HRSA HIV/AIDS Bureau

Ending the HIV Epidemic in the U.S. (EHE) Initiative

Qualitative Summary of Progress

March 2021–February 2022

HRSA
Ryan White HIV/AIDS Program

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Information about HRSA's role in the *Ending the HIV Epidemic in the U.S.* initiative: hrsa.gov/ending-hiv-epidemic

Information about the HRSA Ryan White HIV/AIDS Program: ryanwhite.hrsa.gov

Educational and technical assistance materials about HIV, the EHE Technical Assistance Provider-innovation network, EHE Systems Coordination Provider, and the Ryan White HIV/AIDS Program: TargetHIV.org

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EXECUTIVE SUMMARY

The purpose of this publication is to describe activities, services, and innovations implemented by *Ending the HIV Epidemic in the U.S.* (EHE) initiative jurisdictional recipients with Health Resources and Services Administration (HRSA) HIV/AIDS Bureau (HAB) EHE funding and to communicate the impact of these efforts on meeting EHE goals. In 2021, HAB EHE-funded providers in the EHE jurisdictions served 22,413 clients new to care and 15,318 clients estimated to be re-engaged in care and received services from EHE-funded outpatient ambulatory health services (OAHS), medical case management (MCM), non-medical case management, and EHE initiative services providers. In just the first two years of the EHE initiative, more than 20 percent of people in EHE jurisdictions who were undiagnosed or not in care were brought into care and served by HAB EHE-funded providers [1].

This publication describes the specific activities jurisdictional EHE recipients implemented to successfully engage, retain, and re-engage these clients in HIV care.

EHE recipients implemented a wide range of activities, including—

- Infrastructure development (e.g., recruitment and hiring, onboarding and training, data infrastructure)
- Community engagement and information dissemination (e.g., social media efforts, marketing campaigns)
- Linkage, retention, and re-engagement activities (e.g., peer navigators, data to care re-engagement efforts)
- Service delivery approaches (e.g., telehealth and use of technology, expanded access)

Overall, from March 2021 through February 2022 (Year 2 of the EHE initiative), recipients were successful in ramping up EHE implementation while carrying forward lessons learned from the first year. During EHE Year 1 (March 2020 through February 2021), recipients mostly implemented startup- and infrastructure-related activities while overcoming many barriers associated with the coronavirus disease 2019 (COVID-19) [2]. Although the COVID-19 pandemic presented challenges for recipients, as COVID-19 vaccines became available, recipients were able to greatly increase implementation activities and services offered.

This publication also describes the overall impact of the EHE initiative. In their Year 2 EHE recipient progress reports, EHE recipients highlighted the impact of EHE funding in meeting provider-identified HIV care and service needs, in addition to expanding the pool of clients who can access services. Below and throughout the report, we will highlight anonymized quotes from recipients.

> *The additional flexibility of Ending the HIV Epidemic in the U.S. (EHE) combined with evolving needs from COVID-19 have driven ingenuity and creativity to meet client needs like the [redacted] telehealth navigation [program]. However, in addition to new ideas being developed, EHE funds have allowed us to ask providers, 'What is that one service that you have wanted to provide for years because it would break down barriers to accessing care, but something has always gotten in the way (funding or Ryan White restrictions)?' By continuously asking and seeking answers to this question, [redacted organization] and the HIV provider community has developed additional programming, like the intensive services program.*

> *Further, Ending the HIV Epidemic in the U.S. activities are designed to address the needs of [people with HIV] who do not qualify for services under the Ryan White system of care. This greatly broadens the scope of access to disproportionately underserved populations without the risk of overlap of service offerings, and ultimately maximiz[es] the use of funding. The activities implemented during the reporting period as noted above have successfully moved [redacted jurisdiction] closer to meeting the needs of priority populations who otherwise would not have available treatment and care options.*

Additionally, recipients reported that EHE funding had an impact on their ability to provide increased staff/case management services, telehealth care, home visits, and a variety of support services (e.g., housing, transportation, food, psychiatry/mental health services).

OVERVIEW OF THE *ENDING THE HIV EPIDEMIC IN THE U.S.* INITIATIVE

The *Ending the HIV Epidemic in the U.S.* (EHE) initiative aims to reduce new HIV infections to less than 3,000 per year, making them a rare occurrence. Without EHE, new HIV transmissions in the United States are predicted to rise, costing more lives and more than $200 billion in direct lifetime medical costs for HIV prevention, care, and medication [3]. The multiyear EHE initiative currently focuses on 48 counties; Washington, D.C.; San Juan, Puerto Rico, where more than 50 percent of new HIV diagnoses occurred; and seven states that have a substantial rural HIV burden (collectively referred to as "EHE jurisdictions"). The four pillars of the EHE initiative—Diagnose, Treat, Prevent, and Respond—represent a strategic approach to ending the HIV epidemic in the United States.

In fiscal year (FY) 2021, the Health Resources and Services Administration (HRSA) HIV/AIDS Bureau (HAB) awarded EHE funds to the 39 Ryan White HIV/AIDS Program (RWHAP) Part A recipients and eight Part B recipients that encompass the EHE jurisdictions. HAB EHE jurisdictional recipients use their existing infrastructure to implement effective and innovative strategies, interventions, approaches, and services to improve health outcomes for people with HIV and reduce new HIV infections in the United States. In total, HRSA HAB awarded $99 million in FY 2021 to 47 EHE jurisdictional recipients, two technical assistance providers, and 12 RWHAP Part F AIDS Education and Training Center (AETC) Program recipients (four national AETCs and eight regional AETCs). Through this funding, HRSA HAB recipients support the efforts of all four EHE pillars, with the EHE jurisdictional recipients placing special emphasis on the Treat and Respond pillars.

HAB EHE-funded jurisdictional recipients work toward EHE goals through RWHAP service categories [4], EHE initiative services, and/or infrastructure enhancements. With EHE initiative funding, recipients can—

- Expand and/or innovate the delivery of RWHAP service categories and/or
- Use funding in ways that do not fit into current RWHAP service categories to support their programmatic goals

Key strategies of the EHE initiative for HAB-funded EHE jurisdictional recipients include the following:

- Implementing evidence-informed and emerging intervention strategies shown to increase linkage to, retention in, and re-engagement in in care focused on those not yet diagnosed, those diagnosed but not in HIV care, and those who are in HIV care but not yet virally suppressed
- Re-engaging people with HIV who were in care but are no longer in ongoing care and are not virally suppressed

RWHAP Part F AETC Program EHE recipients developed and implemented innovative strategies and activities for training and supporting health care team members and students in support of the EHE goals. From July 2020 through June 2021, the eight regional AETCs conducted 335 EHE-funded trainings and trained 3,286 HIV care professionals.

HAB technical assistance (TA) providers include the Technical Assistance Provider-innovation network (TAP-in), which builds organizational capacity and provides technical assistance to

jurisdictions, and the EHE Systems Coordination Provider (SCP), which supports recipients to coordinate EHE activities across different sources of funding and assists with bringing nontraditional stakeholders and partners to the table.

This publication describes activities, services, and innovations implemented by 47 EHE jurisdictional recipients (hereafter referred to as “EHE recipients”) with HAB EHE funding and highlights the impact of these efforts on meeting the EHE goals.

HIGHLIGHTS OF YEAR 2

Infrastructure Development

Infrastructure-related activities were completed to increase organizational capacity. Most of these activities centered on adding to the existing workforce, onboarding and training staff, building data infrastructure, and expanding and developing new partnerships. These foundational activities were the building blocks that laid the groundwork for successful implementation and service delivery activities.

Workforce: Recruitment, Hiring, and Development

EHE recipients developed their organizational infrastructure through hiring, training, and professional development activities of new staff and existing personnel. Although many EHE recipients reported being fully staffed (i.e., no current staffing needs), several EHE recipients advertised vacancies or hired additional staff.

After staff were hired, onboarding activities included staff trainings, such as community health worker certification programs, cultural humility/cultural responsiveness training, peer navigation training, and voluntary counselor training. Other trainings focused on an introduction and overview of EHE, professional development, and team-building activities.

Data Infrastructure

EHE recipients focused on developing and expanding data infrastructure activities to support EHE implementation. In addition to hiring and training staff to support data infrastructure, data management, and monitoring and evaluation activities, EHE recipients also purchased and developed various types of data software. These software programs assisted EHE recipients with, for example, data collection and analysis, using electronic medical record systems, and monitoring information about client engagement in care. EHE recipients applied these software programs to "data to care" activities, linkage to care, referrals, service delivery, and cluster detection and response, among others.

Some EHE recipients reported upgrading their existing software and data processes to implement more advanced methods of documenting client information. Other software updates enhanced electronic medical care systems with flag options to better identify clients within priority populations.

Data sharing agreements and activities to facilitate best data sharing processes and practices were widely reported among EHE recipients. HAB technical assistance providers also delivered technical assistance on data sharing and data visualization and provided other data-related support. The EHE recipient quote below details collaborative efforts to facilitate data sharing.

> *…County Government is currently in the process of executing a data sharing agreement in order to be able to exchange client level information for those reported as out of care in [our data system]. The ability to exchange information with the State on a regular basis will allow the Early Intervention Services team to find clients … efficiently and attempt re-engagement to care.*

Of note, many of these activities fell under the umbrella of "Data to Care," [5] a public health strategy that optimizes existing data sources to reach out-of-care clients, and significantly overlapped with activities that are covered in other sections of this publication.

New and Expanded Partnerships

Information on new and/or expanded partnerships showcased a range of organizations that EHE recipients engaged with to meet their EHE initiative goals.

In addition to expanding conventional or traditional partnerships, EHE recipients established innovative partnerships focused on social determinants of health, meeting clients where they are (geographically or socially), engaging with different venues, enhancing client referral processes, and other areas. Because every organization and program is different, EHE recipients were encouraged to use EHE funding to seek and maintain partnerships that are most relevant to the needs of their clients and communities.

Types of New and Expanded Partnerships Established by EHE Recipients

Technical Assistance	• Technical assistance providers • Data and evaluation support • TRAIN Learning Network • RWHAP Part F Regional AIDS Education and Training Centers (AETCs), AETC National Coordinating Resource Center
Federal, State, and Other Governmental Agencies	• HRSA Health Center Program • U.S. Department of Housing and Urban Development, Housing Opportunities for People with AIDS (known as HOPWA) • Correctional facilities • Disease intervention specialists within state and local health departments • Health departments
Community-Based	• Community-based health centers • Community coalitions • Community-based organizations (e.g., Health Education Resource Centers, Boys and Girls Club) • Nonprofit organizations
Clinical Services	• Ambulatory care services sites (e.g., health care centers, health department clinics, urgent care) • AIDS service organizations and counseling/testing sites • Medical provider associations, family planning services • Trauma response and clinical quality management teams • Pharmacies and wellness clinics
Transportation and Support Services	• Mobile medical units • Rideshare services • Food pantries • Legal services • Substance use rehabilitation facilities

EHE partnerships were formed to assist with the following activities:

- Bundle HIV/sexually transmitted infection (STI) testing with HIV linkage to care efforts (e.g., leveraging COVID-19 vaccination as a point of entry, providing web-ordered home STI testing kits).
- Provide training to health care professionals and staff (e.g., partnering with RWHAP AETC recipients to provide harm-reduction training to medical case managers and health advocates).
- Support and improve client education, linkage to care, rapid antiretroviral therapy (ART), and retention-in-care efforts.
- Improve medication access.
- Conduct interventions and outreach in the evenings and in more rural areas.
- Utilize another organization's property/venue in ZIP codes with high rates of HIV to reach clients.
- Provide expanded support services for clients.
- Receive referrals from other organizations for EHE-supported services.
- Plan and conduct community events.
- Receive specialized technical assistance.

One recipient describes how service reach was expanded through partnerships:

> *In partnership with our contracted community organization [redacted], additional HIV interventions and outreach are conducted in the evening in the ZIP codes where there is burden of HIV for our priority populations.*

Another recipient describes how referrals were received through partnerships:

> *Another strength has been collaboration with external agencies, such as urgent cares and [redacted nonprofit]. They have agreed to place our care coordination activities into their resource guides or to provide our Care Coordinators' contact information to an individual who is newly diagnosed. We have discussed that the [redacted] Care Coordinator would be made available to assist an individual in clinic if needed.*

Community Engagement and Information Dissemination

Community engagement and information dissemination activities were implemented to identify potential clients, distribute information, and procure feedback and input from the community to build relationships. Through these outreach events and activities, EHE recipients increased awareness of EHE activities, EHE services, support groups, linkage/navigation resources, and other support services. Many EHE recipients reported building authentic and trusting community relationships to better understand and serve clients who are a part of those communities.

Community Engagement Activities

EHE recipients sought input and advice from stakeholders involved in HIV planning councils, strategic planning committees, state committees, steering committee meetings, planning body meetings, workgroups, EHE task forces, and advisory group consultations. Community members and people with lived experience participated in and were consulted during community collaboratives, consumer advisory committees, community feedback and listening sessions, community engagement forums, peer support planning sessions, and statewide planning meetings. Community activities and meetings were held both in person and virtually. Some community forums and focus groups were created explicitly to obtain feedback on EHE initiative planning, whereas others existed prior to the EHE initiative.

EHE recipients reported significant involvement and participation in third-party collaboratives and conveyed many needs, ideas, and discussion points that emerged from community meetings. Some EHE recipients reported needs for and ideas on peer navigation training, development of procedures for self-testing, technical assistance needs around pre- and post-HIV self-testing, and the role of addressing mental health in increasing linkage/retention efforts. Recipients used the discussions and information from these meetings to guide the development of requests for proposals (RFPs) and for ideas on how to direct future activities. EHE recipients used many of the group meetings as opportunities to give EHE presentations introducing planned implementation efforts and interventions.

A few examples of community engagement events include National Transgender HIV Testing Day, Pride Month activities, and community action conversations. Many of the community engagement activities and events were implemented with the assistance of the community-based organizations listed in the new and expanded partnerships section.

During this reporting period, EHE recipients also drafted community engagement workplans and obtained support from HAB technical assistance providers on community engagement activities. Additional input was obtained during focus groups or surveys with community members, providers, and clients.

Information Dissemination Activities

EHE recipients disseminated information via engagement liaison teams, recipient websites, HRSA webinars, RFPs, community presentations, health fairs, mobile medical units, clinical and community settings, phone and text lines, and advertising, among other mechanisms.

Some of the materials disseminated were translated into other languages, such as Spanish, to increase reach. Overall, these dissemination avenues provided EHE recipients with opportunities to share information about the EHE initiative, care and linkage services, support services (e.g., housing, peer groups), and more.

Social Media Dissemination

Information dissemination via social media occurred through digital ads (e.g., Google Ads placements), social media graphics, social media banners, and other methods. EHE recipients conducted social media campaigns on such topics as HIV education, anti-stigma and stigma reduction, and pre-exposure prophylaxis (PrEP) awareness.

EHE recipients also partnered with advertising and marketing agencies to enhance their reach via social media. Overall, social media dissemination was especially helpful in continuing EHE implementation amid the COVID-19 pandemic.

> *Ending the HIV Epidemic in the U.S. (EHE) initiative funds were also used to promote a social media campaign focused on EHE awareness and connecting [redacted] County individuals to treatment and care services. [Redacted] County has contracted with [a marketing firm] who fields all campaign concepts and messaging through a series of focus groups [composed] of EHE priority populations. This ensures messaging is [focused] and speaks meaningfully to those who have either fallen out of care or are unfamiliar with Ryan White programs and services.*

Linkage, Retention, Re-engagement

Linkage, retention, and re-engagement efforts included identifying newly diagnosed and out-of-care clients, partnering with other organizations (e.g., coordinating receipt of referrals), deploying relevant interventions and programs, and utilizing specialized staff to assist with efforts, particularly community health workers and peer navigators. Populations that data show have particularly high need included, but are not limited to, Black/African American gay, bisexual, and other men who have sex with men; Hispanic/Latino gay, bisexual, and other men who have sex with men; Black/African American women; transgender people; youth and young adults; people who were unstably housed; people with co-occurring conditions; people who were newly diagnosed; and people with unmet needs who are now returning to care.

Data to Care

Most EHE recipients reported optimizing existing data sources to identify individuals who may be out of care or at risk for falling out of care; these efforts are sometimes referred to as "data to care." Staff used existing resources and data systems from state health departments and other organizations to identify and contact clients who might benefit from additional support services and resources. EHE recipients also created and used their own data systems to assist with these efforts.

Linkage, Retention, and Re-engagement Activities

EHE recipients implemented many activities that impacted linkage to care, retention in care, and re-engagement in care, including the following:

- HIV testing in nontraditional settings (e.g., mobile/pop-up testing sites, home test kits, walk-up testing services)
- Providing telehealth services
- Reviewing charts and lab work to validate whether clients were engaged in care
- Creating Data Sharing Agreements with other agencies (e.g., health departments) to find out-of-care clients and re-engage them into care
- Linking those who test positive in emergency departments through hospital linkage programs

- Monitoring a client's first dose of ART by using Directly Observed Therapy
- Assigning pharmacists to clinics to monitor medical adherence
- Establishing partnerships with hospital retention-in-care teams
- Accepting referrals from county disease intervention specialists, partner agencies, care lines, and clinics and having tailored and responsive referrals
- Shadowing of health department patient navigators by linkage-to-care specialists to gain additional experience
- Having physicians on staff who travel to outreach clinics and make home visits
- Identifying clients out of or lost to care using CAREWare and electronic health record databases
- Implementing rapid ART
- Calling in a timely manner to reschedule clients who missed visits

These activities were sometimes part of existing RWHAP service categories, and other times they were new activities that were not within existing RWHAP service categories. The most reported RWHAP service categories [4] that supported linkage, retention, and re-engagement in care included—

- Early intervention services
- Housing
- Medical case management
- Medical transportation
- Mental health
- Outpatient ambulatory health services
- Substance use disorder services

Several HIV care interventions focused on HIV education, retention in care, re-engagement in care, viral suppression, and medication adherence among priority populations, such as those who were newly diagnosed and people recently released from incarceration. Medical case management and referrals for social support services (e.g., housing, oral health, substance use, medical transportation, economic and employment, nutrition) were especially useful in assisting with re-engagement and retention efforts.

Communications to Those Out of Care

The following communications-related activities assisted with linkage, retention, and re-engagement efforts:

- Letters to on-file addresses
- Pocket brochures
- Phone calls and follow-up calls
- Text messages
- Field visits, including visiting last known addresses
- Outreach efforts to increase awareness of linkage services
- Smartphone applications
- Public Health Service Agreements to provide EHE clients expedited medical appointments

Community Health Workers and Peer Navigators

EHE recipients employed community health workers (CHWs) and peer navigators (PNs) to support people with HIV across the HIV care continuum. In EHE implementation, CHWs and PNs played a particularly critical role in supporting linkage to and retention in care among people with HIV and alleviating barriers that may prevent clients from entering and staying in care. They often drew from lived experience, which supports clients in reaching/maintaining viral suppression.

Community Health Worker and Peer Navigator Activities Along the HIV Care Continuum

Diagnosis	• Referring community members for HIV testing • Assisting with HIV prevention and testing activities, including provision of self-test kits • Providing support for individuals who are newly diagnosed
Linkage	• Accompanying clients to medical and other core service visits • Linking clients who are newly diagnosed and who have fallen out of care • Facilitating acquisition of Anti-Retroviral Treatment (ART) • Referring and/or linking clients to medical, psychosocial, and support services
Retention	• Engaging and re-engaging clients in care • Following up with clients who faced challenges staying in care • Offering online support to assist with engagement in care • Building patient health literacy (e.g., discussing the importance of treatment and benefits of viral suppression) • Providing support/education to improve adherence, coping skills, and quality of life • Coordinating clients' care and supporting providers after warm handoffs from clinicians • Supporting clients' medical and treatment retention goals • Participating in HIV support groups

EHE recipients reported that CHWs and PNs also empowered clients by discussing challenges to care and treatment, providing assistance with health systems navigation, and offering language support.

> *[Our] community health workers (CHWs) have a shared or unique lived experience of [people with HIV] and provide peer support that includes emotional support and health systems navigation. Ending the HIV Epidemic in the U.S.–funded CHWs work closely with Medical Case Managers and other members of a client's clinical care team to provide community-level education, adherence counseling, and lost to care outreach.*

> *Community health workers accompany clients to medical visits and other core service visits, perform field work to relocate Ryan White HIV/AIDS Program lost-to-care clients, and facilitate positive patient–provider interactions, often bridging the gap between technical medical language and patient health literacy.*

Service Delivery Approaches

EHE recipients implemented a variety of service delivery approaches to better serve clients by expanding access to RWHAP core medical, support, and EHE initiative services, particularly with technology.

Expanded Access Services

EHE recipients continued service and access expansion activities during Year 2 of the EHE initiative. These activities provided low-barrier services to clients, thereby increasing service access and linking, retaining, and re-engaging more clients into care.

Clients continued to extend clinical service hours, including hours for HIV testing, offering services in the early morning, evening, and weekend. EHE recipients also combined appointments for efficiency.

Many EHE recipients reported outreach services that expanded access. Recipients reported deploying providers, nurses, outreach and community health workers, and other staff into the community to provide services to clients facing barriers to accessing care in traditional settings (e.g., transportation, stigma, childcare). These services included collaborating with a pharmacy courier to deliver medication; offering home visits for HIV care, at-home HIV testing programs, in-home phlebotomy services (blood draws), and pop-up clinics in communities; deploying outreach workers to unhoused people in encampments; and arranging for providers to travel to outreach clinics. Staff members also were deployed into hospitals to deliver care to inpatient clients.

One recipient discussed expanding access to people who are experiencing homelessness or are unstably housed:

> *We recently awarded [redacted housing organization] … to support provider and outreach worker time, client incentives, program supplies, and emergency financial assistance to people living with HIV who are homeless and using drugs. They provide services in encampments, engagement centers, and neighborhoods where this population spends time.*

EHE recipients continued to address transportation barriers through the provision of ride share and taxi services, mobile medical units, and telemedicine services (as previously described). Telehealth services were especially helpful in expanding services into jails and rural areas. EHE recipients also purchased equipment, including tablets, phones, and mobile medical units, to support telehealth services.

> *The [redacted] program has utilized the Ending the HIV Epidemic in the U.S. program to expand services in local jails. The use of telemedicine visits and teleconferencing for case management has been welcomed by local jails, resulting in decreased burden in managing inmates' HIV care.*

Telehealth and Use of Technology

Many EHE recipients offered telehealth services to clients to overcome service delivery barriers. Many of the activities listed are a continuation of flexibilities initially offered during the onset of the COVID-19 pandemic that addressed barriers to in-person visits and services. EHE recipients also limited in-person time required for services (e.g., by streamlining the intake process and reducing information requested on client intake forms that have previously been provided to the organization). Examples of telehealth activities included—

- Providing subrecipient funding to support telehealth services/visits
- Extending telemedicine service hours, including weekends
- Increasing the number of subrecipient agencies reporting the use of teleconferencing software
- Expanding or creating a texting platform intervention (i.e., Text Messaging to Treat) and mobile applications (e.g., PositiveLinks Cares app)
- Hiring telehealth coordinators to assist with mobile applications, tracking clients, and updating EHE providers on clients
- Offering telemedicine visits to expand services offered to people experiencing incarceration
- Providing online peer support

EHE recipients provided resources to clients to overcome technology access barriers, which were particularly beneficial for those without internet access at home.

> *Utilizing Lyft and telehealth to initiate rapid antiretroviral therapy has been beneficial with linking new and re-engaged patients into care … We provided participants with phones and data plans to stay engaged with their case managers and providers.*

> *Barriers with linkage to care and re-engagement are being decreased by use of technology and virtual intakes with Case Management Department…*

Cluster Detection and Response

Although many EHE recipients did not report identifying any new clusters or cluster response activities, some EHE recipients reported how they identified clusters and delivered resources to clients who were newly diagnosed with HIV.

Strategies for Identifying Clusters

Partnerships were key to quickly identifying clusters so that EHE recipients could then deploy resources. Many EHE recipients collaborated with their outbreak response teams, and some established formal collaborations with health departments of neighboring geographic areas to be alerted of new emerging clusters.

In addition to having access to data via health departments and other responses, EHE recipients funded their own data sharing systems, surveillance systems, and dashboards to identify clusters and work across organizational silos. Great care was taken to ensure the security of these systems. Data, evaluation, and epidemiology staff also assisted with efforts to identify clusters through outbreak summaries.

Some EHE recipients also reported providing their staff with training on cluster detection and response best practices.

> *These workshops will cover ethical considerations for HIV surveillance, such as consent and data protection, community engagement and collaboration among persons living with HIV, health departments, providers, and other community agencies needed for an effective response.*

Delivering Resources to Clusters

Once clusters were identified, EHE recipients worked quickly to deploy resources to the affected areas. Many reported maintaining cluster response committees and cluster/outbreak response protocols to assist with these efforts.

Key response activities included using mobile health services to deploy resources to affected ZIP codes; offering HIV testing and educational events; providing linkage resources and partner services; and deploying linkage to care coordinators and other outreach staff to deliver services to areas in need. EHE recipients also partnered with other organizations to deliver resources (e.g., transitional housing, substance use disorder treatment, food and toiletries). Areas to deliver services to were typically identified through notifications to EHE recipients by the health department or other partners. Data were also used to identify priority populations within certain outreach and service delivery areas.

> *One of our Ending the HIV Epidemic in the U.S.–funded agencies (four of our Ryan White HIV/AIDS Program–funded agencies) are currently working collaboratively with the [redacted] HIV surveillance unit to complete expanded partner services interviews to learn about barriers to pre-exposure prophylaxis among a cluster primarily composed of [redacted] men who have sex with men. Our cluster response activities are centered primarily on re-engagement of out-of-care cluster members and [key] efforts for viral load suppression for cluster members who are in care but who are not virally suppressed.*

Impact and Innovation

EHE initiative funding enabled EHE recipients to deliver a variety of innovative and expanded services that would not be possible with RWHAP funding alone. This allowed EHE recipients to meet the needs of people with HIV who are new to care or re-engaged in care and improve retention efforts for those currently in care, ultimately meeting the greater EHE goals of improving the health and quality of life of people with HIV. The following quotes highlight examples of various expanded and innovative services and the impact these services have had on EHE recipients and the clients they serve.

EHE initiative funding provided resources for rigorous follow-up to clients who are out of care:

> *…this funding allows expansion of [retention] services to include the more rigorous reminder calls and follow-up calls that are specifically [aimed] toward individuals who are at risk of or have fallen out of care.*

Provision of telehealth and additional support services were reported by several recipients:

> *Ending the HIV Epidemic in the U.S. (EHE) services/activities differ from non-EHE Ryan White HIV/AIDS Program services/activities through the expansion of nontraditional and supportive services and the provision of telehealth and hormone therapy. Funding was allocated [redacted] for medical and support services to supplement the current Part A infrastructure and to promote rapid treatment. These capacity-building efforts support Pillar Two by expanding access to HIV care and treatment for people with HIV in the jurisdiction.*

> *Ending the HIV Epidemic in the U.S. services differ from Ryan White HIV/AIDS Program services by allowing for the Retention Specialist to provide outreach and support packages, including hygiene, nutritional snacks, and gift cards for clients to purchase additional necessities.*

Some recipients reported providing home visits for EHE clients to expand access to care:

> *Home visits are not conducted on non–Ending the HIV Epidemic in the U.S. (EHE) patients. EHE initiative funding allows for special collaboration between Managed Care and Linkage to Care Departments to outreach lost to care clients and clients in danger of falling out of care. [Early Intervention Services] is not under the Ryan White HIV/AIDS Program contract—all of these EHE services are new to [redacted].*

EHE funding further assisted with program evaluation and clinical quality management activities:

> *Ending the HIV Epidemic in the U.S. (EHE) funding allows the organization to set aside funds to support the improvement of HIV care, and assuring patients have adequate access to HIV and treatment services in a timely manner, and to periodically review program for gaps to be addressed. A baseline assessment of HIV-positive clients was completed, and performance measures and activities were established. EHE activities will monitor and establish clinical quality management projects around linkage to care and prescribed antiretroviral therapy.*

EHE funding allowed for increased staff time and resources for EHE clients:

> *Ending the HIV Epidemic in the U.S. (EHE) services differ from non-EHE initiative Ryan White HIV/AIDS Program services in the time and effort the EHE staff can dedicate to each client. A non-EHE case manager would not have as much dedicated time to give the individualized attention to the clients that need more frequent and intensive follow-up, like those members of the [redacted] Project [primary] population. In most of [our jurisdiction's] Ryan White–funded clinics, a regular caseload for a Medical Case Manager is at least 100 clients … This would not permit the [medical case management staff] to focus more on [EHE] clients that need additional attention to remain in care and reach their health outcomes, without compromising the other clients' time and attention requirements.*

EHE funding assisted EHE recipients with overcoming barriers related to social determinants of health:

> *[Redacted intensive services program] provides resources that have the greatest impact on an individual's social determinants of health. These include food, housing, transportation, income (jobs/entitlements), and education. Current Ryan White restrictions limit the capacity by which providers can assist clients in overcoming these barriers that would enable them to become fully self-sufficient and in turn assist them in being medically adherent and virally suppressed.*

EHE funding was used to fill in provider-identified needs in HIV care and service:

> *The additional flexibility of Ending the HIV Epidemic in the U.S. (EHE) combined with evolving needs from COVID-19 have driven ingenuity and creativity to meet client needs like the [redacted] telehealth navigation [program]. However, in addition to new ideas being developed, EHE funds have allowed us to ask providers, 'What is that one service that you have wanted to provide for years because it would break down barriers to accessing care but something has always gotten in the way (funding or Ryan White restrictions)?' By continuously asking and seeking answers to this question, [redacted organization] and the HIV provider community have developed additional programming, like the intensive services program. Programs like [perinatal-focused self-care groups] take one step beyond the basic needs and treat the whole person.*

EHE funding was used to expand the pool of clients accessing services:

> *Further, Ending the HIV Epidemic in the U.S. activities are designed to address the needs of [people with HIV] who do not qualify for services under the Ryan White system of care. This greatly broadens the scope of access to disproportionately underserved populations without the risk of overlap of service offerings, and ultimately maximiz[es] the use of funding. The activities implemented during the reporting period as noted above have successfully moved [redacted jurisdiction] closer to meeting the needs of priority populations that otherwise would not have available treatment and care options.*

EHE funds expanded housing and rental assistance support services:

> *Although the [redacted jurisdiction] Ryan White HIV/AIDS Program (RWHAP) provides housing services, these services are short term or limited housing support services for people with HIV. The RWHAP funds Short-Term Supportive Housing; Emergency Financial Assistance for Rent, Utilities, and Deposits; and the Short-Term Rental Assistance Program. Through the Ending the HIV Epidemic in the U.S. Transitional Rental Assistance Program, clients will be able to access longer-term housing with supportive case management services, which greatly impacts their overall ability to link to and be retained in medical care and to transition to permanent housing.*

EHE recipients reported providing additional HIV care to high-acuity individuals:

> *The [redacted] program [focuses on] [high-acuity] people with HIV who do not qualify for the Ryan White HIV/AIDS Program (RWHAP) and have not been successful in engaging in HIV care except when they are part of the RWHAP. The client population includes those who have risk factors for falling out of care and other poor health outcomes, such as severe mental health needs (e.g., schizophrenia), chronic homelessness, or substance use.*

EHE funding broadened HIV psychiatry and mental health services:

> *[redacted] mobile behavior unit that deploy trained professionals to respond to people experiencing a mental health crisis with compassion and clinical expertise. The mobile behavior unit is instrumental to serving Ryan White HIV/AIDS Program clients within the community and near their residences.*

> *While mental health services are currently offered with Ryan White HIV/AIDS Program funding, psychiatry services are not and have been an identified need for many years. As mentioned above, [our jurisdiction] was able to successfully partner with a psychiatrist from the behavioral health services department to provide psychiatric services utilizing Ending the HIV Epidemic in the U.S. funding.*

Overcoming Barriers and Challenges

EHE recipients reported several barriers and challenges during the reporting period. Below are some of the most common themes on barriers and challenges that EHE recipients faced and how EHE recipients overcame them.

Staffing Challenges

The most common challenge among EHE recipients was staffing issues regarding vacancies, retention, temporary reassignments (particularly due to COVID-19 and emergency response activities), and limitations on staff capacity. Some EHE recipients also reported human resource issues related to delays in posting positions and contract executions. Other staffing issues included staff burnout, low morale, and staff resignations in order to pursue better opportunities.

An example of downstream implications of staff departures:

> *Because of the ongoing COVID-19 pandemic and resultant global economic turmoil, employee recruitment and retention have been significant challenges for both the recipient and subrecipients. Due to these challenges, there has been a loss of historical and institutional knowledge, and onboarding new Ending the HIV Epidemic in the U.S. (EHE) Initiative support staff during the next four months will require existing personnel to dedicate time for training. We anticipate a learning curve … however, the additional team members will strengthen the jurisdiction's EHE programs and services to the community.*

One recipient discussed their organization's efforts to address staff burnout:

> *[redacted] continues to make progress with staff recruitment and retention, despite recent capacity challenges … [redacted] is engaged in a pilot hybrid work model to support flexibility and increase staff retention … In addition, the [redacted] is investing in staff development and wellness. The goals of these investments include staff advancement, creating a culture of collective care, and overall staff satisfaction.*

COVID-19 Impact on Service Delivery

COVID-19 continued to have an impact on EHE recipients during Year 2 of the EHE initiative. In addition to challenges with staff being temporarily reassigned to emergency response activities, COVID-19 also prevented in-person events, meetings, outreach activities, and some service delivery. At times, planned activities had to be shifted due to COVID-19 surges.

> *The COVID-19 pandemic remains an ongoing challenge from the last reporting period. Safety precautions limited in-person community engagement activities for much of the reporting period, including community health fairs where testing and in-person referrals have historically occurred.*

Technology Challenges Around Access and Literacy

Some EHE recipients reported facing technology-related challenges impacting their service delivery efforts. Some clients lacked access to technical and virtual platforms due to lack of internet access, device access, and/or issues with high-speed internet. These issues were particularly felt in rural areas. Others reported that some clients reported technology literacy issues. In some cases, new protocols had to be created for telehealth visits and services.

> *Another continued barrier to care is the lack of technology to reach and assist the priority populations. Many clients do not have access to reliable internet for telehealth visits. In some rural regions of the state, there is limited access to high-speed internet or minimal bandwidth. Even with access to technology, some individuals need to be seen in a clinic for testing and medical care. Many discussions at the state level have included this topic and how to best serve the priority populations in remote areas.*

Community Concerns Around Cluster Detection and Response

Several EHE recipients reported community concerns about cluster detection and response. One recipient discussed how efforts were taken to build community trust and address concerns via important partnerships with community-based organizations.

> *We have also spent time with community-based organizations to understand the community because of the importance of building trust and respecting their opinions in this collaborative effort as it relates to clusters.*

Data Sharing Challenges and Delays

Many EHE recipients reported challenges around access to data, which affected their ability to rapidly obtain up-to-date information on out-of-care clients, delayed notification of identified clusters, and delayed client referral processes.

> *The epidemiologists at the [redacted department of health] were also redirected toward COVID-19 response, which resulted in an extended delay in receiving new 'not in care lists' (NIC), a list of individuals who tested positive in the last 5 years and have not received any care in the past 18 months. In late May, [we] received from [redacted department of health] its first NIC list, and efforts to investigate and engage individuals not in care were immediately launched.*

Lack of Support Services

Some EHE recipients reported challenges linking clients to support services.

> *One ongoing challenge in retention in care and viral suppression is the need for affordable housing, mental health, and substance misuse services. Most mental health service organizations are running a 1- to 3-month wait for appointments. Substance misuse treatment facilities have similar wait times, and the wait for affordable housing can be years to a lifetime. Our jurisdiction is working to address these challenges by funding subrecipient activities that help to increase the capacity of these systems and by joining the Cicatelli Associates Inc. Technical Assistance Provider-innovation Housing Learning Community, which will help our jurisdiction 'foster an HIV housing strategy that musters new and existing resources to meet HIV housing needs.*

TECHNICAL NOTES

Report Details

This publication uses narrative information from EHE progress reports submitted to HRSA HAB during Year 2 of the EHE initiative by each of the 47 HAB jurisdictional EHE recipients for March 2021 through February 2022. The EHE progress reports have three reporting periods: March through June, July through October, and November through February. In these EHE progress reports, EHE recipients report on their activities and accomplishments; barriers and challenges faced during EHE implementation; and successes, lessons learned, and best practices. The EHE progress reports complement quantitative data submitted through other mechanisms and provide HRSA HAB with information about the progress made on EHE activities and the contextual factors impacting EHE implementation.

Information contained within this qualitative publication are aggregate syntheses of EHE recipients' activities, accomplishments, and services delivered to clients, as reported in their EHE progress reports. All quotes are direct, anonymized text from EHE recipient progress reports.

Limitations of Findings

The current EHE initiative focuses on specific jurisdictions with the highest burden of HIV. Therefore, the EHE progress reports submitted via the HRSA Electronic Handbooks System represent information only from the 39 RWHAP Part A EHE recipients and eight Part B EHE recipients that encompass the EHE jurisdictions and their subrecipient service providers.

These EHE progress reports include only the activities, services, and accomplishments that were supported by FY 2021 HAB EHE funding and reported by EHE recipients. The reports do not represent the totality of HAB-funded activities and services in these jurisdictions because EHE recipients may use other funding to deliver services and activities, including RWHAP Parts A, B, C, and D funding; RWHAP FY 2021 CARES Act funding; and RWHAP-related funding (e.g., program income or pharmaceutical rebates). Additionally, these activities do not represent the totality of EHE-supported activities in these jurisdictions because EHE jurisdictional recipients may have received EHE funding from HRSA's Bureau of Primary Health Care, the CDC, and/or other federal agencies (e.g., National Institutes of Health) to implement specific EHE interventions and activities. The EHE jurisdictional recipients may also have received support from EHE-funded AETC recipients or TA providers.

Information provided by EHE recipients on their EHE activities beyond those reported in the EHE progress reports is not captured in this publication. In addition, EHE recipients are not explicitly asked to provide demographic information in the progress reports about the clients identified or served. Demographic and other characteristics data are collected via other HRSA HAB data-reporting mechanisms, such as the Ryan White HIV/AIDS Program Services Report and AIDS Drug Assistance Program Data Report.

REFERENCES

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2. HRSA. September 2022. *HIV/AIDS Bureau Ending the HIV Epidemic in the U.S. (EHE) Initiative Qualitative Summary of Progress, March 2020–February 2021*. Available at ryanwhite.hrsa.gov/data/reports.

3. Azar, A. February 6, 2019. "Ending the HIV Epidemic: A Plan for America." U.S. Department of Health and Human Services. Available at hiv.gov/blog/ending-hiv-epidemic-plan-america.

4. HRSA. October 2018. "Ryan White HIV/AIDS Program Services: Eligible Individuals & Allowable Uses of Funds: Policy Clarification Notice (PCN) #16-02. Revised 10/22/18." Available at ryanwhite.hrsa.gov/sites/default/files/ryanwhite/grants/service-category-pcn-16-02-final.pdf.

5. Centers for Disease Control and Prevention. March 2023. *Data to Care.* Available at cdc.gov/hiv/effective-interventions/treat/data-to-care/index.html.

APPENDIX

Ryan White HIV/AIDS Program Parts A and B Jurisdictions EHE Awards

Grant Recipient	Jurisdiction	EHE Focus County(ies) or State
Eligible Metropolitan Areas		
Atlanta, GA	Atlanta, GA	Cobb County; DeKalb County; Fulton County; Gwinnett County
Baltimore, MD	Baltimore, MD	Baltimore City
Boston, MA	Boston, MA	Suffolk County
Chicago, IL	Chicago, IL	Cook County
Dallas, TX	Dallas, TX	Dallas County
Detroit, MI	Detroit, MI	Wayne County
Ft. Lauderdale, FL	Fort Lauderdale, FL	Broward County
Houston, TX	Houston, TX	Harris County
Los Angeles, CA	Los Angeles, CA	Los Angeles County
Miami, FL	Miami, FL	Miami–Dade County
New Orleans, LA	New Orleans, LA	Orleans Parish
New York, NY	New York, NY	Bronx County; Kings County; New York County; Queens County
Newark, NJ	Newark, NJ	Essex County
Orlando, FL	Orlando, FL	Orange County
Philadelphia, PA	Philadelphia, PA	Philadelphia County
Phoenix, AZ	Phoenix, AZ	Maricopa County
San Diego, CA	San Diego, CA	San Diego County
San Francisco, CA	San Francisco, CA	San Francisco County
San Juan, PR	San Juan, PR	San Juan Municipio
Tampa–St. Petersburg, FL	Tampa, FL	Hillsborough County; Pinellas County
Washington, DC	Washington, DC	District of Columbia; Montgomery County, MD; Prince George's County, MD
West Palm Beach, FL	West Palm Beach, FL	Palm Beach County
Transitional Grant Areas		
Austin, TX	Austin, TX	Travis County
Baton Rouge, LA	Baton Rouge, LA	East Baton Rouge Parish
Charlotte, NC/Gastonia, SC	Charlotte, NC	Mecklenburg County, NC
Cleveland–Lorain–Elyria, OH	Cleveland, OH	Cuyahoga County
Columbus, OH	Columbus, OH	Franklin County
Ft. Worth, TX	Fort Worth, TX	Tarrant County
Indianapolis, IN	Indianapolis, IN	Marion County
Jacksonville, FL	Jacksonville, FL	Duval County
Jersey City, NJ	Jersey City, NJ	Hudson County
Las Vegas, NV	Las Vegas, NV	Clark County
Memphis, TN	Memphis, TN	Shelby County
Oakland, CA	Oakland, CA	Alameda County
Orange County, CA	Santa Ana, CA	Orange County
Riverside–San Bernardino, CA	San Bernardino, CA	Riverside County; San Bernardino County
Sacramento, CA	Sacramento, CA	Sacramento County
San Antonio, TX	San Antonio, TX	Bexar County
Seattle, WA	Seattle, WA	King County
States		
Alabama	Alabama	State
Arkansas	Arkansas	State
Kentucky	Kentucky	State
Mississippi	Mississippi	State
Missouri	Missouri	State
Ohio	Ohio	Hamilton County
Oklahoma	Oklahoma	State
South Carolina	South Carolina	State

ADDITIONAL RESOURCES

Centers for Disease Control and Prevention, HIV prevention resources: cdc.gov/hiv

Health Resources and Services Administration, HIV/AIDS programs: ryanwhite.hrsa.gov

HIV.gov, the nation's source for timely and relevant federal HIV policies, programs, and resources

RWHAP Compass Dashboard, a user-friendly, interactive data tool to visualize the reach, impact, and outcomes of the RWHAP: ryanwhite.hrsa.gov/data/dashboard

TargetHIV, tools for the Ryan White HIV/AIDS Program Community: targethiv.org