Accelerating State and Local HIV Planning to End the HIV Epidemic in the U.S. (EHE)

A Thematic Analysis of EHE Jurisdictional Plans

State/Territory with EHE Counties

EHE State

Ending the HIV Epidemic

Executive Summary

Innovative and community-driven solutions are at the heart of the Ending the HIV Epidemic in the United States (EHE) initiative. In September 2019, the Centers for Disease Control and Prevention (CDC) awarded $12 million from the U.S. Department of Health and Human Services' Minority HIV/AIDS Fund (HHS) (MHAF) to 32 state and local health departments to develop comprehensive EHE plans tailored by and for each community. These health departments represent 48 counties, San Juan, Puerto Rico, Washington, D.C., and seven states with a substantial rural burden of HIV. These jurisdictions account for more than half of all new HIV diagnoses in the U.S.

Each EHE plan was developed in collaboration with partners, including people with and at risk for HIV, and is based on local epidemiology and social determinants of health data. Overall, EHE plans outline the strategies and activities the jurisdictions intend to implement to end the HIV epidemic in their communities. Additionally, plans name available funding sources including, federal agencies, state funds, charitable foundations, private sector partnerships, national associations, and local HIV service organizations.

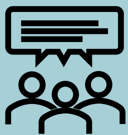
Community engagement is paramount to the success of these plans. Achieving the goals of the EHE initiative involves continual collaboration with critical stakeholders and broad-based partners to increase coordination and improvement of HIV programs throughout the jurisdictions.

Updated EHE jurisdictional plans were submitted to CDC by December 31, 2020, and a thematic analysis of the plans began in the spring of 2021. This report contains a key set of findings from the review and includes information on community engagement, barriers and facilitators to EHE success, and innovative activities proposed by jurisdictions to advance local HIV diagnoses, treatment, prevention, and response work.

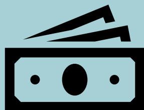
Overall, jurisdictions developed comprehensive, innovative, and community-driven plans. EHE plans included the following sections: community engagement, epidemiological profile, situational analysis, and EHE planning, strategies, and activities for the four EHE pillars. The plans address issues ranging from discrimination and systemic racism - which contribute to differences in health care quality and access - to advancing status neutral service delivery programs. Jurisdictions heard the voices of many of the people disproportionately affected by HIV and developed strategies to address their needs.

There is great potential in these plans to radically improve HIV prevention and care in the U.S. As EHE implementation efforts continue, each jurisdiction is expected to continue to refine and modify its plan to meet the HIV prevention needs of their communities and address current service challenges, including disruptions due to COVID-19. EHE plans and planning documents are available online for stakeholders and community partners to review.

Key Findings for State and Federal Partners



Strengthen the coordination of interagency resources to maximize the impact of federal funding and programmatic resources, including capacity building and technical assistance efforts.



Expand the availability of funding to grassroots and community-based organizations to address systemic challenges to HIV prevention and care, such as housing insecurity and access to mental health services.

Fortify evaluation efforts to hold jurisdictions accountable for implementing their EHE plans and expanding meaningful community engagement.

Introduction to HIV Planning

EHE jurisdictional plans should synergistically work together with other HIV planning processes to create a comprehensive set of national, state, and local HIV planning documents including, The National HIV/AIDS Strategy (2022-2025) and Integrated HIV Prevention and Care Plans.

The Notice of Funding Opportunity (NOFO) PS19-1906: Strategic Partnerships and Planning to Support Ending the HIV Epidemic in the United States – Component B: Accelerating State and Local HIV Planning to End the HIV Epidemic was published in June 2019. In September 2019, CDC awarded $12 million from the HHS MHAF to 32 state and local health departments representing 48 counties; San Juan, Puerto Rico; Washington, D.C., and seven states with a substantial rural burden of HIV. These jurisdictions account for more than half of all new HIV diagnoses in the U.S.

HHS MHAF provided the initial EHE jurisdictions with the resources needed to engage their local communities, HIV planning bodies, HIV prevention and care providers, and other critical partners in an accelerated and ongoing collaborative process to develop plans that address the four EHE pillars: Diagnose, Treat, Prevent, and Respond. Health departments conducted a rapid planning process and submitted draft EHE plans by December 31, 2019. An interagency review panel, including staff from CDC, the Health Resources and Services Administration, and the Department of Health and Human Services' Office of Infectious Disease Policy, provided feedback to the jurisdictions in the spring of 2020. Due to the COVID-19 pandemic, CDC extended the deadline for jurisdictions to submit revised and updated EHE plans to December 31, 2020.

EHE plans are "living documents," and each jurisdiction is expected to modify and update its plan to meet the HIV prevention needs of their communities and address current service challenges. Federal agencies will also continue to provide guidance, best practices, and technical assistance to EHE jurisdictions and share creative community-based solutions to help them address new and evolving challenges.

Understanding the HIV Planning Processes

National HIV/AIDS Strategy (2022-2025)

The National HIV/AIDS Strategy (2022-2025) provides stakeholders across the nation with a roadmap to accelerate efforts to end the HIV epidemic in the United States by 2030. The Strategy reflects President Biden's commitment to re-energize and strengthen a whole-of-society response to the epidemic while supporting people with HIV and reducing HIV associated morbidity and mortality.

Integrated HIV Prevention & Care Plans

Ryan White HIV/AIDS Program Part A and B recipients and CDC-funded state and local health departments work together to coordinate efforts to fulfill legislative and CDC/HRSA programmatic requirements in one umbrella plan. Where applicable, EHE plans should complement, align, and enhance the Integrated HIV Prevention Care and Care Plans. Plans are submitted by health departments in all 50 states, Washington, D.C., Puerto Rico, and the U.S. Virgin Islands.

Jurisdictional EHE Plans

EHE jurisdictional plans are state/county level roadmaps that outline the strategies and activities the 57 EHE jurisdictions will use to address the HIV epidemic in their community holistically. The plans should mention all funding sources that support efforts to end the HIV epidemic, including federal agencies (CDC, HRSA, HUD, IHS, NIH, and SAMHSA), public/private partnerships, and state/community resources.

Community Engagement

The community engagement process involves key stakeholders and community partners who work together to identify strategies that improve the effectiveness and cultural responsiveness of HIV prevention and care programs. This process also enhances coordination across state and local jurisdictions and American Indian/Alaska Native tribally designated organizations. Specifically, jurisdictions were expected to engage various local entities, including prevention and care integrated planning bodies, the community, and service providers. CDC published guidance to assist jurisdictions with their community engagement efforts. The guidance explicitly advised jurisdictions to bring new voices to the planning table, including persons with HIV (PWH) and communities disproportionately affected by HIV. Their participation in the planning process and input into the final plan ensure proposed programmatic activities are conducted in acceptable ways to the local population. This aspect of the planning process is critical for successfully increasing reach to people in communities experiencing health disparities and who have either not had access to or felt included as part of the intended audience for such prevention and care programs.

Types of Partners

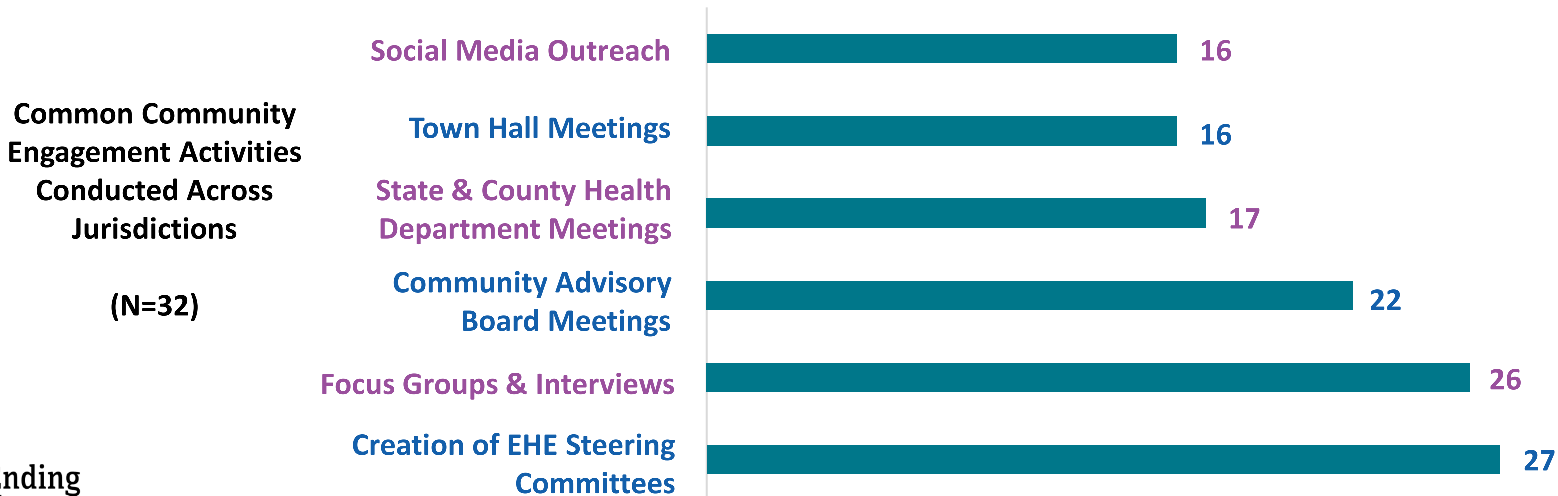
All jurisdictions engaged local community partners and HIV care providers. Twenty-five jurisdictions explicitly referenced engaging new partners or partners that have not been involved in the HIV planning before but are essential to ending the HIV epidemic in the local community. Some jurisdictions did not list any new partners in their plans as was recommended by CDC. Nevertheless, it is promising to see the breadth of new partners engaged in their community's HIV planning process for the first time. It is important to note that some categories of partners may not be new to all jurisdictions.

Examples of Non-Traditional & New Partners Identified by One or More Jurisdictions

Organizations	Populations	Providers	Institutions
Faith-Based Organizations & Churches	People Experiencing Homelessness	Pharmacists	Historically Black Colleges & Universities
Professional Medical Associations	People with HIV	Social Workers	Correctional Facilities
Health Insurance Organizations	Transgender Community Members	Substance Abuse Providers	Hospital Systems
Youth-Based Advocacy Organizations	Sex Workers	Educators from School Sex Ed. Programs	Domestic Violence Centers
Black Professional & Social Organizations	People that were Formerly Incarcerated	Women's Healthcare Providers	Public Housing Authorities

Reach of Community Engagement Activities

To reach a diverse set of community members who have not traditionally been engaged, the EHE planning guidance recommended jurisdictions consider new approaches and methods for conducting community engagement. Consequently, there was a wide variety of strategies and activities that were used by jurisdictions to meet the needs of their community. Conducting focus groups/interviews and creating EHE steering committees were among the two most popular strategies used by jurisdictions to conduct community engagement.



Community Engagement

Specific jurisdictions that conducted particularly innovative or notable community engagement activities include:

Alabama - To ensure the End HIV Alabama planning body was representative of the community, leadership distributed a survey to capture a demographic snapshot of the team. The results of this survey allowed planners to focus on populations that were not represented in the planning process for recruitment efforts. The survey results revealed that future recruitment efforts need to be focused on individuals with lower income, people with transgender experience, legislators, youth, people of Hispanic ethnicity, and community members who do not represent an agency or organization.

Florida - Pinellas County engaged local youth by hosting "Teen Talk Thurzdaze," which were monthly webinars that provided a space for youth to express and educate themselves freely about the HIV epidemic, sex, and peer pressure. The discussions were led by representatives revered by youth (e.g., Green Bay Packers Wide Receiver Marquez Valdes-Scantling) and approximately 50 youth/students were in attendance per meeting.

Indiana - Marion County conducted the most extensive survey in the known history of HIV work in the jurisdiction. Over 880 individuals from EHE priority populations completed the survey. Survey respondents were recruited through social media channels and in-person through service providers and faith communities. The survey was notable for engaging significant numbers of people who self-identified as Black (40%), Hispanic or Latino (18%), gay or lesbian (28%), transgender (7%), adolescent (5%), and living in majority-minority zip codes (14%).

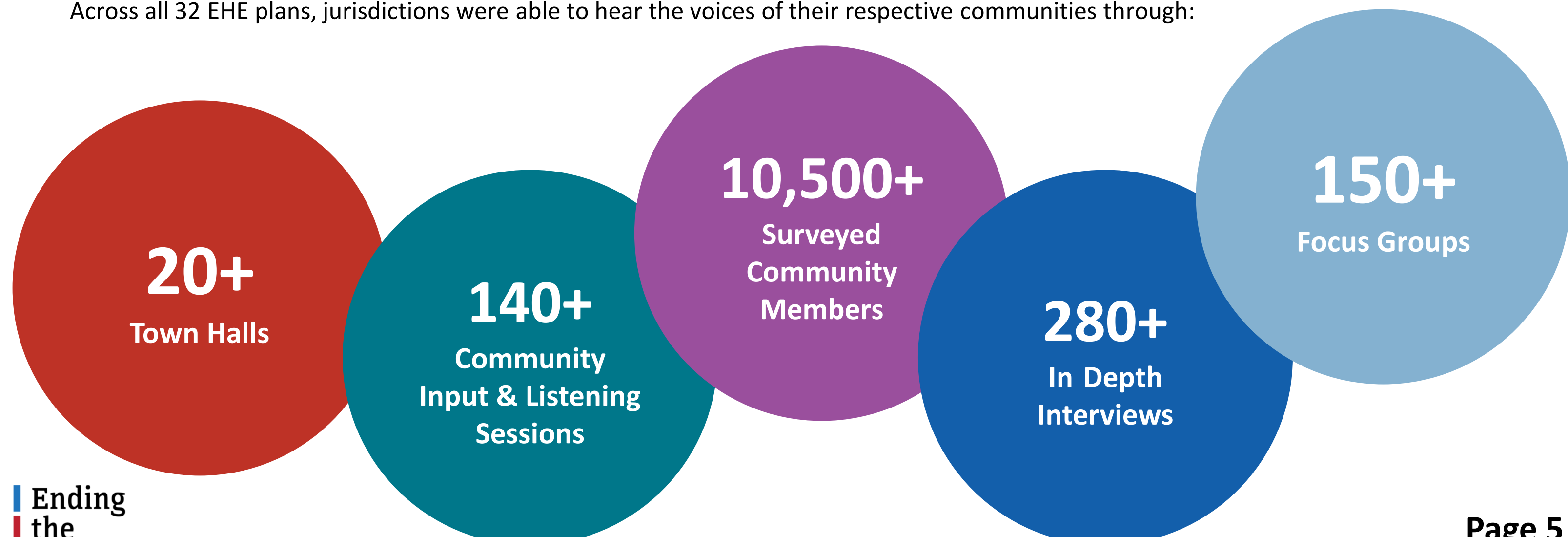
Los Angeles - The Los Angeles County Department of Public Health released their draft EHE plan to community stakeholders as part of a 30-day public comment period. The public comment period was promoted at an EHE town hall and resulted in 17 pages of online comments from the public and two pages of comments from participants at a virtual EHE Spanish-language town hall. Los Angeles County also noted that HHS' Prevention through Active Community Engagement (PACE Officers) was a vital resource to help advance local EHE community engagement efforts.

Maryland - Prince George's County invested in extensive media outreach to advertise its community engagement activities. In total, 478 commercials aired using their tagline #CancelHIV. These commercials aired during NFL football games and multiple newscasts. Additionally, the advertisements were widely disseminated online and seen in the region over 20 million times.

Community Engagement Advertisement from Prince George's County, Maryland

Mississippi - To enhance community engagement and develop their EHE plan, the Mississippi Department of Health employed multiple subcontractors, including the Black AIDS Institute, to lead engagement efforts. In addition, the National Coalition of STD Directors was awarded a contract to ensure that STIs and disease intervention specialists were represented in the EHE plan. Lastly, AIDS United was contracted to ensure that all messages and feedback heard via the various community engagement activities were captured in the EHE plan.

Across all 32 EHE plans, jurisdictions were able to hear the voices of their respective communities through:

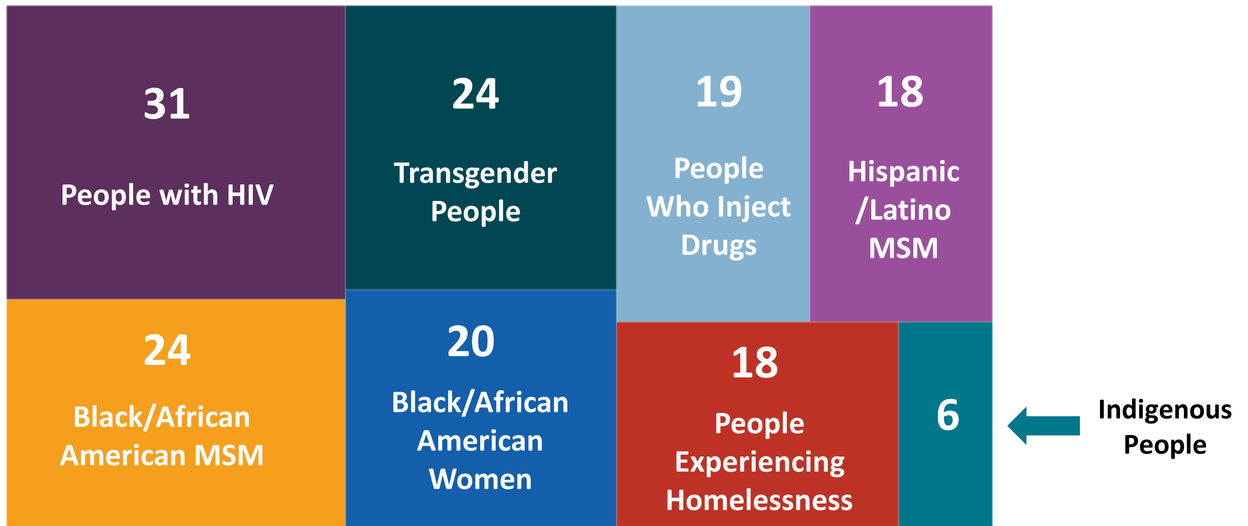


Community Engagement

Engagement of Disproportionately Affected Populations

CDC expected all planning groups to directly engage and include populations most disproportionately affected by HIV in their respective communities. Out of the 32 EHE plans, 31 engaged one or more of the following priority populations: PWH, transgender persons, Hispanic/Latino men who have sex with men (MSM), Black/African American MSM, Black/African American women, Indigenous Persons, Persons who Inject Drugs (PWID), and persons experiencing homelessness. Additional populations that jurisdictions engaged, albeit to a lesser extent, include young persons, non-U.S. born persons, and persons returning from an incarceration setting. It is promising to see the variety of voices heard and echoed throughout the plans.

Number of Jurisdictions Reporting Engaging Disproportionately Affected Populations

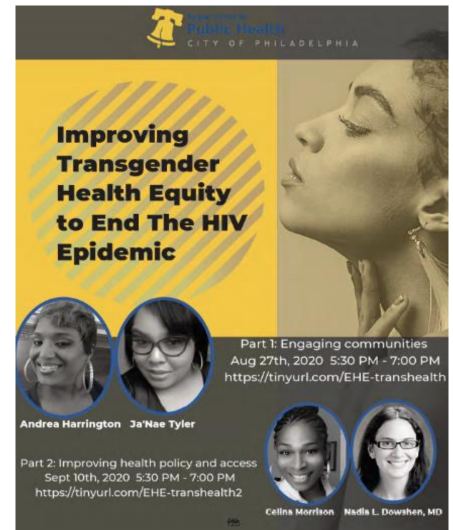


Specific jurisdictions that conducted particularly innovative or notable community engagement activities with disproportionally affected populations include:

Louisiana - Both Orleans Parish and East Baton Rouge Parish conducted focus groups that included PWID. In East Baton Rouge Parish, two focus groups with a total of 18 PWID participants were conducted to gather input to the strategies for the Diagnose, Treat, Prevent, and Respond pillars.

Philadelphia - The Philadelphia Department of Public Health hosted an EHE Transgender Health Equity virtual event. Guest speakers from multiple communities were invited. Panelists included the director of the Mayor's Office of LGBT Affairs, the founding director of the adolescent gender clinic at Children's Hospital of Philadelphia, a community advocate, and a public health worker.

San Francisco - The San Francisco Community Health Center solicited input from people experiencing homelessness and housing instability. As a result, in June and September 2020, 178 people experiencing homelessness were surveyed by staff members that were trained in culturally competent and trauma-informed interviewing methods. This process provided significant insight into the stigma that people experiencing homelessness face when accessing healthcare services.



Community Engagement Advertisement from Philadelphia, Pennsylvania

South Carolina - To understand the unique challenges faced by Hispanic/Latino communities, a series of three Spanish-language forums were hosted by the Department of Health and Environmental Control for the Spanish-speaking population of South Carolina. Participants for these forums were recruited by bilingual health department staff and HIV planning leadership.

Community Engagement Challenges & Opportunities

Community Engagement in Rural States

Seven states (Alabama, Arkansas, Kentucky, Mississippi, Missouri, Oklahoma, and South Carolina) were selected as initial EHE jurisdictions due to their substantial rural burden of HIV. Many of these states conducted community engagement with their respective rural populations.

Kentucky - Six regional planning groups were engaged to ensure adequate representation from all parts of the state. Representatives from each regional group were invited to be part of the statewide planning group. There were 12 members from across the six regions of Kentucky, with 50% representing community members, including persons with HIV, and 50% representing community stakeholders.

Mississippi - Focus groups and in-depth interviews were conducted in rural parts of the state. The focus group participants drew attention to the lack of HIV education and awareness in the Mississippi Delta. Additionally, participants identified racism as a factor for the high rates of HIV in the Delta. Many participants discussed racism in terms of their relationships with white service providers. Notably, they expressed experiencing microaggressions from their health service providers, which made the participants question the quality of care they were receiving.

COVID 19 Impact

The COVID-19 pandemic disrupted the planning process of all 32 jurisdictions. Many jurisdictions had to reassign staff to the COVID-19 response, which limited the number of community engagement activities they could conduct. Additionally, all jurisdictions transitioned many community engagement activities to virtual platforms. Despite the challenges COVID-19 caused jurisdictions, many communities were able to leverage virtual engagement to continue activities.

Arkansas - The Arkansas Department of Health and its partner community-based organizations (CBOs) facilitated eight community input sessions – including three in-person and five online – as part of its EHE planning process. The onset of COVID-19 in March of 2020 necessitated pivoting to an online format to ensure safety.

Community Engagement Advertisement from Arkansas in Response to the COVID-19 Pandemic

ARKANSAS

RESPONDS TO COVID-19

YOUR OPINION STILL MATTERS!

To continue HIV Prevention efforts during the COVID-19 pandemic, the Arkansas Department of Health HIV Prevention Program and partnering agencies will host virtual engagement sessions.

By joining us for open and interactive sessions about HIV, you will work with us to end the HIV epidemic in Arkansas. Each live stream will host a space for you to voice your opinions on how you can help create a plan to end the HIV epidemic in Arkansas.

Arkansas's Urban Response to HIV

- HIV & Hip Hop
- HIV & The LGBTQ Community
- Stigma
- PrEP

Tomeka "The Boss" Franklin

@meke_selfmade_boss

Social Media Influencer, Booking agent, Entertainer, Advocate, Writer and Producer. #BOSSTALK

INTERACT

INFORM

WIN!

know now

Get Tested. Get Treated For HIV & STDS.

Kentucky – The Kentucky Department of Public Health held virtual meetings, which proved even more effective than the previously planned in-person meetings. Participants expressed a broader sense of safety to share their opinions openly and especially appreciated the option to speak with or without the use of video. Virtual meetings also eliminated the need to find transportation for participants who otherwise would not have traveled. In addition, community members who did not have computer or internet access were given a phone to participate in the virtual meetings.

Los Angeles County - The EHE planning commission switched all meetings to a virtual platform to allow community partners to continue to participate in critical deliberations. Interestingly, this resulted in a notable increase in community participation in these meetings, including an estimated 25% increase in new participants in the monthly meetings and a 50% increase in new participants at the commission's virtual lunch and learn series, which reviews and promotes HIV services available across the county.

Community Barriers & Facilitators

Jurisdictions were asked to conduct a situational analysis and provide a snapshot summary of the strengths, challenges, and identified needs of key aspects of HIV prevention and care activities. This snapshot was expected to synthesize local epidemiologic data and information gathered from engagement with local planning bodies, partners, and the community. Additionally, this analysis was expected to be informed by and include consultation of other federal, state, and locally funded implementation partners. The social determinants of health emerged as critical barriers to be addressed; environmental, social, and structural issues can limit the access to and impact of HIV prevention and care. Many of the barriers are interconnected, including racism, economic insecurity, access to education, healthcare, adequate housing, and stigma.

Racism

Twenty-three jurisdictions identified or discussed racism as a threat to public health both in general and specifically related to HIV. Systemic racism impacts other barriers identified by jurisdictions, such as economic insecurity and access to education and healthcare. Given the racial/ethnic disparities in HIV, it is critical for jurisdictions to acknowledge the role systemic racism plays in limiting access to HIV prevention and treatment services in priority populations. The Washington, D.C. Department of Health intends to develop a framework for promoting social justice and plans to have conversations about how racism affects the work of EHE. They defined internal principles for addressing racism and agreed-upon metrics to measure progress as they work to become an anti-racist organization.

Economic Insecurity and Poverty

Twenty-four jurisdictions identified economic insecurity as a barrier that EHE efforts must address. Housing and food insecurity fall within the overarching theme of economic insecurity: thirteen jurisdictions listed food insecurity, and 27 listed housing instability as barriers to HIV prevention and care. Many jurisdictions noted a lack of safe and affordable housing options. For example, in California, economic pressures related to housing lead to a migration of persons within the state to more remote and isolated areas that have decreased access to HIV care and essential support services. Likewise, Houston's plan listed housing as its most needed yet unfunded service. Additionally, individuals facing economic insecurity are more likely to work jobs without health insurance and time off to attend medical appointments. Both factors can significantly impact access to HIV prevention and treatment services. Another concern for populations facing economic insecurity is childcare. Individuals may not have access to affordable childcare and may need to bring their children to appointments, interfering with discussions involving sensitive subjects related to sexual health.

"Not having enough food is trauma inducing. Not having a secure and safe place to live is trauma inducing. Working in conditions that may lead you to contract a disease that could not only disable and kill you but also your loved ones is trauma inducing. Not being able to access essential services because of a hostile police force and federal government, inducing ICE is trauma inducing."

-Community Member from San Francisco

Education Access

Access to education was noted by 26 jurisdictions as a barrier to EHE implementation. Both general and health literacy were listed as barriers to HIV prevention and care within some jurisdictional plans. Many jurisdictions, including Arkansas, Georgia, Missouri, South Carolina, and Texas, listed a lack of comprehensive sex education in schools as a barrier that can also contribute to insufficient community knowledge related to HIV prevention and treatment.

Healthcare Access

The most prevalent barrier listed by jurisdictional plans was access to healthcare, with 29 jurisdictions citing it as a barrier to HIV prevention and care. Twenty jurisdictions cited insurance status as a barrier. In jurisdictions without Medicaid expansion or with a large population of undocumented immigrants, insurance status is a particularly significant barrier to medical care. Additionally, many jurisdictions reported a shortage of HIV clinical providers or "provider deserts" as a substantial barrier to HIV care. In areas with limited HIV clinical providers, patients may have to travel long distances to receive care, a significant burden for people who do not have access to transportation. Furthermore, many individuals cannot attend appointments during traditional hours due to work schedules or cannot take paid time off to attend healthcare appointments. Another common theme related to access to healthcare was that many jurisdictions reported having complex health systems that are hard for patients to navigate. Many also find it difficult to coordinate health insurance benefits.

Healthcare Access (Continued)

An additional healthcare barrier relates to providers themselves. Some jurisdictions reported primary care providers had limited training on HIV treatment and prevention. Potentially due to this lack of training, several jurisdictions found a lack of provider willingness to prescribe PrEP. Another issue surrounding providers is the provision of culturally appropriate, gender affirming, and trauma-informed care; many jurisdictions reported a lack of culturally appropriate and/or culturally competent providers and few providers that reflect the populations disproportionately affected by HIV. A related concern for some jurisdictions was a lack of bilingual or multilingual healthcare providers and/or translation or interpretation services. Finally, jurisdictions also mentioned some providers' resistance to discussing sexual health, sexual orientation, gender identity, and STIs as a barrier to healthcare access.

A final concern for many jurisdictions was misinformation and medical mistrust in their communities. Medical mistrust often stems from a history of systemic racism and communities of color being taken advantage of by the medical community. Other medical mistrust stems from misinformation, low rates of health literacy, or community members not knowing where to turn for accurate and reliable information.

> **"Money is not what we need, we need infrastructure. More clinics in rural communities, a focus on literacy overall, and jobs so people can provide for themselves. A number of people would fall through the cracks if we didn't have the Ryan White program because we are a state that hasn't expanded Medicaid. "**
>
> ***-Community Member from Mississippi***

Stigma & Discrimination of LGBTQ Persons

LGBTQ stigma and discrimination were other barriers frequently cited by jurisdictions. Twenty-one jurisdictions mentioned homophobia, and 19 jurisdictions mentioned transphobia as barriers to HIV prevention and care. Stigma and discrimination of LGBTQ populations can significantly impact their willingness to trust healthcare providers. Many jurisdictions reported having providers unable to effectively discuss sexual orientation, sexual history, and gender identity with their patients, which is a critical gap in competently providing care to patients. An additional concern included stigma and discrimination within the LGBTQ community itself. For example, in a community engagement session in Michigan, numerous Black MSM who took PrEP admitted that they were reluctant to share using the medication due to a perception within the LGBTQ community of sexual promiscuity among those who are on PrEP.

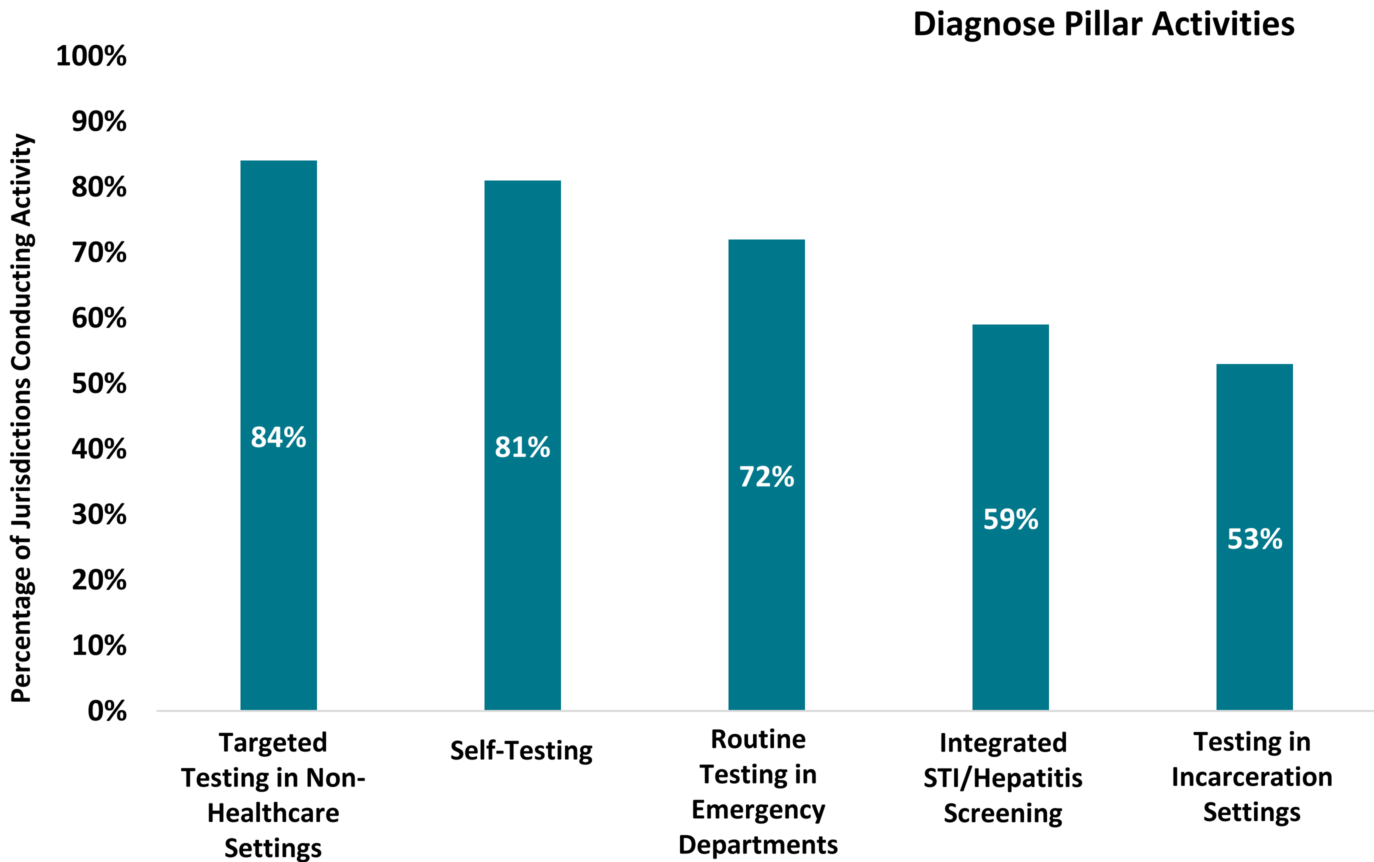
Community Facilitators

Jurisdictions listed a vast number of assets and facilitators in implementing their EHE plans. Many jurisdictions cited their community-based organizations, including HIV service and religious organizations, as critical facilitators. Louisiana, Maryland, Massachusetts, and Michigan all cited Medicaid expansion as an essential asset in their jurisdictions. Other jurisdictions noted having an expansive HIV health infrastructure already in place. For example, California cited legislative and policy changes that have expanded PrEP access to include pharmacies and telemedicine providers, as well as increased funding for Syringe Services Programs. Additionally, the Los Angeles County Health Department plans to add HIV and STIs to a new surveillance data system in July 2021. This system will offer large-scale improvements to overall data management, facilitate data linkages across diseases, and improve timely access to surveillance data for staff working with clients. San Francisco listed same-day HIV treatment initiation and their one-stop integrated HIV care clinic networks as additional assets in their jurisdiction.

Review by EHE Pillars: Diagnose

The thematic review process sought to determine if jurisdictions included common priority and evidence-based strategies. As a result, all jurisdictions had some of the priority strategies in addition to other activities. Additionally, many jurisdictions explicitly discussed how they adjusted strategies and activities due to the COVID-19 pandemic. Therefore, it is likely the jurisdictions that did not expressly state the impact of COVID-19 were still affected by the pandemic and adjusted their strategies and activities accordingly.

The EHE jurisdictional plans included the following priority and evidence-based strategies for the Diagnose pillar. Fifteen jurisdictions adjusted their strategies because of COVID-19, and 26 jurisdictions identified specific barriers that need to be addressed to implement related strategies in their communities effectively.



Additionally, many jurisdictions tailored their strategies under the diagnose pillar to the populations disproportionately affected by HIV, including transgender women (14), Black/African American MSM (13), Black/African American Women (9), Hispanic/Latino MSM (13), and PWID (13).

Jurisdiction Highlights

Alabama - The EHE plan proposes to conduct integrated STI, HIV, HCV, HBV screening through the Bureau of Clinical Diseases at designated AIDS Service Organizations and other healthcare facilities providing PrEP services. They also plan to expand expedited and rapid HIV and syphilis testing to non-county health department facilities.

San Francisco - The EHE plan includes creating a mobile unit and scouting team that will provide outreach, testing, and referrals within homeless encampments. The plan also addresses a status-neutral and syndemic approach to HIV prevention and treatment by implementing a new framework for testing services that link HIV testing, PrEP, STI screening, and HCV testing. They intend to encourage testing facilities to provide clients with rapid and ideally point-of-care testing for HIV, HCV, and STIs, including self-collected swabs for gonorrhea and chlamydia. Their plan also includes providing testing for HIV, HCV, and STIs at group-sponsored events for families of formerly incarcerated individuals, providing incentives for testing, and funding HIV and HCV screenings at key pharmacies in the jurisdiction. Additionally, the plan intends to implement an HIV/STI program that will mail test kits to members of priority populations.

Review by EHE Pillars: Diagnose

Jurisdiction Highlights (Continued)

Puerto Rico - The Puerto Rico Department of Health will request all providers to modify their existing electronic medical records to standardize HIV screening for all patients at least once, regardless of their risk, and annually for those that report high-risk behaviors. To implement a rapid linkage to care, the Puerto Rico Department of Health will collaborate with the San Juan Health Department to develop protocols for rapid linkage to HIV medical care for all new cases within seven days of diagnosis for their participants.

Houston - Houston plans to increase the accessibility of home HIV testing kits by promoting rapid HIV self-test distribution programs. Furthermore, Houston plans to implement a free home HIV test kit pilot project in 2021 and organize community events to distribute HIV self-test kits to populations with higher risk but limited access to testing.

Ohio - Hamilton County plans to increase HIV testing by expanding at-home testing, increasing testing at syringe service programs, exploring innovative models of testing to reach PWID populations, exploring technology solutions to assist people when they are trying to find testing, and ensuring HIV testing is included in routine STD testing.

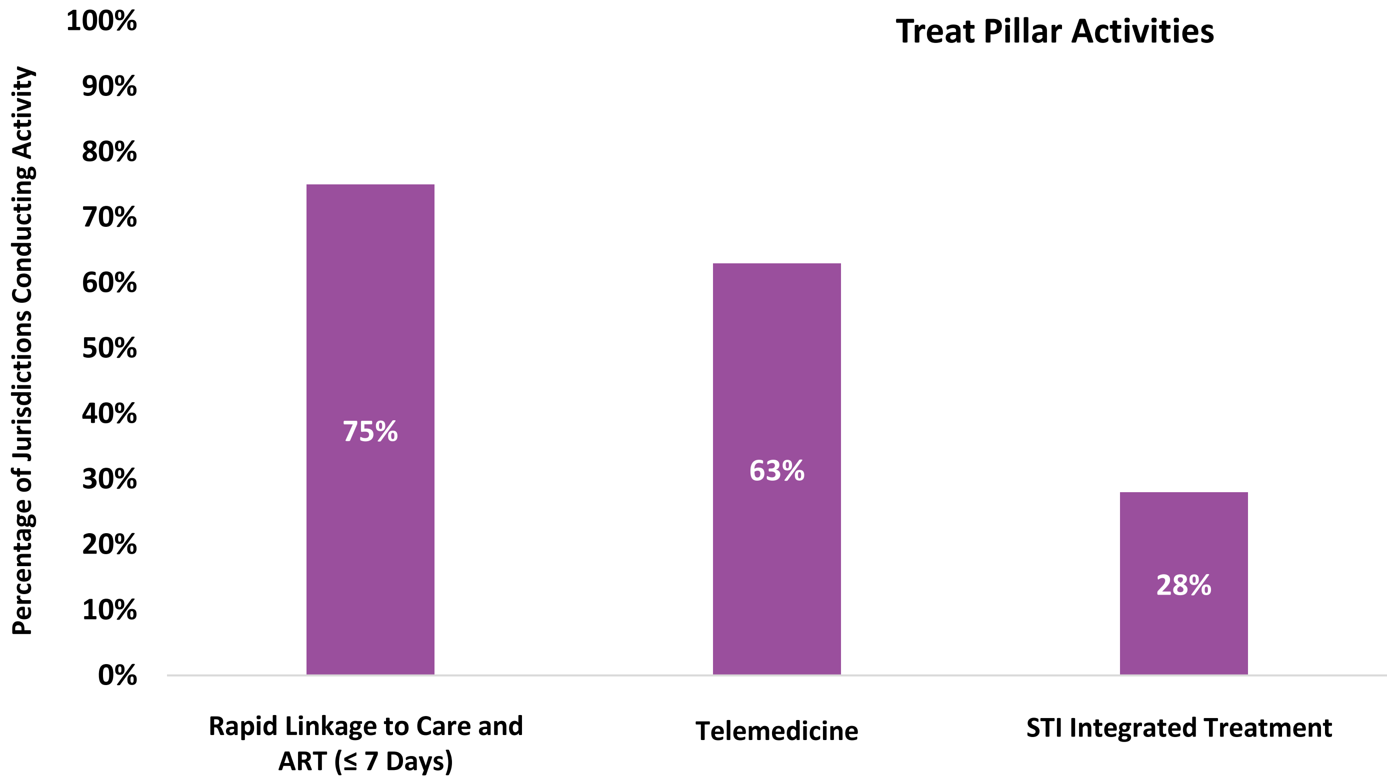
Washington - Washington plans to increase routine HIV testing in clinical settings; the jurisdiction will work with health care organizations and community health centers throughout King County to identify and implement strategies to expand routine HIV testing and re-screening for people at increased risk of HIV. This work will focus on clinical settings such as emergency departments, hospitals, Federally Qualified Health Centers, and other primary care settings, emphasizing organizations serving people outside of the central Seattle core. For example, since many people at high risk for HIV in King County, including persons experiencing homelessness and/or engaged in drug use and sex work, receive health care through emergency departments, they plan to facilitate a learning collaborative across emergency departments. This learning collaborative will support the identification and implementation of innovative strategies and sustainable structural changes that increase routine HIV testing within their respective settings. In addition, consistent with a syndemic approach, they plan to encourage clinical settings to offer testing for viral hepatitis, STI's, and other comorbidities.

"HIV testing needs to be more visual in all neighborhoods. People need to start talking about HIV more, this needs to be a conversation in the Duval County Public Schools. The more people are comfortable talking about HIV and accepting that youth and elders are also contracting HIV the greater the chances to decrease the number of new cases."

-Healthcare Provider from Florida

Review by EHE Pillars: Treat

The EHE jurisdictional plans included the following priority and evidence-based strategies for the Treat pillar. In addition, nine jurisdictions adjusted their strategies because of COVID-19, and 29 jurisdictions identified specific barriers that need to be addressed to implement treatment-related strategies in their communities effectively.



Additionally, many jurisdictions tailored their treatment strategies to the populations disproportionately affected by HIV, including transgender women (15), Black/African American MSM (10), Black/African American Women (11), Hispanic/Latino MSM (10), and PWID (15).

Jurisdiction Highlights

Alabama - The Alabama EHE plan describes a process to identify people with HIV not in care for at least 12 months by scaling up their data to care program using the Enhanced HIV/AIDS Reporting System. The state also plans to develop a data-sharing agreement with the Alabama Medicaid Agency to increase their ability to identify PWH who are not in care biannually and assess the opportunity to identify persons with HIV and HCV coinfection. The plan includes activities to train county health department staff on telehealth programming to support and promote long-distance clinical health care.

Tennessee - To increase linkage to care for persons who have experienced incarceration, the Tennessee EHE plan proposes to develop a flow process with the criminal justice system to improve the linkage-to-care process upon release. They will consult with the Ryan White HIV/AIDS Care Program to find agencies that provide linkage-to-care services, including people returning from incarceration. In addition, they will provide education for medical staff and administrative staff of criminal justice facilities on HIV-related services and partner with re-entry programs to offer information and resources.

South Carolina - South Carolina plans to close the gap in services for incarcerated inmates returning to the community; the department of health will partner with the department of corrections and organizations around the state to ensure current discharge planning programs are expanded and aligned with the statewide EHE Rapid Continuum of Care Program.

Review by EHE Pillars: Treat

Jurisdiction Highlights (Continued)

Oklahoma - Oklahoma plans to increase access to HIV care; key activities in Oklahoma's plan include increasing: 1) the use of rapid start treatment, 2) the number of providers who can treat HIV, and 3) the number of case managers to handle the resulting increase in clients. The plan will also enable pharmacists to initiate ARV treatment to get patients on medications faster and use mobile vans in rural areas for testing, treatment, checkups, and PrEP.

San Francisco – San Francisco plans to address the syndemic of HIV, HCV, and STIs; the San Francisco EHE plan will deliver same-day diagnosis and treatment. One aspect of the plan will ensure sufficient system capacity to provide same-day HIV treatment in primary care clinics throughout the San Francisco Health Network. In addition, they will support an initiative for rapid HCV treatment at the same places that serve PWID, such as (but not limited to) syringe access services, mobile testing sites, and health fairs. Finally, they will expand STI-specific partnerships related to programs for presumptive STI treatment and "partner packs."

Florida - In Florida, EHE counties will work to expand the rapid access to treatment model (known as Test and Treat) by using patient access points of Test and Treat sites. They intend to support mobile units to provide access to care for individuals experiencing transportation issues. They will use telehealth to establish initial visits, engage PWH, and monitor medication adherence. Finally, they plan to educate hospital staff and primary care providers to begin treatment at initial HIV diagnosis.

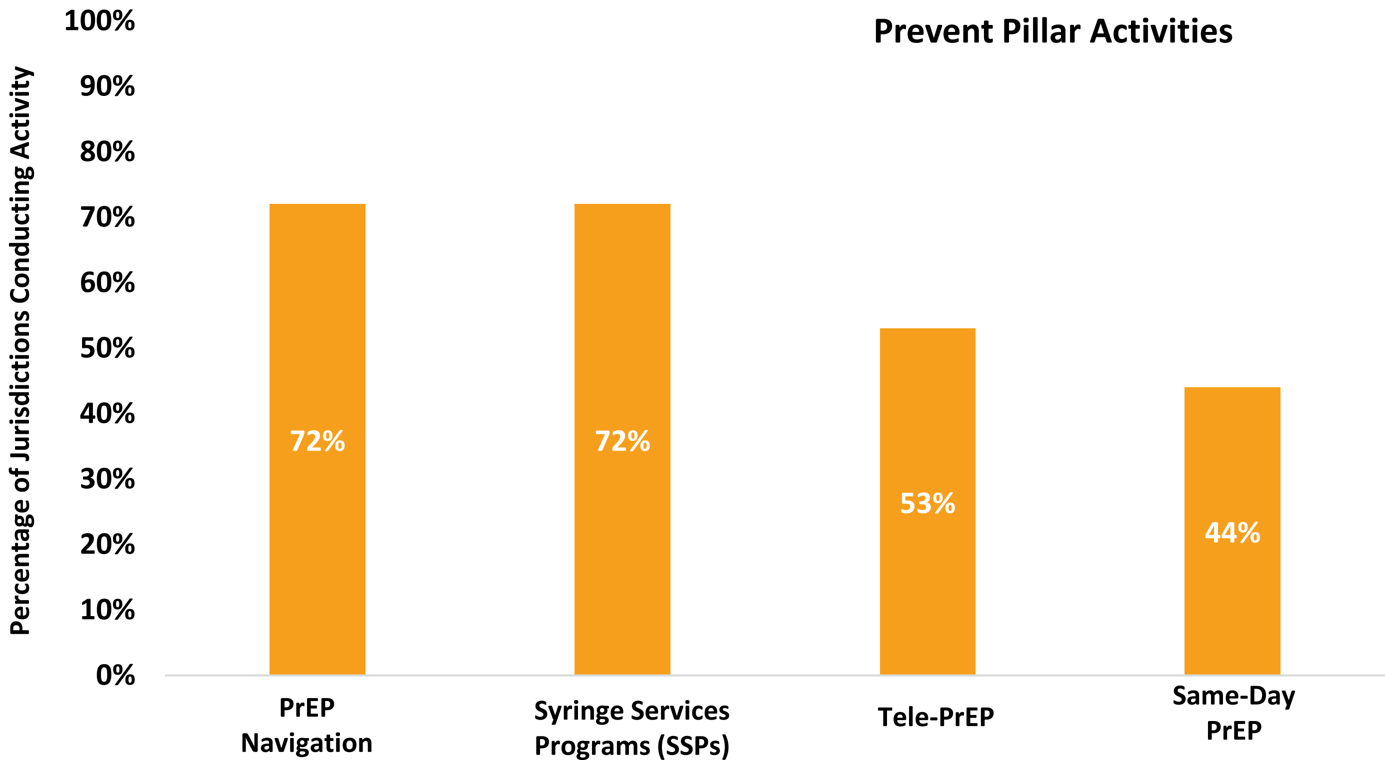
Texas - The Texas EHE plan intends to involve PWH and leaders from communities of color to determine the best methods to address health disparities and inequities. This approach can result in increased pathways to care, including telehealth/ telemedicine, primary care, and mobile care. In addition, they propose to support vulnerable populations to achieve and maintain viral load suppression using incentives. Finally, Texas plans to partner with local pharmacies to provide seamless HIV medication access, adherence counseling, linkage to additional resources, and identifying patients at risk of falling out of care by year three.

"HIV is an epidemic, but you can be on treatment and live a normal life. People are living much longer. I think having peers give that information would help."

-Community Member from Nevada

Review by EHE Pillars: Prevent

The EHE jurisdictional plans included the following priority and evidence-based strategies for the Prevent pillar. In addition, nine jurisdictions adjusted their strategies because of COVID-19, and 28 jurisdictions identified specific barriers that need to be addressed to implement treatment-related strategies in their communities effectively.



Additionally, many jurisdictions tailored their prevention strategies to the populations disproportionately affected by HIV, including transgender women (13), Black/African American MSM (13), Black/African American Women (9), Hispanic/Latino MSM (11), and PWID (18).

Jurisdiction Highlights

Alabama - While SSPs are currently prohibited in Alabama, the jurisdiction plans to create a subcommittee within their planning group to work with CBOs to educate the community about SSPs. This subcommittee will also work with state legislators to discuss policy changes that would support the legalization of SSPs.

Georgia - Georgia EHE counties will work to increase the number of CBOs that provide PrEP services or increase the number of referral agreements with other organizations with established PrEP services. They also plan to increase the number of pharmacies that dispense PrEP medications, especially in communities where priority populations live. Additionally, the jurisdiction intends to increase the number of clinical providers who prescribe PrEP, focusing on primary care providers. Finally, the Georgia plan includes identifying funding sources that would cover PrEP-associated laboratory costs to offer the medication to individuals without any associated charges to ensure people who benefit from PrEP have access to the medication. While working to increase access to PrEP, Georgia will also improve access to HIV prevention education and messaging throughout the community.

Review by EHE Pillars: Prevent

Jurisdiction Highlights (Continued)

Kentucky - Kentucky has 74 Syringe Services Programs operating in 62 counties, with one county approved but not yet operational. Their EHE plan includes presenting to other local governing bodies to support the creation of new SSPs and the use of best practices at existing and new SSPs. Kentucky will promote HIV testing, linkage to care, PrEP, and harm reduction strategies where SSPs are operating. Additionally, Kentucky will work to increase the use of and access to SSP services among PWID by promoting flexible hours for SSPs, utilizing mobile vans or offsite buildings for SSPs, and exploring transportation options for individuals to access SSPs.

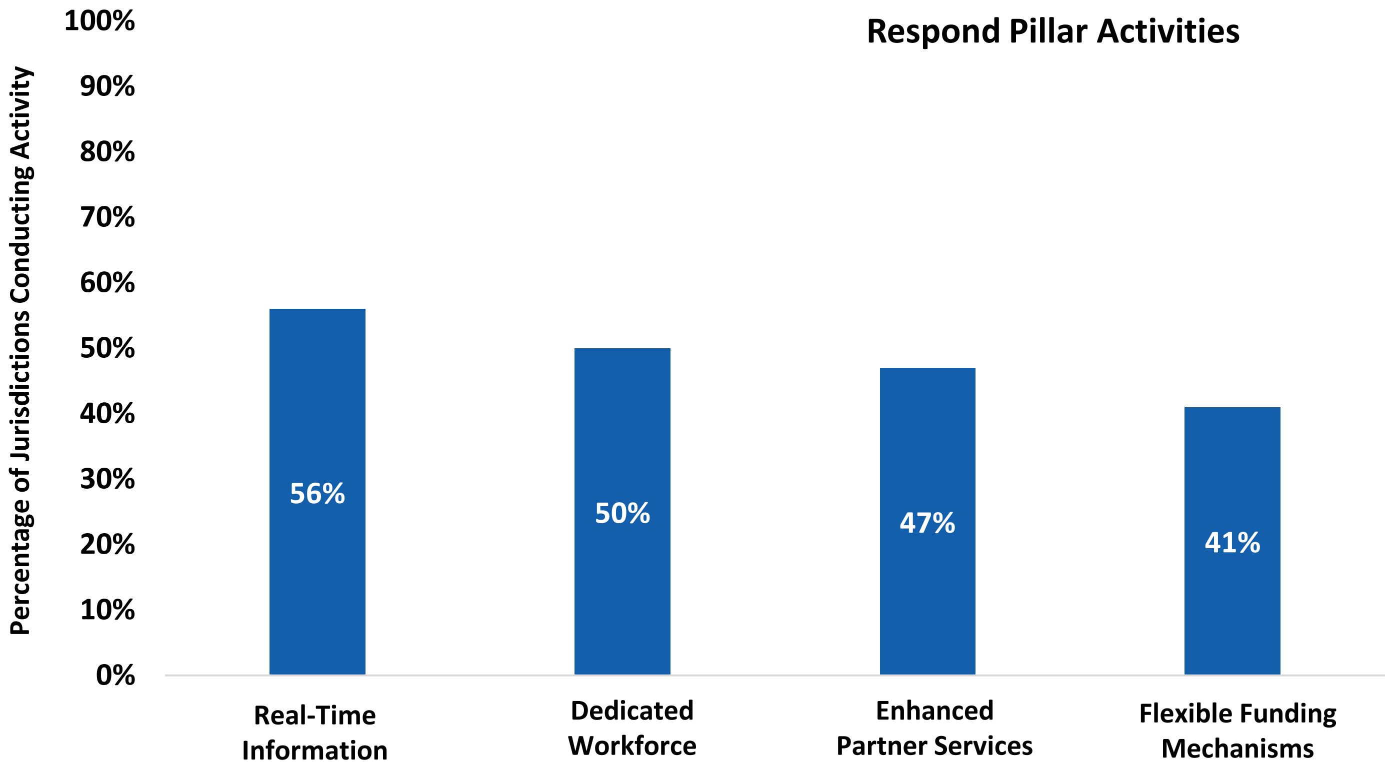
Nevada - Nevada plans to implement a Condom Distribution Plan (CDP) to ensure condoms are available and accessible to all communities in the state. The CDP will provide free condoms through wide-scale distribution and promote and distribute activities at individual, organizational, and environmental levels. The plan also includes the implementation of a social marketing campaign that will promote condom use and the integration of additional risk-reduction interventions and services in the community. The CDP will focus on priority populations, including Black/African American and Hispanic/Latino MSM. In addition, Nevada plans to implement a component of a status-neutral approach that increases HIV screening and provides referrals and linkages to PrEP. Nevada also plans to increase access to sterile syringes through comprehensive SSPs and non-traditional methods like mobile outreach, vending machines, and secondary exchange.

Washington - Washington state plans to expand access to PrEP by increasing the number of providers who prescribe PrEP, using a component of a status-neutral approach by linking individuals who test negative for HIV to PrEP, and using pharmacy models for PrEP delivery. The jurisdiction is also working towards increasing access to PrEP through training and technical assistance with CBOs, community health centers, and medical providers. If additional funds become available, the jurisdiction would like to expand PrEP access through telehealth and mobile models.

> **"We're eager to offer PrEP to our clients but don't know where to begin and who to bring to the table."**
> ***-Healthcare Provider from South Carolina***

Review by EHE Pillars: Respond

The EHE jurisdictional plans included the following priority and evidence-based strategies for the Respond pillar. In addition, nine jurisdictions adjusted their strategies because of COVID-19, and 23 jurisdictions identified specific barriers that need to be addressed to implement treatment-related strategies in their communities effectively.



Additionally, many jurisdictions tailored their response strategies to the populations disproportionately affected by HIV, including transgender women (7), Black/African American MSM (6), Black/African American Women (5), Hispanic/Latino MSM (6), and PWID (7).

Jurisdiction Highlights

Arizona - Arizona plans to develop a humanized approach to public-facing materials and processes relating to cluster detection and response. Specifically, Arizona wants to ensure that misunderstandings around cluster detection and molecular data use do not create barriers that prevent people from getting tested for HIV. The jurisdiction plans to examine the implications of privacy, criminalization, and the perception of "being tracked" that stem from community understandings of cluster detection and molecular surveillance. Additionally, public health officials will work with the community to determine how the health department should transparently communicate information about clusters while protecting individual anonymity.

Maryland - Maryland's Prince George's County plans to provide comprehensive training to develop a local response team consisting of community outreach workers, DIS staff, and providers called the Response Team of Prince George's County Health Department. This team will work to identify HIV clusters and rapidly navigate PWH to care and support services. In addition, the Response Team will partner with mental health providers, law enforcement, politicians, and community leaders to promote the work they are doing and decrease anxiety and fear in the community concerning the possibility of disclosure. Furthermore, a social media team will work with the Response Team to educate individuals about prevention and care in cluster areas. The team also plans to partner with social media influencers and peers to engage and educate those in the community.

Review by EHE Pillars: Respond

Jurisdiction Highlights (Continued)

Florida - Hillsborough County plans to develop a countywide strategy to identify and respond to HIV transmission networks. This strategy will use surveillance data to identify and improve response to HIV transmission networks. Specifically, the jurisdiction plans to enter into memorandums of agreement with homeless, migrant, and immigrant-serving agencies to be better respond to transmission networks.

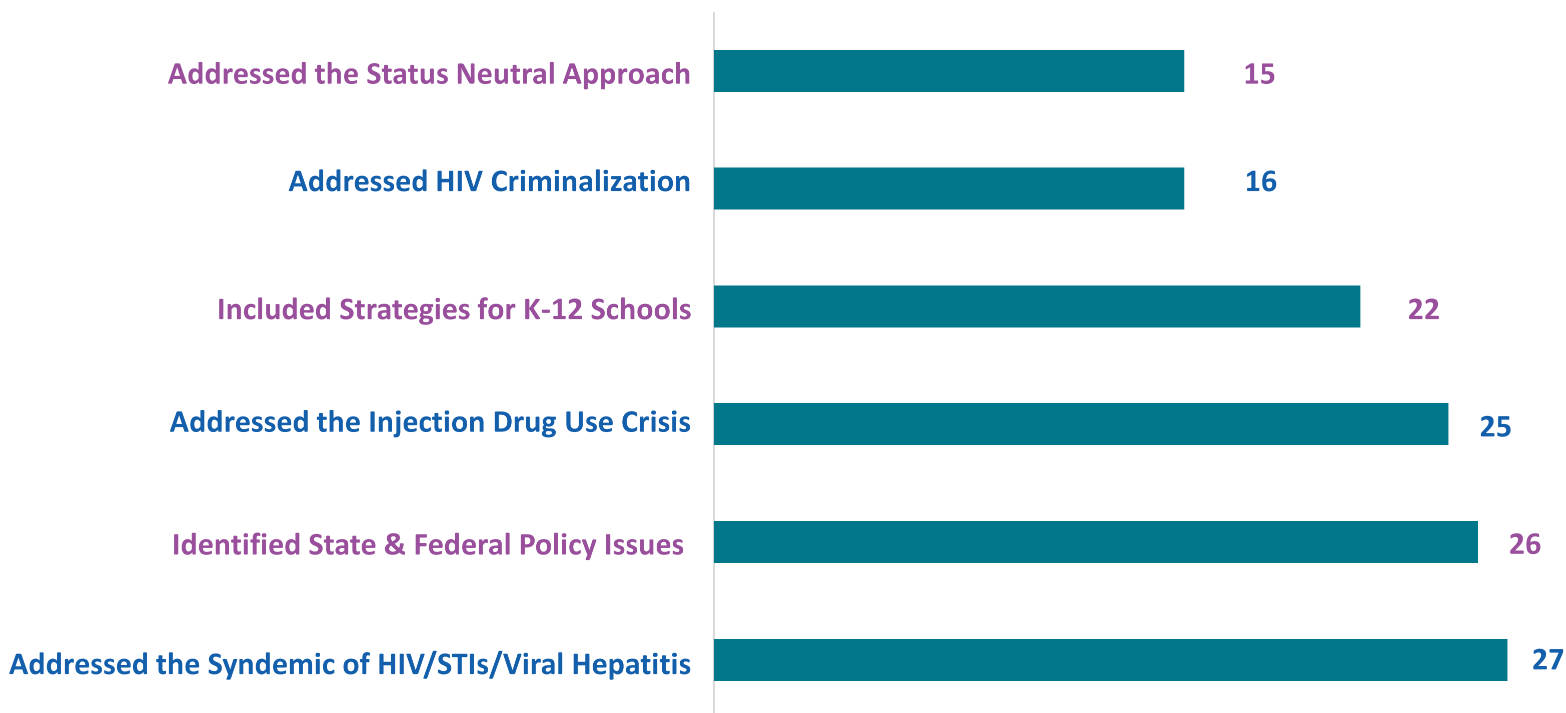
Nevada - Nevada plans to develop a statewide task force to explore the development and use of molecular data and its impact on the community, including mistrust, hesitation in testing, and fear of criminal implications.

Massachusetts - Massachusetts plans to tactfully engage providers in the HIV Massachusetts Cluster and Outbreak Detection and Response Plan. This plan will ensure all providers understand how the HIV surveillance program operates and the importance of gathering and reporting complete HIV surveillance information (e.g., risk information). In addition, the jurisdiction will create guidance for providers on prioritizing day-to-day activities while responding to outbreaks.

Washington - Washington plans to use a syndemic approach to provide outreach services to members of HIV clusters with an unsuppressed viral load to help them reach viral suppression and offer them partner services. Additional services will include STI and hepatitis treatment, primary care services, mental health and substance use disorder treatment (including harm reduction), and social services.

Cross Cutting Issues

Nearly all 32 jurisdictional plans addressed one or more of the cross-cutting issues below.



The Status Neutral Approach

The status-neutral approach aims to engage a person in ongoing prevention or treatment regardless of their status. Fifteen jurisdictions supported status-neutral approaches to HIV prevention and care. Common strategies included conducting a status-neutral needs assessment, developing marketing campaigns with status-neutral messaging, and educating providers and patients on status-neutral methods.

San Francisco - San Francisco developed a plan to include a status-neutral approach to planning and service provision. This approach will prioritize the needs of people most affected by HIV regardless of HIV status, establish a status-neutral peer program for transgender women, and allow the blending of HIV prevention and care funding streams to allow a single staff person to provide a full array of status-neutral HIV services.

HIV Criminalization & Legal Issues*

HIV criminalization laws have negatively impacted prevention and care efforts because they may discourage testing due to a fear of stigma, incarceration, and discrimination. Sixteen jurisdictions address HIV criminalization in their plans and identify strategies such as educating the community, conducting training for PWH about their rights, and providing legislation training on decriminalizing HIV.

Georgia - Georgia's EHE plan calls for a reform to the HIV transmission criminalization law through strategies such as advocacy days at the Georgia capitol during the legislative session and formal one-on-one meetings with elected officials to discuss needed policy changes.

Tennessee - Tennessee's EHE plan hopes to modernize current Tennessee state HIV criminalization laws to reflect findings from scientific research. Key activities include encouraging members of local HIV-servicing clinics to participate in advocacy groups to modernize state HIV laws, providing training to legislators on decriminalizing HIV, and providing training to HIV-positive individuals on rights, laws, and what constitutes felony charges.

* Federal funds may not be used by jurisdictions for advocacy purposes, including advocating for changes in legislation

Cross Cutting Issues

K-12 Schools

Engagement of K-12 schools and local education agencies is essential to ending the HIV epidemic. Twenty-two jurisdictions included strategies related to K-12 Schools. Common strategies included the implementation of a standardized comprehensive sex education curriculum, student health surveys, linkage to clinical services from school-based health centers, improved parent engagement, condom access in schools, and training for K-12 educators. Of the 20 EHE counties that also receive funding from CDC's Division of Adolescent and School Health for HIV prevention work, only six engaged their local education agencies.

Houston- The Houston Independent School District (HISD) is one of the 20 local education agencies directly funded by CDC to conduct HIV, STI, and unintended pregnancy prevention activities with students. The HISD program includes the Youth Risk Behavior Survey (YRBS), which assesses middle and high school student behaviors related to sexual activity, implementation of an HISD-developed HIV prevention curriculum in middle and high schools, HIV prevention professional development for educators, and student engagement activities, including an annual HIV Prevention Parent/Teen Health Summit in their EHE plan.

Pennsylvania- Pennsylvania is exploring a school-based HIV testing initiative with community partners and parent groups. The jurisdiction will continue to have city wide distribution of free condoms including in high schools and other locations accessed by youth.

CDC Funds Local Education Agencies in 20 EHE Counties for HIV Prevention Work

Los Angeles (CA)
Alameda County (CA)
San Diego County (CA)
San Francisco (CA)
Broward County (FL)
Duval County (FL)
Hillsborough County (FL)
Orange County (FL)
Palm Beach County (FL)
Cook County (IL)
Suffolk County (MA)
Essex County (NJ)
New York City (NY)
Cuyahoga County (OH)
Philadelphia (PA)
Shelby County (TN)
Tarrant County (TX)
Houston (TX)
King County (WA)
Washington D.C.

Injection Drug Use Crisis

Addressing the injection drug use crisis is critical in ending the HIV epidemic. Injection drug use is associated with an increase in the incidence and morbidity of viral hepatitis and HIV. Twenty-five jurisdictions have proposed evidence-based strategies to address substance use. They include expanding harm reduction services, integrating mental health and substance use disorder treatment into HIV care, and increasing the number of venues and prescribers that offer syringe services and medication for opioid use disorder.

Washington, D.C. - The District of Columbia plans to increase the number of community partners using harm reduction approaches (including peer-led), building capacity to address polysubstance use, and combining HIV prevention (including PrEP) with opioid treatment. Additionally, the city plans on expanding harm reduction and opioid-related services, including developing hepatitis C screening and treatment, medication for opioid use disorder, syringe exchange services, and wraparound services for PWH.

Indiana - Indiana plans to implement a "harm reduction peer navigator program" and expand locations and hours of mobile syringe services/fixed-site services for syringe access, testing, and PrEP. Additionally, the state plans on expanding harm reduction coalitions and working groups to advise on public education campaigns about harm reduction. Working with elected officials, prosecutors, law enforcement, and the media will be critical in increasing the public's understanding and support for evidence-based harm reduction services.

"PWID experience outright discrimination and vile treatment if they go to the ER with a medical issues. We need to get enlightened doctors to speak with their peers. Doctors listen only to other doctors."

-Stakeholder from South Carolina

Cross Cutting Issues

State & Federal Policy Issues

Twenty-six jurisdictions identified policy issues related to HIV prevention, including lack of Medicaid expansion; changes in federal immigration policies; policies that hinder the establishment and/or expansion of SSPs; access to HIV/STI screening for minors; and sex education in K-12 schools.

Mississippi - Mississippi identified three actions that the Governor and the state legislature would have to take for their EHE plan to be successful, including 1) expanding Medicaid; 2) aligning the state's HIV criminalization law with science; and 3) removing the statewide mandate on abstinence-only sex education. In its place, they will implement a comprehensive and age-appropriate sex education curriculum alongside abstinence-plus messaging.

Nevada - Nevada will recommend changes and updates to numerous state policies that challenge the successful implementation of their EHE plan. Specifically, the state hopes to mandate that opt-out HIV and Hepatitis C screening be offered in all primary care, urgent care, and emergency department settings. Additionally, the state hopes to mandate continuing education for healthcare providers around HIV, viral hepatitis, STIs, sexual health, and the social determinants of health.

The Syndemic Perspective

The syndemic perspective acknowledges the overlapping epidemics of HIV, STIs, and Viral Hepatitis. Twenty-seven jurisdictions have plans that address the syndemic. Common strategies included: integrating testing for HIV, STIs, and HCV; conducting training for primary care providers to routinely screen for HIV, STIs, and HCV, as a regular part of health care; launching community awareness campaigns about the link between HIV /STIs; and increasing the use of HIV/STI self-tests.

Baltimore City - Baltimore plans to develop a city-wide sexual health strategy, including HIV, STIs, family planning, and overall sexual health and wellness. They will work in conjunction with the Baltimore City Health Department's Bureaus of Maternal and Child Health and School Health and the Office of Youth Violence Prevention and external partners to develop plans and coordinate services. Initially, this work will focus on youth and then expand to include all ages. This strategy will strengthen education, awareness, treatment, reporting, stigma reduction, and outbreak control.

Arizona - Arizona plans to integrate HIV, STI, HCV testing, and substance use and mental health services. In addition, they will employ social media strategies to promote HIV and STI testing and coordinate with STI and viral hepatitis partners to ensure cluster detection and response efforts can plan for overlapping outbreaks.

> **"Why not come here and receive testing for HIV, STDs, Hep. C, life skills, hormone therapy, mental health therapy, and substance abuse counseling…if that's what you desire to have? Get you something to eat, a car lift, just make it as easy as possible for you to be more involved in bettering you and betting your healthcare. Have that experience more common for you. Not enabling you but the next time you have that experience you want to go there."**
>
> ***-Community Member from San Francisco***

HIV Workforce

Nearly all jurisdictions acknowledged the need to expand the HIV workforce to meet the goals of the EHE initiative. Typical workforce needs included, increasing the number of social workers, community health workers, PrEP navigators, case managers, linkage to care specialists, nurses, disease investigation specialists, epidemiologists, and mental healthcare providers. Increasing the capacity of the HIV workforce is essential to expanding service delivery hours, increasing the capacity of partner services, and enhancing Data-to-Care efforts. Additionally, jurisdictions noted the need for the HIV workforce to reflect the communities they serve and be trained in culturally competent, trauma-informed, sex-positive, and gender-affirming care. Many jurisdictions included strategies to increase the diversity of the HIV workforce by recruiting and training new staff directly from the communities using HIV prevention and care services.

Arkansas - Feedback from focus groups indicated that some Hispanic community members inherently distrust translation services due to fear of being affiliated with law enforcement and Immigration and Customs Enforcement. Consequently, Arkansas plans to prioritize the recruitment and retention of Hispanic and LGBTQ affirming healthcare providers and promote the development of Hispanic leaders in community-based organizations. Additionally, the EHE plan calls for hiring Spanish-speaking staff members and volunteers in areas with a large Hispanic population.

San Francisco - Participant feedback from community engagement sections indicated that representation was critical in determining how people perceived and used medical clinics. Additionally, participants indicated that investments in the HIV workforce must be genuine and go beyond “tokenism.” Specifically, the community members indicated that only having Black/Brown persons in lower-paid positions such as outreach workers, navigators, and medical assistants highlight the inherent systemic racism in the HIV prevention/care system.

North Carolina - North Carolina conducted an HIV workforce capacity assessment. Results found a great need to entice new HIV medical providers to the Mecklenburg County workforce as there would need to be approximately 80 new HIV care providers added to the community over the next ten years to keep up with demand and to replace a retiring workforce. Specifically, the plan calls for resources to attract physician’s assistants, nurse practitioners, medical doctors, and doctors of osteopathic medicine.

Philadelphia - Philadelphia created a fifth pillar for their EHE plan to address HIV workforce development. Specific strategies to address the needs of the HIV workforce in the community include (1) conducting an assessment of the size, experience, and competency of the workforce; (2) developing the scope and expanse of the prevention workforce to center the needs of focused populations; (3) using HIV public health data to develop the capacity of the HIV care workforce; and (4) developing capacity to implement services responsive to the changing landscape of healthcare-related to the COVID-19 pandemic.

“I would personally like to see EHE support the enhancement of the Black public health workforce. This should include science and treatment knowledge, social justice, racial equality, emotional intelligence, anti-stigma language, trauma informed care and other public health outcomes interjectionally.”

-Community Member from San Francisco

Federal Partners

Thirty-one of the 32 EHE jurisdictional plans included specific mention of federal agencies in their plans with whom they intend to work. By default, all jurisdictions will work with CDC and HRSA since each agency is providing EHE-specific funding.

Housing and Urban Development (HUD)

Specific reference to HUD or the Housing Opportunities for Persons with AIDS (HOPWA) was identified in nearly all EHE plans, most typically as a funding source and as a needed partner for EHE activities. Of note, 27 jurisdictions identified housing as an issue to be addressed, and 18 included representatives for homeless populations in their engagement process. More jurisdictions will likely engage with HUD to address these issues in addition to those that specifically mentioned HUD as a resource in their EHE plans.

Arizona - Arizona plans to strengthen communication and collaboration between Ryan White HIV/AIDS Care Programs and the HOPWA program, including ways to streamline data sharing and eligibility.

Arkansas - The EHE plan notes that improved coordination is necessary between the multiple HOPWA providers, care management teams, and other CBOs. It was pointed out that there are too many obstacles and challenges to accessing and navigating existing housing services. The plan also notes that case management services could be strengthened to ensure a thorough evaluation of a person's housing status and referred to HOPWA services when needed. Mandated training of housing case managers regarding HOPWA statutes and improving the waitlist time for HOPWA was also identified as solutions.

Mississippi - Mississippi plans to work with HOPWA and other housing agencies to increase stable and long-term housing options for people with HIV. The EHE plan also will examine the feasibility of expanding short-term housing via Ryan White funds.

Nevada - The Nevada plan explores a policy change for HOPWA eligibility to remove minor offensives or prior eviction from criteria so more people can qualify for housing services.

New York City - NYC plans to provide housing as an HIV prevention strategy for members of priority populations experiencing homelessness or unstable housing.

Ohio - Ohio plans to continue to ensure PWH maintain or achieve stable housing status by 1) promoting emergency-based rental and utility assistance to prevent homelessness through HOPWA partners; 2) continuing to provide permanent housing placement for PWH needing assistance through HOPWA; 3) maintaining engagement with the local continuum of care services to provide tenant-based rental assistance vouchers to PWH under the CDPH HOPWA program; 4) expanding support for short-term supportive housing to divert PWH from homeless shelters through the HOPWA, and 5) promoting the new HOPWA workforce development for PWH to sustain and support permanent housing.

South Carolina - South Carolina plans to increase the number of PWH who receive housing assistance through HOPWA by at least five percent.

Texas - The Texas EHE plan intends to address barriers to accessing HIV care, behavioral health, substance abuse treatment, and housing services, which inhibit the ability to remain adherent to medications. The jurisdiction intends to partner with the HOPWA program to develop a strategy to reduce barriers to housing. The plan intends to identify housing as prevention methods, research current housing as prevention models (specifically those geared towards youth) and implement a housing as prevention model.

Federal Partners

Substance Abuse and Mental Health Services Administration (SAMHSA)

As one of several collaborating HHS agencies participating in the Ending the HIV Epidemic in the U.S. initiative, SAMHSA's principal goals are to: reduce new HIV infections, improve HIV-related health outcomes, and reduce HIV-related health disparities for racial and ethnic minority communities. SAMHSA will do this by increasing testing frequency and referrals to treatment for HIV-positive individuals and PrEP for HIV-negative individuals and supporting linkage to treatment for enrollees who test positive. In addition, in November 2020, SAMHSA released Prevention and Treatment of HIV Among People Living with Substance Use and/or Mental Disorders, a guidebook that addresses the co-occurrence of HIV and mental illness and/or substance use disorder (SUD) and reviews effective programs and practices to prevent HIV and, for those with HIV, to increase linkage and retention to care to improve health outcomes.

Nine jurisdictions (Florida, Chicago, Louisiana, Maryland, Baltimore, Michigan, New York City, Houston, Washington, D.C.) included a mention of SAMHSA in their EHE plans. Most refer to SAMHSA as a partner or a potential funding source for substance use disorder or mental health activities.

Houston - Houston's plan noted that SAMHSA directly funds a Ryan-White HIV/AIDS Care Program mental health agency, which facilitates further integration of substance use disorder and mental health treatment within the Ryan White system of care.

Louisiana - The Louisiana EHE plan noted that four organizations in New Orleans (New Orleans Health Department, Council on Alcohol and Drug Abuse for Greater New Orleans, Odyssey House, and CrescentCare) are funded by SAMHSA grants focusing on HIV and substance use prevention among young minority groups, including young Black gay and bisexual men and LGBTQIA+ youth. The Office of Health Policy and AIDS Funding and the New Orleans Regional AIDS Planning Council coordinate closely with these organizations to align education, prevention, testing, and linkage activities and ensure these grant-funded projects operate in alignment with one another.

National Institutes of Health (NIH)

NIH provides grant funding to support EHE activities in several ways. Applicants for NIH grants need to propose collaborations with local implementing partners such as city, county, and state public health departments, local and regional clinics, and health care facilities, clinicians, providers of medication-assisted treatment for opioid use disorder, and community- and faith-based organizations funded by CDC, HRSA, IHS, and/or SAMHSA. These collaborations are meant to align with EHE jurisdictional plans.

Seven jurisdictions (California, Kentucky, Maryland, Baltimore City, Ohio, Washington, Washington, D.C.) mentioned using NIH supplemental grants to support EHE activities. Most referenced NIH as a funding source for projects.

Washington, D.C. - The EHE plan noted that D.C. was awarded NIH EHE supplements for planning new approaches on PrEP, molecular data, and rapid initiation of ART.

California - California's EHE plan noted that Alameda County, Orange County, Riverside County, San Bernardino County, and San Diego County support California-based NIH Center for AIDS Research (CFAR) programs. There are four NIH-funded CFAR EHE supplemental projects currently underway in Alameda County. One project (using NIH funding) for EHE in Alameda County led to the alignment and strengthening of two sources of data: HIV case-based surveillance that tracks new diagnoses through health outcomes, and National HIV Behavioral Surveillance (NHBS) that identifies barriers to diagnosis, care, and prevention in communities at risk. These CFAR funds have enabled: meetings of investigators and county officials, collection of community stakeholder input; joint analyses; cross-country training; and pilot testing of NHBS methods. The plan notes that extending NHBS from San Francisco into Alameda County could also lead to a model protocol to bring NHBS coverage to other priority counties and cities, improving epidemiological understanding and enhancing counties' ability to respond to HIV outbreaks.

Federal Partners

Centers for Medicare and Medicaid Services (CMS)

Medicaid spending on HIV accounts for 30% of all federal spending on HIV care. In 2017, CDC estimated that of those with diagnosed HIV, 42% had some form of Medicaid coverage. CMS involvement at the federal and state levels can have a tremendous impact on advancing HIV policy, improving access to HIV prevention and care, and cost-effectively improving health outcomes. The CMS Centers most relevant to EHE is the Center for Medicaid and CHIP Services (CMCS), the Center for Consumer Information and Insurance Oversight (CCIIO), the Center for Medicare and Medicaid Innovation (CMMI), and the Center for Clinical Standards and Quality (CCSQ).

Five jurisdictions (Baltimore, Nevada, New York City, Houston, Washington, D.C.) mentioned CMS in their EHE plans. Essentially all plans recognized the importance of Medicaid and Medicare as a source of funding for HIV care and prevention.

Washington, D.C. - The District of Columbia plans to work with the Department of Health Care Finance and the Department of Insurance, Securities, and Banking to promote health care coverage policies that support rapid HIV care and treatment initiation. Additionally, they plan to collaborate with the Department of Health Care Finance as a monitoring data source for the Diagnose pillar.

Houston - Houston plans to improve coordination of efforts of service providers and public providers, including Medicare/Medicaid.

Baltimore - Baltimore plans to analyze insurance plans with Medicaid carve-in rules established in 2020 for HIV-related services and medications coverage. The health department staff, and case managers must stay abreast of new carve-in regulations and other Medicaid medication updates to provide quality insurance navigation for people with HIV. They also plan to educate health insurance navigators on HIV and insurance coverage. They will also work with the Maryland AIDS Drug Assistance Program and Medicaid to provide training and informational sessions on medication coverage updates.

New York City - New York City plans to increase the number of Medicaid recipients in New York State filling prescriptions for PrEP to 30,000 by 2020 (New York City goal is in development).

Indian Health Service (IHS)

IHS was mentioned in four jurisdictions' EHE plans (Arizona, Baltimore, Michigan, Oklahoma) as a federal agency whose activities support EHE.

Veterans' Health Administration (VHA)

The VHA provides HIV care and HIV prevention services for eligible veterans. Four EHE jurisdictional plans mentioned the VHA in the situational analysis. However, there was no mention of involvement of the VHA facilities in the plans. Of note, the original guidance for developing the EHE plans did not mention including the VHA.

Moving Forward

EHE plans are available online. While the funding period for EHE planning ended on December 31, 2020, it is expected that jurisdictions will update their EHE plans over time. CDC funds the jurisdictions through the cooperative agreement PS20-2010: Integrated HIV Programs for Health Departments to Support Ending the HIV Epidemic in the United States. CDC project officers hold monthly calls with each jurisdiction to check on the progress of each element included in this cooperative agreement, including EHE planning. Strategies and activities in CDC's implementation cooperative agreement with the jurisdictions are consistent with and responsive to EHE plans; however, EHE activities may be supplemented from various governmental, private, and foundation support in each jurisdiction. In addition, the CDC project officers are working with jurisdictions to identify any anticipated updates to the EHE plan based on activities conducted in the jurisdiction. For instance, if a jurisdiction noted having EHE activities being addressed using other funding sources not included in the current EHE plan, CDC will recommend adding that activity to the EHE plan.

For CDC's EHE implementation cooperative agreement with the jurisdictions, CDC will routinely monitor and evaluate the program's progress, including the implemented strategies and activities. As a component of these monitoring efforts, CDC will request a description of the process for making updates to the EHE plans. Updated EHE plans are expected to be posted on the jurisdiction's website.