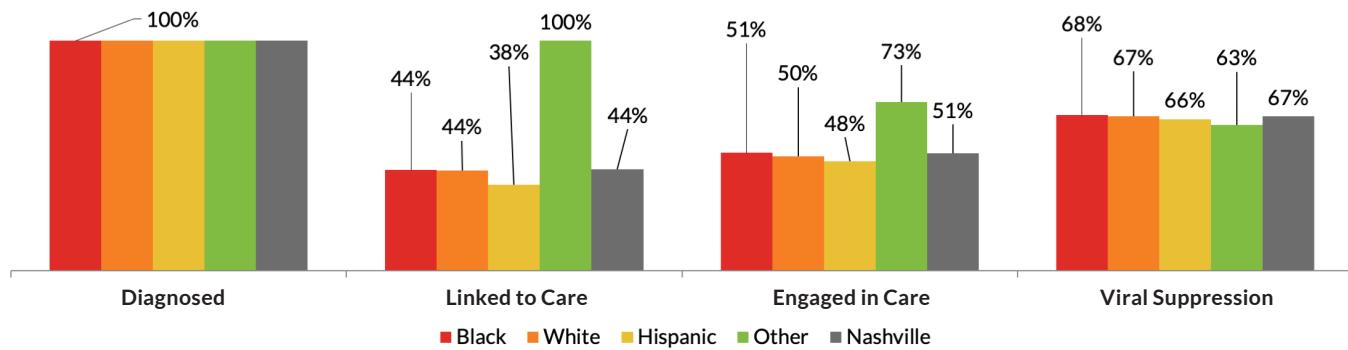


Source: Tennessee enhanced HIV/AIDS Reporting System (eHARS), accessed June 30, 2018.

Rate: number of people living with HIV per 100,000.

Racial/ethnic disparities are also reported among HIV-related health outcomes as Blacks/African Americans and Hispanics/Latinos generally experience lower percentages of linkage to care, engagement in HIV care, and viral suppression compared to overall averages in Nashville (Figure 6).

FIGURE 6. HIV-RELATED HEALTH OUTCOMES BY RACE/ETHNICITY – NASHVILLE, 2016



Source: Tennessee enhanced HIV/AIDS Reporting System (eHARS), accessed June 30, 2018.

Within the HIV epidemic there are hidden populations, which include transgender and homeless individuals that are particularly vulnerable to HIV infection. According to the CDC, roughly half of transgender people who were diagnosed with HIV between 2009 and 2014 lived in the south. Further, this report estimated that around a quarter of transgender women are living with HIV^[3]. However, these data may be underreported as a result of challenges in identifying and reporting gender identity in local and state HIV surveillance programs^[4].

In addition to the transgender population, persons experiencing homelessness are impacted by higher rates of HIV compared to the stably-housed population. In 2006, the National Alliance to End Homelessness estimated that 3.4% of the homeless population was HIV positive compared to 0.4% of the general population^[5]. Homeless individuals are also less likely to access appropriate HIV medical care, access and adhere to ART, and achieve sustained viral suppression^[6].

CHAPTER 3: COMMITMENT TO EQUITY & SOCIAL JUSTICE IN ENDING THE EPIDEMIC

Participants in Nashville's EtE planning process have been staunch in their commitment to health equity and social justice - not only in the work they perform day-in and day-out across the community, but in the approach to the EtE planning process and the content of this Plan itself.

Health equity is the concept that all people have a fair and just opportunity to achieve personal and community-wide health. Environments where people live, work, learn, and play directly impact individual and population health, and the conditions found in some of Nashville's most challenged neighborhoods have played a substantial role in sustaining HIV disparities among some segments of Nashville residents. Unfortunately, the ability to reverse these trends and end the epidemic of HIV among all Nashville residents are unduly influenced by institutional frameworks such as racism, homophobia, transphobia, and other societal factors that fuel discrimination, stigma, and unequal access to housing, education, income, employment, transportation, and health care.

As part of Nashville's commitment to promote health equity and social justice, the Plan outlines goals, objectives, and action steps to reach communities that are disproportionately impacted by HIV. The recommendations of this Plan are a call to action for many institutions that create, manage, and distribute resources that directly impact the health of the Nashville community, and these same institutions are charged with the important responsibility of ensuring equitable resource allocation; efforts and assets need to be directed towards populations that have historically been disproportionately impacted by HIV. Throughout the Plan, action steps refer to these communities as priority populations, which may include both PLWH and those at heightened risk for HIV because of the environments in which they live, work, learn, or play.

Specifically, Nashville EtE priority HIV populations include, but are not limited to:

- Gay, Bisexual and Other Men Who Have Sex With Men (MSM)
- Young Black and Latino MSM
- Youth and Young Adults, Aged 13-24 Years
- Heterosexual Black Women
- Transgender Persons
- Persons Who Inject Drugs
- PLWH Experiencing Unstable Housing
- PLWH Who are Economically Disenfranchised
- PLWH Who Experience Unequitable Access to Insurance
- Incarcerated/Institutionalized Persons
- Sex Workers

Health equity is both a process and an outcome. As such, equity should be reflected in the way partners work with each other and with the community to achieve all of Nashville's EtE goals for all populations by 2024.

CHAPTER 4: THE PLANNING PROCESS

In the Summer of 2017 and with support from community stakeholders, the Mayor of Nashville made a commitment to support the development of an EtE Plan for the city. Then on World AIDS Day, December 1, 2017, an Ending the Epidemic Summit was held with participation from approximately 120 community members that included HIV advocates, AIDS services organizations, other social service providers, HIV medical providers, other primary care providers, academia, communities of faith, social justice advocates, pharmaceutical industry representatives and others.

The purpose of the Summit was to galvanize the community around EtE and solicit ideas for direction of the planning process. Topics covered during the Summit included: Current Status of Prevention and Cure Research; The State of HIV and AIDS in Nashville; How Coalitions Can Use Collective Impact Strategies to Move the Needle; and Looking at HIV through a Social Justice Lens.

From the outset, organizers of the 2017 Summit set guiding principles to inform the entire engagement and planning process. The guiding principles were developed by the community and consistently served as a foundational guidance as the EtE planning process unfolded.



In April 2018, the Mayor appointed an EtE Task Force to serve in an advisory role overseeing the planning process. The Task Force was comprised of community leaders from multiple disciplines including HIV treatment and support, HIV research, public health, faith-based institutions, policy makers, pharmacy, primary care, youth services, health advocacy and people living with HIV.

The Task Force was responsible for developing goals for the EtE Plan and advising on structure, procedure and the development of recommendations throughout the planning process. The Task Force established the following goals to guide the planning process:

By 2024, Nashville will:

1. ENSURE THAT 90% OF NASHVILLE RESIDENTS LIVING WITH HIV KNOW THEIR SEROSTATUS
2. DECREASE BY TWO-THIRDS THE NUMBER OF NASHVILLE RESIDENTS WITH NEWLY ACQUIRED HIV
3. LINK 90% OF THOSE DIAGNOSED WITH HIV TO CARE WITHIN ONE MONTH OF DIAGNOSIS
4. ENGAGE 90% OF PEOPLE DIAGNOSED WITH HIV IN CARE
5. ENSURE THAT 90% OF THOSE ENGAGED IN CARE WILL ACHIEVE VIRAL SUPPRESSION
6. ELIMINATE DISPARITIES IN HIV OUTCOMES. GOALS WILL BE ACHIEVED AMONG ALL POPULATIONS, REQUIRING GREATER FOCUS ON POPULATIONS DISPROPORTIONATELY IMPACTED BY HIV AND/OR UNEQUALLY REPRESENTED AMONG HEALTH OUTCOMES.

As an inclusive community planning process, community members from across disciplines and experience were invited to participate in recommendation development through six EtE Action Committees:

- Access to Treatment and Care
- Community Education and Stigma
- Data
- Policy
- Prevention
- Social Determinants of Health

Approximately 120 individuals participated as members of Action Committees, each of which met six times over a 5-month period between June and October to develop the recommendations in this report. Diversity in the committees, including significant representation from people living with HIV, was key in achieving priorities that were reflective of the Nashville community. Also key to a successful process was the establishment of a Coordinating Committee, which worked to set the charge to the committees, structure and facilitate the committee work, set the environment that allowed for meaningful engagement, and integrate outputs from each of their committees. Committee leadership was critical in achieving a successful plan.

CHAPTER 5: RECOMMENDATIONS FOR ENDING THE EPIDEMIC IN NASHVILLE

The recommendations contained within this chapter are the direct result of the EtE Action Committee meetings that were held between late June and early October 2018. Two additional meetings were convened during this time, an All-Committees meeting hosted by Meharry Medical College and a Joint Committee Meeting that focused on developing recommendations related to comprehensive youth-focused sexual education.

Approximately 120 participants attended at least one meeting over this planning period, and the contributions of time and creativity offered by these individuals, identified in Appendix i., form a strong foundation from which to move these recommendations into action over the coming five years.

Recommendations on the following pages are organized under each of the six EtE Goal Statements, with Objective Statements and Action Items describing the work that is necessary in order to achieve these goals. Chapter 6, *Implementation - Putting This Plan Into Practice*, includes additional steps that will be necessary in order to move these recommendations forward in a successful manner.

Goal 1

Ensure that 90% of Nashville Residents Living with HIV Know Their Serostatus

According to the CDC, approximately 162,500 people in the United States living with HIV are unaware of their status. Knowing one's status is critical to accessing appropriate care and prevention resources. With approximately 40% of new HIV transmissions coming from those who are unaware of their HIV status, there is an immediate need to increase the proportion of Nashville residents that know their status in order to end the HIV epidemic in Nashville.

Objective 1

Promote Routine HIV Testing in Health Care Settings

Fostering an environment in which HIV testing is integrated as a routine component of care is important to normalizing HIV testing and ultimately breaking down stigma against HIV.

Action A

Encourage opt-out testing in healthcare settings under the jurisdiction of Davidson County for those aged 13 years and older

This includes, but is not limited to, all hospital emergency departments, primary care offices, and correctional health care facilities.

Action B

Evaluate content of HIV testing policies and implementation of these in all hospital Emergency Departments (EDs)

Assist in the development of opt-out HIV testing policies for hospital EDs without policies and assess the strength/implementation of those hospital EDs with existing policies to identify areas for improvement.

Action C	Disseminate HIV testing information packets and provide in-person trainings to all health care providers Packet should contain testing recommendations, reporting requirements, referral services, patient education materials, and provider education materials.
Action D	Establish sector-specific task forces to implement HIV testing at points of care outside of hospital Emergency Departments This includes (but not limited to) task forces representing the following sectors: dental, pharmacy, primary care and A&D service providers.

Objective 2 Increase Availability of HIV Testing

Ensure Nashville residents have ample access to convenient and confidential HIV testing by increasing HIV testing in community-based settings outside the traditional health care system.

Action A	Expand community-based HIV testing by identifying funding not limited by a 1% positivity rate requirement Locate non-federal funds and/or compile research to prove cost-effectiveness of community based testing for positivity rates below 1%.
Action B	Fund a mobile testing unit(s) to be used for community-based testing events
Action C	Use GIS mapping to determine geographic priority areas for mobile testing unit to frequent
Action D	Partner with music and entertainment industry to offer testing at nightlife venues
Action E	Enhance partnerships with faith-based organizations (FBOs) to offer HIV testing
Action F	Partner with local universities to offer HIV testing at large-scale sporting and academic events
Action G	Offer HIV testing at large-scale community and cultural events throughout Nashville
Action H	Post a comprehensive calendar of all community-based testing events on EtE Website/Database

Objective 3 Increase Acceptability of HIV Testing

Increasing access to free and confidential HIV testing must be paired closely with strategies to increase utilization through targeted interventions and mass marketing.

Action A Normalize everyone having a HIV status through mass marketing

The campaign should combat stigma and motivate action. Consider language related to “the only bad HIV status is an unknown status”. The campaign should also inform viewers on where and how to get tested.

Action B Utilize community health workers (CHWs) to implement social and sexual network referral strategies for HIV testing

Compensate people from priority populations for referring other community members to HIV testing through paid CHW positions (elaborated on in Goal IV, Objective 5).

Action C Increase access to free at-home HIV testing kits paired with counseling and referral service information

Establish a mechanism to facilitate requests for and distribution of free at-home HIV testing kits.

Action D Leverage routine Hepatitis C testing in health care settings to increase acceptance of HIV testing

Certain populations may be more amenable to routine Hepatitis C testing. With the recent availability of free Hepatitis C testing at various points of care in Nashville, providers should be encouraged to leverage the acceptability of Hepatitis C testing to increase acceptance of HIV testing by encouraging and offering HIV testing during that same encounter.

Goal 2

Decrease by Two-Thirds the Number of Nashville Residents with Newly-Acquired HIV

In order to decrease the overall prevalence of HIV within the Nashville community, new transmissions must decrease by at least two-thirds by 2024. Interrupting transmission will require a multipronged approach that blends together health education, treatment as prevention for those living with HIV, and allocating prevention resources to those at the greatest risk of acquiring HIV.

Objective 1

Create EtE Mass Media Campaign and Website

In order to increase community engagement and awareness of the EtE movement, and the various associated resources, a wide-scale and recognizable media campaign must be created. To increase transparency, the public should have access to data that tracks progression towards all EtE goals.

Action A

Create a website to house resources and data illustrating progress towards EtE goals

The website should house information on where to access key prevention resources such as PrEP, PEP, condoms, HIV testing, and HIV treatment/care. The website should also house education materials on HIV and sexual health. Finally, to increase transparency and community accountability, a public-facing data dashboard should track progress towards all EtE goals.

Action B

Hire a professional marketing team to design and brand the EtE Nashville movement with campaigns to reduce stigma, increase awareness about and utilization of HIV prevention sources

The mass media campaign should have consistent branding, promote action, address stigma, and provide information about where to access resources. Key messages should include transmission facts, U=U, PrEP / PEP, and the benefits of knowing your HIV status.

Action C

Involve Nashville arts and entertainment industry and acquire celebrity endorsements for campaign

Action D

Vet campaign with PLWH and priority populations prior to mobilization

All campaign materials should be vetted by PLWH to ensure stigma is not being perpetuated. Further, specific groups such as older PLWH and priority populations should be included in vetting the campaign.

Action E **Promote campaign broadly through diverse mechanisms, channels, and venues**
Suggested channels include (but are not limited to) social media, radio, TV, newspapers, local magazines, billboards, WeGo signage, street art/murals, and flyers at widely frequented venues such as the DMV, public restrooms, and voting registration venues.

Action F **Work with PLWH, priority populations, and service providers to develop clear and consistent messaging around HIV citywide**

Objective 2 **Provide Comprehensive Sexual Health Information in Nashville**

Comprehensive, accurate, and appropriate sexual health information empowers people to make informed choices related to their own sexual health and the health of their partners. Additionally, comprehensive sex education has been shown to lead to better health outcomes including reduced rates of sexually transmitted diseases and increased condom usage. Therefore, ensuring all people in Nashville have access to sexual health information is critical to addressing HIV transmission and building a culture of sexual health in Nashville.

Action A **Eliminate/modernize laws that limit the range of sex education topics and demonstrations in public schools**

This includes the law limiting condom demonstrations within Tennessee public schools.

Action B **Implement standardized, age-appropriate sex education (3 R's curriculum) across Metro Nashville Public Schools (MNPS) and measure learning outcomes**

Support MNPS and Alignment Nashville's Adolescent Sexual Responsibility team efforts to implement the "Rights, Respect, and Responsibility" sexual health education curriculum. As part of this curriculum, HIV should be addressed annually. Measure changes in risk behaviors, attitudes, knowledge, and stigma through YRBS and BRFSS surveys.

Action C **Provide sex education in the community through online and in-person delivery that complements and expands on 3 R's curriculum for youth, parents, and health care providers**
Online modules should be interactive, involve knowledge checks, and provide real-world scenarios tailored to specific audiences. In-person trainings should be provided in areas with the greatest HIV burden.

Action D **Include "Ask an Expert" forum on EtE Website/Database to answer anonymous sexual health questions**

Utilize trained sexual health educators to provide accurate and comprehensive responses.

Action E **Provide in-person trainings for FBOs to reconcile values and sexual health education**
Ensure the faith-based community is engaged and supportive of sexual health education efforts through targeted outreach and specialized trainings.

Action F	Develop sexual health materials that cover safer sex practices in more complex situations
Action G	Require all TennCare providers to discuss sexual health privately at every health visit for all ages 13+ years as recommended by the American Medical Association and the American Academy of Pediatrics

Objective 3 Increase Condom Accessibility, Acceptability, & Utilization

Increase free and convenient access to condoms through a widespread and strategic condom distribution plan paired with marketing strategies to increase community willingness and competency in utilizing condoms.

Action A	Design comprehensive condom distribution plan (CDP) with tailored approaches for priority populations According to the CDC, CDPs have been proven to increase condom use, prevent HIV and other STDs, and save money. CDPs give rise to structural-level environmental changes that increases availability, accessibility, and acceptability of condoms.
Action B	Use EtE marketing team to design recognizable branding for CDP This may include “Nashville” packaging, consistent signage at CDP locations, or branded bowl to house condoms at distribution locations.
Action C	Partner with name brand condom companies to offer a variety of condom choices at CDP sites
Action D	Place a free condom locator on EtE Website/Database and consider designing a locator app
Action E	Eroticize condom usage through mass media campaign to increase acceptability and utilization Marketing that frames condoms as pleasurable have been proven to increase acceptability and utilization of condoms.

Objective 4 Increase Availability, Accessibility, & Affordability of PrEP / PEP

Pre-exposure prophylaxis (PrEP) and post-exposure prophylaxis (PEP) are important biomedical advances that provide ways to prevent HIV transmission even in the face of exposure. Increasing use of these prevention tools by individuals at risk of HIV exposure necessitates increasing the number of locations offering PrEP / PEP services, creating convenient points of access for those at greatest risk, and addressing financial barriers.

- Action A Increase the number of sites and prescribers of PrEP / PEP in Davidson County**
Map out all PrEP / PEP providers in Davidson County, and identify gaps in coverage. Actively recruit sites/physicians in these areas to become PrEP / PEP prescribers. Provide potential prescribers with a brochure on the benefits of becoming a prescriber, link them to in-person PrEP / PEP trainings, and provide them with a comprehensive PrEP starter kit for integrating PrEP / PEP into their practice.
- Action B House a comprehensive PrEP / PEP locator on the EtE Website/Database**
Distinguish those providers/sites that accept uninsured or underinsured patients for PrEP / PEP services.
- Action C Establish non-occupational PEP policies in all hospital Emergency Departments**
Advocate for policies that provide PEP starter kits paired with strong referral services for continuation of medication regimen. Ensure policies have established best practices for sexual assault victims. Encourage hospital EDs to refer all individuals accessing PEP to PrEP services by establishing contact between the client and a PrEP navigator.
- Action D Explore pharmacists prescribing PEP starter kits (with referral services for continuation)**
Assemble a group of specialty pharmacies to design a plan to facilitate PEP prescriptions at pharmacies in order to increase immediate access to medication during hours outside the scope of primary care offices.
- Action E Increase proportion of Nashville residents with health insurance**
Advocate for the expansion of Medicaid and increase private insurance enrollment assistance programs with targeted outreach to priority populations.
- Action F Address insurance denial issues through a list of suggested ICD-10-CM codes for providers**
Develop and/or adopt a list of acceptable ICD-10-CM codes to PrEP prescribers that will not result in denial of health coverage or life insurance.
- Action G Identify funding to mitigate financial impact of associated lab work**
- Action H Disseminate financial assistance program resource guides to community and health care providers**

Action I	Identify funding to mitigate financial impact of PrEP / PEP for those that cannot access financial assistance programs
Action J	Increase the number of PrEP navigators Actively recruit and hire PrEP navigators from designated priority populations.

Objective 5 Increase Knowledge About & Utilization of PrEP / PEP

In order to widen utilization of PrEP and PEP services, PrEP / PEP education needs to be dramatically increased and targeted to reach those at the greatest risk of HIV. This paired with adherence strategies will be key to growing the number of people in priority populations utilizing PrEP / PEP services.

Action A	Increase community knowledge of PrEP / PEP through mass media campaign
Action B	Utilize CHWs to implement social and sexual network referral strategies for PrEP / PEP referrals Compensate individuals in priority populations who refer other community members to PrEP / PEP through paid CHW positions (elaborated on in Goal IV, Objective 5).
Action C	Integrate PrEP eligibility screening and education into nursing protocols across Davidson County Encourage all major health care organizations in Davidson County to add PrEP screening and education into primary care and sexual health visits.
Action D	Integrate PrEP / PEP education into health care professional curricula Encourage all health care related college programs in Davidson County to integrate PrEP / PEP education into their curricula.
Action E	Explore tailored strategies to increase PrEP adherence among people who inject drugs Consider a modified DOT strategy where PrEP prescriptions are kept on the mobile Syringe Service Program so clients can pick up their daily medication along with their unused syringe supplies.
Action F	Establish a PrEP Buddy Program Connect those newly accessing PrEP services with someone well into the continuation to provide guidance and support.
Action G	Ensure PrEP / PEP messaging is one of the central components of the EtE mass media campaign

Objective 6 Expand Reach of and Services at Syringe Service Programs

People who inject drugs remain especially vulnerable to HIV. Syringe Service Programs (SSPs) have been proven to reduce HIV vulnerability of PWID. Expanding the reach of SSPs and increasing the breadth of HIV prevention resources offered is a key strategy to reaching this priority population. Further, the implications of an opioid/HIV overlap in an urban area would be severe therefore underlining the importance of bolstering SSPs in Nashville.

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| Action A | Provide education on the rationale and legality of SSPs to community members and people who engage PWID |
| Action B | Increase number of HIV organizations and health departments with SSPs in Davidson County

Integrate syringe exchange into existing HIV programs. |
| Action C | Implement opt-out HIV and HCV testing at all SSPs for all people 13 years and older |
| Action D | Identify funding for additional mobile SSP unit(s) |
| Action E | Increase breadth of prevention resources at SSPs

Consider integrating PrEP / PEP services, link those that test positive to HIV or HCV to care, provide free wound care, and house HIV related medications including PrEP, PEP, and ART on mobile SSPs to facilitate a modified DOT option for clientele. |
| Action F | Increase access to nonprescription sale of syringes in pharmacies |

Goal 3

Link 90% of Those Diagnosed with HIV to Care Within One Month of Diagnosis

Ensuring that newly-diagnosed PLWH have the greatest opportunity to live long and healthy lives starts with linking these individuals to care effectively and efficiently. Meeting this goal will require the removal of barriers to care, strategies to strengthen existing systems, and the expansion of expedited HIV services.

Objective 1

Accelerate Initiation of ART for Newly Diagnosed PLWH

Early treatment initiation of ART has been linked to reduced mortality and morbidity among people newly-diagnosed with HIV. Therefore, identifying strategies to accelerate treatment initiation is key to ensuring optimal health outcomes for PLWH.

Action A

Establish expedited eligibility protocols for all people diagnosed with HIV to increase immediate integration into coordinated care

Action B

Establish same-day initiation of ART for newly diagnosed PLWH where evidence of effectiveness exists

Identify funding and key partners to implement same-day initiation of ART.

Action C

Evolve EIS systems of care to strengthen referrals from providers outside traditional HIV systems of care

Consider assigning each major health care organization to a particular EIS worker(s) to strengthen relationships and facilitate more consistent communication.

Objective 2

Expand & Enhance Partner Services

Partner services is a free and confidential strategy to link those potentially exposed to HIV to testing, treatment and other HIV prevention resources, where applicable. In this way, partner services can reduce further transmission and ensure more optimal health outcomes for those exposed to HIV.

Action A

Ensure all PLWH routinely receive partner services to link current and former partners to care

Recommend that partner services be routinely offered during HIV points of care as sexual partners may change over time.

Action B	Ensure all disease intervention specialists (DIS) receive standardized training Training should include modules on partner services, motivational interviewing, cultural competency, and trauma informed care.
Action C	Recruit and hire DIS from within priority populations to bolster capacity and cultural competency

Objective 3 **Identify and Respond to Barriers Related to Linkage to Care**

In order to address barriers to care appropriately, there must first be a detailed understanding of local and community specific barriers to accessing care. These findings will then drive strategies to reduce and/or eliminate these barriers so all newly diagnosed PLWH can effectively be linked to care.

Action A	Conduct primary research with priority populations to identify barriers to care and health priorities This should include primary research (i.e. focus groups) and secondary research (i.e. literature review).
Action B	Design and implement specialized strategies to respond to identified barriers for priority populations

Objective 4 **Strengthen EIS Systems to Expedite Linkage to Care**

Early Intervention Services (EIS) workers serve a critical role in linking newly diagnosed PLWH to HIV treatment, case management, and other supportive services. Strengthening the capacity of EIS systems to collaborate with partners outside the traditional HIV network of care will ensure all newly diagnosed PLWH have access to a full complement of services.

Action A	Foster relationships between EIS and medical providers outside the traditional HIV network of care Utilize academic detailing strategies to reach out to primary care providers and hospital Emergency Departments that serve a high volume of PLWH to provide in-person education on services offered by EIS, and the benefits of immediately linking their clients to EIS personnel.
Action B	Assign hospital Emergency Departments one or more EIS personnel to be a direct point of contact for immediate referrals upon diagnosis
Action C	Increase capacity of EIS systems by recruiting and hiring EIS personnel from priority populations

Goal 4

Engage 90% of People Diagnosed with HIV in Care

Creating an environment where all PLWH can feel empowered to become engaged and stay engaged in care will lead to better health outcomes on an individual and community level. Achieving this will require interventions within existing systems of care, the implementation of new models of care, strengthening support networks, and policy changes.

Objective 1

Strengthen EIS Systems to Facilitate Engagement in HIV Care

Early Intervention Services (EIS) workers set the landscape for engagement in care by establishing rapport with newly diagnosed PLWH, initially connecting them to HIV care, and transitioning clients to prolonged case management. Ensuring that EIS systems of care are standardized and strengthened will ensure high quality and early engagement in care.

Action A

Evaluate current EIS systems and tailor interventions to strengthen service delivery

Hold focus groups with EIS workers and with a diverse cross-section of their clients to assess strengths, challenges, and gaps in care.

Action B

Establish enhanced EIS with specialized case management

Create specialized and intensive case management for clients with complex situations and/or comorbidities such as mental health challenges or substance use disorder.

Action C

Standardize EIS training

Ensure all EIS workers receive standardized training that includes modules on cultural competency, and trauma informed care.

Objective 2

Foster Engagement Through Health Care Interventions

In order to engage and retain PLWH in care there is a need to ensure that all points of service delivery are welcoming, affirming, comprehensive, and collaborative.

Action A

Re-brand Metro STI clinic as a Sexual Health Center and make care delivered more comprehensive

Strategize and collaborate to incorporate primary care in the Metro Sexual Health Center.

Action B

Determine optimum hours and location(s) for care among priority populations

Extend/change the hours of the Metro Sexual Health Center to center customer convenience and consider additional clinic locations.

Action C	Strengthen data sharing and harmonization to facilitate tracking of patients during major transitions of care For example, ensure patients entering/exiting incarceration and patients transitioning out of pediatric care are appropriately referred and tracked to avoid gaps in care.
Action D	Fully integrate mental health and substance abuse assessment/treatment into the HIV care continuum
Action E	Expand provider education to increase client retention Continued education should include HIV specific education, cultural competency trainings, and trauma informed approaches to care.
Action F	Require HIV literacy program for all jail staff Training should address stigma, mode of transmission, cultural competency, and trauma informed care.
Action G	Require jails in Davidson County to link PLWH to ASOs Ensure an appointment is scheduled prior to release to avoid any gaps in HIV care.
Action H	Conduct primary research among PLWH in priority populations to identify community specific barriers to care and health care priorities Create community-specific strategies to reduce/eliminate barriers and address all health care priorities that fall above HIV care to optimize sustained engagement.

Objective 3 **Facilitate an Environment of Engagement Through Policy Change**

	Administrative and policy amendments that create and sustain an environment where people have the opportunity to access and utilize insurance effectively is key to increasing engagement in care.
Action A	Preserve current Medicaid coverage by opposing attempts to restrict eligibility and/or benefits, and advocate to expand Medicaid coverage in Tennessee
Action B	Advocate with insurance to get explanation of benefits (EOBs) documents sent to patients versus policy holders This strategy is crucial to engaging youth in care whom are still under their parent's insurance.
Action C	Advocate that insurance companies to adopt non-discrimination policies to protect transgender people

Action D	Prevent restrictive drug formulary practices through legislative and administrative means (e.g. tiering of HIV medications, quantity limits, and prior authorization requirements) This includes tiering of HIV medications, quantity limits, and prior authorization requirements.
Action E	Ensure that drug companies apply co-pay prescription benefits of plan

Objective 4 **Foster a Culture of Engagement Through Peer Support Networks**

Peer support networks provide an opportunity to build community among PLWH and among HIV care providers to increase lateral support and engagement in care.

Action A	Create peer support networks for HIV care providers Support networks will positively impact cohesion and collaboration among HIV care providers (medical and non-medical).
Action B	Create specialized peer support networks for PLWH among priority populations This will increase lateral support among PLWH who have similar lived experiences and challenges.
Action C	Provide “Healthy Relationships” programming to all PLWH This skills-based intervention provides PLWH the tools to disclose their HIV serostatus to others, navigate HIV-related stressors, and develop safer sex practices.
Action D	Develop anonymous online forums where PLWH can seek peer support

Objective 5 **Implement a CHW Model to Facilitate Coordinated Care**

A Community Health Worker (CHW) model for coordinated care expands on a case management model to facilitate the provision of both biomedical and social support services. This more holistic approach to care encompasses addressing the social, educational, financial, and developmental needs of clients through individualized and comprehensive coordinated care delivered by culturally and linguistically competent CHWs.

Action A	Implement a CHW model to provide comprehensive and coordinated care services to all PLWH
Action B	Recruit and hire CHWs from priority populations
Action C	Develop standardized CHW curricula Training should include modules on cultural competence, trauma informed care, and strategies to provide care coordination among nontraditional partners.

Action D	Create specialized CHW positions for clients with specific needs Consider specialists in the following areas: re-engagement, housing, employment navigation, and prevention (i.e. testing and PrEP / PEP referrals).
Action E	Increase health literacy of PLWH through health education programs delivered by CHWs

Objective 6 **Strengthen Re-Engagement Strategies for PLWH Lost to Care**

Re-engaging PLWH that are lost along the HIV care continuum is essential to decreasing mortality, morbidity, and HIV transmission so that better health outcomes can be achieved at the individual and community level. Achieving this objective will necessitate enhanced data surveillance combined with intensified and individualized outreach by re-engagement specialists.

Action A	Establish “Data-to-Care” protocols to reconnect those lost to care to health services Data-to-care is a strategy that uses client-level data to identify people lost on the HIV care continuum so they can be re-engaged. This requires improved surveillance and data sharing agreements that allow the local health department to generate “not-in-care” lists to be shared with designated CHWs to prioritize for re-engagement.
Action B	Fund CHW re-engagement specialists to locate and integrate those lost to care into services These clients should receive intensified care with enhanced communication and coordination to ensure retention and success.
Action C	Incentivize re-engagement through client-specific barrier reduction
Action D	Explore the development of a system to accurately measure PLWH migrating between care systems

Goal 5

Ensure that 90% of Those Engaged in Care Will Achieve Viral Suppression

Achieving viral suppression (defined by having less than 200 copies per milliliter of blood) has been linked to better health outcomes for PLWH and prevention of HIV transmission through sexual activity. This concept, known as “Treatment as Prevention” or TasP, is an important strategy to ensure the health of PLWH while simultaneously reducing new HIV transmission.

Objective 1

Standardize Access to Full Complement of Services for All PLWH

Ryan White clients have been shown to achieve better health outcomes compared to PLWH who do not qualify or are not enrolled in Ryan White services. This may be in part linked to the broad and comprehensive complement of HIV services that Ryan White clients may access. These services promote greater engagement in care, and in turn increased rates of viral suppression. Ensuring that all PLWH have access to a diverse array of services is critical to achieving and sustaining viral suppression among all PLWH.

Action A

Increase provider/agency awareness of the value and availability of support services for PLWH

Utilize CHWs to provide academic detailing to HIV care providers both within and outside the traditional HIV network of care.

Action B

Educate community about services available to PLWH and where/how to access resources

Action C

Identify funding to provide wrap-around services for non-Ryan White clients

Ensure that the comprehensive services and level of care provided to Ryan White clients is available to all PLWH regardless of eligibility.

Action D

Strengthen existing systems of care through collaboration across agencies via formal MOUs

Objective 2 Promote Viral Suppression Through U=U Education

Undetectable = Untransmittable (U=U) means that a virally suppressed PLWH has effectively no risk of transmitting HIV to their sexual partner(s). U=U is a powerful and transformative TasP message that combats stigma, encourages engagement in care, and revolutionizes the social and sexual world of PLWH. Sharing the U=U message broadly is a key tactic promoting the value of viral suppression and its overall role in ending the HIV epidemic.

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| Action A | Create U=U provider information packets and distribute to all HIV care providers in Davidson County |
| | This should include the value of U=U messaging, tips for how to talk to patients about U=U, and the wealth of scientific research that supports U=U. |
| Action B | Integrate U=U messaging into HIV curricula and continued education for health care professionals |
| Action C | Recommend the integration of U=U education into nursing protocols for HIV care |
| Action D | Create and disseminate U=U education to community through targeted outreach by CHWs |
| Action E | Ensure U=U messaging is one of the central components of the EtE mass media campaign |

Objective 3 Implement Strategies to Increase Medication Adherence

Assisting PLWH in achieving viral suppression necessitates creating strategies to ensure medication adherence. Supporting PLWH, especially those newly diagnosed, in creating a medication routine that ensures consistency, and providing extra support to those struggling with adherence is vital to increasing positive health outcomes.

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| Action A | Establish and implement pharmacy notification programs to prevent lapses in medication
Design a system that notifies a CHW when a PLWH fails to pick up their HIV medication, so they can re-engage the client in treatment. |
| Action B | Utilize application-based medication assistance programs to provide daily reminders to PLWH |

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| Action C | Connect all PLWH to peer support networks
Such peer support networks could connect PLWH either via a web-based application or in-person. |
| Action D | Promote medication adherence among all PLWH
Provide tangible incentives for picking up HIV medication and for achieving viral suppression. |

Objective 4 **Ensure Sustained Access to Medication for all PLWH**

Achieving and sustaining viral suppression depends on a sustained access to medication for all PLWH regardless of ability to pay.

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| Action A | Provide access to Hepatitis/HIV/STI medications for all patients covered by TennCare |
| Action B | Ensure those who do not have access to health insurance or cost assistance programs can access a sustained supply of HIV medications regardless of ability to pay |

Goal 6

Eliminate Disparities in HIV Outcomes

The Nashville EtE goals will be achieved among all populations, requiring greater focus on populations underachieving optimal outcomes. Allocating greater resources and efforts towards specified priority populations will be crucial to achieving equitable HIV outcomes for all people in Nashville.

Objective 1 Bolster Workforce Development and Economic Empowerment

Creating and supporting employment opportunities for people in priority populations will lead to greater economic empowerment, reduced vulnerability to HIV, and other negative health outcomes.

- Action A** Create CHWs dedicated to employment navigation
- Action B** Recruit and hire CHWs who are living with HIV and/or are among priority populations
- Action C** Advocate for PLWH as a designated priority population for employment services
- Action D** Support and expand financial literacy programs for all PLWH and priority populations
- Action E** Advocate to expand predatory-free lending zones
- Action F** Increase coordinated representation of PLWH at citywide advocacy efforts to improve financial equity

Objective 2 Increase Access to Transportation

Increasing access to affordable and reliable transportation is critical to ensuring PLWH and those within priority populations can access HIV care and prevention resources.

- Action A** Increase coordinated representation of PLWH in citywide advocacy efforts to expand and improve transportation services
- Action B** Establish and foster relationships with ride-sharing companies for medical appointment transportation
This includes creating partnerships with Uber, Lyft and any other ride-sharing companies to increase affordability and access to transportation within privately owned vehicles.
- Action C** Increase gas assistance programs for PLWH using private vehicles for medical transportation
- Action D** Increase access to subsidized public transportation for PLWH

Objective 3 Increase Access to Affordable Housing

Access to safe and affordable housing has been linked to more positive health outcomes among PLWH and to reduced community vulnerability to HIV. Therefore, advocating for the expansion of affordable housing is critical to ending the HIV epidemic in Nashville. Further, messaging and implementation of Housing First practices and policies should be considered.

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| Action A | Increase housing literacy and housing rights resources for PLWH and priority populations
Utilize CHWs that specialize in housing navigation to deliver housing literacy programming. |
| Action B | Increase coordinated representation of PLWH in citywide advocacy efforts to improve housing affordability |
| Action C | Increase availability of Shelter Plus Care vouchers be designated for PLWH
Ensure that PLWH that have multiple comorbidities or other compound vulnerabilities are prioritized higher. |
| Action D | Identify housing partners to provide emergency housing
Ensure that PLWH are designated as a priority population with emergency housing partners. |
| Action E | Dedicate CHW positions for housing navigation that address both short and long-term housing solutions |
| Action F | Increase access to short-term housing resources for PLWH |
| Action G | Increase the availability of affordable housing units designated for PLWH |

Objective 4 Address and Reduce Stigma and Discrimination of PLWH

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| Action A | Modernize HIV criminalization laws to reflect current science about transmission |
| Action B | Make HIV education and anti-stigma training accessible online and in-person to non-traditional service providers and community organizations |
| Action C | Provide cultural competency and trauma informed education to all HIV care providers online and in-person |
| Action D | Partner with the Metro Human Relations Commission to address instances of discrimination against PLWH |
| Action E | Use secret shoppers and consumer surveys to identify areas of improvement for providers and provide specialized training and solutions to address discriminatory practices/behaviors |

**OVERARCHING
DATA ACTIVITIES**

Monitor available data sources, evaluate progress toward achieving EtE goals, objectives, and actions and disseminate outcomes to the public

The following action steps will be driven by the Data Action Committee in order to accurately measure EtE goals and subsequently convey progress to the public.

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| Action A | Coordinate definitions and data related to HIV prevention and care interventions across state and local levels, including measures related to experiences of stigma and interventions to address stigma |
| Action B | Enhance collaborations between HIV prevention and surveillance programs at the state and local levels |
| Action C | Collaborate with oversight body and EtE coordinator to monitor and report on progress (including via EtE website) |
| Action D | Consult with oversight body and EtE coordinator to respond to evolving data needs |

CHAPTER 6: IMPLEMENTATION - PUTTING THIS PLAN INTO PRACTICE

Members of the EtE Task Force implored the six Action Committees to be aspirational in their work. The recommendations that emerged are comprehensive and far-reaching, and successful implementation will no doubt need to take advantage of the momentum that has built in the community during the development of this plan.

It is also important to note the recommendations identified in this plan are not intended to be limiting or exclusive of new strategies that emerge in the coming years, and it is likely that priorities will evolve going forward as progress is made towards achieving Nashville's EtE goals. Over the next five years, scientific advancements will provide new and enhanced treatment and prevention tools and new resources will become available that can be used in the fight to end the epidemic. These opportunities should be pursued aggressively and without hesitation.

During the planning process, the Task Force and Coordinating Committee identified several keys to successful implementation of the Plan's recommendations. These keys include the following, and represent significant recommendations in their own right:

Convene a standing Oversight Body to guide implementation of the Plan's recommendations.

The full and successful implementation of the Plan's recommendations will greatly benefit from the creation of a standing Oversight Body. Through a collective impact framework, the Oversight Body would assume responsibility for the successful implementation of the Plan's recommendations. Much like the role the EtE Task Force played during the planning process, the Oversight Body would provide strategic guidance to staff and partners who will be implementing recommendations, help attract the participation of new and nontraditional partners in the fight to end the epidemic, assemble and sustain the financial resources necessary for success, and foster and grow support from elected officials and other representatives at all levels of government.

The Oversight Body should reflect key stakeholder groups from within and outside of the existing network of HIV care and service providers, and should include direct representation of people living with HIV and the populations at greatest risk of exposure.

Create a dedicated staff position within the Nashville Metro Public Health Department to coordinate the EtE initiative.

In concert with the establishment of a standing Oversight Body, the Metro Public Health Department should establish a new, dedicated staff position to coordinate the EtE initiative. The staff member would complement existing MPH HIV program staff and be responsible for providing critical stakeholder coordination and project management services over the five year planning horizon. Additionally, the staff member would be asked to organize and staff the Oversight Body, develop and coordinate requests for funding, and serve as a key point of contact for the public and stakeholders with respect to progress made toward achieving Nashville's EtE Goals.

Increase and diversify funding necessary to fully implement the Plan's recommendations.

As described previously, the recommendations outlined in this Plan are aspirational in nature and made without regard to the availability of existing funding. They do not reflect what can be done, they reflect what needs to be done to end the epidemic. As such, one of the most critical factors for future success in achieving the EtE goals will be the ability to increase and diversify the sources and amounts of funding that are supporting work described within this Plan. Federal, state and local government funding should grow and continue to be combined with a renewed focus on corporate and philanthropic investments.

Achieve policy changes necessary to implement fully the Plan's recommendations

Policy change at the local, state and federal level is a critical factor for success in achieving Nashville's EtE goals. Recommendations related to policy are woven throughout the Plan. As with funding, these recommendations are aspirational and focus on what needs to be done rather than what can be done- at least in the immediate future. Developing a strategic approach to successful policy change will be an important responsibility during implementation of this Plan.

Sustain commitments from new and existing partners.

During the EtE planning process, approximately 120 individuals representing nearly 50 institutions came together on a regular basis over four months to identify challenges and opportunities and to go to work in framing the recommendations contained within this Plan. Despite the level of effort that these community leaders put forth, the work has only begun: the Plan that has taken six months to develop will take five years to successfully implement.

Existing partners and stakeholders will need to redouble their commitment to the effort, and new partners need to be brought to the table, for example leaders in housing, education, criminal justice, and economic opportunity. While the Oversight Body and staff described earlier will play a role in engaging these partners and holding them accountable to their commitments, organizations throughout Nashville will need to lean forward and make good on their capabilities in order for Nashville's EtE goals to be fully achieved.

Establish a Data Monitoring Team to provide ongoing measurement and evaluation capabilities, track progress and communicate success.

During the planning process, the Data Action Committee provided expert guidance to the other five Action Committees on how recommendations could best be measured and evaluated over the five year planning horizon (see Appendix ii). The Data Action Committee also worked to evaluate potential limitations in existing data sources and data collection systems, and developed data-specific recommendations that are summarized in Figure 7.

FIGURE 7. DESCRIPTION OF DATA RESOURCES, CORE ETE METRICS, AND THE DATA MAPPING PROCESS BETWEEN THE TWO

- Metro Public Health Department (MPHD) may extend Data Use Agreements with State to include others
- Epidemiology/Biostatistics (merging & harmonizing data, deriving metrics, reporting results using dashboard) done at MPHD, with support as needed

Alternative Metrics:

- Linkage/Engagement by Clinical Visits (+ Labs)
- Longitudinal Measures
- Durable Viral Suppression

Developed with input from Data Committee

Data Sources:

(Data Use Agreement between State & Metro)

- eHARS
- CAREWare
- PTBMIS
- EvaluationWeb
- US Census Bureau

Data Map

Link Sources with Measured & Derived Variables to Construct Metrics

Metrics:

- 90% Know HIV Status
- 2/3 decrease in new HIV acquisitions
- 90% Linked within 1 Month
- 90% Engaged in Care
- 90% Virally Suppressed

New Partnerships & Data Use Agreements

New Data Sources:

- Pharma
- Pharmacy Data
- Insurance
- Hospitalization

- % Undiagnosed determined by algorithm using CD4+ of HIV Diagnosed
- % Linked/Engaged: CD4+ or HIV-1 RNA \leq 1 month after HIV diagnosis/twice $>$ 90 days apart per year
- % Virally Suppressed: HIV-1 RNA $<$ 200 copies/mL, at last measure in year

The Data Action Committee should be reconvened on an ongoing basis as the EtE Data Monitoring Team, and should set out to advance work that is reflected in the data-related recommendations outlined in Figure 7 and also work as a service unit in support of the project teams and staff that will be actively working to implement the recommendations contained within the EtE Plan.

Appendix i

Action Committee Participants

POLICY ACTION COMMITTEE

Larry Frampton, Nashville CARES (Co-Chair)
Brady Morris, Nashville Regional HIV Planning Council (Co-Chair)
Ken Barton, TAADAS
Joe Burchfield, Nashville CARES Board Member
Cedrina Calder, Meharry Medical College
Nicolas Calvin, Nashville CARES
Sheri Giorgio, ABBVIE
Margaret Hargreaves, Meharry Medical College
Jami Hargrove, Nashville CARES
Estie Harris, Harris Frazier Government Relations
Ray Holloman, HCE/Trans Empowerment Project
Kessy Jean, Meharry Medical College
Mary Linden Salter, TAADAS
Kim Maltempo, Greater Nashville Regional Council
Tara McKay, Vanderbilt University
Charlene Oliver, Office of U.S. Rep. Jim Cooper
Jessica Powell, Meharry Medical College
Nicole Quinones, Vanderbilt MPH
Peter Rebeiro, Vanderbilt University Medical Center
Marisa Richmond, Metro Nashville Human Relations Commission
Carlin Rushing, Fisk University
Jim Schmidt, Schmidt Government Solutions
Tarik Smith, Meharry Medical College
Libby Thurman, Tennessee Primary Care Association
Naomi Turner, Meharry/First Response Center
Neely Williams, Certified Public Nurse
Rebecca Wilson, Tristar/HCA

ACCESS TO TREATMENT & CARE ACTION COMMITTEE

Rev. Terry Terrell, Metropolitan Interdenominational Church First Response Center (Chair)
Sally Besuden, Metro Nashville Homelessness Commission
Nicholas Calvin, Nashville CARES
Sabrina Gandy, Tennessee Department of Health
George Grayson, HUTN/AMP
Carrie Harter, ViiV Healthcare
Patrick Luther, Nashville CARES
Joy Mayanja, Janssen
Brady Morris, Nashville Regional HIV Planning Council

Ryan Moss, Vanderbilt
Jessica Powell, Meharry Medical College
Chase Richardson, Walgreen's
Kim Rivers, Neighborhood Health
Terry Sabella, Tennessee Primary Care Association
Marlene Sanders, Merck
Tarik Smith, Meharry Medical College
Tom Starling, Mental Health Association of Middle Tennessee
Pam Sylakowski, Metro Nashville Public Health Department
Michael Tribble, Meharry Medical College
Naomi Turner, Meharry Medical College/First Response Center
John Ujwok, Nashville International Center for Empowerment
Claire Wisely, Medical Foundation of Nashville
Valerie Woods, Street Works
Del Ray Zimmerman, Vanderbilt

SOCIAL DETERMINANTS OF HEALTH ACTION COMMITTEE

Jessica Hoke, Nashville CARES (Co-Chair)
Tarik Smith, Meharry Medical College (Co-Chair)
Leah Alexander, Meharry Medical College
Katina Beard, Matthew Walker Health Center
Joy Berry, Nashville CARES
Nicholas Calvin, Nashville CARES
Larry Frampton, Nashville CARES
Bill Friskics-Warren, Park Center
Delaney Lackey, Vanderbilt MPH Student
Jacinta Leavell, Meharry Medical College
Justin Lofton, My House
Brian Marshall, Mashup! Nashville
Carolyn Maxwell, Metro Nashville Public Health Department
Charity Neal, Matthew Walker Health Center
Frieda Outlaw, Healthy Nashville
Erin Pickney, Nashville CARES
Caroline Portis-Jenkins, Connectus Health
Pam Sylakowski, Metro Nashville Public Health Department
Lisa Waszkiewicz, Nashville CARES

COMMUNITY EDUCATION & STIGMA ACTION COMMITTEE

Clare Bolds, SE AIDS Education Training Center (Co-Chair)
Ebony Gordon, Nashville CARES (Co-Chair)
Leah Alexander, Meharry Medical College
Elizabeth Bradner, Planned Parenthood
Larry Frampton, Nashville CARES
George Grayson, HCA
Jarissa Greenard, Vanderbilt University Medical Center

Barbara Gunn-Lartey, MHRC
Margaret Hargreaves, Meharry Medical College
Jami Hargrove, Nashville CARES
Sierra Harris, Vanderbilt University Medical Center
Emilee Hemler, Nashville CARES
Troy Jenkins, Metro Nashville Homelessness Commission
Justin Lofton, My House
Brian Marshall, Mashup! Nashville
Brady Morris, Nashville Regional HIV Planning Commission
Brenda Morrow, Organized Neighbors of Edgehill/FRC
Roberta Nelson, Vanderbilt LGBTQ Life
Susan O'Hara, Vanderbilt University Medical Center
Grace Parker, SE AIDS Education Training Center
Charles Pettiford, Meharry Medical College
Tarik Smith, Meharry Medical Center
Ron Snitker, Nashville LGBT Chamber
Tom Starling, Mental Health Association of Middle Tennessee
Judy Stilke, Vanderbilt University Medical Center
Tiye Link, Nashville CARES
Bryan Uttz, Community Activist
Tom Ward, Oasis Center
Tracy Watkins, Vanderbilt University Medical Center
Catherine Wyatt Morley
Kira Zemanick, Vanderbilt University Medical Center
Tiye Link, Nashville CARES

DATA ACTION COMMITTEE

Meredith Brantley, Tennessee Department of Health (Co-Chair)
Josh Love, Metro Nashville Public Health Department (Co-Chair)
Peter Rebeiro, Vanderbilt University Medical Center (Co-Chair)
Lauren Brown, Nashville CARES
Kari Campbell, SEAETC
Mekeila Cook, Meharry Medical College
Amber Coyne, Metro Nashville Public Health Department
Margaret Hargreaves, Meharry Medical College
Phil Johnston, Belmont University
Sean Kelly, Vanderbilt University Medical Center
Justin Lofton, My House
Carolyn Maxwell, Metro Nashville Public Health Department
Sam MacMaster, Journey Pure
Randi Rosack, Tennessee Department of Health
Pam Russo, Catholic Charities of Tennessee
Tarik Smith, Meharry Medical College
John Ujwok, Nashville International Center for Empowerment
Lisa Waszkiewicz, Nashville CARES
Cathryn Wyatt Morley

PREVENTION ACTION COMMITTEE

Amber Coyne, Metro Nashville Public Health Department (Co-Chair)
Justin Lofton, My House/Streetworks (Co-Chair)
Brady Morris, Nashville Regional HIV Planning Council (Co-Chair)
Ron Balcarras, Deloitte
Katherine Buchman, Tennessee Department of Health
Sarah Cooper, Tennessee Department of Health
Joshua Farrell, Walgreens
Larry Frampton, Nashville CARES
David Frederick, Nashville CARES
George Grayson, HTUN
Heather Grome, Vanderbilt Comprehensive Care Center
Barbara Gunn Lartey, Metro Nashville Human Relations Commission
David Haas, Tennessee CFAR/Vanderbilt University Medical Center
Margaret Hargreaves, Meharry Medical College
John Jarik, NICE
Jeremiah Johnson, Treatment Action Group
Sean Kelly, Vanderbilt Comprehensive Care Center
Valerie Klein, Centerstone
Josh Love, Metro Nashville Public Health Department
Patrick Luther, Nashville CARES
Brenda Morrow, ONE/FRC
Korlu McCainster, Meharry
Jamie Regan, Nashville CARES
Mandi Ryan, Centerstone
Allison Sanders, Tennessee Department of Health
Tom Starling, Mental Health America
Sherise Stogner, Vanderbilt Comprehensive Care Center
Kimberly Truss, Tennessee Department of Health
Ryan Uttz, Community Activist
Ida Watts-Harris, Meharry Medical College

Many of the individuals listed above also participated in an All-Committees meeting held at Meharry Medical College on August 8, 2018 and in a Special Joint Action Committee focused on Comprehensive Sexual Education held at the Lentz Public Health Center on September 24, 2018.

Appendix ii

Metrics & Data Sources to Track Progress Towards Ending the Epidemic

Goal/Objective/Action	Metric(s)	Data Source(s)
Goal 1 Ensure that 90% of Nashville Residents Living with HIV Know Their Serostatus	<i>Percentage of PLWH who are unaware of their status</i>	eHARS
Objective 1 Promote Routine HIV Testing in Health Care Settings		
Action A Encourage opt-out testing in healthcare settings under the jurisdiction of Davidson County for those aged 13 years and older	<i>Number of healthcare facilities implementing opt-out testing in Davidson County during the measurement year</i> <i>Percentage of Nashville residents receiving a HIV test</i>	Hospital Emergency Departments, primary care offices, and correctional health care facilities TDH HIV Surveillance Program
Action B Evaluate content of HIV testing policies and implementation of these in all hospital Emergency Departments (EDs)	<i>Binary - were HIV testing policies and implementation practices in hospital EDs evaluated or not</i>	Hospital EDs eHARS
Action C Disseminate HIV testing information packets and provide in-person trainings to all health care providers	<i>Number of HIV testing information packets distributed</i> <i>Number of in-person trainings conducted</i>	Entity responsible for information packet distribution and in-person trainings
Action D Establish sector-specific task forces to implement HIV testing at points of care outside of hospital Emergency Departments	<i>Number of sector task forces formed to implement HIV testing</i> <i>Number of points of care/sites for HIV testing where sector-specific task forces are operating</i> <i>Number of HIV tests performed during the measurement year</i>	Sector-specific task forces for HIV testing EtE Website/Database
Objective 2 Increase Availability of HIV Testing		
Action A Expand community-based HIV testing by identifying funding not limited by a 1 percent positivity rate requirement	<i>Binary - was funding identified or not</i> <i>Amount of money spent on expansion of testing sites/services</i> <i>Number of HIV testing toolkits disseminated to health care providers</i> <i>Number of additional testing sites during the measurement year</i>	Funding sources EtE Website/Database
Action B Fund a mobile testing unit(s) to be used for community-based testing events	<i>Binary - was mobile testing unit(s) funded for community-based testing events or not</i>	EtE Website/Database
Action C Use GIS mapping to determine geographic priority areas for mobile testing unit to frequent	<i>Binary - was GIS mapping used to determine priority areas for mobile testing or not</i>	eHARS EtE Website/Database
Action D Partner with music and entertainment industry to offer testing at nightlife venues	<i>Number of testing events conducted at nightlife venues during the measurement year</i> <i>Number of HIV tests performed at nightlife venues during the measurement year</i>	TDH HIV Surveillance Program Entities conducting HIV testing at nightlife venues (e.g., My House)
Action E Enhance partnerships with faith-based organizations (FBOs) to offer HIV testing	<i>Number of FBOs offering HIV testing during the measurement year</i> <i>Number of HIV tests performed at FBOs during the measurement year</i>	TDH HIV Surveillance Program Entities conducting HIV testing at FBOs
Action F Partner with local universities to offer HIV testing at large-scale sporting and academic events	<i>Number of testing events conducted at large-scale sporting and academic events during the measurement year</i> <i>Number of HIV tests performed at large-scale sporting and academic events during the measurement year</i>	TDH HIV Surveillance Program Entities conducting HIV testing at large-scale sporting and academic events

Action G	Offer HIV testing at large-scale community and cultural events throughout Nashville	<i>Number of community and cultural events where HIV testing was held during the measurement year</i> <i>Number of HIV tests performed at large-scale community and cultural events during the measurement year</i>	TDH HIV Surveillance Program Entities conducting HIV testing at large-scale community and cultural events (e.g., My House) CAREWare (Ryan White outreach events only)
Action H	Post a comprehensive calendar of all community-based testing events on EtE Website/Database	<i>Binary - was comprehensive calendar developed/ posted during the measurement year or not</i>	EtE Website/Database
Objective 3 Increase Acceptability of HIV Testing			
Action A	Normalize everyone having a HIV status through mass marketing	<i>Binary - was mass marketing campaign to normalize HIV status awareness carried out or not</i>	EtE Website/Database
Action B	Utilize community health workers (CHWs) to implement social and sexual network referral strategies for HIV testing	<i>Proportion of providers utilizing CHWs to implement social and sexual network referral strategies for HIV testing during the measurement year</i>	City/private/ ASO programs utilizing CHWs
Action C	Increase access to free at-home HIV testing kits paired with counseling and referral service information	<i>Number of free at-home HIV testing kits distributed during the measurement year</i> <i>Binary - did at-home HIV testing kits include counseling and referral service information or not</i>	City/private/ ASO programs distributing at-home HIV testing kits
Goal 2	Decrease by Two-Thirds the Number of Nashville Residents with Newly-Acquired HIV	<i>Number of new HIV diagnoses during first and last year of implementation of EtE Plan</i>	eHARS
Objective 1 Create EtE Mass Media Campaign and Website			
Action A	Create a website to house resources and data illustrating progress towards EtE goals	<i>Binary - was EtE Website/Database developed or not</i>	EtE Website/Database
Action B	Hire a professional marketing team to design and brand the EtE Nashville movement with campaigns to reduce stigma, increase awareness about and utilization of HIV prevention sources	<i>Binary - was professional marketing team hired to design branding for EtE Nashville or not</i> <i>Number of social marketing campaigns and other activities focused on targeted populations</i>	EtE Website/Database
Action C	Involve Nashville arts and entertainment industry and acquire celebrity endorsements for campaign	<i>Number of endorsements received from the Nashville arts and entertainment industry</i>	EtE Website/Database
Action D	Vet campaign with PLWH and priority populations prior to mobilization	<i>Number of meetings held among PLWH and priority populations to assess the EtE mass media campaign prior to launch</i>	EtE Website/Database
Action E	Promote campaign broadly through diverse mechanisms, channels, and venues	<i>Number of different mechanisms, channels, and venues via which the EtE campaign was promoted</i>	EtE Website/Database
Action F	Work with PLWH, priority populations, and service providers to develop clear and consistent messaging around HIV citywide	<i>Binary - was a communication strategy around HIV (i.e., clear and consistent messaging) developed or not</i>	EtE Website/Database
Objective 2 Provide Comprehensive Sexual Health Information in Nashville			
Action A	Eliminate/modernize laws that limit the range of sex education topics and demonstrations in public schools	<i>Number of laws limiting the range of sex education topics and demonstrations in public schools that were eliminated</i> <i>Number of laws limiting the range of sex education topics and demonstrations in public schools that were created/modernized</i>	State legislative record/annotated code

Action B	Implement standardized, age-appropriate sex education (3 R's curriculum) across Metro Nashville Public Schools (MNPS) and measure learning outcomes	<i>Binary - was 3 R's curriculum implemented across Metro Nashville Public Schools or not</i> <i>Percentage of Metro Nashville Public Schools implementing standardized, age-appropriate sex education</i>	MNPS Youth Risk Behavior Surveillance System (YRBSS) Behavioral Risk Factor Surveillance System (BRFSS)
Action C	Provide sex education in the community through online and in-person delivery that complements and expands on 3 R's curriculum for youth, parents, and health care providers	<i>Binary - was platform able to deliver online sex education identified/developed or not</i> <i>Binary - was sex education offered online or not</i> <i>Number of people completing online sex education during the measurement year</i> <i>Number of in-person sex education classes held during the measurement year</i> <i>Number of attendees at in-person sex education classes held during the measurement year</i> <i>Recorded scores/pass rates for course standard each year</i> <i>Proportion of students/families taking the course each year</i>	MNPS
Action D	Include "Ask an Expert" forum on EtE Website/Database to answer anonymous sexual health questions	<i>Binary - was "Ask an Expert" forum created/maintained on EtE Website/Database or not</i>	EtE Website/Database
Action E	Provide in-person trainings for FBOs to reconcile values and sexual health education	<i>Number of in-person trainings held for FBOs during the measurement year</i>	Organizations providing sexual health education FBOs
Action F	Develop sexual health materials that cover safer sex practices in more complex situations	<i>Binary - were sexual health materials covering safer sex practices developed or not</i>	EtE Website/Database
Action G	Require all TennCare providers to discuss sexual health privately at every health visit for all ages 13+ years as recommended by the American Medical Association and the American Academy of Pediatrics	<i>Binary - was standardized policy developed/adopted for all TennCare providers</i> <i>Number of TennCare providers implementing policy and discussing sexual health at every health visit</i>	TennCare
Objective 3 Increase Condom Accessibility, Acceptability, and Utilization			
Action A	Design comprehensive condom distribution plan (CDP) with tailored approaches for priority populations	<i>Binary - was CDP developed with tailored approach for priority populations or not</i> <i>Number of CDP sites in Nashville</i> <i>Number of condoms distributed citywide during the measurement year</i>	EtE Website/Database Participating CDP sites
Action B	Use EtE marketing team to design recognizable branding for CDP	<i>Binary - was recognizable branding for CDP developed by EtE marketing team or not</i>	EtE marketing team
Action C	Partner with name brand condom companies to offer a variety of condom choices at CDP sites	<i>Number of partnerships developed with condom companies to expand condom choices at CDP sites</i> <i>Number of condoms distributed citywide during the measurement year</i>	EtE Website/Database
Action D	Place a free condom locator on EtE Website/Database and consider designing a locator app	<i>Binary - was free condom locator placed on EtE Website/Database or not</i> <i>Number of condoms distributed citywide during the measurement year</i>	EtE Website/Database
Action E	Eroticize condom usage through mass media campaign to increase acceptability and utilization	<i>Binary - was erotic messaging/branding incorporated into the mass media campaign or not</i> <i>Number of condoms distributed citywide during the measurement year</i>	EtE Website/Database

Objective 4	Increase Availability, Accessibility, and Affordability of PrEP / PEP		
Action A	Increase the number of sites and prescribers of PrEP / PEP in Davidson County	<p>Binary - was evaluation conducted to assess/identify sites/providers interested in providing PrEP / PEP or not</p> <p>Number of PrEP / PEP training events held for interested sites/providers during the measurement year</p> <p>Number of providers participating in PrEP / PEP training events</p> <p>Number of sites offering PrEP / PEP services in Davidson County</p> <p>Percentage of PrEP / PEP prescribers in high incidence areas</p> <p>Percentage of priority populations (e.g., MSM, PWID, high-risk heterosexuals) on PrEP in Davidson County</p> <p>Percentage of PrEP-eligible population receiving PrEP during the measurement year</p> <p>Proportion PrEP-eligible population who receive/fill a PrEP prescription during the measurement year</p>	MPHD TDH HIV Prevention Program
Action B	House a comprehensive PrEP / PEP locator on the EtE Website/Database	Binary - was comprehensive PrEP / PEP locator placed on EtE Website/Database or not	EtE Website/Database
Action C	Establish non-occupational PEP policies in all hospital Emergency Departments	<p>Binary - was non-occupational PEP policy developed or not</p> <p>Proportion of hospital emergency departments implementing non-occupational PEP policy</p>	Hospital EDs
Action D	Explore pharmacists prescribing PEP starter kits (with referral services for continuation)	Binary - was evaluation conducted to explore pharmacists prescribing PEP started kits or not	Pharmacies (e.g., Walgreens, CVS)
Action E	Increase proportion of Nashville residents with health insurance	Proportion of Nashville residents with health insurance during the measurement year	American Community Survey - Table ID S2701
Action F	Address insurance denial issues through a list of suggested ICD-10-CM codes for providers	<p>Binary - was list of suggested ICD-10-CM codes created or not</p> <p>Number of providers implementing code list</p>	Health care providers (e.g., hospital emergency departments, primary care offices, and correctional health care facilities)
Action G	Identify funding to mitigate financial impact of associated lab work	Binary - was funding identified to mitigate financial impact of lab work or not	EtE Coordinator
Action H	Disseminate financial assistance program resource guides to community and health care providers	<p>Binary - were financial assistance program resource guides developed or not</p> <p>Number of community and health care providers distributing financial assistance program resource guides</p>	Health care providers (e.g., hospital emergency departments, primary care offices, and correctional health care facilities)
Action I	Identify funding to mitigate financial impact of PrEP / PEP for those that cannot access financial assistance programs	<p>Binary - was funding identified to mitigate financial impact of PrEP / PEP for those unable to access financial assistance programs or not</p> <p>Number of clients receiving support through ADAP for PrEP medication assistance</p> <p>Percentage of low-income priority populations (e.g., MSM, PWID, high-risk heterosexuals) on PrEP in Davidson County</p>	EtE Coordinator MPHD TDH ADAP
Action J	Increase the number of PrEP navigators	<p>Binary - was baseline analysis conducted to evaluate the number of PrEP navigators in Davidson County or not</p> <p>Number of PrEP navigation programs in Davidson County</p> <p>Number of PrEP navigators in Davidson County</p> <p>Number of clients served by PrEP navigation programs</p>	City/private/ASO programs utilizing PrEP navigators

Objective 5 Increase Knowledge About and Utilization of PrEP / PEP			
Action A	Increase community knowledge of PrEP / PEP through mass media campaign	Amount of money spent on education campaign about PrEP / PEP Percentage of PrEP / PEP-prescribing locations listed on the EtE Website/Database (via the PrEP / PEP locator) Number of PrEP / PEP educational materials distributed in Davidson County	EtE Website/Database Organizations/agencies distributing PrEP / PEP educational materials
Action B	Utilize CHWs to implement social and sexual network referral strategies for PrEP / PEP referrals	Number of sites with CHWs that implement social and sexual network referral strategies for PrEP / PEP Number of PrEP / PEP referrals made by CHWs that utilized social and sexual network referral strategies during the measurement year	ASOs utilizing CHWs for PrEP / PEP referrals
Action C	Integrate PrEP eligibility screening and education into nursing protocols across Davidson County	Number of sites where nursing protocols include PrEP eligibility screening and education	Health care providers (e.g., hospital emergency departments, primary care offices, and correctional health care facilities)
Action D	Integrate PrEP / PEP education into health care professional curricula	Number of local health care programs where PrEP / PEP education is integrated into the curriculum	Health care related programs (e.g., colleges, universities)
Action E	Explore tailored strategies to increase PrEP adherence among people who inject drugs	Binary - was tailored strategy identified/developed to increase PrEP adherence among PWID or not Number of sites/providers incorporating tailored PrEP adherence strategies directed at PWID as part of their PrEP programs Proportion of PWID who adhere to PrEP	Health care providers (e.g., hospital emergency departments, primary care offices, and correctional health care facilities) ASOs MPHD Sexual Health Center
Action F	Establish a PrEP Buddy Program	Binary - was PrEP Buddy Program designed for community implementation or not Number of providers offering a PrEP Buddy Program during the measurement year	ASOs
Action G	Ensure PrEP / PEP messaging is one of the central components of the EtE mass media campaign	Binary - was PrEP / PEP included as a core component of the EtE mass media campaign or not	EtE Coordinator
Objective 6 Expand Reach of and Services at Syringe Service Programs			
Action A	Provide education on the rationale and legality of SSPs to community and people who engage PWID	Binary - was training program on the rationale and legality of SSPs developed or not Number of community events where education on the rationale and legality of SSPs was provided Number of community members and people who engage PWID that received education on the rationale and legality of SSPs during the measurement year	Entities providing education on SSPs
Action B	Increase number of HIV organizations and health departments with SSPs in Davidson County	Number of HIV organizations/health departments with SSPs Number of prevention-funded programs that offer syringe exchange services Number of Ryan White-funded programs that offer syringe exchange services Percentage of Nashvillians living within 5 miles of a syringe exchange program or pharmacy that sells syringes without a prescription	Ryan White TDH HIV Prevention Program
Action C	Implement opt-out HIV and HCV testing at all SSPs for all people 13 years and older	Proportion of SSPs implementing opt-out HIV and HCV testing	TDH HIV Prevention Program
Action D	Identify funding for additional mobile SSP unit(s)	Number of additional funding sources identified for additional mobile SSP unit(s)	TDH HIV Prevention Program EtE Coordinator

Action E	Increase breadth of prevention resources at SSPs	Proportion of SSPs offering PrEP services Proportion of SSPs distributing condoms Proportion of SSPs providing EIS/referral services	TDH HIV Prevention Program
Action F	Increase access to nonprescription sale of syringes in pharmacies	Number of pharmacies participating in nonprescription sale of syringes	Pharmacies (e.g., Walgreens, CVS)
Goal 3	Link 90% of Those Diagnosed with HIV to Care Within One Month of Diagnosis	<i>Percentage of newly-diagnosed individuals having ≥ 1 CD4 or VL test result reported within 30 days of diagnosis</i> <i>Optional: Refine primary linkage measure to include additional indicators of linkage not limited to CD4 and VL testing (e.g., documentation of medical appointments, ART prescription)</i> <i>Optional: Median time to viral suppression for newly-diagnosed individuals</i>	eHARS

Objective 1 Accelerate Initiation of ART for Newly Diagnosed PLWH

Action A	Establish expedited eligibility protocols for all people diagnosed with HIV to increase immediate integration into coordinated care	Binary - were expedited eligibility protocols developed or not Number of sites implementing expedited eligibility protocols during the measurement year	ASOs Ryan White
Action B	Establish same-day initiation of ART for newly diagnosed PLWH where evidence of effectiveness exists	Binary - was same-day ART initiation (based on established strategies) implemented or not Number of sites implementing same-day ART initiation Proportion of newly diagnosed individuals who receive same-day ART initiation Of newly diagnosed individuals who receive same-day ART initiation, proportion who stay engaged in care over 12, 18, and 24 months	Health care providers (e.g., hospital emergency departments, primary care offices, and correctional health care facilities)
Action C	Evolve EIS systems of care to strengthen referrals from providers outside traditional HIV systems of care	Number of PLWH receiving Ryan White-funded case management services within 30 days of diagnosis	CAREWare (Ryan White clients only)

Objective 2 Expand and Enhance Partner Services

Action A	Ensure all PLWH routinely receive partner services to link current and former partners to care	Percentage of newly diagnosed PLWH who were offered partner services Percentage of newly diagnosed PLWH who accepted partner services Percentage of Ryan White clients who are offered partner services Number of partners contacted through partner services Number of newly diagnosed PLWH identified via partner contacts	PRISM (add variable to capture) PTBMIS (query those tested for STDs and/or HIV) CAREWare (Ryan White clients only)
Action B	Ensure all disease intervention specialists (DIS) receive standardized training	Binary - was standardized DIS training developed or not Percentage of DIS that received standardized training by site/provider during the measurement year	ASOs MPHD HIV Surveillance Program
Action C	Recruit and hire DIS from within priority populations to bolster capacity and cultural competency	Number of DIS from priority populations hired during the measurement year Percentage of DIS from priority populations at each site/provider	ASOs MPHD

Objective 3 Identify and Respond to Barriers Related to Linkage to Care

Action A	Conduct primary research with priority populations to identify barriers to care and health priorities	Number of studies/focus groups conducted with priority populations to identify barriers to care and health priorities	MPHD Local colleges/universities (e.g., Meharry, Vanderbilt) Tennessee Center For AIDS Research (CFAR) Focus groups
Action B	Design and implement specialized strategies to respond to identified barriers for priority populations	Number of strategies developed that address identified barriers among priority populations (resulting from prior studies/focus groups) Number of strategies implemented that address identified barriers among priority populations (resulting from prior studies/focus groups) Percentage of newly diagnosed individuals from priority populations linked to care within one month of diagnosis	ASOs Local colleges/universities (e.g., Meharry, Vanderbilt) MPHD HIV Surveillance Program

Objective 4	Strengthen EIS Systems to Expedite Linkage to Care		
Action A	Foster relationships between EIS and medical providers outside the traditional HIV network of care	<i>Percentage of newly diagnosed individuals from priority populations linked to care within one month of diagnosis</i>	eHARS
Action B	Assign hospital Emergency Departments one or more EIS personnel to be a direct point of contact for immediate referrals upon diagnosis	<i>Number of hospital EDs with at least one EIS serving as a direct point of contact for referrals</i> <i>Percentage of newly diagnosed individuals linked to care within one month of diagnosis</i>	Hospital EDs eHARS
Action C	Increase capacity of EIS systems by recruiting and hiring EIS personnel from priority populations	<i>Number of EIS from priority populations hired during the measurement year</i> <i>Percentage of EIS from priority populations at each site/provider</i> <i>Percentage of newly diagnosed individuals from priority populations linked to care within one month of diagnosis</i>	ASOs MPHD HIV Surveillance Program eHARS
Goal 4	Engage 90% of People Diagnosed with HIV in Care	<i>Percentage of PLWH who received ≥ 2 CD4 or VL test results, performed at least 3 months apart, during the measurement year</i> Optional: Refine primary engagement/retention measure or allow for alternate measures of retention to look at one-year windows in addition to longer follow-up periods (helps identify movement of individuals in and out of care); include other indicators for contact/engagement with care (e.g., ART prescription and 30-day or 90-day pick-up data), to include patients who are stably treated but have more infrequent laboratory testing	eHARS
Objective 1	Strengthen EIS Systems to Facilitate Engagement in HIV Care		
Action A	Evaluate current EIS systems and tailor interventions to strengthen service delivery	<i>Percentage of newly diagnosed individuals linked to care within one month of diagnosis</i> <i>Number of PLWH receiving Ryan White-funded services within 30 days of diagnosis</i>	eHARS CAREWare (Ryan White clients only)
Action B	Establish enhanced EIS with specialized case management	<i>Percentage of newly diagnosed individuals linked to care within one month of diagnosis</i>	eHARS
Action C	Standardize EIS training	<i>Binary - was standardized EIS training protocol developed or not</i> <i>Number of providers implementing standardizing EIS training during the measurement year</i>	ASOs MPHD HIV Surveillance Program
Objective 2	Foster Engagement Through Health Care Interventions		
Action A	Re-brand Metro STI clinic as a Sexual Health Center and make care delivered more comprehensive	<i>Binary - was MPHSD STI clinic renamed or not</i> <i>Binary - were comprehensive services (e.g., PrEP) incorporated in to care delivery system at MPHSD STI clinic or not</i>	MPHD Sexual Health Center
Action B	Determine optimum hours for care among priority populations	<i>Binary - was survey distributed among priority populations to determine optimum hours of operation or not</i> <i>Percentage of PLWH from priority populations who are engaged in care</i>	MPHD Sexual Health Center eHARS
Action C	Strengthen data sharing and harmonization to facilitate tracking of patients during major transitions of care	<i>Binary - was data sharing agreement established between TDH, MPHSD, and providers or not</i>	MPHD HIV Surveillance Program

Action D	Fully integrate mental health and substance abuse assessment/treatment into the HIV care continuum	<p><i>Binary - was evaluation conducted to assess mental health/substance abuse screening practices among providers or not</i></p> <p><i>Proportion of patients screened for mental health and substance abuse during case management intake</i></p> <p><i>Proportion of patients screened for mental health and substance abuse during medical visit</i></p> <p><i>Number of PLWH who accessed mental health services</i></p> <p><i>Number of PLWH who accessed substance use treatment/harm reduction services</i></p> <p><i>Percentage of PLWH with an unmet need for mental health services</i></p> <p><i>Percentage of PLWH with an unmet need for substance use treatment/harm reduction services</i></p> <p><i>Track change in screening numbers among MCM; evaluate screening completion among providers (as indicated by labs, observation, and self-report)</i></p> <p><i>Proportion of PLWH/priority populations receiving medical care who receive referrals for mental health services/substance abuse, when diagnosed with mental health services/substance abuse issue (or with evidence of one)</i></p>	CAREWare (Ryan White clients only)
Action E	Expand provider education to increase client retention	<p><i>Number of trainings conducted to increase client retention</i></p> <p><i>Number of providers receiving training on increasing client retention</i></p> <p><i>Percentage of PLWH engaged/retained in care</i></p>	ASOs HARS
Action F	Require HIV literacy program for all jail staff	<p><i>Number of jails with HIV literacy program</i></p> <p><i>Number of jail staff attending HIV literacy program</i></p>	Davidson County correctional facilities
Action G	Require jails in Davidson County to link PLWH to ASOs	<p><i>Binary - was policy developed/adopted to require jails link PLWH to ASOs upon discharge or not</i></p> <p><i>Percentage of PLWH released from county jails that are linked to care within 30 days</i></p>	eHARS PRISM MPHDP HIV Surveillance Program Law enforcement agencies
Action H	Conduct primary research among PLWH in priority populations to identify community specific barriers to care and health care priorities	<p><i>Number of studies conducted that involve PLWH from priority populations and community-specific barriers</i></p>	MPHD Local colleges/universities (e.g., Meharry, Vanderbilt) TN CFAR
Objective 3 Facilitate an Environment of Engagement Through Policy Change			
Action A	Preserve current Medicaid coverage by opposing attempts to restrict eligibility and/or benefits, and advocate to expand Medicaid coverage in Tennessee	<p><i>Binary - was additional federal Medicaid funding accepted or not (in each year)</i></p>	State legislative record/annotated code
Action B	Advocate with insurance to get explanation of benefits (EOBs) documents sent to patients versus policy holders	<p><i>Number of health insurance providers agreeing to send EOBs directly to patients</i></p>	Health insurance providers
Action C	Advocate insurance companies to adopt non-discrimination policies to protect transgender people	<p><i>Binary - was assessment of discrimination against transgender people conducted (by Metro Human Relations Commission or similar entity) or not</i></p> <p><i>Binary - were non-discrimination policies adopted to protect transgender people or not</i></p>	Metro Human Relations Commission
Action D	Prevent restrictive drug formulary practices through legislative and administrative means (e.g. tiering of HIV medications, quantity limits, and prior authorization requirements)	<p><i>Number of restrictive drug formulary practices prevented during the measurement year</i></p>	State legislative record/annotated code
Action E	Ensure that drug companies apply co-pay prescription benefits of plan	<p><i>Binary - did drug companies apply co-pay prescription benefits or not</i></p>	Pharmaceutical companies

Objective 4	Foster a Culture of Engagement Through Peer Support Networks		
Action A	Create peer support networks for HIV care providers	Number of peer support networks established/maintained in each year Number of providers with at least one peer navigator on staff Number of providers trained on peer/client navigation	City/private/ASO programs establishing peer support network
Action B	Create specialized peer support networks for PLWH among priority populations	Number of specialized peer support networks among priority populations established/maintained in each year	City/private/ASO programs establishing peer support network
Action C	Provide "Healthy Relationships" programming to all PLWH	Number of organizations providing "Healthy Relationships" programming Number of PLWH participating in "Healthy Relationships" programming during the measurement year	City/private/ASO programs providing Healthy Relationships programming
Action D	Develop anonymous online forums where PLWH can seek peer support	Number of anonymous online forums offering peer support developed during the measurement year	EtE Website or other online forums
Objective 5	Implement a CHW Model to Facilitate Coordinated Care		
Action A	Implement a CHW model to provide comprehensive and coordinated care services to all PLWH	Number of providers implementing a CHW model during the measurement year	City/private/ASO programs implementing a CHW model
Action B	Recruit and hire CHWs from priority populations	Number of CHWs from priority populations recruited/hired during the measurement year	City/private/ASO programs implementing a CHW model
Action C	Develop standardized CHW curricula	Binary - was standardized CHW curricula developed or not	City/private/ASO programs implementing a CHW model
Action D	Create specialized CHW positions for clients with specific needs	Number of specialized CHW positions created during the measurement year Number of sites/providers with specialized CHW positions	City/private/ASO programs implementing a CHW model
Action E	Increase health literacy of PLWH through health education programs delivered by CHWs	Number of PLWH receiving health education delivered by CHWs during the measurement year Percent increase from pre/post health literacy assessment	City/private/ASO programs implementing a CHW model
Objective 6	Strengthen Re-Engagement Strategies for PLWH Lost to Care		
Action A	Establish "Data-to-Care" protocols to reconnect those lost to care to health services	Binary - were "Data-to-Care" protocols established or not Percentage of PLWH who are classified as lost to care	MPHD TDH HIV Surveillance Program eHARS CAREWare (Ryan White clients only)
Action B	Fund CHW re-engagement specialists to locate and integrate those lost to care into services	Number of funded CHW re-engagement specialists during the measurement year Percentage of PLWH who are classified as lost to care	ASOs eHARS CAREWare (Ryan White clients only)
Action C	Incentivize re-engagement through client-specific barrier reduction	Number of providers implementing client-specific barrier reduction Percentage of PLWH who are classified as lost to care	ASO eHARS CAREWare (Ryan White clients only)
Action D	Explore the development of a system to accurately measure PLWH migrating between care systems	Binary - was communication strategy between providers and local health department staff to identify patients who are lost to care developed or not Proportion of PLWH in Nashville who are accurately classified as out of care in the local HIV surveillance system	ASOs MPHD HIV Surveillance Program TDH HIV Surveillance Program

Goal 5	Ensure that 90% of Those Engaged in Care Will Achieve Viral Suppression	<i>Among PLWH engaged in care, the percentage of PLWH who received a VL test result of < 200 copies/mL at the most recent viral load test during the measurement year</i>	eHARS
Objective 1	Standardize Access to Full Complement of Services for All PLWH		
Action A	Increase provider/agency awareness of the value and availability of support services for PLWH	Number of provider/agency visits by CHW to increase awareness of support services for PLWH	City/private/ ASO programs
Action B	Educate community about services available to PLWH and where/how to access resources	Number of community training events about services available to PLWH Binary - was information on services available to PLWH included on EtE Website/Database or not	City/private/ASO programs EtE Website/Database
Action C	Identify funding to provide wrap-around services for non-Ryan White clients	Binary - was funding for wrap-around services for non-Ryan White clients identified or not	Ryan White
Action D	Strengthen existing systems of care through collaboration across agencies via formal MOUs	Number of providers developing/signing on to collaborative network via formal Memorandums of Understanding (MOUs)	City/private/ASO programs MPHD HIV Surveillance Program TDH HIV Surveillance Program
Objective 2	Promote Viral Suppression Through U=U Education		
Action A	Create U=U provider information packets and distribute to all HIV care providers in Davidson County	Binary - were U=U provider information packets created or not Number of U=U provider information packets distributed during the measurement year	EtE HIV Education Group (to be created)
Action B	Integrate U=U messaging into HIV curricula and continued education for health care professionals	Binary - was U=U messaging integrated into HIV curricula and continued education or not	HIV education organizations (e.g., Southeast AETC) or other organizations providing HIV education to health care professionals
Action C	Recommend the integration of U=U education into nursing protocols for HIV care	Binary - was U=U education recommended to be integrated into nursing protocols for HIV care or not	Hospital emergency departments, primary care offices, and correctional health care facilities
Action D	Create and disseminate U=U education to community through targeted outreach by CHWs	Binary - were U=U educational materials developed or not Number of U=U educational materials distributed by CHWs during the measurement year	EtE Coordinator City/private/ ASO programs disseminating U=U educational packets
Action E	Ensure U=U messaging is one of the central components of the EtE mass media campaign	Binary - was U=U included as a core component of the EtE mass media campaign or not	EtE mass media campaign
Objective 3	Implement Strategies to Increase Medication Adherence		
Action A	Establish and implement pharmacy notification programs to prevent lapses in medication	Number of known pharmacy tickler programs Percentage of PLWH who adhere to their prescribed ART regimen Percentage of PLWH who are virally suppressed Percentage of ADAP clients who missed prescription refills who had appropriate follow-up to ensure continued engagement in care Percentage of ADAP pharmacies that provide medication adherence support for PLWH	Pharmacies (e.g. Walgreens, CVS) eHARS TDH ADAP
Action B	Utilize application-based medication assistance programs to provide daily reminders to PLWH	Binary - was application-based medication assistance program developed or not Percentage of PLWH who adhere to their prescribed ART regimen Percentage of PLWH who are virally suppressed	Pharmacies (e.g. Walgreens, CVS) eHARS

Action C	Connect all PLWH to peer support networks	<i>Percentage of PLWH connected to a peer support network</i>	ASOs (non-Ryan White clients), CAREWare (Ryan White clients only)
Action D	Promote medication adherence among all PLWH	<i>Binary - was medication adherence included in the EtE mass media campaign or not</i> <i>Percentage of PLWH who adhere to their prescribed ART regimen</i> <i>Percentage of PLWH who are virally suppressed</i>	EtE Coordinator eHARS
Objective 4 Ensure Sustained Access to Medication for all PLWH			
Action A	Provide access to Hepatitis/HIV/STI medications for all patients covered by TennCare formulary	<i>Percentage of PLWH who adhere to their prescribed ART regimen</i> <i>Percentage of PLWH who are virally suppressed</i>	TDH Viral Hepatitis Surveillance Program eHARS BRFSS
Action B	Ensure those who do not have access to health insurance or cost assistance programs can access a sustained supply of HIV medications regardless of ability to pay	<i>Binary - was a strategy/program to ensure access to a sustained supply of HIV medication identified/created or not</i> <i>Percentage of PLWH who adhere to their prescribed ART regimen</i> <i>Percentage of PLWH who are virally suppressed</i>	Pharmacies (e.g. Walgreens, CVS) eHARS
Goal 6	Eliminate Disparities in HIV Outcomes	<i>Percentage of PLWH who are unaware of their status during the measurement year (by subpopulation)</i> <i>Percentage of newly-diagnosed individuals having ≥ 1 CD4 or VL test result reported within 30 days of diagnosis (by subpopulation)</i> <i>Percentage of PLWH who received ≥ 2 CD4 or VL test results, performed at least 3 months apart, during the measurement year (by subpopulation)</i> <i>Percentage of PLWH who are receiving care that have achieved viral suppression (by subpopulation)</i>	eHARS

Objective 1 Bolster Workforce Development and Economic Empowerment			
Action A	Create CHWs dedicated to employment navigation	<i>Number of CHW positions created that focus on employment navigation during the measurement year</i>	City/private/ ASO programs implementing a CHW model
Action B	Recruit and hire CHWs who are living with HIV and/or are among priority populations	<i>Number of CHWs who are living with HIV and/or among priority populations recruited/hired during the measurement year</i>	City/private/ ASO programs implementing a CHW model
Action C	Advocate for PLWH as a designated priority population for employment services	<i>Proportion of PLWH who are unemployed during the measurement year</i> <i>Number of CHWs recruited/hired who are PLWH during the measurement year</i>	TBD City/private/ ASO programs
Action D	Support and expand financial literacy programs for all PLWH and priority populations	<i>Number of providers incorporating financial literacy programs during the measurement year</i> <i>Number of PLWH/priority populations participating in financial literacy programs during the measurement year</i>	City/private/ASO programs Health care organizations (including Hospital EDs, primary care offices, and correctional health care facilities)
Action E	Advocate to expand predatory-free lending zones	<i>Binary - was expansion of predatory-free lending zones advocated for by PLWH or not</i> <i>Binary - were predatory-free lending zones expanded upon or not</i>	U.S. Department of Housing and Urban Development (HUD) Private/public fair housing agencies Metro Human Relations Commission
Action F	Increase coordinated representation of PLWH at citywide advocacy efforts to improve financial equity	<i>Binary - were PLWH represented at citywide advocacy efforts to improve financial equity or not</i>	EtE Coordinator

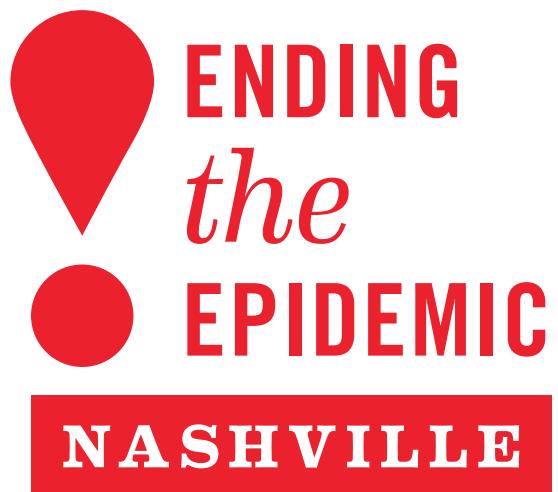
Objective 2	Increase Access to Transportation		
Action A	Increase coordinated representation of PLWH in efforts citywide advocacy efforts to expand and improve transportation services	Number of representatives actively participating in citywide advocacy efforts to improve transportation services	EtE Coordinator
Action B	Establish and foster relationships with ride-sharing companies for medical appointment transportation	Number of partnerships established with ride-sharing companies	City/private/ASO programs CAREWare (Ryan White clients only)
Action C	Increase gas assistance programs for PLWH using private vehicles for medical transportation	Number of PLWH receiving gas assistance services during the measurement year	City/private/ASO programs CAREWare (Ryan White clients only)
Action D	Increase access to subsidized public transportation for PLWH	Number of PLWH receiving transportation vouchers during the measurement year	Metro Transit Authority
Objective 3	Increase Access to Affordable Housing		
Action A	Increase housing literacy and housing rights resources for PLWH and priority populations	Percentage of PLWH who are homeless Percentage of Ryan White clients who are stably housed	Homeless PLWH - To Be Developed (TBD) CAREWare (Ryan White clients only)
Action B	Increase coordinated representation of PLWH in citywide advocacy efforts to improve housing affordability	Number of representatives actively participating in citywide advocacy efforts to improve housing affordability (e.g., Urban Housing Solutions, Welcome Home Coalition, Open Table Nashville, Transit and Affordability Taskforce)	EtE Coordinator
Action C	Advocate that a portion of Shelter Plus Care vouchers be designated for PLWH	Proportion of Shelter Plus Care vouchers designated for PLWH	Metro Development and Housing Agency (MDHA)
Action D	Identify housing partners to provide emergency housing	Number of housing partners identified to provide emergency housing to PLWH	TBD
Action E	Dedicate CHW positions for housing navigation that address both short and long-term housing solutions	Number of organizations offering CHW positions that specialize in short and long-term solutions Number of CHW positions specializing in short and long-term housing solutions	City/private/ASO programs dedicating CHW positions for housing navigation
Action F	Increase access to short-term housing resources for PLWH	Number/amount of short-term housing resources identified	Housing Opportunities for Persons with AIDS (HOPWA)
Action G	Increase the availability of affordable housing units designated for PLWH	Percentage of affordable housing units designated for PLWH	MDHA HOPWA
Objective 4	Address and Reduce Stigma and Discrimination of PLWH		
Action A	Modernize HIV criminalization laws to reflect current science about transmission	Binary - was law repealed or not (in each year) Number of HIV-specific criminal laws in Tennessee	State legislative record/annotated code
Action B	Make HIV education and anti-stigma training accessible online and in-person to non-traditional service providers and community organizations	Binary - was standardized stigma survey (e.g. Internalized Stigma of AIDS (ISAT), Internalized AIDS-related Stigma Scale (IA-RSS)) distributed to online and in-person participants or not	City/private/ASO programs distributing stigma surveys
Action C	Provide cultural competency and trauma informed education to all HIV care providers online and in-person	Number/proportion of HIV care providers receiving online/in-person cultural competency and trauma informed education Number of cultural competency and trauma informed education trainings conducted	HIV education organizations (e.g., Southeast AETC)
Action D	Partner with the Metro Human Relations Commission to formally address instances of discrimination against PLWH	Binary - was partnership established with the Metro Human Relations Commission or not Binary - was assessment of discrimination against PLWH conducted or not Number of data-driven policy and research reports conducted regarding discrimination against PLWH	Metro Human Relations Commission

Action E	Use secret shoppers and consumer surveys to identify areas of improvement for providers and provide specialized training and solutions address discriminatory practices/behaviors	<i>Binary - were consumer surveys developed to identify discriminatory practices/behaviors or not</i> <i>Number of survey responses collected during the measurement year</i> <i>Number of sites/providers where secret shoppers/consumer surveys were conducted during the measurement year</i> <i>Proportion of sites/providers receiving specialized trainings to address discriminatory practices/behaviors</i>	TBD
OVERARCHING DATA ACTIVITIES	Monitor available data sources, evaluate progress toward achieving EtE goals, objectives, and actions and disseminating these outcomes to the public		
Action A	Coordinate definitions and data related to HIV Prevention and care interventions across state and local levels, including measures related to experiences of stigma and interventions to address stigma	<i>Number of definitions for Partner Services and linkage to care variables in use in prevention, care, and surveillance databases</i> <i>HIV Adult Case Report Form updates to make form consistent with Partner Services and linkage to care variable definitions</i>	<i>EtE Data Committee</i> <i>MPHD HIV Surveillance Program</i> <i>TDH HIV Surveillance Program</i>
Action B	Enhance collaborations between HIV Prevention and Surveillance programs at the state and local levels	<i>Unified guidance on data security and confidentiality for use of HIV surveillance data at the state and local levels (i.e., Data to Care)</i> <i>Number of local health department staff who received training on unified security and confidentiality guidance</i>	<i>EtE Data Committee</i> <i>MPHD HIV Surveillance Program</i> <i>TDH HIV Surveillance Program</i>
Action C	Collaborate with oversight committee and EtE coordinator to monitor and report on progress (including via EtE website)	<i>Binary - were quarterly reports on progress toward meeting EtE plan goals provided to the oversight committee or not</i> <i>Binary - were public-facing dashboards on the EtE Website developed during the measurement year or not</i>	<i>EtE Data Committee</i> <i>EtE Website/Database</i>
Action D	Consult with oversight committee and EtE coordinator to respond to evolving data needs	<i>Number of new data sources identified/developed during the measurement year</i>	<i>EtE Data Committee</i>
Action D	Consult with oversight committee and EtE coordinator to respond to evolving data needs	<i>Number of new data sources identified/developed during the measurement year</i>	<i>EtE Data Committee</i>

Appendix iii

References

1. Dailey AF, Hoots BE, Hall HI, et al. Vital Signs: Human Immunodeficiency Virus Testing and Diagnosis Delays – United States. MMWR Morb Mortal Wkly Rep 2017;66:1300–1306.
2. Office of National AIDS Policy. National HIV/AIDS Strategy for the United States. 2015. Available at: <https://aids.gov/federal-resources/national-hiv-aids-strategy/nhas-update.pdf>. Accessed August 1, 2015.
3. Clark H, Babu AS, Wiewel EW, Opoku J, Crepaz N. Diagnosed HIV Infection in Transgender Adults and Adolescents: Results from the National HIV Surveillance System, 2009-2014. *AIDS Behav.* 2017;21(9):2774-2783.
4. Sizemore LA, Rebeiro PF, McGoy SL. Improving HIV Surveillance Among Transgender Populations in Tennessee. *LGBT Health.* 2016;3(3):208-13.
5. National Alliance to End Homelessness. “Homelessness and HIV/AIDS.” Aug. 2006. Available from <http://www.endhomelessness.org>
6. Aidala AA, Wilson MG, Shubert V, et al. Housing Status, Medical Care, and Health Outcomes Among People Living With HIV/AIDS: A Systematic Review. *Am J Public Health.* 2016;106(1):e1-e23



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