Attachment 1: WORK PLAN

Goal 1: Increase access to care to ensure PLWH receive treatment rapidly			
Objective A: Utilize targeted marketing campaigns to increase awareness of HIV core medical and support services in the jurisdictions annually			
Key Action Steps	**Completion Date**	**Responsibility [1]**	**Progress Measure(s)**
1. Identify subcontractor to facilitate focus groups with target populations to identify ideal media	10/20	HPM-S	• Facilitated focus groups • Various media campaigns • Website traffic • Page views
2. Design prototype and markups for pilot testing with focus groups	12/20	HPM-S, QMS	
3. Execute Targeted Awareness Campaign	2/21, Annually	HPM-S	
4. Monitor effectiveness of advertisements	Ongoing	HPM-S, QMS	
Objective B: Enhance and improve capacity of services and infrastructure for quality care			
Key Action Steps	**Completion Date**	**Responsibility**	**Progress Measure(s)**
1. Expand the capacity within Fulton County Government to plan, monitor, and evaluate EtHE activities by hiring EtHE staff	6/20	Dir, DDir	• Hired staff
2. Work with TAP, SCP, consultants and community partners to plan and evaluate opportunities to enhance service delivery and infrastructure for care and treatment.	9/20	HPM-P	• Epidemiologic report • Facilitated focus groups • Client satisfaction results • Needs Assessment results
a. Prepare current epidemiologic profile and situational analysis based on surveillance data in the EtHE jurisdictions and the CDC EtHE Plan	5/20	Epi	
b. Conduct focus groups to plan and design EtHE activities	9/20	CES	
c. Conduct Annual Client Satisfaction Survey	2/22, ongoing	Epi	
d. Conduct a Needs Assessment	2/21, 2/23, 2/25	CES, Epi	
3. Establish a centralized intake team to link newly diagnosed clients to medical care and re-engage those lost to care	2/21, ongoing	HPM-S	• Incidence Rate • Prevalence Rate • Linkage to Care within 30 days • Linkage to Care within 3 days • Retention Rate
a. Plan and design the implementation of centralized linkage system	7/20	CES, HPM-P, EC, CQMC	
b. Solicit and procure subcontractor to execute centralized linkage	8/20	HPM-P	
c. Train linkage staff and HIV service providers on the new process	10/20, ongoing	Sub	
d. Monitor and evaluate centralized linkages	Ongoing	EC, HPM-P, HPM-S, PA	
4. Extend or establish non-traditional hours for RWHAP services	2/21, ongoing	EtHE staff, Sub	
a. Solicit and procure subcontractors to execute services	8/20	HPM-S	

[1] Community Engagement Specialist (CES); Health Program Manager-Services (HPM-S); Health Program Manager-Programs (HPM-P); Director (Dir); Deputy Director (DDir); Evaluation Consultant (EC); Subrecipient (Sub); Project Officer (PO), CQM Coordinator (CQMC); Epidemiologist (Epi); Quality Management Specialist (QMS); Project Analyst (PA); Data Manager (DM); Database Specialist (DS); Information Analyst (IA).

b. Monitor and evaluate effectiveness of services	Ongoing	POs; QMS	• Types of services procured • Service Utilization • Incidence Rate • Linkage to Care within 30 days • Retention Rate
5. Develop opportunities for telehealth and mobile services	2/21	EtHE staff, sub	• Sevice Utilization • Incidence Rate • Linkage to Care within 30 days • Retention Rate
a. Solicit and procure service providers	8/20	Dir, DDir, HPM-P	
b. Implement OAHS, MH/SA & MCM telehealth services	10/20	Sub	
c. Implement mobile clinic for treatment and care	7/23	Dir, DDir, HPM-P	
d. Evaluate telehealth/mobile services and recommend improvement	3/21, ongoing	EC, PM, PA	
Objective B: Advance the competencies of the HIV health workforce to ensure the delivery of quality services			
Key Action Steps	**Completion Date**	**Responsibility**	**Progress Measure(s)**
1. Provide ongoing customer service and/or cultural competency training for HIV Service Providers	2/22, ongoing	HPM-S	• Number of training participants • Increased in Skills and Knowledge
2. Provide training for peer staff and opportunities for peer certification	2/22, ongoing	CES	
3. Provide training/technical assistance to improve the quality of service delivery	2/21, 6/21, 6/22, 6/23, 6/24	HPM-P, QMS	
Goal 2: Improve health outcomes to reach sustained viral suppression			
Objective A: Engage and retain PLWH in medical care			
Key Action Steps	**Completion Date**	**Responsibility**	**Progress Measure(s)**
1. Develop and implement Data to Care team to respond quickly to potential HIV outbreaks to get needed prevention and treatment services to people who need them	2/21; ongoing	Epi, PAs	• Incidence Rate • Prevalence Rate • Retention Rates • Viral Suppression Rates
a. Work with DPH to detect clusters using HIE, SENDSS, and creating of Out of Care List.	2/22; ongoing	DM, Epi	
2. Partner with FCBOH to provide OAHS services to Persons who inject Drugs.	4/21; ongoing	HPM-S, POs	
Objective B: Increase access to medications			
Key Action Steps	**Completion Date**	**Responsibility**	**Progress Measure(s)**
1. Partner with DPH to ensure the availability of medications to improve health outcomes and viral suppression through increase of ADAP funding	2/22, 2/23, 2/24, 2/25	HPM-S	• ADAP enrollment rates • Prescribed ART Rate • Viral Load Suppression Rates

Goal 3: Reduce barriers to care by responding to outbreaks and addressing disparities in the jurisdiction			
Objective A: Utilize evidence-based interventions for targeted subpopulations			
Key Action Steps	**Completion Date**	**Responsibility**	**Progress Measure(s)**
1. Implement intervention related to Health Literacy	10/20	HPM-P	• Interventions initiated • Retention Rate • Viral Load Suppression
2. Implement intervention related to Stigma and Discrimination	10/20	HPM-P	
3. Monitor, Evaluate, and Improve Evidence-based interventions	2/21, 4/21, ongoing	PAs	
Objective B: Integrate data systems to improve care coordination through the metro Atlanta area			
Key Action Steps	**Completion Date**	**Responsibility**	**Progress Measure(s)**
1. Plan the development and execution of an integrated data management information system	12/20	DM, DS, Epi	• Project Phase Completion • Incidence Rate • Prevalence Rate • Retention Rate • Viral Load Suppression • Training Manual
2. Test and pilot data management information system	4/21	DM, DS, Epi	
3. Implement Central Intake Portal for client enrollment into care	2/22	DM, DS	
4. Implement an interface with Housing Data System	2/22	DM, DS	
5. Implement an appointment reminder system for clients	2/25	DM, DS	
6. Implement an interface with an insurance and/or proof of employment data warehouse	2/25	DM, DS, IA	
7. Train staff and end users on data management information system	2/21	DM, DS, IA	
8. Monitor and evaluate the functionality and utilization of data management information system	Ongoing	DM, DS, IA	
9. Evaluate client demographics, health trends and outcomes.	4/22, 7/22, 10/22, 2/23, ongoing	Epi, PA	
10. Improve the data management information system for end users and reporting.	5/22, ongoing	IA, PA	
Objective C: Increase the provision of core medical and supportive services aim to reduce barriers to care			
Key Action Steps	**Completion Date**	**Responsibility**	**Progress Measure(s)**
1. Plan and develop implementation strategies for innovative services	7/20	HPM-P, PA, EC	• Incidence Rate • Linkage Rates • Retention Rate • Viral Load Suppression • Service utilization • Housing demographics • Website traffic • Page Views
2. Implement housing assistance to PLWH in need	10/20	HPM-S	
3. Expand social media intervention to assist clients in linkage/retention	4/20	PAs	
4. Implement an automated clinic for rapid treatment and care	8/22, ongoing	PAs	
5. Monitor, evaluate, and improve services for PLWH	1/21, 4/21, ongoing	PAs, EC	