HRSA HIV/AIDS Bureau

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

Qualitative Summary of Progress

March 2020–February 2021

The Health Resources and Services Administration (HRSA) HIV/AIDS Bureau (HAB) *Ending the HIV Epidemic in the U.S. (EHE) Initiative Qualitative Summary of Progress* is published by the Division of Policy and Data, HAB, HRSA, U.S. Department of Health and Human Services, Rockville, Maryland.

Data presented in this summary represent information submitted to HRSA HAB via EHE progress reports and include data from March 2020 through February 2021 (Year 1 of the EHE initiative).

The *Ending the HIV Epidemic in the U.S. (EHE) Initiative Qualitative Summary of Progress* is not copyrighted and may be used and copied without permission. Citation of the source is, however, appreciated.

Suggested Citation

Health Resources and Services Administration. HIV/AIDS Bureau, *Ending the HIV Epidemic in the U.S. (EHE) Initiative Qualitative Summary of Progress: March 2020–February 2021*. https://ryanwhite.hrsa.gov/data/reports. Published September 2022.

Health Resources and Services Administration

Carole Johnson .... Administrator

HIV/AIDS Bureau, Health Resources and Services Administration

Laura W. Cheever, MD, ScM .... Associate Administrator

Heather Hauck, MSW, LICSW .... Deputy Associate Administrator

Yemisi Odusanya, MPH .... HAB EHE Senior Advisor, Office of the Associate Administrator

Tracy Matthews, MHA, RN .... CAPT, USPHS; Acting Director, Division of Policy and Data

Chrissy Abrahms Woodland, MBA .... Director, Division of Metropolitan HIV/AIDS Programs

Susan Robilotto, DO .... Director, Division of State HIV/AIDS Programs

Jeanean Willis Marsh, DPM .... CAPT, USPHS; Director, Office of Program Support

Paul Belkin .... Executive Officer, Office of Operations and Management

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

Publication of this summary was made possible by the contributions of the EHE recipients that provided EHE progress reports to HRSA.

HRSA HAB would like to acknowledge the important work EHE recipients, subrecipients, and stakeholders have been doing in response to the coronavirus disease 2019 (COVID-19) public health emergency and the incredible efforts made to submit EHE progress reports in a responsive manner during this time.

CONTENTS

COMMENTARY 1

Ending the HIV Epidemic in the U.S. Initiative Overview 1

Highlights of Year 1 (FY 2020) EHE Activities and Accomplishments 2

Expansion of RWHAP Service Categories 2

Linkage to Care and Re-engagement Activities 3

Priority Populations Identified by EHE Recipients 4

Leveraging Technology and Improving Access 4

Community Engagement, Enhancing Infrastructure, and Partnerships 5

Cluster Response 7

Barriers and Solutions for Implementation, Including the Impact of COVID-19 7

TECHNICAL NOTES 10

Limitations 12

RESOURCES 13

COMMENTARY

Ending the HIV Epidemic in the U.S. Initiative Overview

The *Ending the HIV Epidemic in the U.S. (EHE)* initiative aims to reduce new HIV infections to less than 3,000 per year by 2030, making new HIV transmissions a rare occurrence. Without adequate intervention, new HIV infections in the United States are predicted to rise, costing more lives and the U.S. government more than $200 billion in direct lifetime medical costs for HIV prevention and medication. The multiyear EHE initiative currently focuses on 48 counties, Washington, D.C., San Juan, Puerto Rico, and 7 states that have a substantial rural HIV burden (collectively referred to as “EHE jurisdictions”). The four pillars of this initiative—Diagnose, Treat, Prevent, and Respond—represent a strategic approach to ending the HIV epidemic in the United States.

The EHE initiative leverages critical scientific advances in HIV prevention, diagnosis, treatment, and care by coordinating the highly successful programs, resources, and infrastructure of many U.S. Department of Health and Human Services (HHS) agencies and offices, including the Health Resources and Services Administration (HRSA). HRSA ensures equitable access to services and support for low-income people with HIV through the Health Center Program and the Ryan White HIV/AIDS Program (RWHAP). The RWHAP’s comprehensive system of HIV care, support services, and medication delivery creates an efficient and effective service delivery mechanism for the EHE initiative.

In fiscal year (FY) 2020, the first year of the EHE initiative, HRSA’s HIV/AIDS Bureau (HAB) awarded EHE funds to the 39 RWHAP Part A recipients and 8 Part B recipients that encompass the EHE jurisdictions (i.e., the 48 counties, Washington, D.C., San Juan, and the 7 rural states). HAB EHE recipients (hereafter referred to as “EHE recipients”) utilize their existing infrastructure to implement effective and innovative strategies, interventions, approaches, and services to reduce new HIV infections in the United States. In total, HRSA HAB awarded $63 million in FY 2020 to these 47 EHE recipients, as well as 2 technical assistance providers and 11 RWHAP AIDS Education and Training Center (AETC) Program recipients.

Key strategies of the EHE initiative for HAB-funded EHE recipients and their service providers include the following:

- Implementing evidence-informed and emerging intervention strategies shown to increase linkage, engagement, and retention 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;
- Providing technical assistance and systems coordination to support effective strategic plans and activities to successfully implement the EHE initiative; and
- Expanding workforce capacity through the efforts of the RWHAP AETCs.

HAB EHE-funded service providers served nearly 19,500 clients who were new or re-engaged in HIV care and treatment during the period March 2020 through December 2020. This exceeded the goal of 18,000 new or re-engaged people with HIV served during in the initial year of the EHE initiative.

The information contained within this summary will be useful for other RWHAP recipients in the development and implementation of strategies and activities to end the HIV epidemic. This document is HRSA HAB’s first publication of qualitative information regarding the EHE initiative. It uses narrative information from EHE progress reports that are submitted up to three times per year to HRSA HAB by EHE recipients. 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.

HAB EHE funding, awarded in March 2020, coincided with the emergence of the coronavirus disease 2019 (COVID-19) pandemic. As EHE recipients rapidly and drastically shifted priorities to respond to the pandemic, many EHE initiative services and activities were delayed or adapted. In addition, many EHE recipients experienced lengthy delays in establishing EHE contracts with subrecipients, which further delayed EHE initiative activities and services. Therefore, readers should interpret and use the information in this FY 2020 Qualitative Summary of Progress in the context of these external factors that affected EHE initiative activities, services, and reporting during this reporting period. More information about these external factors is described within this summary.

Highlights of Year 1 (FY 2020) EHE Activities and Accomplishments

EHE recipients made significant progress toward implementing their EHE initiative activities despite challenges posed by the COVID-19 pandemic. These activities included expanding service delivery models, planning linkage to care and re-engagement activities, identifying priority populations for EHE activities, leveraging technology and improving access, increasing community engagement, enhancing infrastructure and partnerships, conducting cluster response activities, and addressing barriers to implementation.

Expansion of RWHAP Service Categories

Of the 47 EHE recipients, more than 70% used their EHE funds to expand the delivery of existing RWHAP core medical and support service categories.[1] In particular, EHE recipients used their EHE funds to support the AIDS Drug Assistance Program (ADAP), Early Intervention Services (EIS), Emergency Financial Assistance (EFA), housing services, medical case management, medical transportation, mental health services, and outpatient substance use services. **Table 1** highlights specific examples of activities conducted within each of these categories.

Table 1. Examples of Expanded RWHAP Service Delivery

RWHAP Service Category	Expanded Service Delivery
AIDS Drug Assistance Program (ADAP)	• 90-day prescriptions, rather than the typical 30 days • No-contact access to prescription drug pickups or deliveries • Dedicated ADAP staff, including rapid antiretroviral therapy (ART) support and pharmacists
Early Intervention Services (EIS)	• EIS specialists to identify clusters, engage with newly diagnosed individuals to link them to care and treatment, address barriers to retention, and locate lost-to-care individuals • Expanded purchase of home HIV test kits, coordinated distribution, and virtual referral for linkage to care
Emergency Financial Assistance (EFA)	• Expanded financial assistance for rent, food, and utilities • Funds for initial antiretroviral medications for rapid ART in primary care settings • Promotion of EFA services to traditional and nontraditional partners
Housing	• Expansion of rental assistance programs to reach people on waiting lists • Enhanced services to include utility payments and emergency lodging • Housing services bundled with trauma-informed mental health and substance use services

[1] Ryan White HIV/AIDS Program Services: Eligible Individuals and Allowable Uses of Funds. Policy Clarification Notice (PCN) #16-02 (revised 10/22/18). ryanwhite.hrsa.gov/sites/default/files/ryanwhite/grants/service-category-pcn-16-02-final.pdf

RWHAP Service Category	Expanded Service Delivery
Medical Case Management	• Specialized care for clients with more intensive behavioral or mental health needs • Care delivery via “one-stop shop” clinics or low-barrier clinics or coupled with other services like housing • Wellness checks at increased frequencies
Medical Transportation	• On-demand ridesharing as part of rapid ART programs
Mental Health Services	• Rapid mental health services to streamline processes and reduce stigma • Counseling and medication treatment with access to a consulting psychiatrist • Bilingual mental health services
Substance Use Services (Outpatient)	• Individual and group counseling

Linkage to Care and Re-engagement Activities

More than half (59.6%) of EHE recipients worked to implement linkage to care and re-engagement activities that did not align exactly with existing RWHAP service categories. However, the activities often built on or contained elements of existing RWHAP service categories.

Examples of linkage to care and re-engagement activities included the following:

- Implementing low-barrier clinics with high-intensity support, incentives, and care coordination
- Coordinating protocols to streamline the client experience, especially for initial contact and referral to services
- Establishing rapid re-engagement protocols after missed appointments
- Implementing evidence-informed and evidence-based interventions to improve linkage to care and re-engagement, such as ARTAS (Anti-Retroviral Treatment and Access to Services), HEART (Helping Enhance Adherence to Antiretroviral Therapy), REPC (Retention Through Enhanced Personal Contacts), and CLEAR (Choosing Life: Empowerment! Action! Results!)
- Coordinating with disease intervention specialists (DIS); partner services; and non-RWHAP HIV counseling, testing, and referral sites

Rapid Antiretroviral Therapy (ART)

Rapid ART programs were developed and/or implemented by many EHE recipients (42.6%). The goal of rapid ART programs is to start ART as soon as possible after an HIV diagnosis, preferably during the first clinic visit or even on the same day as diagnosis. EHE recipients implemented rapid ART programs for people who were newly linked to care and people who were re-engaged in care.

Examples of rapid ART activities included the following:

- Employing a dedicated rapid-linkage-to-care coordinator
- Implementing Red Carpet Entry programs that include rapid ART
- Providing either ART starter packs or a 30-day supply at the conclusion of the first client interaction
- Beginning treatment within 7 days of diagnosis with an at-home or self-administered HIV test

Navigators and Community Health Workers

Many EHE recipients (42.6%) engaged navigators to help clients manage their HIV care and navigate the broader health care system, including support services and services to meet subsistence needs. Often, these navigators supplemented and enhanced traditional case management activities.

The staff who provided specific services to clients included—

- Peer navigators, community health workers, and community resource navigators to address social determinants of health
- Health care navigators to enroll clients in health care coverage, register for health care, and schedule health care appointments
- Telehealth navigators to provide technology and educational services, including assistance navigating online medical records access and telehealth appointments
- Case management coordinators who are also disease intervention specialists

Priority Populations Identified by EHE Recipients

EHE recipients identified populations within their jurisdictions that they would prioritize for EHE activities. Many EHE recipients identified more than one priority population.

Nearly all EHE recipients prioritized racial and ethnic minority groups. In particular, 76.6% prioritized Black/African American individuals and 44.7% prioritized Hispanic/Latino individuals. Nearly two-thirds prioritized men of color who have sex with men (61.7%), nearly one-third prioritized women of color (29.8%), and 8.5% prioritized transgender people of color. Other jurisdictions prioritized youth of color (4.3%) and heterosexual people of color (10.6%).

More than three-quarters of EHE recipients prioritized men for their EHE activities (76.6%). More than one-third prioritized women (38.3%), and more than one-quarter prioritized transgender people (27.7%).

Social determinants of health greatly affect HIV care access and outcomes, leading some EHE recipients to prioritize populations that face distinct barriers to HIV care. Nearly one-third of jurisdictions (29.8%) prioritized people with substance use concerns. Some jurisdictions prioritized individuals with unstable housing (12.8%), and 10.6% prioritized people experiencing incarceration.

Leveraging Technology and Improving Access

Telehealth

Telehealth played a significant role in the implementation of EHE activities for more than three-quarters (76.6%) of EHE recipients. In their initial EHE workplans, many EHE recipients had planned to implement telehealth-based services. With the COVID-19 pandemic leading to a rapid uptake of telehealth, these EHE recipients and others expedited the implementation of telehealth.

Examples of telehealth activities included—

- Purchasing access to telehealth platforms
- Planning and establishing procedures for the provision of and billing for telehealth services
- Providing clients with technology and training them on how to use it
- Delivering such services as text messaging interventions, mental health rapid services, and regular client check-ins
- Implementing mobile apps for linkage and retention in care (e.g., the Positive Links Cares intervention)
- Implementing other technologies, such as video directly observed therapy

Expanded Access

EHE recipients removed structural barriers to care by expanding service delivery hours or delivering services in new or nontraditional locations (40.4%) or purchasing equipment to facilitate service delivery (36.2%).

Expanded service delivery included additional morning, evening, and weekend hours. Walk-in appointments at traditional and nontraditional hours also were made available to reach more clients.

Some recipients began to deliver services in new locations, such as local jails. Many EHE recipients also co-located services in a single physical location using a “one-stop shop” model. Other EHE recipients leveraged innovative spaces for service delivery, including mobile, home-based, and drive-through service delivery.

Equipment purchased to facilitate service delivery included laptops, tablets, cellphones, and internet/telephone service for both clients and staff. Some EHE recipients purchased vehicles to bring mobile services directly to clients, while others purchased equipment for a specific service category (e.g., dental equipment to expand oral health services).

Community Engagement, Enhancing Infrastructure, and Partnerships

Community Engagement, Information Dissemination, and Outreach

Collective success in meeting the goals of the EHE initiative depends on how well communities are involved in the planning, development, and implementation of HIV care and treatment strategies. HRSA HAB identified five guiding principles for community engagement efforts as their being intentional, committed, sustainable, flexible and tailored, and transformational.

Nearly all (97.9%) EHE recipients conducted community engagement activities or activities to drive and focus their jurisdictional planning for EHE implementation. These activities included hosting community listening sessions, meetings, town halls, and conversations with people with lived experience, direct service providers, and representatives from community-based organizations. Some EHE recipients expanded existing community engagement groups—such as community advisory boards and planning bodies—to incorporate new voices and perspectives in the community engagement and planning processes. Other EHE recipients formed new workgroups and task forces focused on EHE implementation.

More than half (53.2%) of EHE recipients developed or implemented marketing and social media campaigns, developed websites and apps, and created resource guides for clients and providers as forms of outreach.

Workforce Expansion and Development

To facilitate and support the implementation of EHE activities, the majority (83.0%) of EHE recipients hired new staff and delivered training to new and existing staff.

Newly hired staff included—

- EHE program coordinators, program managers, and grants managers
- Client-facing staff, including community health workers and peer navigators
- Specialists in data, epidemiology, health equity, community engagement, and information technology
- Individuals who reflect the community being served by EHE activities across all disciplines

EHE recipients also provided training and professional development on a variety of topics, including—

- EHE, HIV prevention and care, health disparities, and epidemiology
- Diversity and equity, leadership, racism, and social justice
- Specific interventions and processes, including trauma-informed care

Data Activities and Infrastructure

Most (93.6%) EHE recipients worked toward advancing their data infrastructure and leveraged data in innovative ways to support implementation of their EHE activities.

Some EHE recipients designed and implemented "Data to Care" projects.[2] These activities included creating "out of care" lists, contacting clients who need regular check-ins, and identifying locations to place mobile care units.

Other EHE recipients initiated or advanced data sharing agreements or memoranda of understanding to share, link, and match data across diverse sources. These agreements included sharing data across providers; across health department components (e.g., with HIV surveillance); and with external partners like corrections, housing organizations, and HIV testing sites.

Some EHE recipients enhanced their data infrastructure and data management through modifications to electronic medical records and data systems like CAREWare.[3] These enhancements help EHE recipients manage eligibility determination and share information between providers and across programs (e.g., ADAP).

Administrative Infrastructure and Partnerships

Nearly all (97.9%) EHE recipients further developed their administrative infrastructure, including—

- Executing strategic planning to implement EHE activities through the formation of task forces, steering committees, workgroups, and advisory boards
- Developing and releasing requests for proposals for contracts and posting EHE staff positions
- Conducting needs assessments and assessments of organizational structures
- Leveraging other federal funding sources, including other HRSA grants and Centers for Disease Control and Prevention (CDC) grants

Additionally, more than 90% (91.5%) of EHE recipients created partnerships with new entities and expanded existing partnerships with clinical organizations, nonclinical organizations, and nontraditional partners (**Table 2**).

[2] Data to Care. cdc.gov/hiv/effective-interventions/treat/data-to-care

[3] CAREWare is a free, electronic health and social support services information system for HRSA's Ryan White HIV/AIDS Program recipients and providers. ryanwhite.hrsa.gov/grants/manage/careware

Table 2. Examples of New and Expanded Partnerships

Clinical Organizations	Nonclinical Organizations	Nontraditional Partners
• HRSA-funded health centers • Pharmacies and pharmaceutical companies • Health departments • Hospitals and emergency departments • Clinics that serve priority populations	• Jails and correctional settings • Syringe services programs • Academic institutions • Housing Opportunities for Persons with AIDS (HOPWA) program and housing organizations • National health and medical organizations and consortia	• Barbershops and salons • Restaurants • Faith-based organizations • Family services agencies

Cluster Response

Although EHE recipients proposed cluster response activities, much of the work in cluster response was redirected to COVID-19 pandemic response efforts. However, nearly half (46.8%) of EHE recipients were still able to make progress on implementing activities under the "Respond" pillar.

Examples of cluster response activities included the following:

- Establishing collaborations and partnerships with HIV surveillance and DIS
- Creating protocols and outbreak response teams
- Conducting community engagement and outreach about molecular epidemiology and cluster detection and response

Barriers and Solutions for Implementation, Including the Impact of COVID-19

In its first year, EHE implementation was challenged by a variety of factors, with the greatest impact attributable to the COVID-19 pandemic. As EHE recipients rapidly and drastically shifted priorities to respond to the pandemic, many EHE initiative services and activities were delayed or adapted.

Barriers to EHE Implementation

Stay-at-home and social distancing measures resulted in the suspension or reduction of in-person activities, including core medical and support services, community engagement, and workforce training. Some examples of factors that affected the delivery of direct, in-person services to clients included:

- Clinic closures and reduced hours of operations
- Prioritization of clients with critical or essential service needs
- Elimination of drop-in or same-day appointments
- Increases in appointment no-shows
- Limited access for peer navigators to accompany and support clients during appointments
- Challenges in measuring retention in care due to clients' delaying care visits

EHE service delivery was hindered by structural barriers to care, including transportation and housing shortages. Many of these needs existed in EHE jurisdictions prior to the COVID-19 pandemic, but they were exacerbated by the pandemic. Jurisdictional responses to COVID-19 impacted the lives of people with HIV and RWHAP clients, leading to changing client needs. Examples include—

- Reduced availability of public transportation during stay-at-home orders
- Unemployment and loss of income
- Loss of housing and need for rental assistance
- Increases in substance use and mental health issues
- Decreases in HIV testing and linkage to care
- Clients' delaying care due to fear of COVID-19 infection
- Clients' returning to care, leading to an increased demand for services as individuals focused more attention on their health in light of COVID-19's burden on people with weakened immune systems

Local states of emergency led to delays or freezes in non-COVID-19 agency operations, which directly impacted EHE implementation. Many jurisdictions experienced delays in procurement processes to execute new contracts and delays and freezes in hiring staff. EHE recipients experienced challenges in award administration because EHE award amounts were less than originally requested and subsequently resulted in lengthy budget revision processes. Many EHE recipients faced challenges filling staff vacancies, which many attributed to noncompetitive salaries, lack of qualified applicants, and incompatibility with local jurisdiction budget cycles. These issues were often exacerbated by COVID-19-related delays in agency operations and administration. In addition, EHE recipients' partner organizations may have had operations suspended or resources redirected to COVID-19 response, limiting the ability of partners to participate in EHE activities.

In response to COVID-19, many local jurisdictions reassigned staff to support COVID-19 response efforts. Regardless of whether staff were formally or informally assigned to COVID-19 response, EHE recipients often responded to COVID-19 efforts within their existing capacity, infrastructure, and operations. Although FY 2020 CARES Act funding to RWHAP recipients assisted with COVID-19 response efforts, grant administration and monitoring placed an additional burden on recipient staff.

Evolving Role of Technology

In many jurisdictions, COVID-19 accelerated the uptake of telehealth and use of technology to reach people with HIV, including service delivery, staff training, and community engagement. However, this accelerated uptake of and reliance on technology during COVID-19 also created a "digital divide" in some areas, both for EHE recipients and providers and for their clients, hampering equitable delivery of and access to care.

EHE recipients reported that some staff, provider staff, and clients expressed discomfort about using technology to engage in telehealth, community engagement, or training. Some of this discomfort stemmed from lack of knowledge about the use of telehealth and other digital platforms. Others expressed concerns about client privacy, such as not being able to ensure that clients had a safe environment in which to attend telehealth appointments, in addition to a general lack of trust about the security of information shared via digital means.

With the rapid pivot to telehealth at the start of EHE implementation, many EHE recipients, providers, and clients often did not have the technological equipment necessary to facilitate digital access to care. Remote work for EHE recipients and providers was hindered by not having access to secure

computer equipment at home or having unstable or unreliable secure internet to access IT networks and telehealth platforms. Many clients also lacked access to computer equipment and mobile devices, and this was exacerbated by the closing of public-access computers during COVID-19 shutdowns.

Solutions Leveraged by EHE Recipients

To address the barriers and challenges listed above, EHE recipients focused on what could safely be accomplished during a pandemic. Their solutions included emphasizing self-care and community among their staff and with their clients, leveraging virtual spaces for both service delivery and outreach, and staggering or scaling back services to ensure that quality care could still be delivered.

EHE recipients introduced new flexibilities that prioritized the health and public safety of their staff and clients, including telehealth for clients and remote work permissions for staff.

EHE recipients also innovated their service delivery by implementing contactless ART pick-up and ART delivery, e-prescribing, and prescribing a 90-day supply of ART to promote prescription access while ensuring social distancing. Many EHE recipients created new ways to deliver services that are traditionally done in-person, such as delivering socially distanced case management or having peer navigators join clients via telephone for clinic visits.

Many EHE recipients identified and acted on opportunities to streamline the client experience, including consolidating services at one clinic and creating policies and procedures to simplify future client interaction. EHE recipients also scaled up activities to address new or greater demand for such services as transportation, rental assistance, EFA, and meal delivery.

In responding to the COVID-19 pandemic, EHE recipients leveraged their existing RWHAP knowledge, partnerships, experience, and resources. In this way, EHE jurisdictions continued to deliver high-quality HIV care and treatment to their clients, while also mitigating COVID-19 risk and responding to the enormous challenges posed by the COVID-19 pandemic.

TECHNICAL NOTES

HRSA HAB awarded EHE funding in March 2020 to the 39 RWHAP Part A recipients and 8 Part B recipients that encompass the EHE jurisdictions (i.e., 48 counties, Washington, D.C., San Juan, Puerto Rico, and the 7 rural states; **Table 3**).

Table 3. 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

Grant Recipient	Jurisdiction	EHE Focus County(ies) or State
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

All EHE recipients submitted two EHE progress reports during the first year of funding: the first progress report covered EHE activities performed March 2020 through October 2020, and the second covered EHE activities performed November 2020 through February 2021.

In these reports, EHE recipients describe progress toward their project goals and objectives for the reporting period and progress on project implementation and evaluation activities. Specifically, EHE recipients report on the following:

- *EHE Activities*: Services delivered through EHE funding during the reporting period, other activities supported by EHE funding during the reporting period, and how these services and activities differed from non-EHE RWHAP services and activities
- *Barriers and Challenges*: New and ongoing barriers and challenges encountered in implementing the EHE work plan during the reporting period, how the jurisdiction addressed them, and anticipated barriers or challenges in the next reporting period
- *Successes, Lessons Learned, and Best Practices*: New and ongoing successes, lessons learned, and best practices encountered when implementing the EHE work plan during the reporting period, as well as successful approaches to reducing or removing barriers to linkage to care, re-engagement in care, and retention in care
- *Contextual Factors*: Factors in the jurisdiction that could affect or have affected the success of EHE implementation and how, if at all, these factors changed during the reporting period
- *Community Input*: Progress made to address issues identified during the community input process, progress made in the implementation of strategies to address these issues, and the effect of these strategies on identifying people with HIV, linking them to care, and retaining them in care
- *Partnerships*: New and existing partnerships with other entities leveraged to support EHE activities during the reporting period, including collaborative activities undertaken with new partners and new, different, or expanded collaborative activities undertaken with existing partners
- *Staffing*: Current and anticipated staffing needs to implement EHE activities

In addition, EHE recipients identified populations within their jurisdiction that they would prioritize for EHE activities in their original application for funding.

To capture and understand the activities implemented and barriers or challenges faced by EHE recipients, HRSA HAB conducted a thematic analysis of the narrative information reported by EHE recipients in the EHE progress reports. This thematic analysis was guided by the HAB EHE Notice of Funding Opportunity and HRSA and HAB priorities.

Limitations

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 recipients and 8 Part B recipients that encompass the EHE jurisdictions and their subrecipient service providers. EHE progress report information contained within this qualitative summary are aggregate syntheses of EHE recipients' activities, accomplishments, and services delivered to clients.

These EHE progress reports include only the activities, services, and accomplishments that were supported by FY 2020 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 2020 CARES Act funding; and RWHAP-related funding (i.e., program income or pharmaceutical rebates). Additionally, these activities do not represent the totality of EHE-supported activities in these jurisdictions because EHE recipients also received EHE funding from the CDC and may have been supported by other federal agencies (e.g., National Institutes of Health) to implement specific EHE interventions and activities.

Information provided by EHE recipients on their EHE activities beyond those reported in the EHE progress reports is not captured in this summary. 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 RWHAP ADAP Data Report.

RESOURCES

1. *Ending the HIV Epidemic in the U.S. (EHE)* Initiative
   hiv.gov/federal-response/ending-the-hiv-epidemic/overview

2. Health Resources and Services Administration (HRSA) EHE
   hrsa.gov/ending-hiv-epidemic

3. HRSA Health Center Program
   bphc.hrsa.gov

   findahealthcenter.hrsa.gov

4. HRSA Ryan White HIV/AIDS Program (RWHAP)
   ryanwhite.hrsa.gov

5. RWHAP Data Reports
   ryanwhite.hrsa.gov/data/reports

6. HRSA HIV/AIDS Bureau EHE Awards
   ryanwhite.hrsa.gov/about/parts-and-initiatives/fy-2020-ending-hiv-epidemic-awards

7. EHE Initiative Triannual Data Reporting Module Resources
   targethiv.org/library/topics/ehe-initiative-triannual-module

8. EHE Data Report
   ryanwhite.hrsa.gov/data/reports

9. RWHAP Fiscal Year 2020 Coronavirus Aid, Relief, and Economic Security (CARES) Act
   ryanwhite.hrsa.gov/grants/coronavirus/fy-2020-cares-act-funding-ryan-white-hivaids-program-recipients

   ryanwhite.hrsa.gov/grants/coronavirus/faq

10. Ryan White HIV/AIDS Program Services: Eligible Individuals and Allowable Uses of Funds. Policy Clarification Notice (PCN) 16-02
    ryanwhite.hrsa.gov/sites/default/files/ryanwhite/grants/service-category-pcn-16-02-final.pdf