CUYAHOGA COUNTY
ENDING THE HIV EPIDEMIC - CARE

Phase 1 Report
Fiscal Years 2020 – 2024

Ending
the
HIV
Epidemic

Executive Summary

Through its first five years in Cuyahoga County, the EHE Initiative has seen many successes. From starting with seven different providers in 2020 at its inception, and ending with eleven at its conclusion in February of 2025, the program was able to serve a total of 7,050 clients all throughout Cuyahoga County. At the conclusion of Phase 1, the program also was able to fund seven different service categories as a means to fill the gaps in HIV care in Northeast Ohio.

The EHE Initiative in Cuyahoga County also improved the care continuum outcomes for all of its clients by the end of Phase 1. In its last fiscal year, 81% of the clients received at least one HIV medical care appointment or had blood lab work done (i.e., had a CD4 count or viral load test); additionally, 85% of the clients were virally suppressed, which is well above the national average for all of those diagnosed with HIV. The majority of EHE clients were male, specifically Black or African American males, between 25-49 years old, and reported being in the in the men who have sex with men (MSM) HIV risk factor category.

Through targeted services and interventions, EHE clients were able to receive transportation to medical appointments, navigate their new HIV diagnosis, receive antiretroviral medication quickly after diagnosis, have assistance with benefits navigation, and have the opportunity to join support groups of peers. All of these services aided in the goal of viral suppression for these clients.

Based on available epidemiological data, the EHE Initiative in Cuyahoga County selected four different populations to focus efforts on throughout Phase 1; these populations of focus included:

- MSM
- MSM of Color (including those who are Black/African American or Hispanic)
- Youth aged 13-24 years old
- Aged 50+ years old (clients who are aging with HIV)

These populations of focus were closely monitored for care continuum outcomes to indicate the success of the services provided. Linkage to care and viral suppression was especially high for these groups. It should also be noted that those aged 50+ were not included at the inception of the EHE initiative, but were added later to accommodate the growing number of clients in this group.

Efforts were also made to enroll those who were newly diagnosed with HIV into the EHE-Care program. While those who were newly diagnosed did not make up a large proportion of the total client population, almost 90% of the total incidence of HIV in Cuyahoga County were enrolled into EHE in 2024. Continued efforts were also placed on linking clients to HIV medical care soon after their diagnosis (within 30 days). At the end of Phase 1, most of those who received a new diagnosis of HIV were linked to care within 13 days of their diagnosis.

The success of this program highlights the need for support services for those who have been diagnosed with HIV. These accomplishments could not have been achieved without the dedicated program staff at the Cuyahoga County Board of Health as well as the service providers who strive to end the HIV epidemic. Most importantly, this program is shaped by the feedback and experiences of those who have been diagnosed with HIV. Their input is invaluable to accomplishing the goals set forth by the initiative.

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1. Introduction

The Ending the HIV Epidemic (EHE) initiative was introduced in the 2019 State of the Union address. This new initiative aimed to reduce the number of new human immunodeficiency virus (HIV) infections in the United States. Using tried-and-true prevention mechanisms, such as undetectable equals untransmissible (U=U), pre-exposure prophylaxis (PrEP), and post-exposure prophylaxis (PEP), the EHE initiative strives to use new methods of prevention to get the number of new HIV infections down to zero.

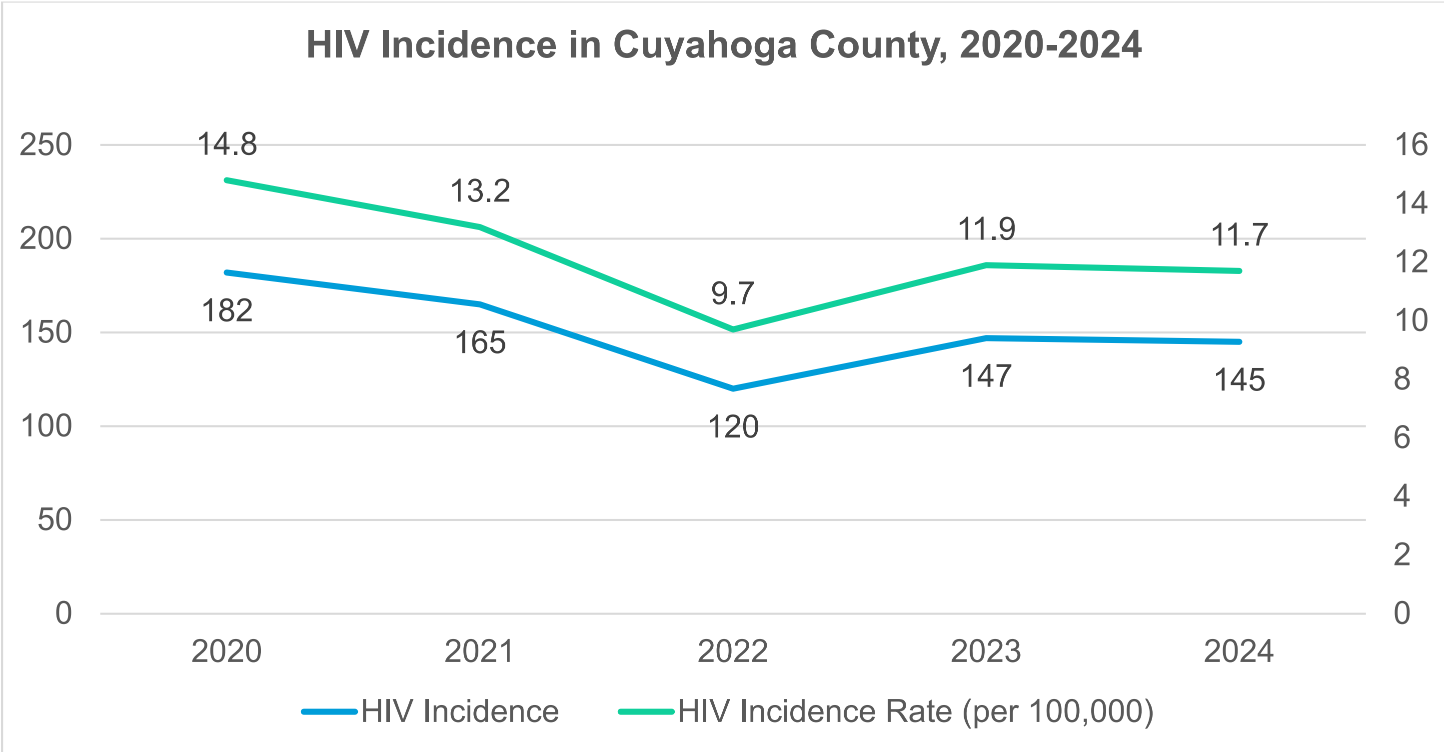
Fifty-seven jurisdictions with the highest occurrence of HIV transmission were targeted for the first round of funding, which included Cuyahoga County, given its long history of investment in HIV services. The county adopted the goals of the national plan, which included a 75 percent reduction in new HIV infections between 2017 to 2025, and a 90 percent reduction in new HIV infections by 2030. The Cuyahoga County Board of Health (CCBH) was awarded funding for Care and Prevention projects and began funding subrecipient partners for services in 2020.

The Centers for Disease Control and Prevention (CDC) identified four pillars for the EHE initiative: prevent, diagnose, treat, and respond. The EHE Jurisdictional Plan outlines action steps for implementation over the first phase of the initiative, with attention given to “treatment as prevention” and rapid linkage to HIV care. EHE-Care funded several subrecipients for core and support services over the five-year span of Phase 1. An evaluation plan was developed by staff epidemiologists to assess the successes of Phase 1 and identify areas where additional support and focus are needed.

2. HIV Incidence and Prevalence, 2020 – 2024

HIV Incidence

A major goal of the EHE initiative is to reduce the number of new HIV infections by 75% in 2025 and by 90% in 2030. In Cuyahoga County, HIV incidence, or the number of new HIV infections, has slightly decreased since the program began in 2020. However, the number of new infections has not yet reached the 75% goal set forth for 2025.



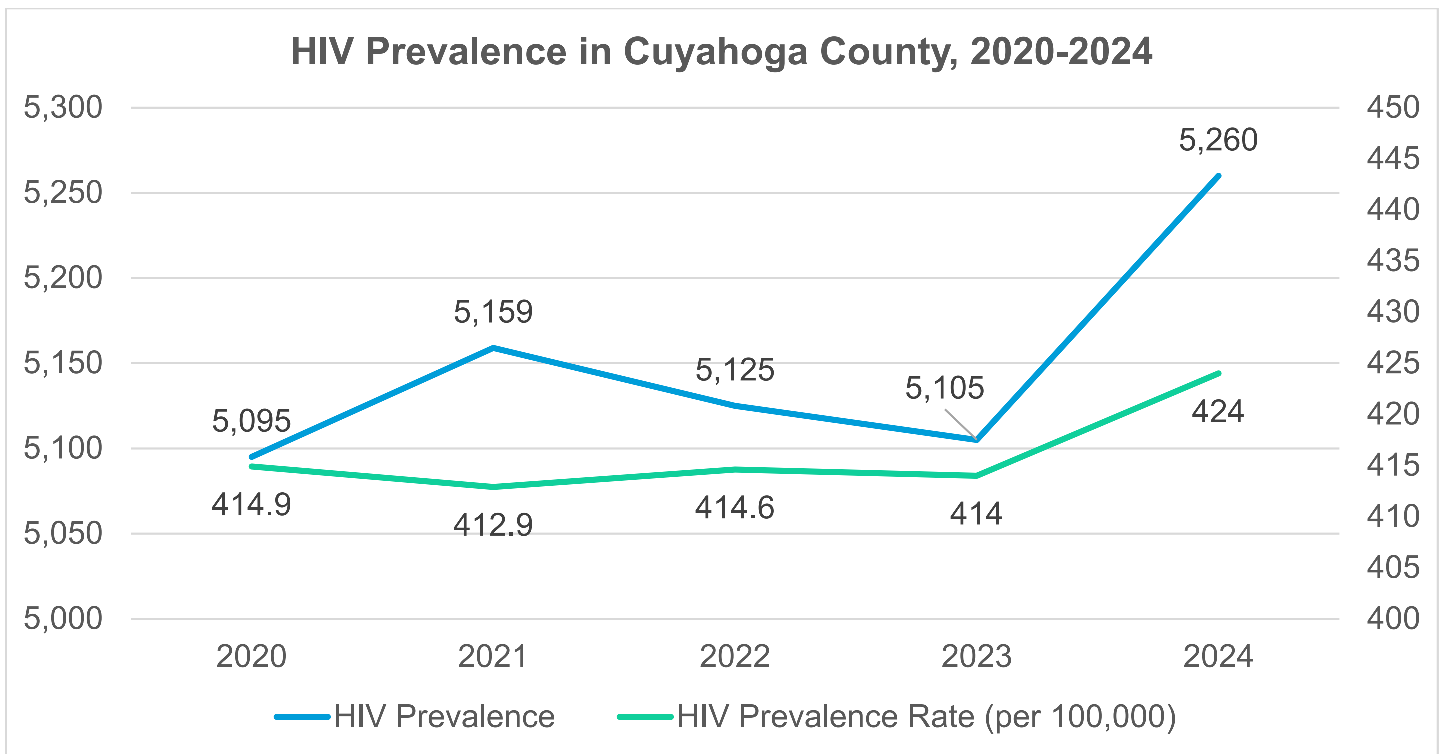
New infections have decreased by 20% in Cuyahoga County since 2020. Rates of new infections remain high in Black/African American males, those who are 20-24 years old, and in men who have sex with men (MSM). More specifically, in 2024:

- 19% of new infections were among those who were 20-24 years' old
- 54% of new infections were among Black/African American males
- 65% of new infections were among MSM

In order to achieve the goal of new infections set forth by the EHE initiative, the number of new infections in Cuyahoga County should be thirty-eight in 2025 and fifteen in 2030 (based on 150 new infections reported in 2018). With 145 new infections reported in 2024, a 74% reduction in infection rates would need to occur. Unfortunately, the number of new infections has not improved much since the original goals were set in place. While we may not know the exact reasons for the increase in the number of new infections, there may be several reasons why we have not seen a reduction. These include systemic inequities of those diagnosed with HIV, unequal or limited access to HIV care and prevention services, as well as testing gaps in certain geographic areas. However, it should be noted that HIV testing biases can also occur, meaning that more HIV tests being done can identify more cases of HIV.

HIV Prevalence

While there were no goals set forth for the number of people with diagnosed HIV (also called HIV prevalence) by the EHE initiative, these totals can speak to the success of PrEP, PEP, antiretroviral prescriptions to those with diagnosed HIV, and to other services provided by the program.



The number of people with HIV (PWH) has steadily been increasing since 2020, with the highest number occurring recently in 2024. Specifically, the total number of people with HIV in Cuyahoga County increased 2% from 2023 to 2024. While population fluctuation could be one factor attributing to this increase, it is also possible that the widespread use of PrEP, PEP, and antiretrovirals coupled with the benefits of the funded services of the EHE initiative are contributing to longevity and better quality of life for those living with HIV.

PWH in 2024:

- Over 50% (n=2,774) were 50 years or older
- 45% were Black/African American males
- 69% were MSM

3. Care Continuum

The HIV care continuum is a model that outlines the stages people with HIV go through from diagnosis of HIV to maintaining viral suppression. It can help to gauge the effectiveness of services rendered, track progress toward goals, and identify treatment gaps. It can also be used at the individual – and population – level. Research has continually shown that people who achieve viral suppression where their viral load is undetectable can live long and health lives and will not transmit HIV to their HIV-negative partners through sex.

There are several steps along the HIV care continuum, which are defined below:

EHE Clients: number of diagnosed individuals who received an EHE funded service in the measurement time period.

Linked to Care (LTC): number of EHE eligible clients that had at least one medical visit, viral load test, or CD4 test in the measurement time period.

Retained in Care (RIC): number of EHE eligible clients who had two or more medical visits, viral load tests, or CD4 tests performed at least three months apart during the measurement time period.

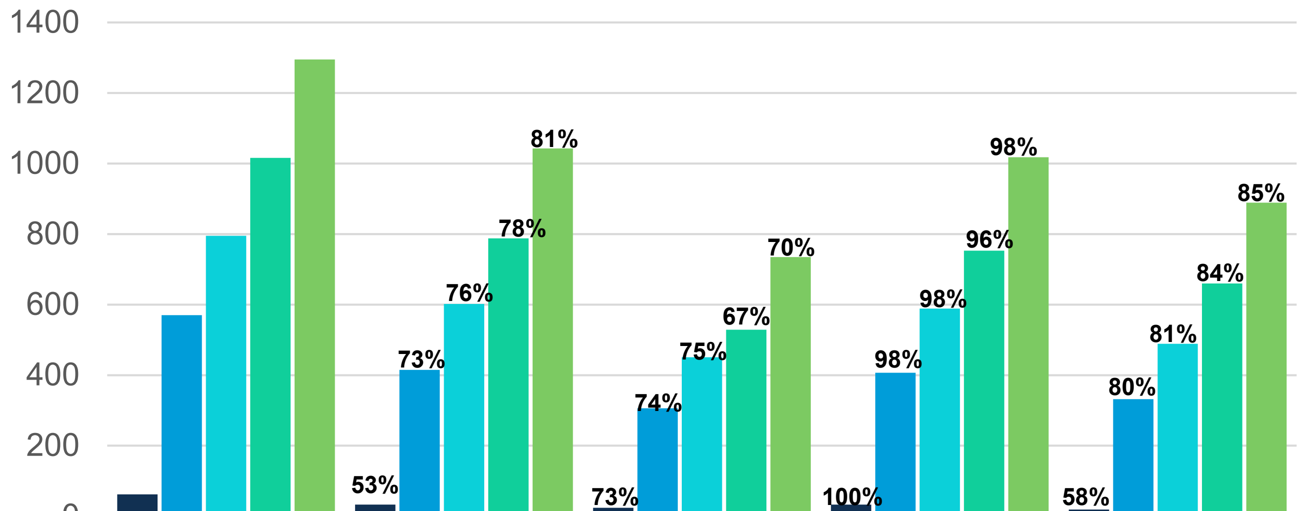
Antiretroviral Use (ART): number of EHE eligible clients receiving medical care who have a documented antiretroviral therapy prescription on record in the measurement time period.

Viral Load Suppression (VLS): number of EHE eligible clients receiving medical care whose most recent HIV viral load within the measurement time period was less than 200 copies/mL.

The care continuum utilizes percentages of those who received care and/or ART medication to determine any treatment gaps within the initiative. These percentages are calculated with different elements of the care continuum and can have different denominators. Formulas for percentage calculations are as follows:

Linked to Care percentage: LTC divided by EHE clients

Retained in Care, Antiretroviral Use, or Viral Load Suppression percentage: RIC or ART or VLS divided by LTC



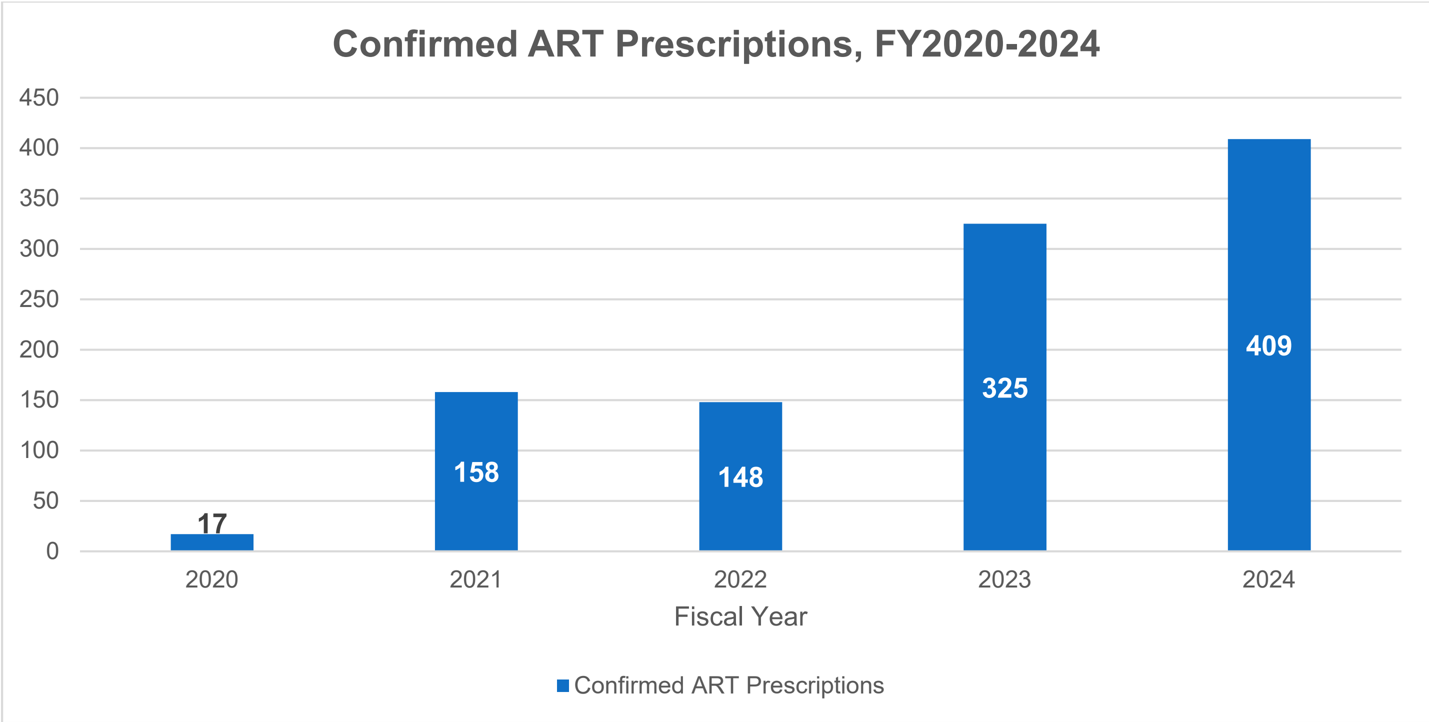
	EHE Clients	LTC	RIC	ART	VLS
FY2020	62	33	24	33	19
FY2021	570	415	306	407	332
FY2022	795	602	451	589	489
FY2023	1,016	788	529	753	660
FY2024	1,295	1,043	735	1,018	889

FY2020 FY2021 FY2022 FY2023 FY2024

As the EHE-Care program has evolved over time in Cuyahoga County, continuum outcomes have improved for clients, with a majority of clients being linked to care, retained in care, prescribed ART, and virally suppressed in the most recent fiscal year. There has especially been vast improvement to client linkage to care and viral suppression since the first year of the intervention. These improved outcomes point to the success of the interventions initiated. It also shows that increased access to diverse methods of care improves outcomes for those with HIV.

Medication Adherence

Part of a client's journey along the HIV care continuum is being prescribed antiretroviral medication (ART) for management of their HIV. Along with keeping medical appointments, taking ART leads to better outcomes, prevents the virus from multiplying, and supports long-term survival. As shown above, a vast majority of clients are prescribed an ART. However, medication adherence, or taking the medication as prescribed and getting proper laboratory blood work and completing medication refills, is the key to sustaining viral load suppression and longevity. While medication can be difficult to verify through available data sources, we are able to look at clients who have confirmed prescriptions in their medical records and compare it to subsequent programs years to determine if a client refilled a prescription for ART.



While confirmed ART prescription totals have increased with subsequent program years throughout Phase 1, the totals represented in the chart above do not correlate with the total numbers of ART prescriptions represented in the ART section of the care continuum. Percentages of total ART prescriptions are as follows:

2020	52%
2021	39%
2022	25%
2023	43%
2024	40%

The discrepancies in ART prescription totals is possibly attributed to missing data for clients or data entry errors in the CAREWare system used to collect program data. It is possible that it is noted in a client's chart that they have been prescribed an antiretroviral prescription, but the specific prescription may not be noted making it difficult to determine adherence.

Among the confirmed ART prescriptions there were 103 clients who had repeat ART prescriptions throughout Phase 1, which accounts for about 3% of the total number of clients. This indicates that these clients were adherent to their ART medication, which can assist with improved outcomes with HIV infection.

Viral Load Suppression

Viral load suppression (VLS) is the reduction of the HIV virus to very low levels in the blood by consistently taking ART; this is defined as having less than 200 copies of the HIV virus per milliliter of blood. Attaining VLS is also known as becoming undetectable; this means that the amount of virus in

the blood is so low that it cannot be detected on a standard laboratory test. Becoming undetectable means that HIV cannot be transmitted, and is the best thing someone living with HIV can do to stay healthy.

VLS is achieved by taking ART medication as prescribed to reduce the amount of HIV in the blood. However, it's important to note that being virally suppressed does not mean someone is cured of HIV. While ART is not a cure, being virally suppressed does provide significant health benefits and aids in HIV prevention efforts. Those who are virally suppressed can live long and healthy lives and cannot transmit HIV through sex.

The EHE Initiative aims to increase the number of people diagnosed with HIV who are virally suppressed to 95%. At the time of the initiative's inception in Cuyahoga County in 2020, VLS was 58%. Through the various services offered with EHE, VLS increased to 85% at the conclusion of Phase 1 in 2025. While the 95% goal was not yet reached at the conclusion of Phase 1, continued efforts of core and support services throughout Phase 2 makes this goal very attainable.

4. Funded Service Categories and Client Totals

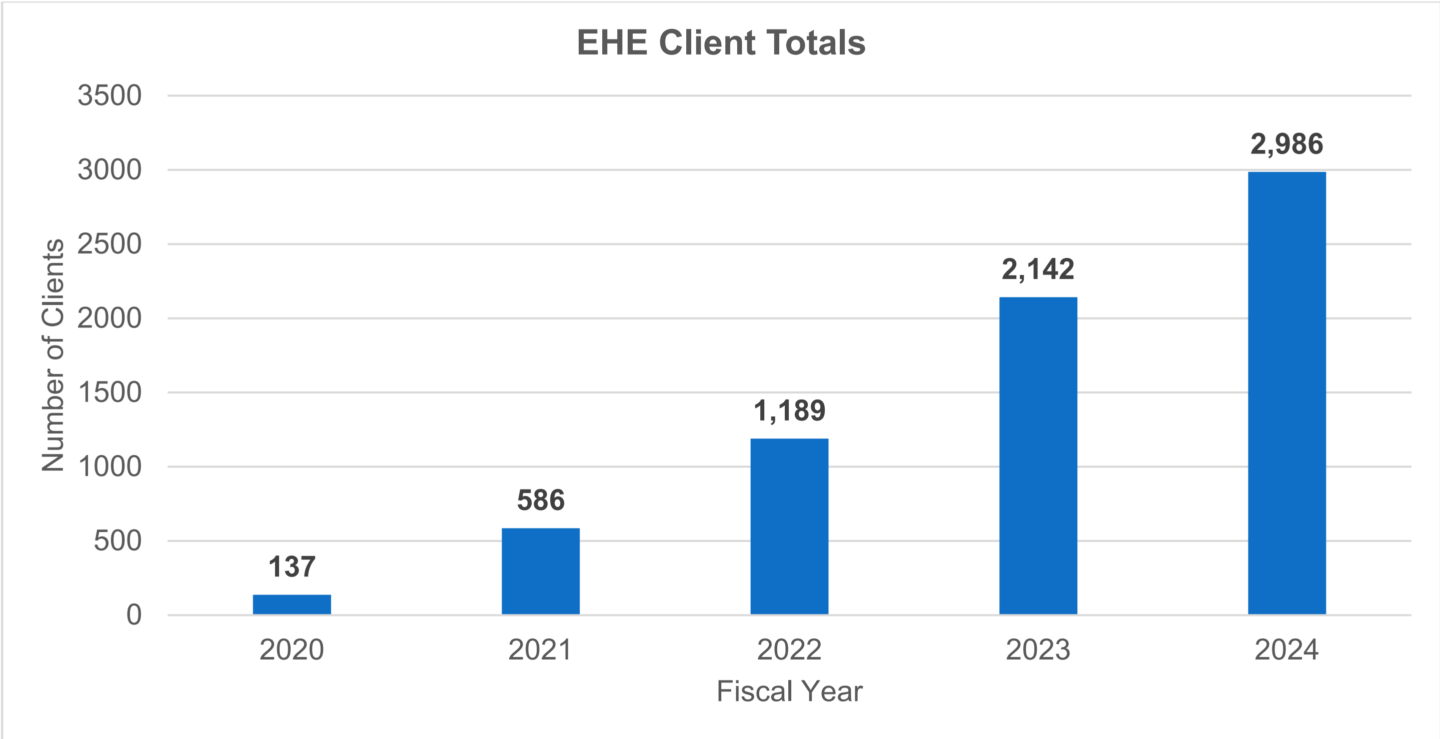
In order to make progress on goals set forth by the EHE Initiative, CCBH and its partners have identified several strategies that touch on many different areas of work related to HIV care. The strategies developed inform the services needed to assist in ending the HIV epidemic. These funded services increase access to HIV diagnosis, develop linkage to care, and encourage peer navigation to boost treatment adherence.

Initially in 2020, only five service categories were funded among seven different providers. Yet, at the end of Phase 1, there were seven funded categories with eleven different agencies providing HIV care services.

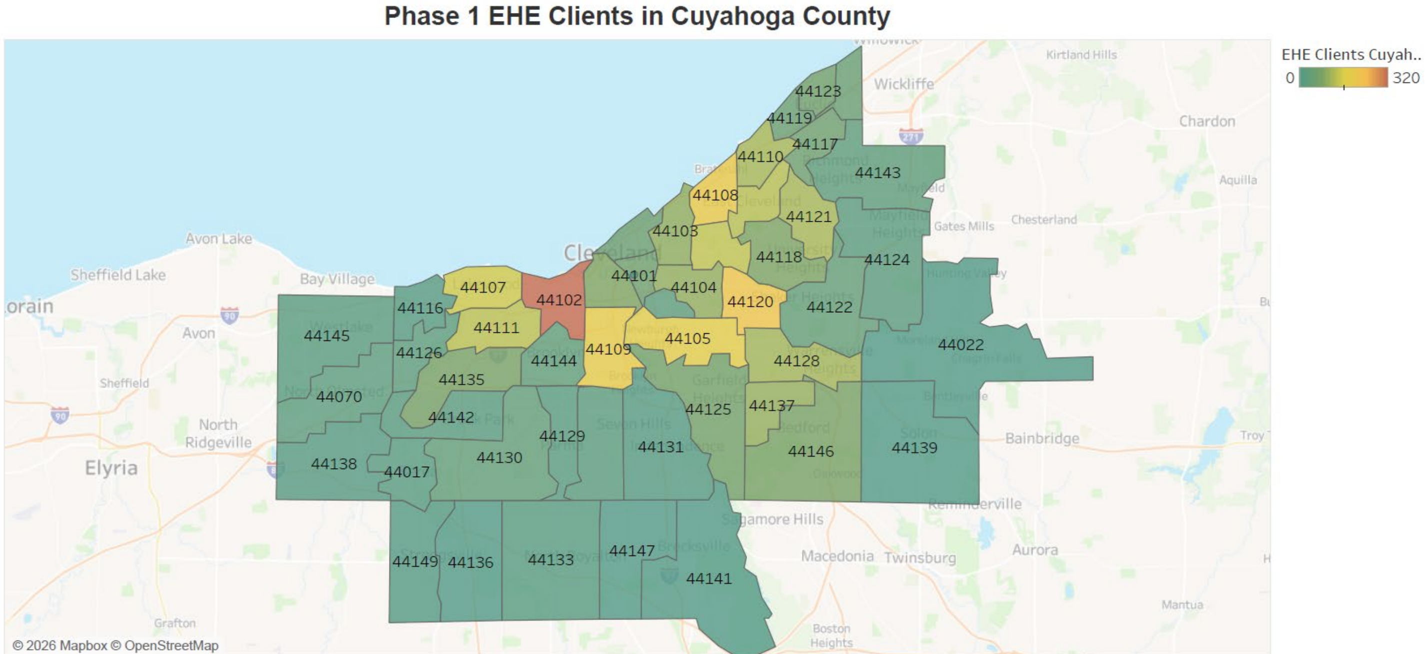
	2020	2021	2022	2023	2024
Data to Care (D2C)	✓	✓	✓		
Early Intervention Services – Community Health Worker/Peer Navigation (EIS)	✓	✓	✓	✓	✓
Emergency Financial Assistance (EFA)			✓	✓	✓
Intensive Medical Case Management (IMCM)	✓	✓	✓	✓	✓
Medical Transportation (MT)		✓	✓	✓	✓
Non-Medical Case Management (NMCM)					✓
Outpatient Ambulatory Health Services – Rapid Start (OAHS)	✓	✓	✓	✓	✓
Psychosocial Support Services (PSS)			✓	✓	✓

Client Demographics

Over the course of Phase 1 of the EHE Initiative, a total of 7,050 clients were served throughout Cuyahoga County.

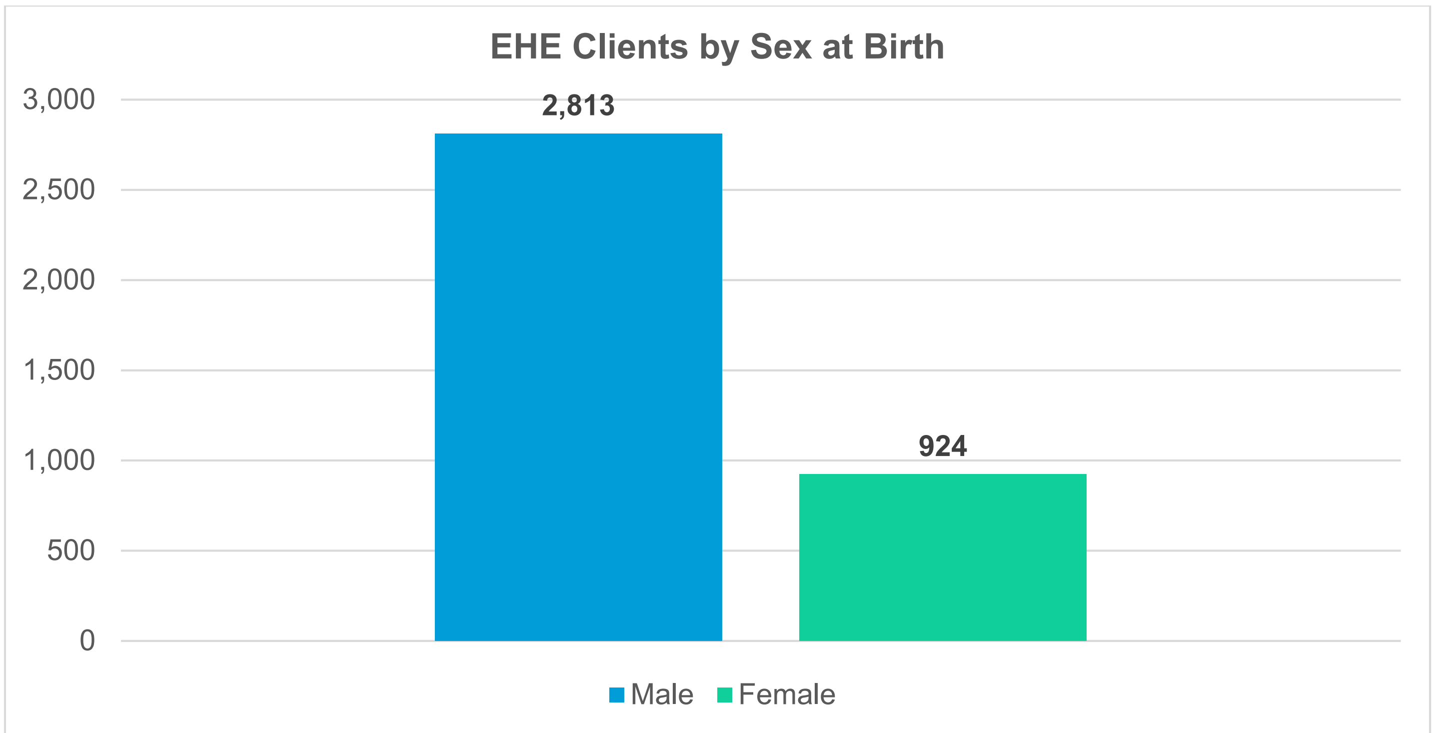


Client totals have increased annually from 2020-2024. Over 40% of the clients were served in fiscal year 2024 alone.



Phase 1 (2020-2024) EHE clients as of 3/23/2026. Data is subject to change are new/updated information becomes available. Zip code reflects residence at time of service. Data source: CAREWare V6.
Map based on Longitude (generated) and Latitude (generated). Color shows suppression. The marks are labeled by Zip Left.

EHE clients were located all over Cuyahoga, with a large concentration residing close in proximity to downtown Cleveland. The most prevalent zip code for EHE clients was 44102 (n=320, 5% of clients).



Those who were male sex at birth consistently constituted the bulk of clients served, around 75%. The number of female sex at birth clients also increased annually. Please note that those who are intersex are not included in above totals.

EHE Clients by Race/Ethnicity and Sex at Birth

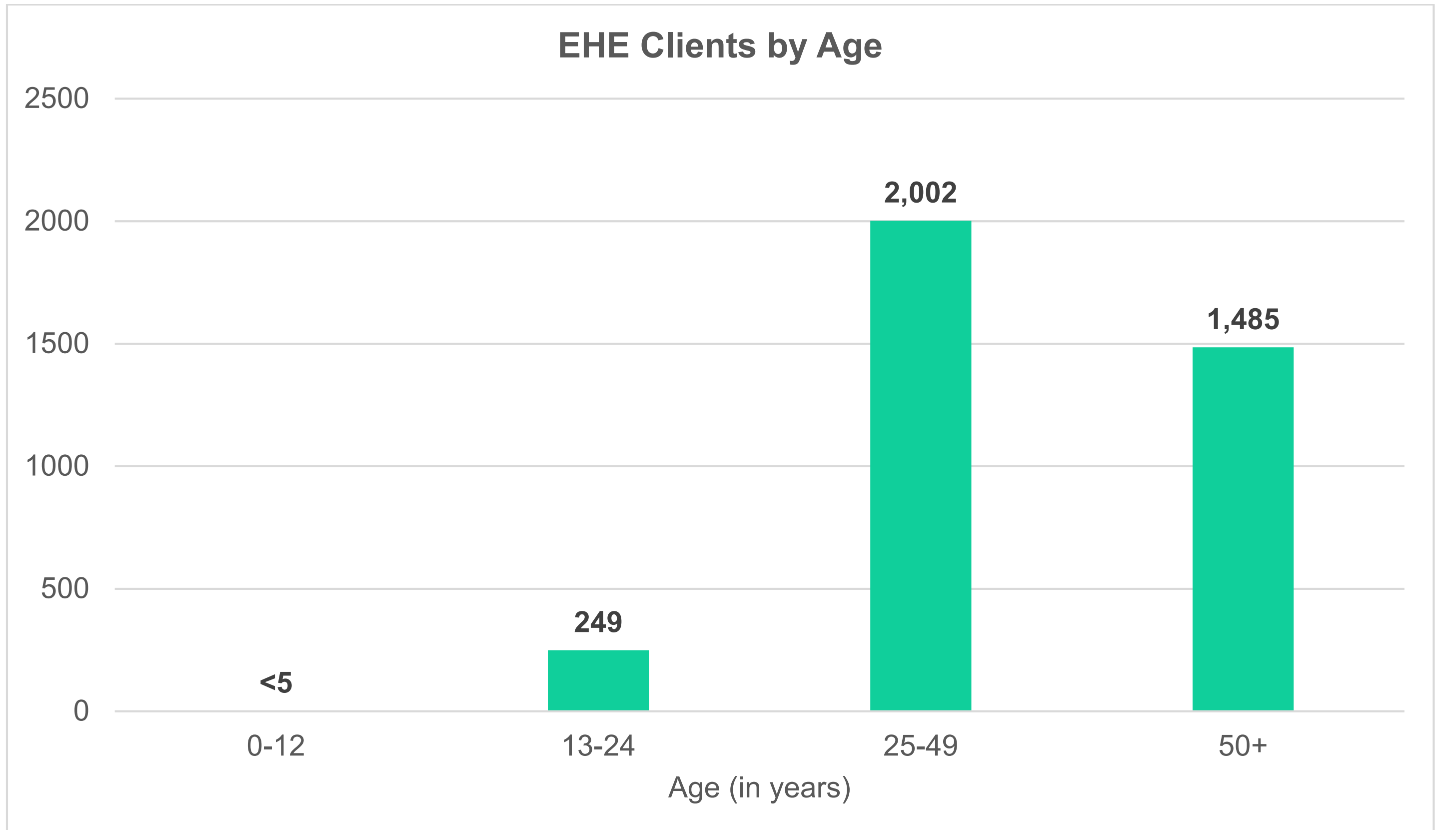
2000
1800
1600
1400
1200
1000
800
600
400
200
0

<5 0
11 0
1,744 679
284 108
55 8
717 129

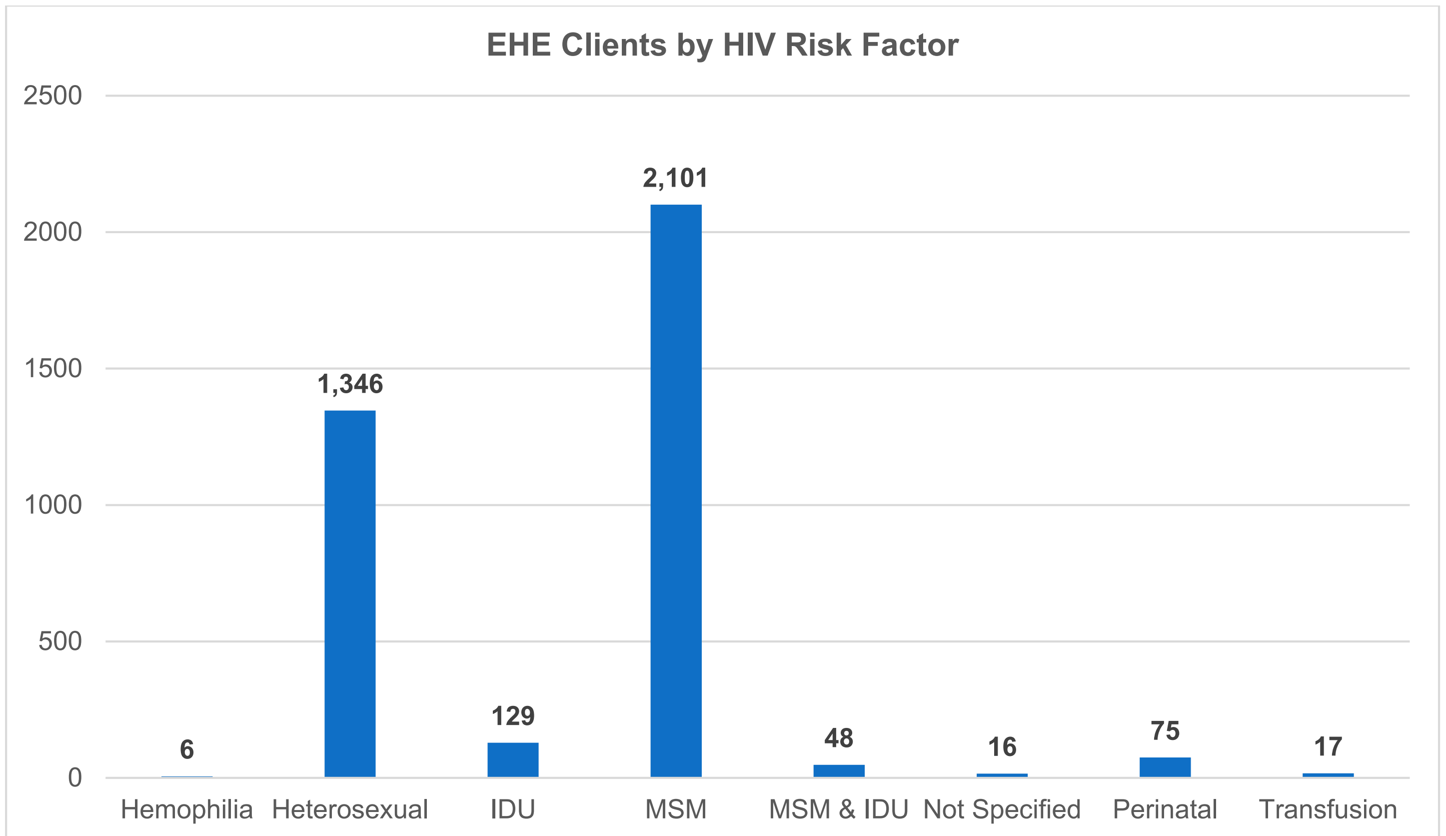
American Indian or Alaskan Native
Asian or Pacific Islander
Black or African American
Hispanic
More Than One Race or Other Race
White

Male Sex at Birth
Female Sex at Birth

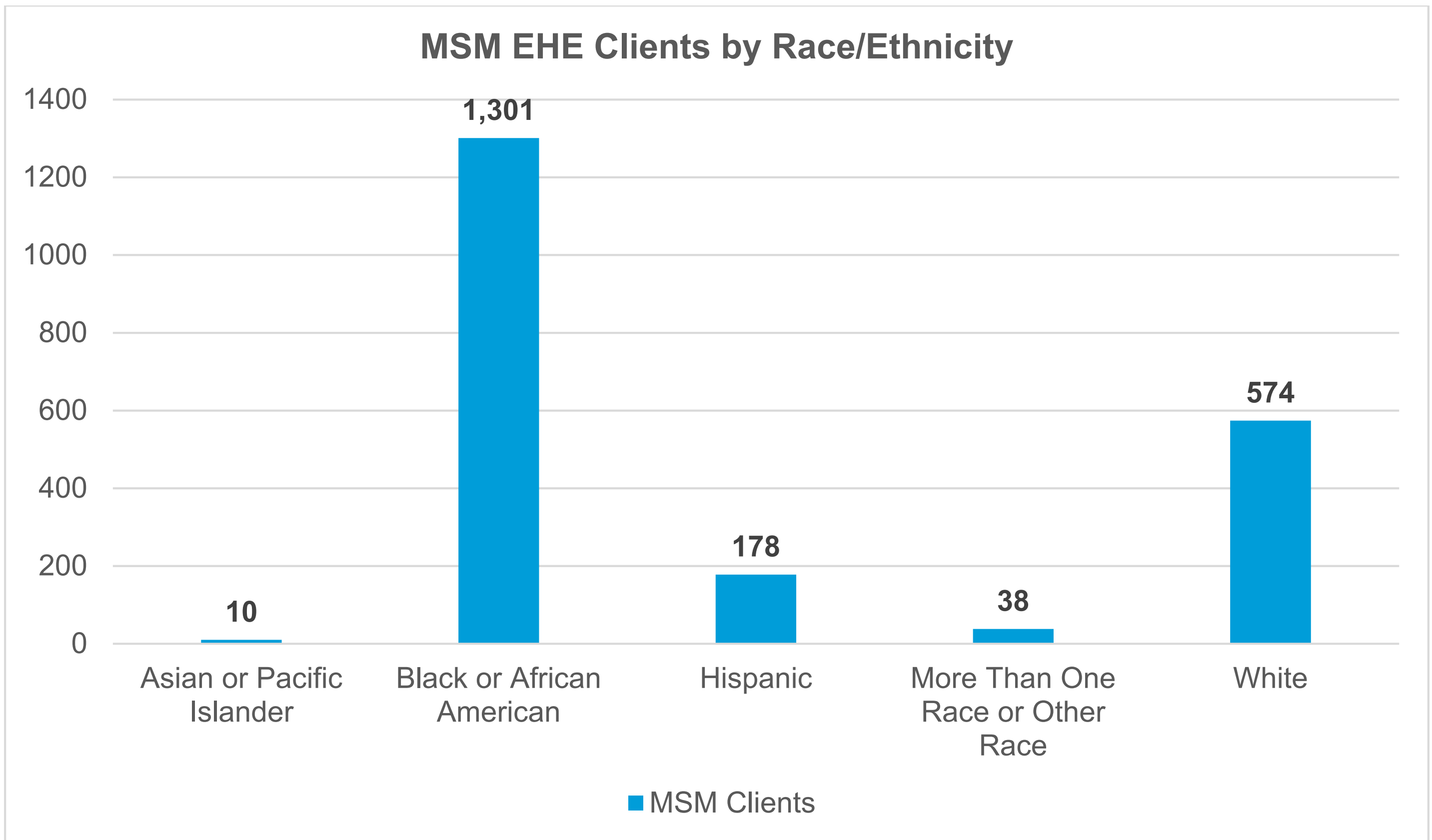
Clients who were Black or African American made up a vast majority of those served in Phase 1; they made up 65% of the clients served from 2020-2024. This was followed by those who are White, constituting 23% of clients served, and those who are Hispanic, constituting 11% of clients served. Specifically, Black or African American males comprised 47% of the total clients served; Hispanic males constituted 8% of clients, while White males comprised 19% of clients.



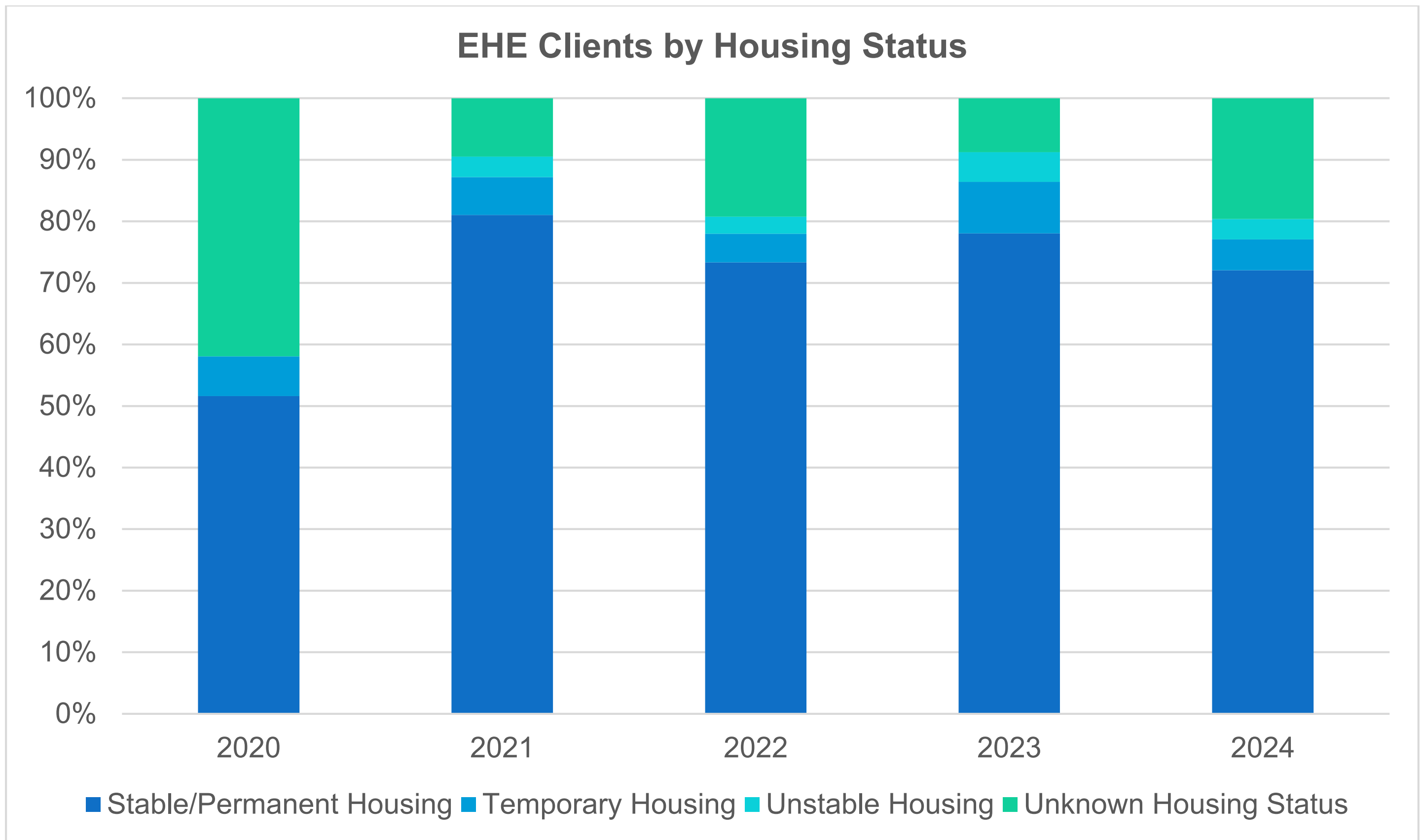
The average age of EHE clients was 45 years old, with clients ranging in age from 8-88 years old. The bulk of EHE clients in Phase 1 fell into the 25-49-year-old age group (53.6%). However, the number of clients who are 50 years or older has been increasing every year since 2020, with 599 (16%) in 2024 alone. This increase in age could indicate that those with HIV are living longer and in need of more services. While the 13-24-year-old age group only constitutes 7% of the total number of EHE clients, this age corresponds with some of the highest incidence of HIV in Cuyahoga County.



While HIV can affect anyone, there are certain risk factors that make some people more vulnerable to infection. HIV Risk Factors are specific behaviors, circumstances, or conditions that increase the likelihood of contracting or transmitting HIV. Through Phase 1, those who are MSM comprised over half (56%) of EHE clients, followed by those who are heterosexual comprised 36%. Other risk factors that had a significant number of clients were those who inject drugs (injection drug use: IDU) which comprised 4% and those who are MSM & IDU which comprised 1.3%.



With MSM being the largest HIV risk factor group, it is important to look at other groups who have utilized EHE for care. When looking at MSM and Race/Ethnicity, Black or African American MSM comprise over a third (35%) of EHE clients. When looking at MSM of Color (specifically, Black or African American MSM and Hispanic MSM combined), they comprised 40% of EHE clients, compared to White MSM comprising 15% of EHE clients.



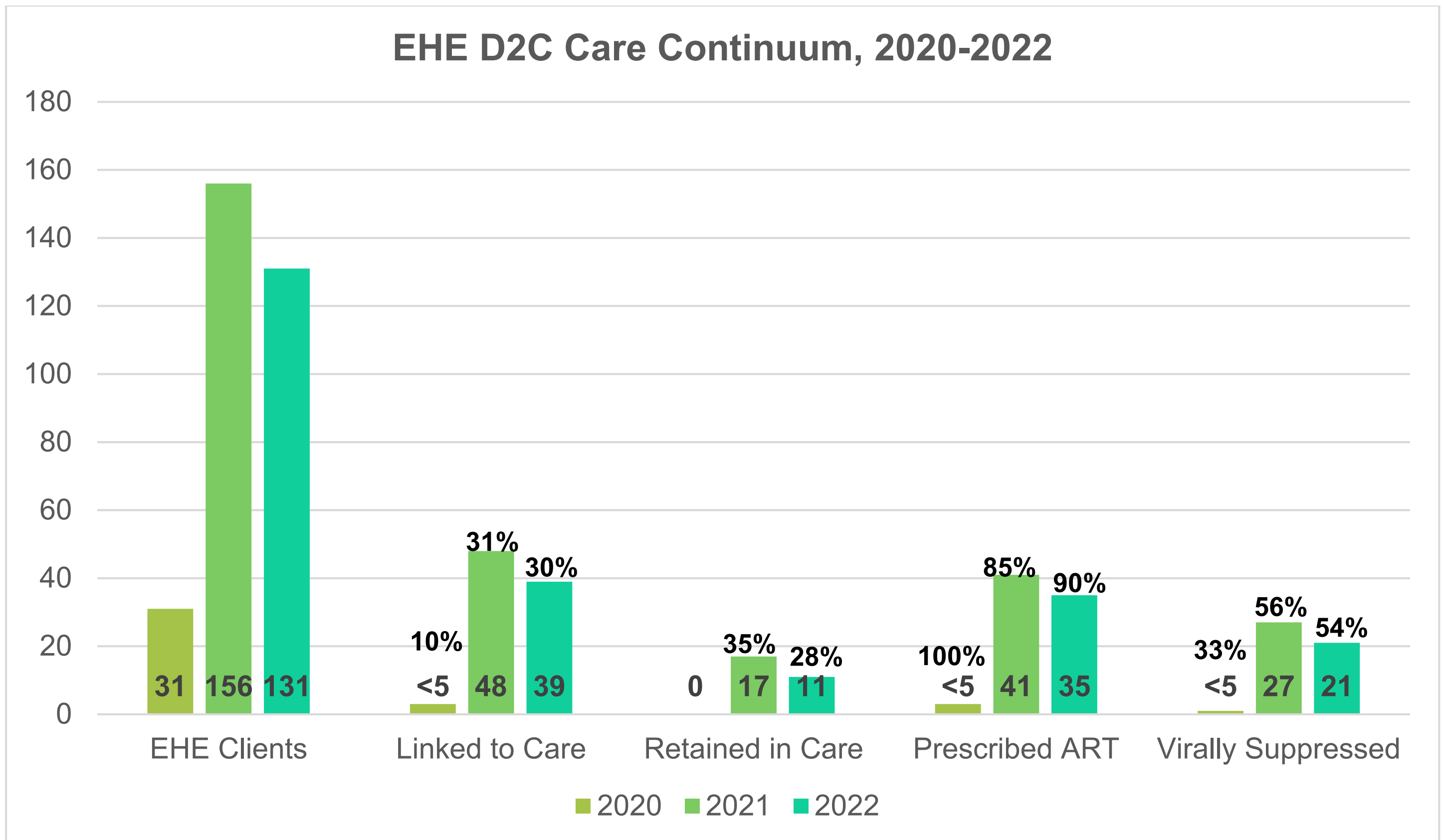
EHE clients were mostly stably housed (75%), meaning that they had a safe and permanent home at the time of their annual assessment. In 2020, only 52% of clients were stably housed. At the conclusion of Phase 1 in 2024, 72% of clients were stably housed.

Care Continuums by Service Category

Data to Care (D2C)

D2C is an HIV prevention strategy promoted by the CDC that utilizes HIV surveillance data and HIV-specific laboratory reports as markers for care to identify individuals who may have fallen out of care or who were never linked to care after being diagnosed with HIV. This strategy also helps to identify those with HIV who are not virally suppressed.

From 2020-2022, the D2C program utilized a collaborative approach that included CCBH and funded healthcare providers. A designated CCBH disease intervention specialist (DIS), in cooperation with funded medical providers, is responsible for investigating the care status of persons identified as not being in care for their HIV and initiating linkage and engagement into care. The program was revised in 2023 and investigation and follow-up was only conducted by the CCBH DIS. Therefore, care continuum data is only available for 2020-2022. The program was also updated in 2024 to focus on clients who had high viral loads and/or CD4 counts, as well as clients who were missing viral load and/or CD4 counts within the last 18 months. This update further prioritizes those who have fallen out of care and may be in need of additional support services.



Care continuum outcomes are relatively low for clients who utilized this service category. However, clients who utilize this service category were most likely not in care previously and therefore would not have had two or more medical care or laboratory visits and would most likely not be virally suppressed. Yet, a vast majority of clients who utilized this service category were prescribed ART, which would aid in improved care continuum outcomes.

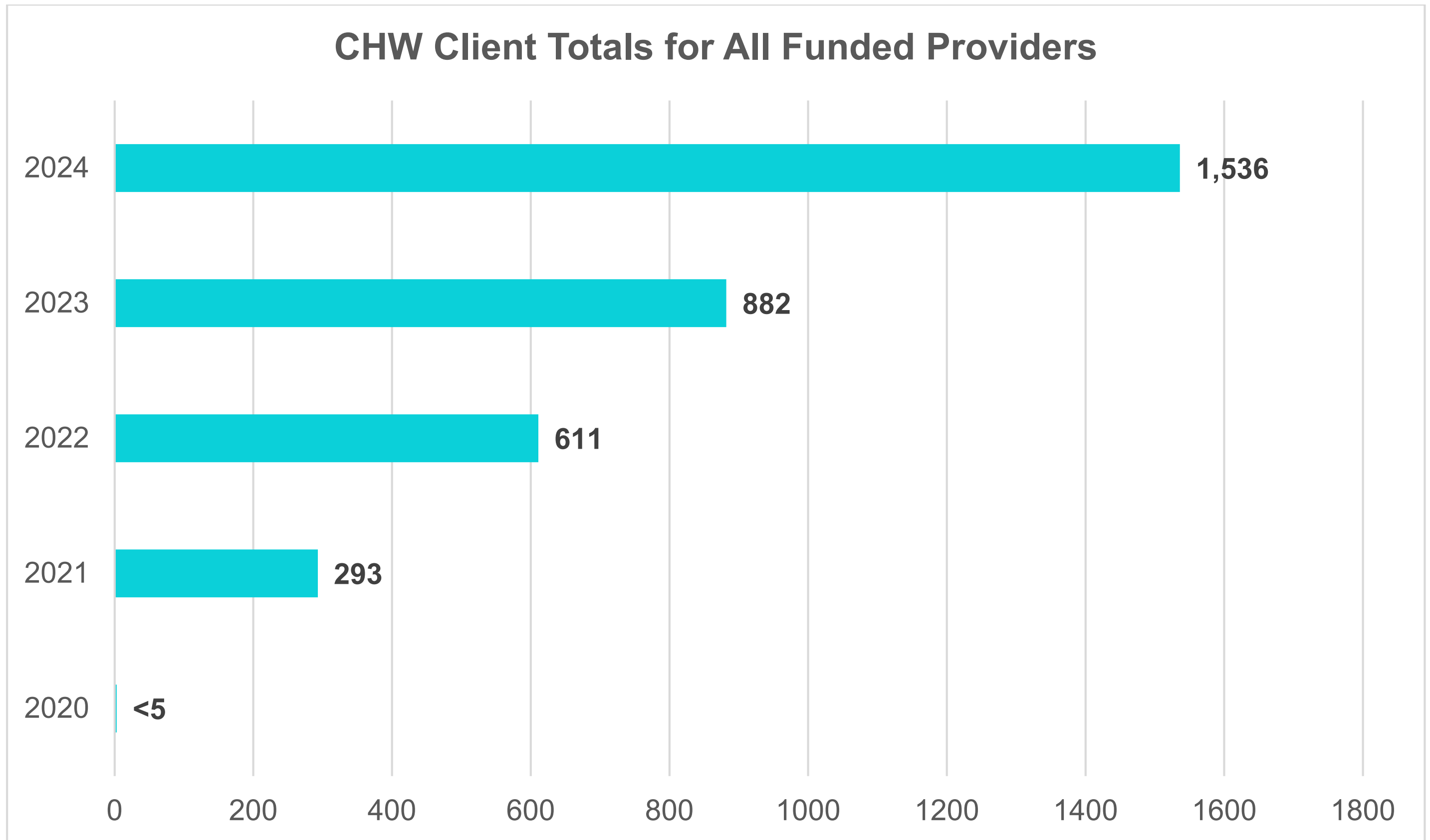
Further details about the D2C service category are available in the subsequent report for the most recent program year on CCBH's website.

Early Intervention Services (EIS) – Credentialed Peer Navigators (Community Health Workers [CHW])

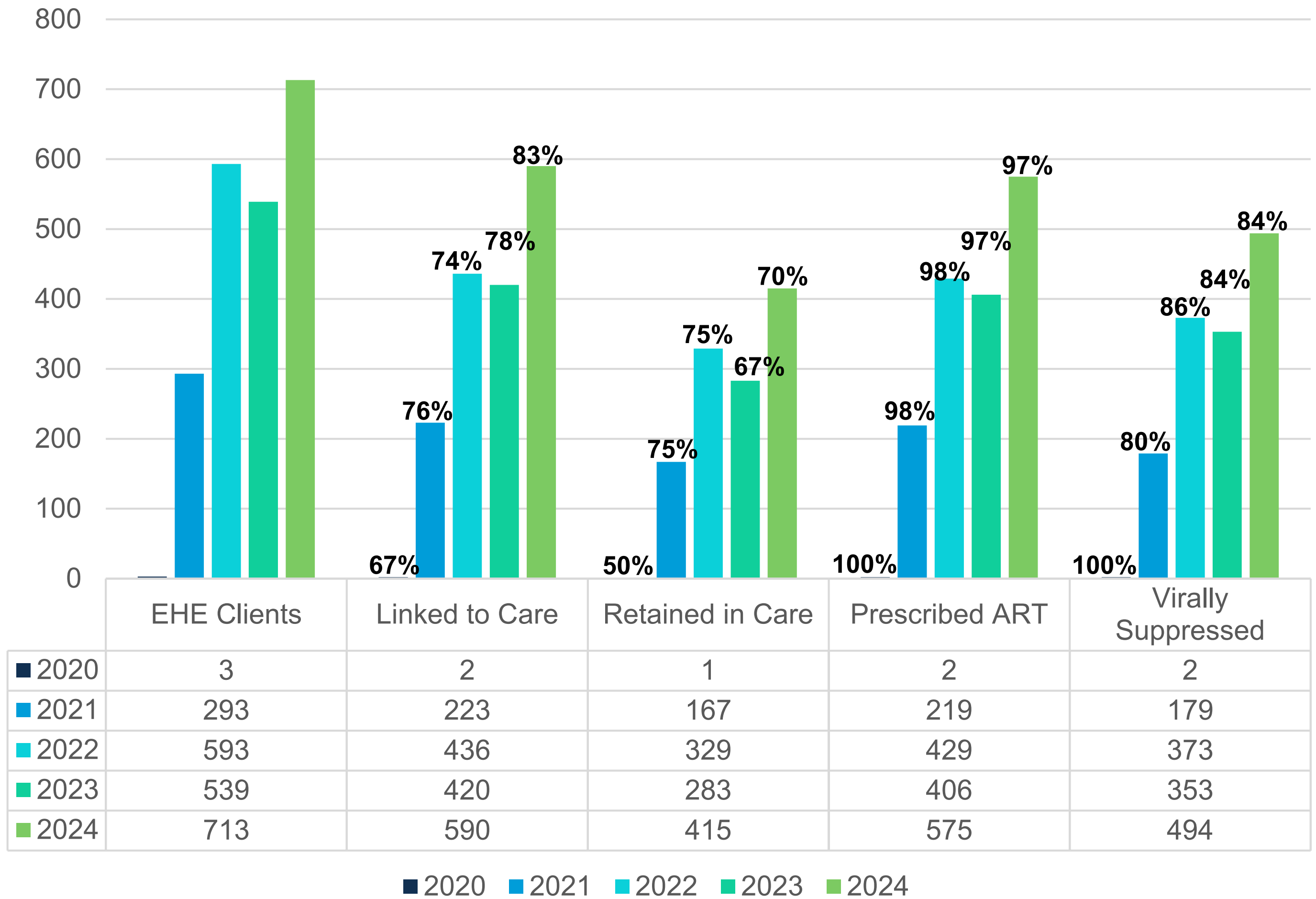
Community Health Workers (CHW), also known as peer navigators, are frontline public health workers. CHWs are trusted members of the community and have a great understanding of the community that is being served. The CHW is able to serve as a liaison between health or social services and the community to access available services and improve the quality and cultural competence of service delivery. The CHW also builds capacity by increasing health knowledge and self-sufficiency through many different activities, such as outreach, community education, informal counseling, social support, and advocacy.

Peer navigators/CHWs work with a social worker to identify clients who would most likely benefit from these services (i.e., those who are not virally suppressed, or are newly diagnosed). The CHW also

helps to identify specific activities that would benefit the client. Successful linkage of clients and activities were tracked to determine success of the program.



The number of clients served by CHW has increased drastically over the course of Phase 1. Almost half (46%) of these clients were served in FY2024 alone.



	EHE Clients	Linked to Care	Retained in Care	Prescribed ART	Virally Suppressed
2020	3	2	1	2	2
2021	293	223	167	219	179
2022	593	436	329	429	373
2023	539	420	283	406	353
2024	713	590	415	575	494

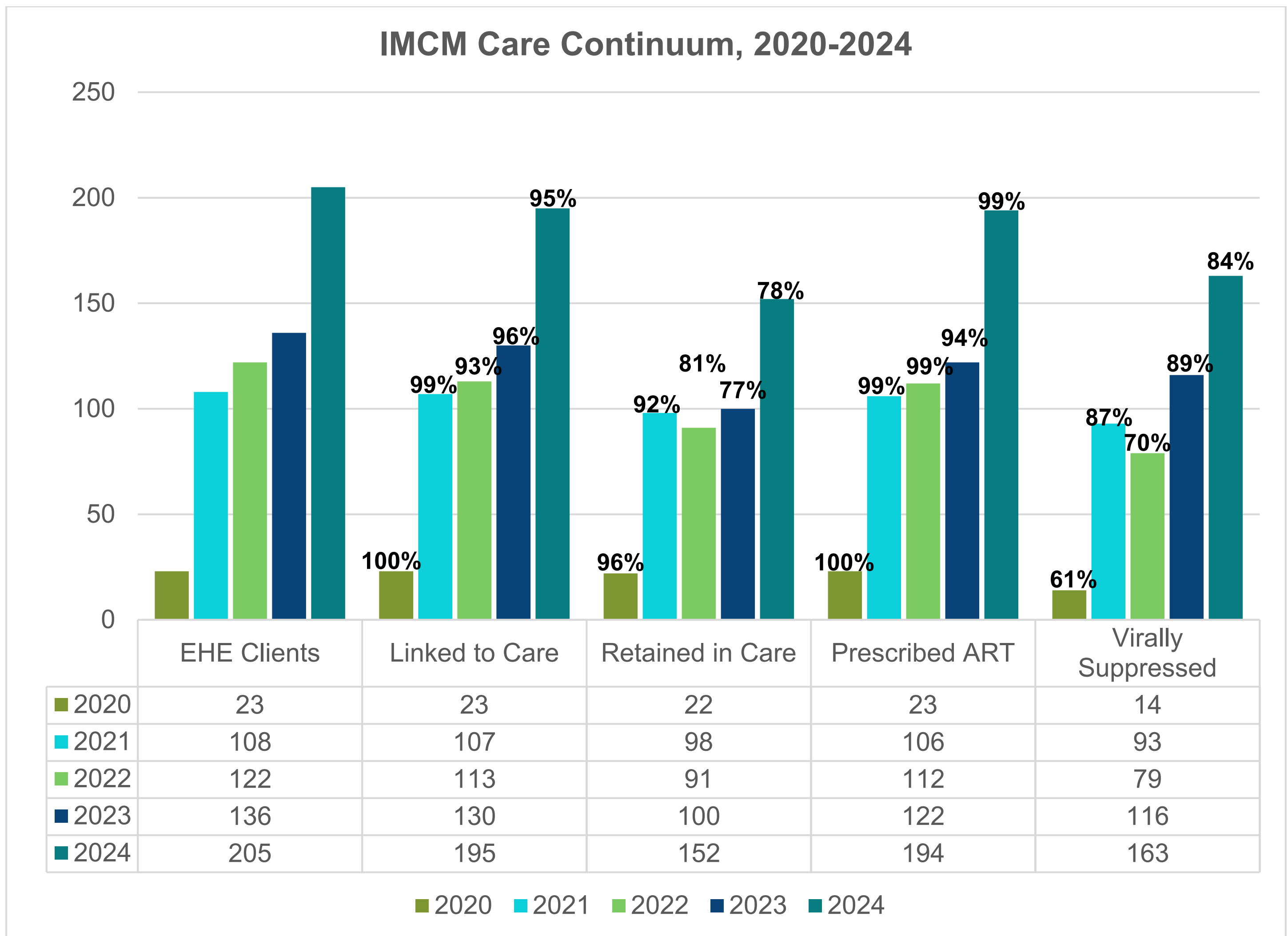
Care continuum outcomes remained relatively steady throughout Phase 1 for CHW/Peer Navigator clients. Retention in care increased dramatically, with a small decline in FY2023.

Intensive Medical Case Management (IMCM)

IMCM is an expansion of Medical Case Management services provided under the Ryan White Part A grant; however, clients do not need to be eligible for Ryan White Part A services in order to receive IMCM under the EHE Initiative. This service category is utilized for clients who have a high acuity score or immediate mental or behavioral health concerns as determined through a comprehensive psychosocial assessment. The objective of this service category is to improve behavioral health outcomes along with providing collaborative care in order to achieve viral suppression. The recommendation for duration of care in IMCM is 18 months; clients are then transitioned to traditional medical case management. While this service category provides rigorous follow-up, the case managers who handle these clients typically have smaller caseloads to enable them to deliver this high level of case management effectively.

IMCM includes all types of case management encounters (e.g., face-to-face, phone contact, or other forms of communication). Activities in this service category include, but are not limited to: assessment

of service needs, development of a comprehensive and individualized care plan, treatment adherence counseling, access to medically appropriate levels of health and support services, and continuous assessment of further needs.



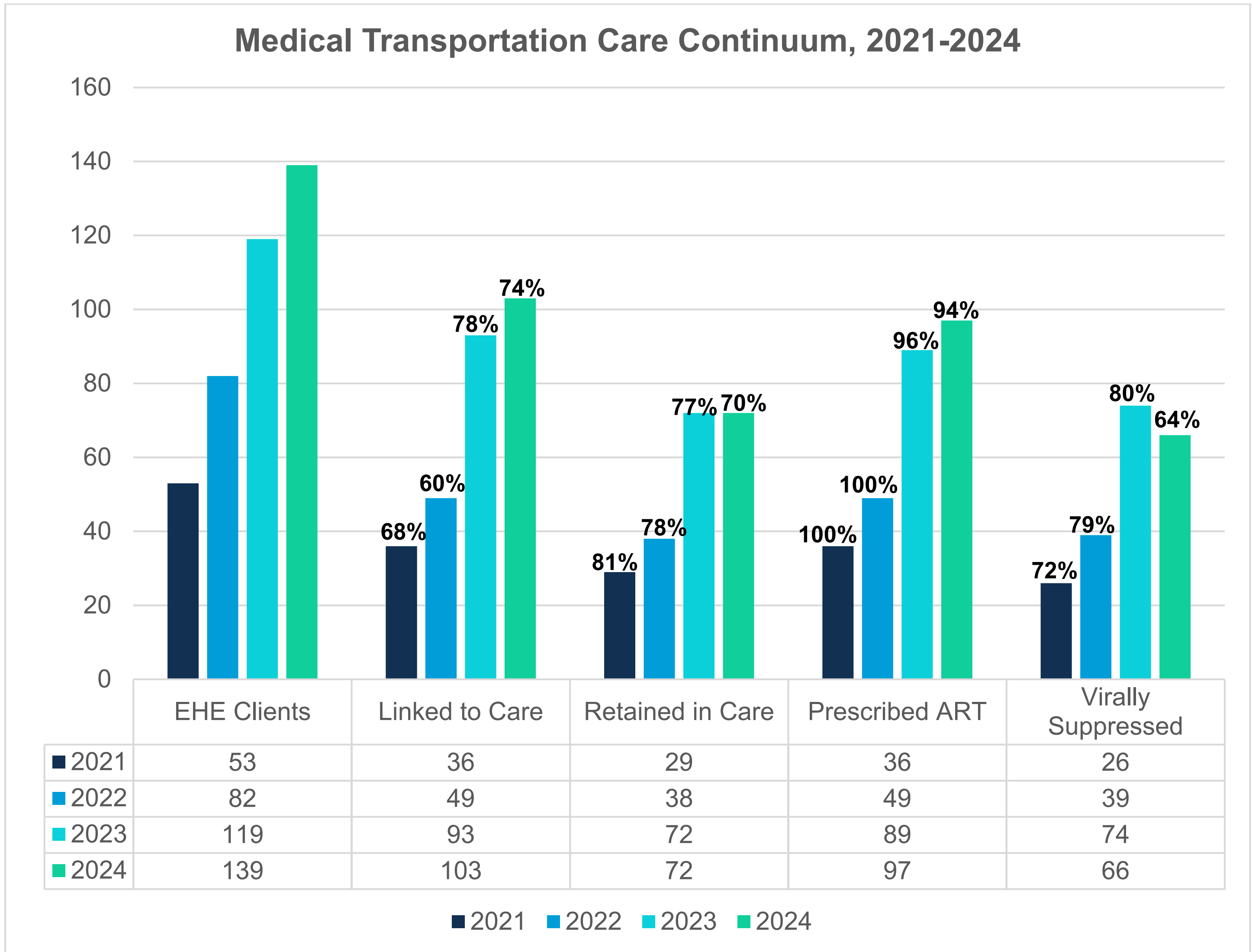
	EHE Clients	Linked to Care	Retained in Care	Prescribed ART	Virally Suppressed
2020	23	23	22	23	14
2021	108	107	98	106	93
2022	122	113	91	112	79
2023	136	130	100	122	116
2024	205	195	152	194	163

Clients who utilize IMCM typically receive more intense follow-up, which can include more contact and medical appointments. Due to this intense case management, clients who utilize this service category should show higher rates of retention in care. As shown in the chart above, IMCM clients have higher rates of retention compared to the overall care continuum for EHE clients (see EHE Care Continuum). IMCM clients also have overall higher rates of viral suppression. These factors indicate the success of the intensive follow-up on care outcomes for clients.

As mentioned above, the goal of IMCM is to transition clients to traditional medical case management after 18 months. At the end of Phase 1, 190 total clients (32%) transitioned out of IMCM. The average amount of time spent in IMCM is 16 months (1 year, 4 months), with almost 75% of clients only spending 1 year in IMCM. Of the 190 clients transitioned out of IMCM, 33% (n=62) of clients were transitioned to Ryan White Part A medical case management. The highest amount of clients was transitioned out of IMCM in FY2022 (56% of the total clients in 2022).

Medical Transportation

The medical transportation service category is used to provide non-emergency transportation to eligible clients in order to increase linkage and retention to care and support services, and ultimately increase viral suppression. Medical transportation may be provided through mileage reimbursement or HIPAA-compliant rideshare. This service category began being funded in 2021 and continued through the end of Phase 1.



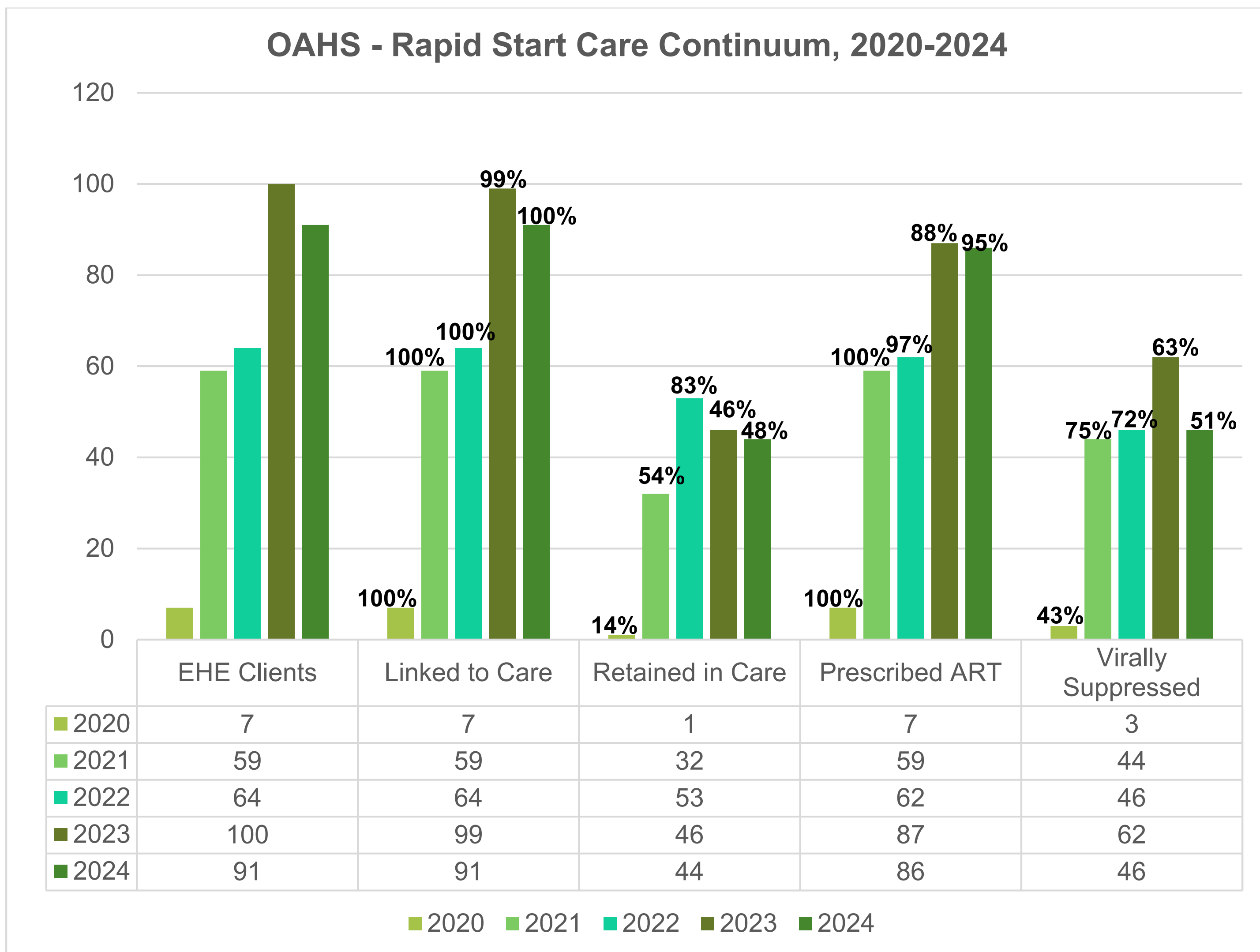
	EHE Clients	Linked to Care	Retained in Care	Prescribed ART	Virally Suppressed
2021	53	36	29	36	26
2022	82	49	38	49	39
2023	119	93	72	89	74
2024	139	103	72	97	66

The number of clients utilizing medical transportation increased during each program year during Phase 1. Linkage to care, retention in care, and viral suppression increased every year until 2024; all continuum measures were below the rates of the overall EHE continuum in 2024.

Outpatient & Ambulatory Health Services (OAHS) – Rapid Start

The OAHS service category is typically used to provide medical care for eligible clients. The EHE Initiative used this service category as a means to provide newly diagnosed or new-to-care clients with prescribed ART at their first medical appointment or interaction with a medical provider. This helps to

remove barriers so a client can immediately begin their journey toward viral suppression. This service category enables patients to have high-intensity support and improved care continuum outcomes.



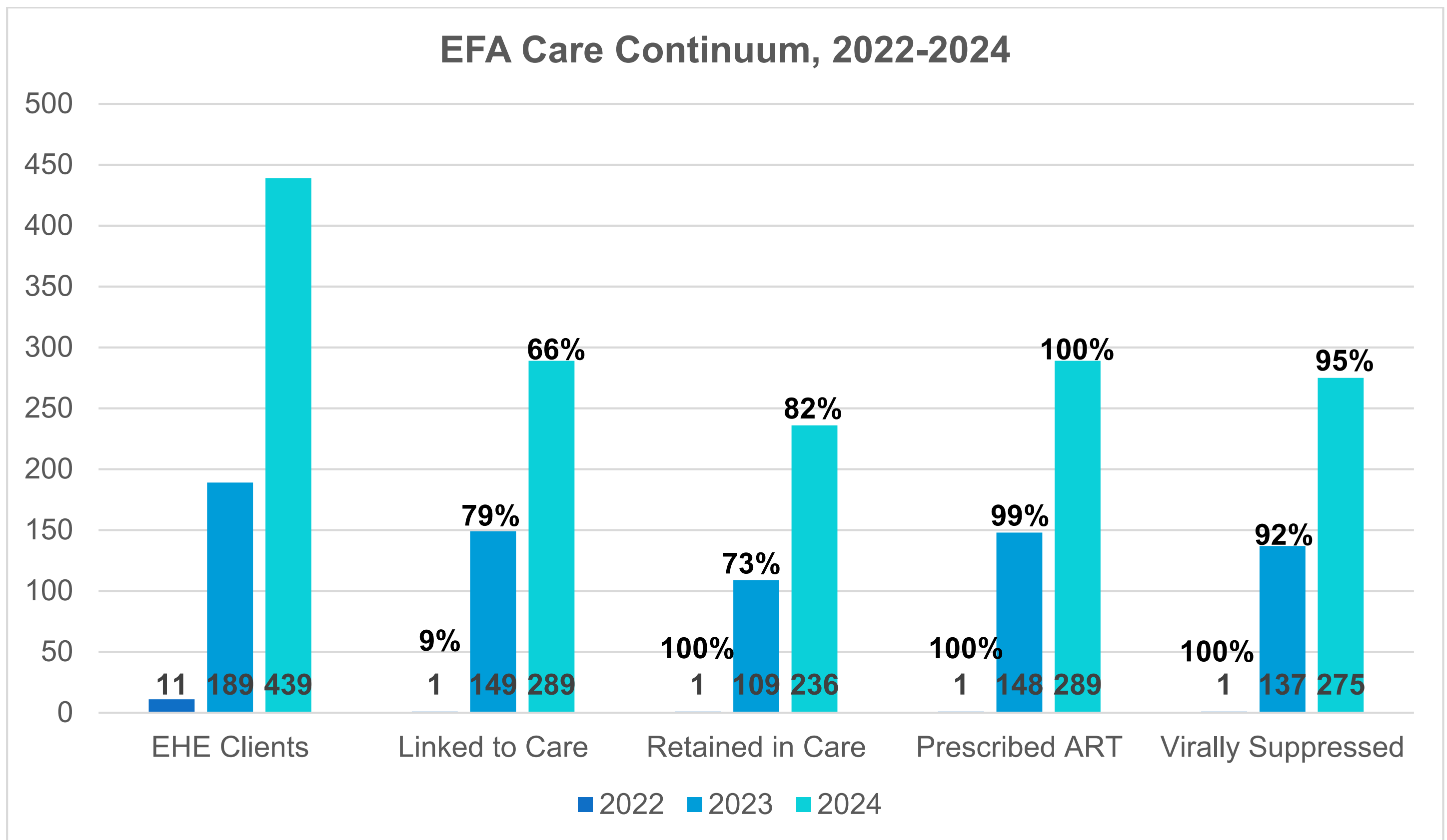
	EHE Clients	Linked to Care	Retained in Care	Prescribed ART	Virally Suppressed
2020	7	7	1	7	3
2021	59	59	32	59	44
2022	64	64	53	62	46
2023	100	99	46	87	62
2024	91	91	44	86	46

Rates of linkage to care and ART prescription were consistently high for clients who utilized this service category. However, retention in care and viral suppression rates were very low among this client population. While the rates seem alarming, this client population comprises those who are either newly diagnosed or have been out-of-care. Many factors impact whether or not a client is retained in care, such as coming to terms with their diagnosis or learning the routine necessary for HIV care. It is also known that viral suppression does not happen instantly and can take years for some clients while an appropriate ART regimen for the client is determined. High rates of linkage to care shows that clients are set up for success and are on the road toward viral suppression.

Emergency Financial Assistance (EFA)

The purpose of the EFA service category is to provide direct financial assistance to eligible clients who are severely affected by the HIV epidemic and the economic barriers to care. The need for this service category is driven by the high levels of poverty among people who have been diagnosed with HIV.

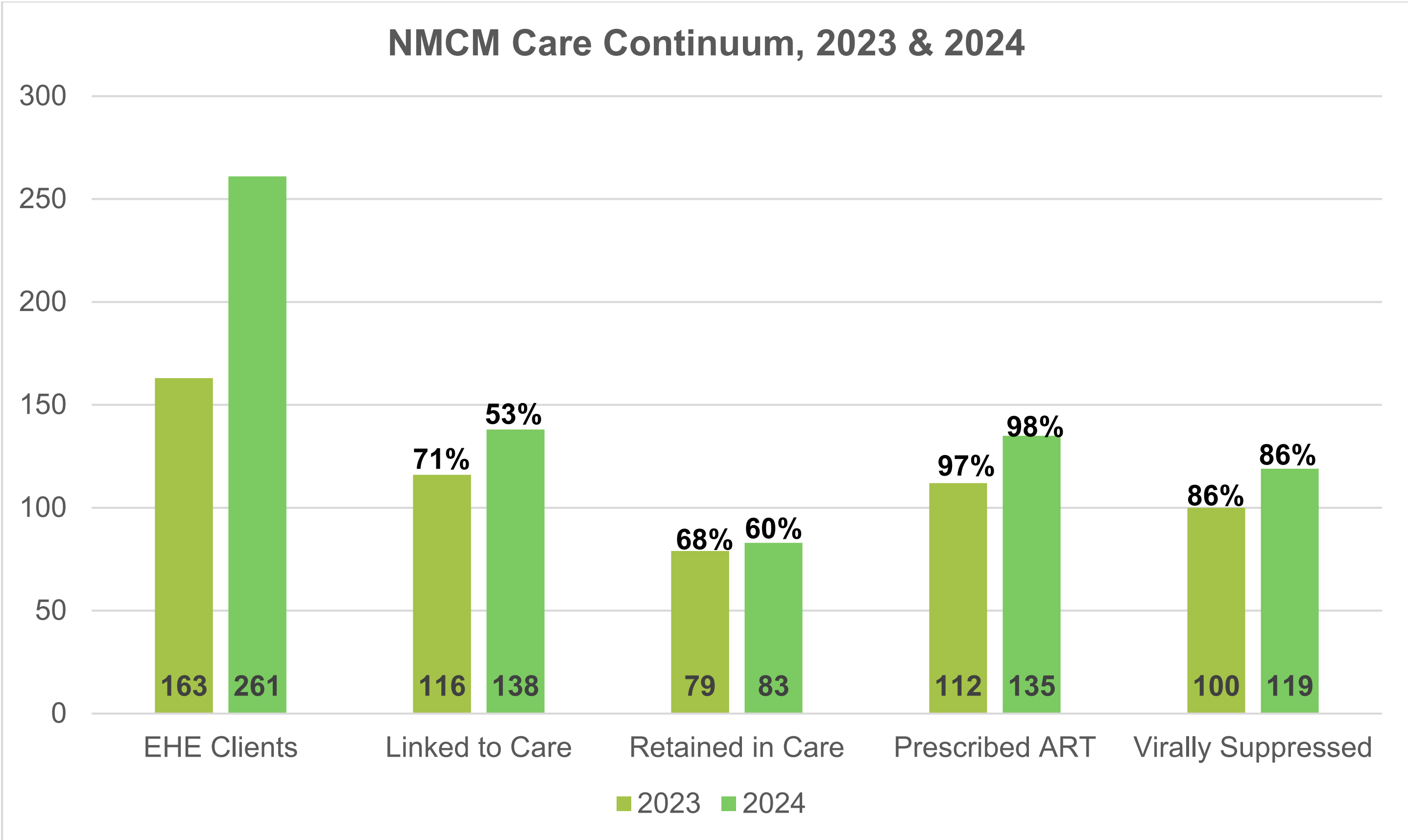
Financial hardship diminishes the ability of those who have been diagnosed with HIV to undertake self-care or access essential health services. This service category aims to provide optimal HIV care and treatment for people with HIV who are low-income, uninsured, and underserved in order to improve their care outcomes. EFA provides limited one-time or short-term payments to assist a client with an emergent need with paying for essential items or services. These payments can include: utilities, housing, food (including groceries or food vouchers), transportation, medication not covered by the AIDS Drug Assistance Program (ADAP) or AIDS Pharmaceutical Assistance. This must occur as a direct payment to an agency or through a voucher program, and must be the payer of last resort. This service category was funded through the EHE Initiative from 2022-2024.



Care continuum outcomes improved annually through Phase 1 for EFA clients. Rates of viral suppression were extremely high for clients who utilized this service category, indicating that even short-term financial assistance can greatly improve outcomes for those who are experiencing financial hardships.

Non-Medical Case Management (NMCM)

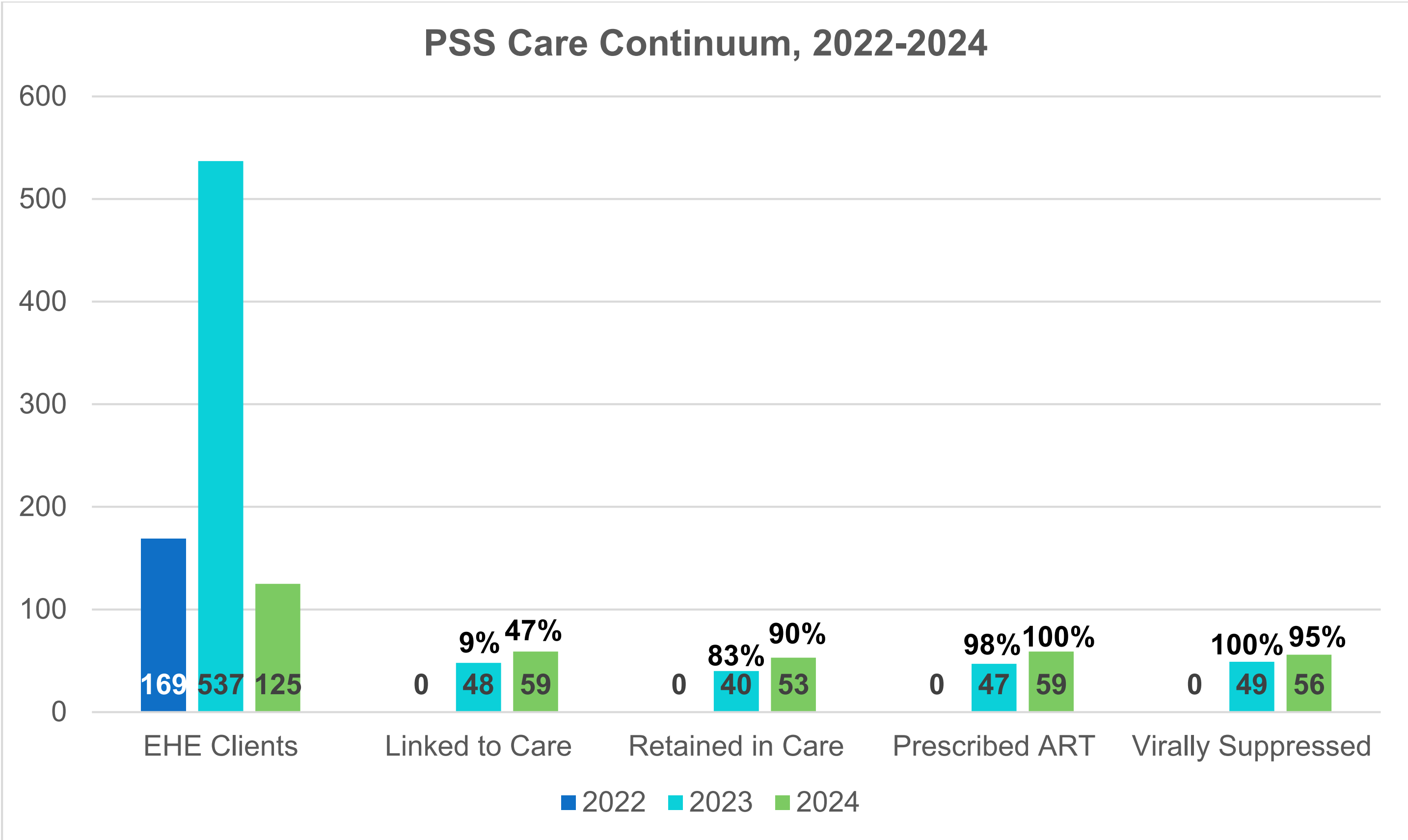
NMCM services aim to provide guidance and assistance in improving access to needed services other than medical care. These can include social, community, legal, and financial services. Ultimately, this service category is used to provide housing and benefit (other public and private programs clients may be eligible for) coordination for people with HIV that aids in medical care adherence and stability. This service category was funded by the EHE Initiative for program years 2023 and 2024.



While rates of linkage and retention are low for this service category, rates of viral suppression are high for those clients who utilized NMCM. This shows that utilization of all available benefits can add to longevity for those who are diagnosed with HIV.

Psychosocial Support Services (PSS)

PSS provides individual and/or group support and counseling services to address continuing behavioral and physical health concerns. It is used for networking among peers to help clients access health and benefits information, develop coping skills, reduce feelings of social isolation, and increase self-determination and self-advocacy, which help improve clients' quality of life. These activities can be conducted through support and counseling activities, HIV support groups, pastoral care or counseling services, or caregiver support. This service category was funded by the EHE Initiative from 2022-2024; however, care continuum information is only available for 2023 and 2024.



While linkage to care rates are relatively low, other continuum measures are very high for clients who utilized PSS. This highlights the importance of peer support to improve HIV outcomes.

Monitoring Outcomes

The Health Resources and Services Administration (HRSA) HIV/AIDS Bureau (HAB) Division of Metropolitan HIV/AIDS Program National Monitoring Standards requires that EHE recipients conduct an annual site visit with each sub-recipient (also known as a provider). This is done to ensure compliance relative to the proper use of federal grant funds and adherence to fiscal, clinical, programmatic and professional guidelines put in place. Providers are required to maintain an individual case record or medical record for each client served. All of the billed services must match the services documented in the client's record. A random sample of client records are reviewed annually for compliance using monitoring tools and standards of care developed by the recipient. Findings and recommendations are given to the provider for each service category if ≤79% of the selected client charts do not meet the standards set forth by the monitoring tools.

Monitoring of the EHE Initiative in Cuyahoga County did not officially begin until program year 2023; pilot monitoring was conducted for 2022 but was not punitive. Monitoring lags by one program year (e.g., fiscal year 2023 is monitored in fiscal year 2024). Common findings from monitoring visits to providers included missing documentation. The D2C service category was not monitored as it was not funded for providers after 2023.

	FY2023	FY2024
OAHS (Rapid Start ART)	No findings.	No findings.
Early Intervention Services (EIS)(CHW/Peer Navigation)	1 finding. 66% of charts reviewed included documentation of services provided related to EIS. 33% of charts reviewed did not include documentation that the viral load was less than 200 copies/ml at last test.	No findings.
Intensive Medical Case Management (IMCM)	2 findings. 67% of charts reviewed included documentation of services provided related to IMCM. 23% of charts reviewed did not include care plans. 77% of charts reviewed did not include documentation that the goals of the care plan were satisfied and IMCM was no longer needed.	2 findings. 67% of charts reviewed included documentation of services provided related to IMCM. 23% of charts reviewed did not include care plans. 77% of charts reviewed did not include documentation that the goals of the care plan were satisfied and IMCM was no longer needed.
Medical Transportation (MT)	No findings.	2 findings. While services were rendered to clients, none of the charts reviewed provided proper documentation.
Emergency Financial Assistance	N/A	4 findings. While services were rendered to clients, none of the charts reviewed provided proper documentation of the details of those services. However, 67% of charts reviewed included documentation of eligibility and need evident in the clients' charts.
Psychosocial Support Services	N/A	No findings.

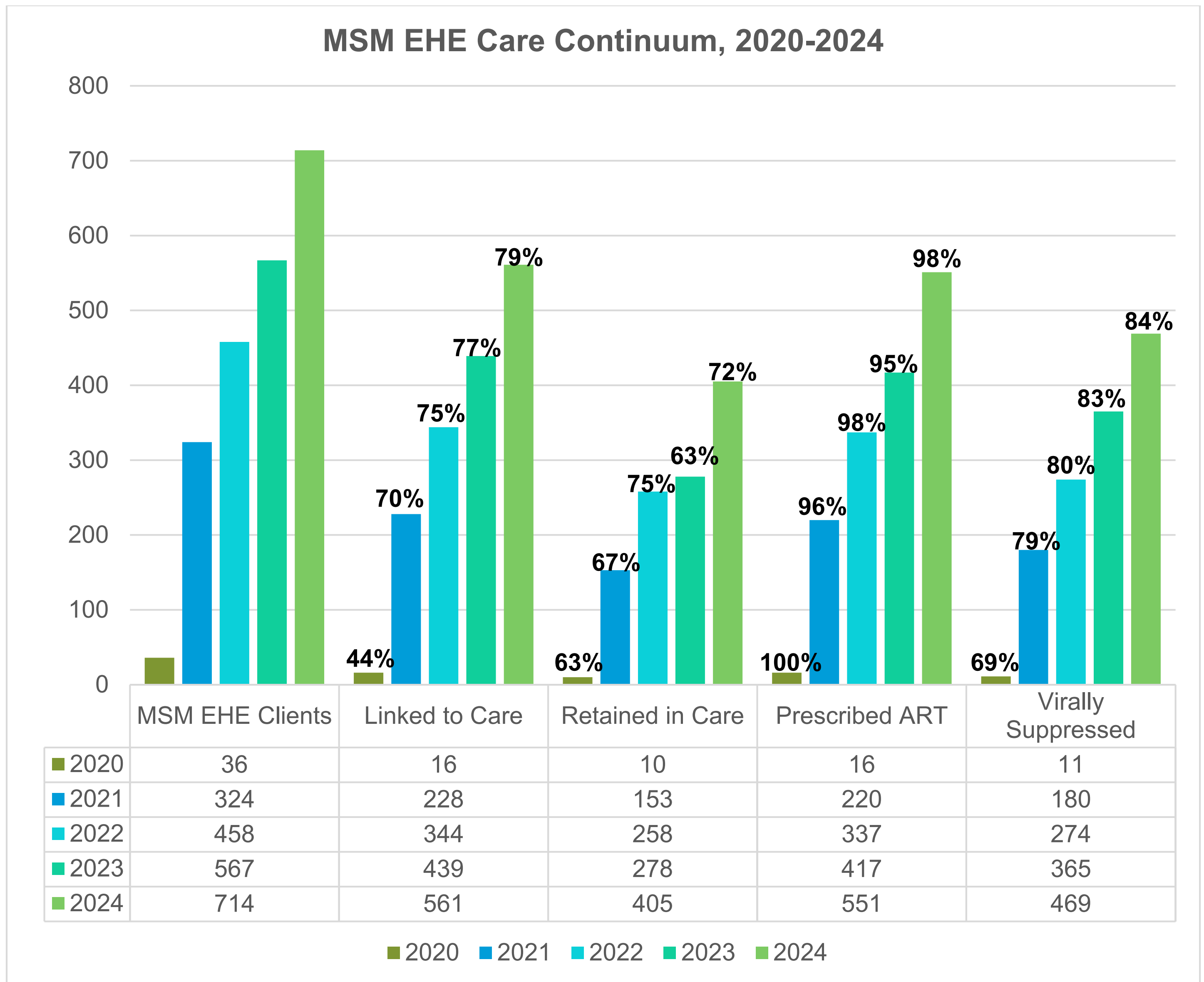
5. Populations of Focus – Care Continuums

Epidemiological surveillance data and qualitative data from community partners indicate that certain populations are disproportionately affected by HIV and have the highest burden of infection. These populations are given special attention when developing interventions and infection prevention strategies. The populations of focus identified through Phase 1 of the EHE Initiative are:

- MSM
- MSM of Color (including those who are Black/African American or Hispanic)
- Youth ages 13-24 years old
- Ages 50+ years old (clients who are aging with HIV)

These populations of focus are closely monitored for care continuum outcomes to indicate the success of interventions in place.

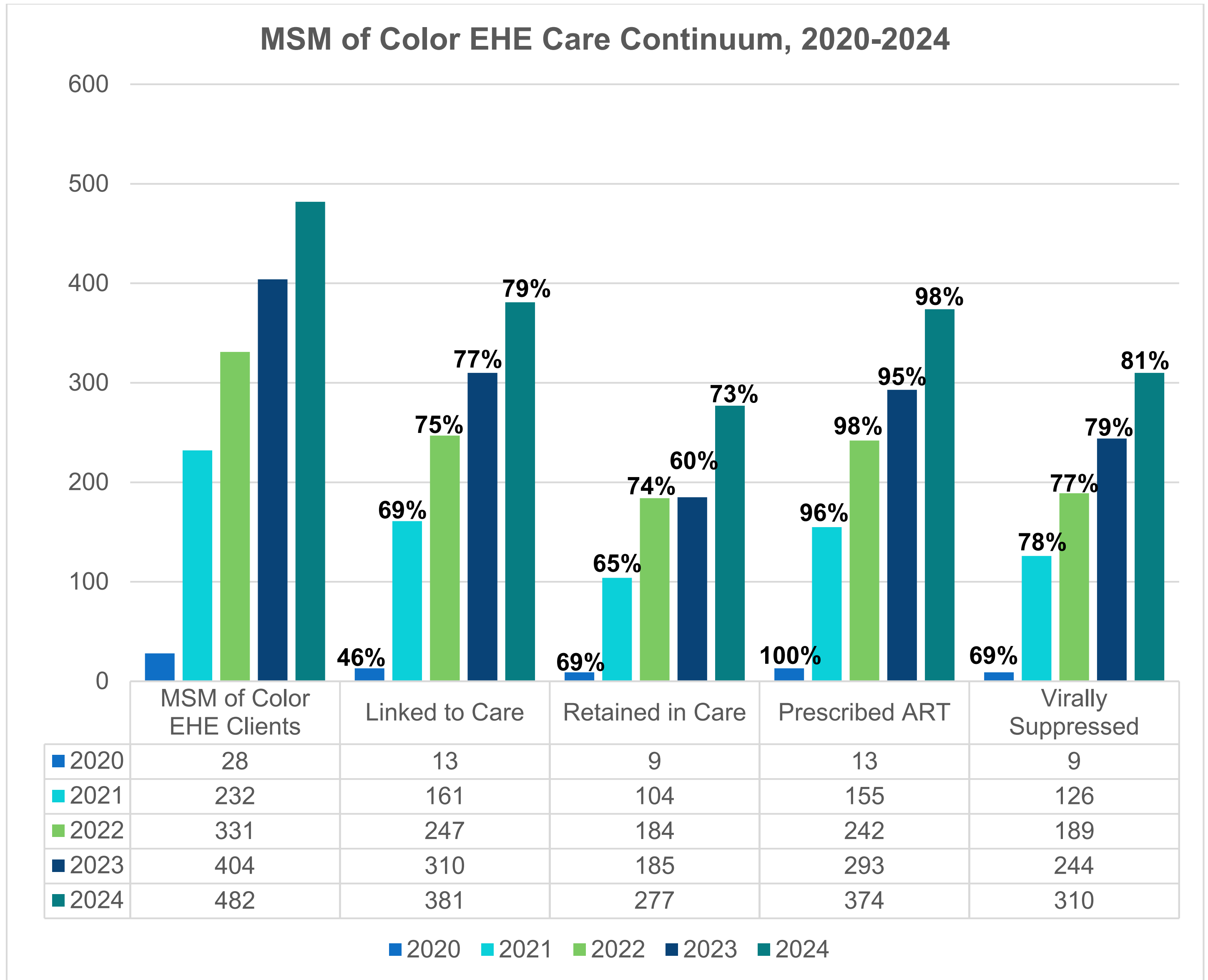
MSM



	MSM EHE Clients	Linked to Care	Retained in Care	Prescribed ART	Virally Suppressed
2020	36	16	10	16	11
2021	324	228	153	220	180
2022	458	344	258	337	274
2023	567	439	278	417	365
2024	714	561	405	551	469

Care continuum outcomes increased throughout the course of Phase 1 for MSM clients. Linkage and retention outcomes for MSM clients were slightly lower than the overall client continuum outcomes. However, viral load suppression for MSM clients was similar to that of the overall client continuum. Though improvement was shown throughout Phase 1, the MSM client population is still experiencing disproportionate effects from HIV and should still receive priority when developing interventions.

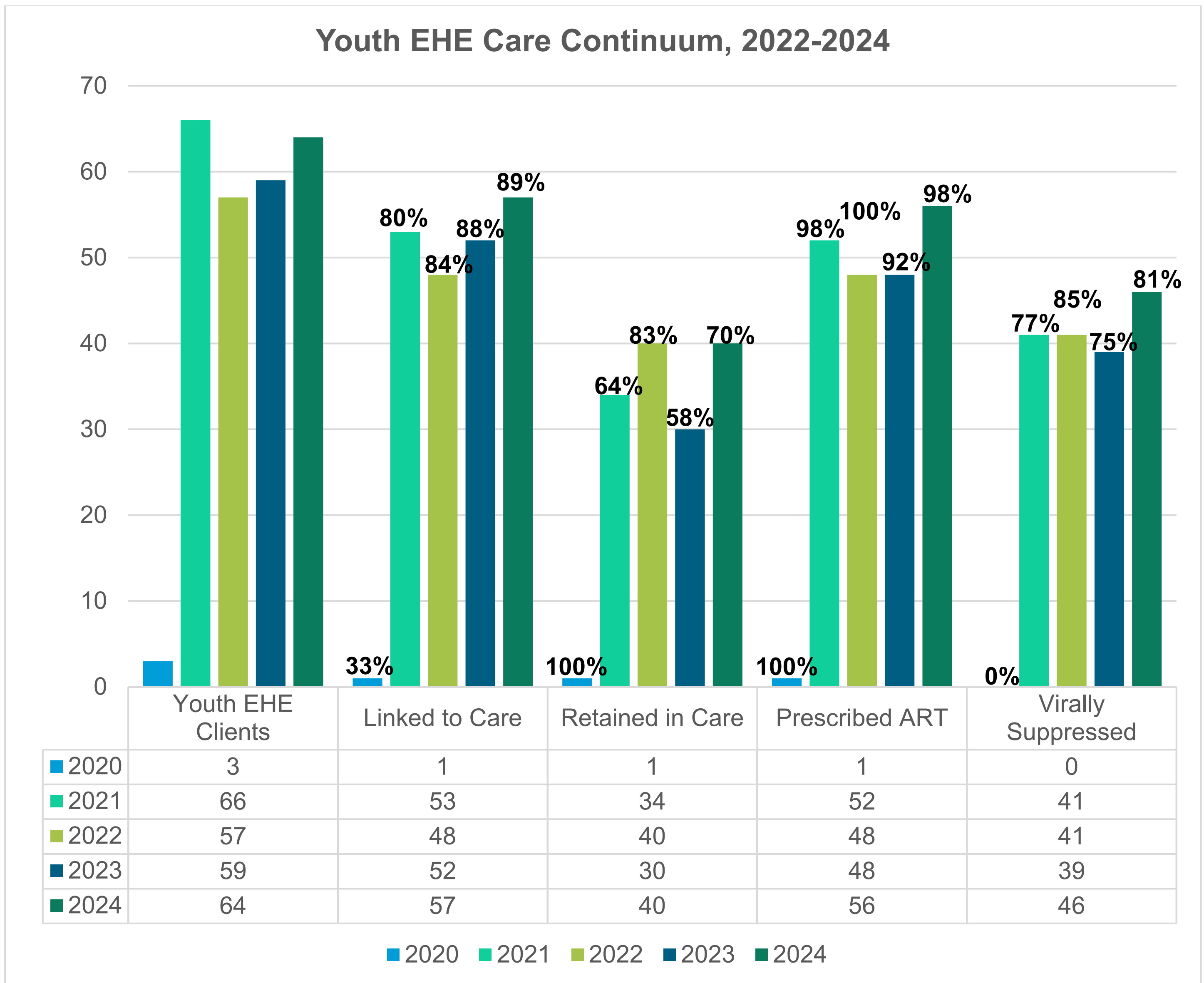
MSM of Color



	MSM of Color EHE Clients	Linked to Care	Retained in Care	Prescribed ART	Virally Suppressed
2020	28	13	9	13	9
2021	232	161	104	155	126
2022	331	247	184	242	189
2023	404	310	185	293	244
2024	482	381	277	374	310

Care continuum outcomes also increased throughout Phase 1 for MSM of Color clients. Similar to MSM clients, outcomes were also slightly lower than the overall care continuum. These outcomes were also lower than MSM EHE clients. While improvement was shown throughout Phase 1, the MSM of Color client population is still experiencing disproportionate effects from HIV.

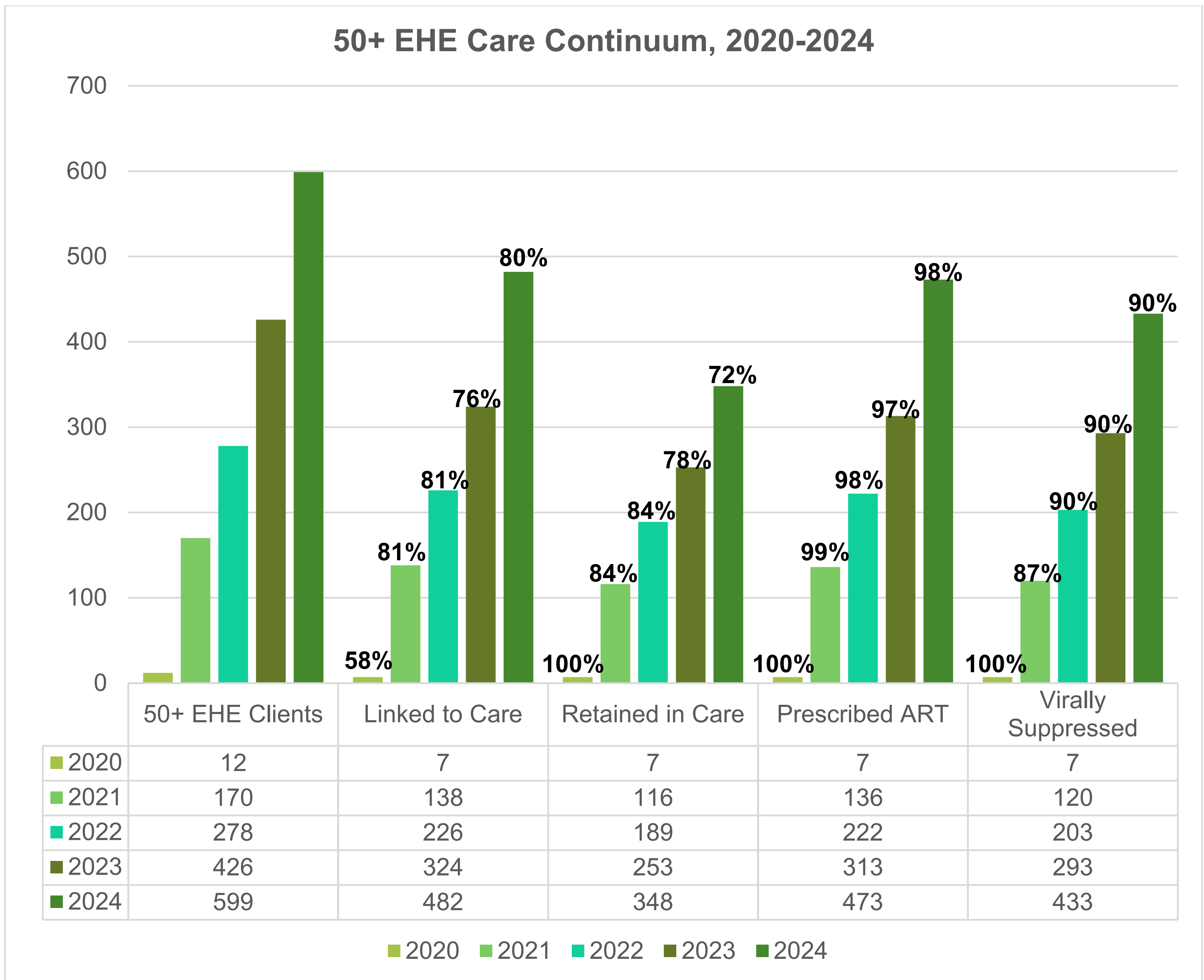
Youth 13-24 Years Old



	Youth EHE Clients	Linked to Care	Retained in Care	Prescribed ART	Virally Suppressed
2020	3	1	1	1	0
2021	66	53	34	52	41
2022	57	48	40	48	41
2023	59	52	30	48	39
2024	64	57	40	56	46

Youth EHE clients continually had higher linkage to care outcomes throughout Phase 1 when compared to the overall linkage to care outcomes. While viral suppression rates were lower in this population, many of the clients in this age group are newly diagnosed and could potentially have not reached viral suppression on current ART regimens. Although care continuum outcomes have increased over time, this population is persistently seeing new diagnoses of HIV and should remain a population of focus.

50+ Years Old



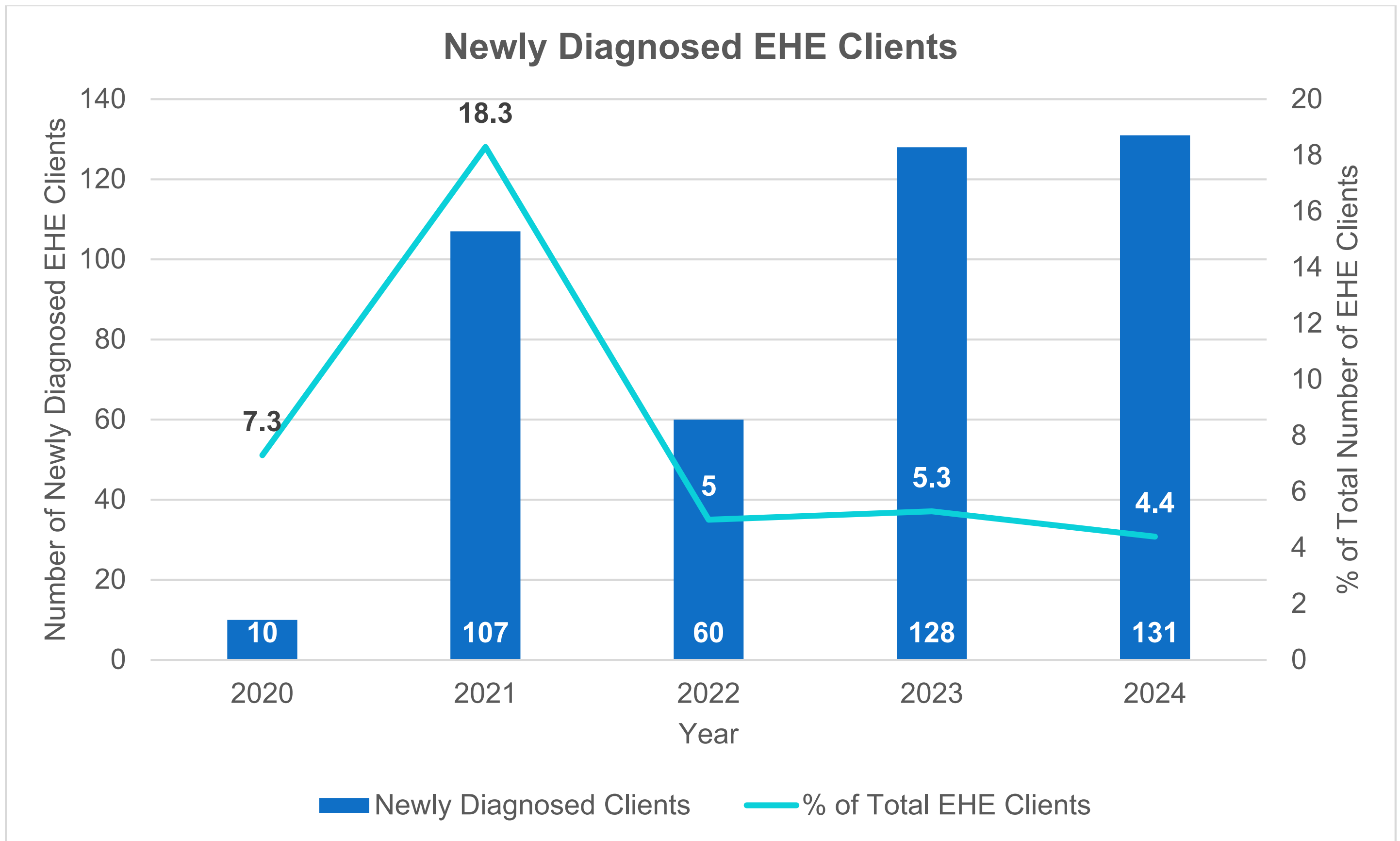
	50+ EHE Clients	Linked to Care	Retained in Care	Prescribed ART	Virally Suppressed
2020	12	7	7	7	7
2021	170	138	116	136	120
2022	278	226	189	222	203
2023	426	324	253	313	293
2024	599	482	348	473	433

Clients fifty-years and older had better care outcomes when compared to the overall care continuum outcomes for all clients. This could speak to clients in this age group having better access to care for their HIV and the success of ART regimens. Though it seems that this population doesn't need additional support, this age group continually makes up the majority of HIV prevalence; PWH are also living longer due to effective ART regimens.

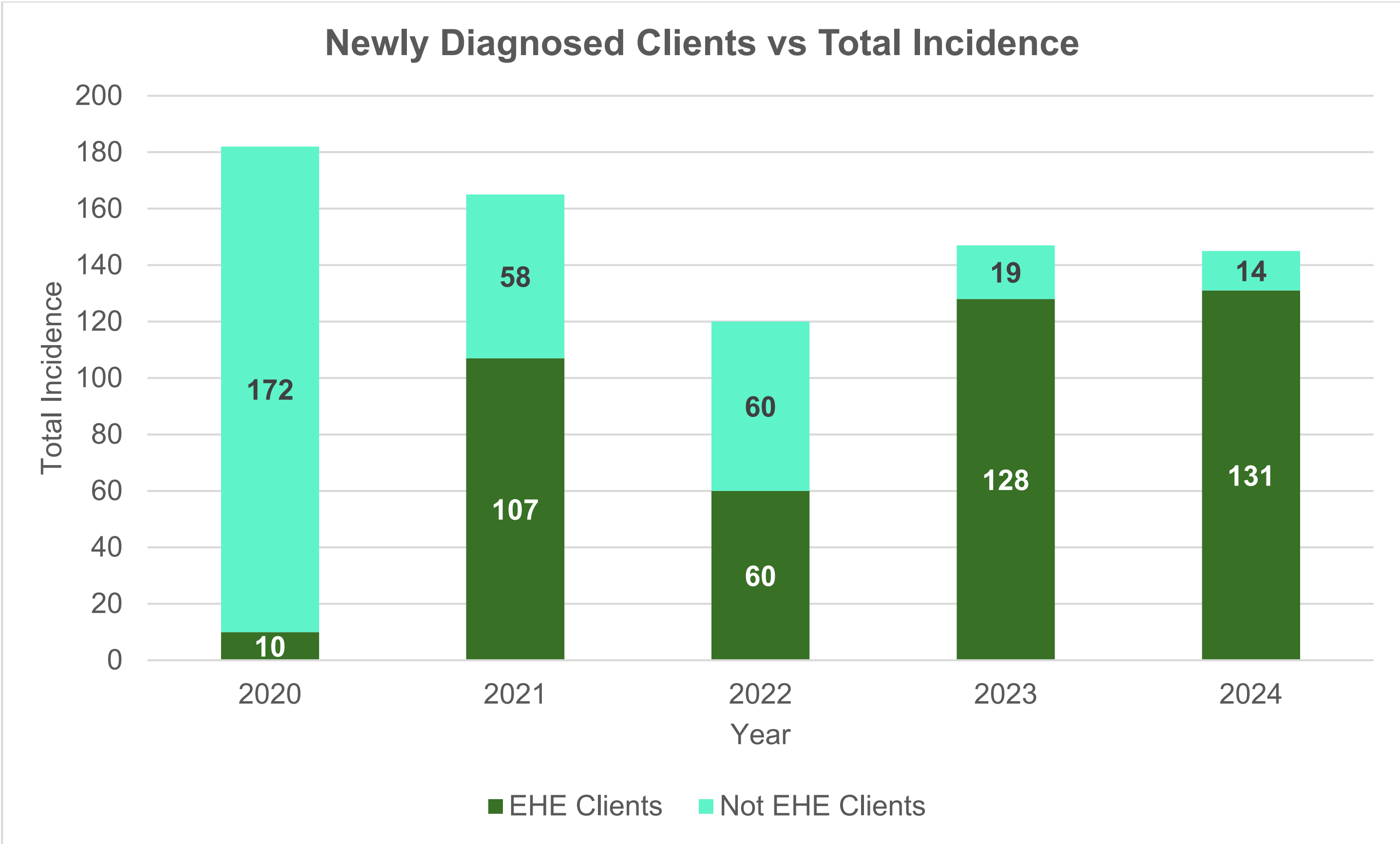
6. Newly HIV Positive Client Enrollment

Research has shown that prompt linkage to care after HIV diagnosis is a crucial step for successful HIV treatment and gets a client one step closer to viral suppression. This in turn improves care outcomes for clients and reduces HIV transmission. Linking clients to care early on in their diagnosis

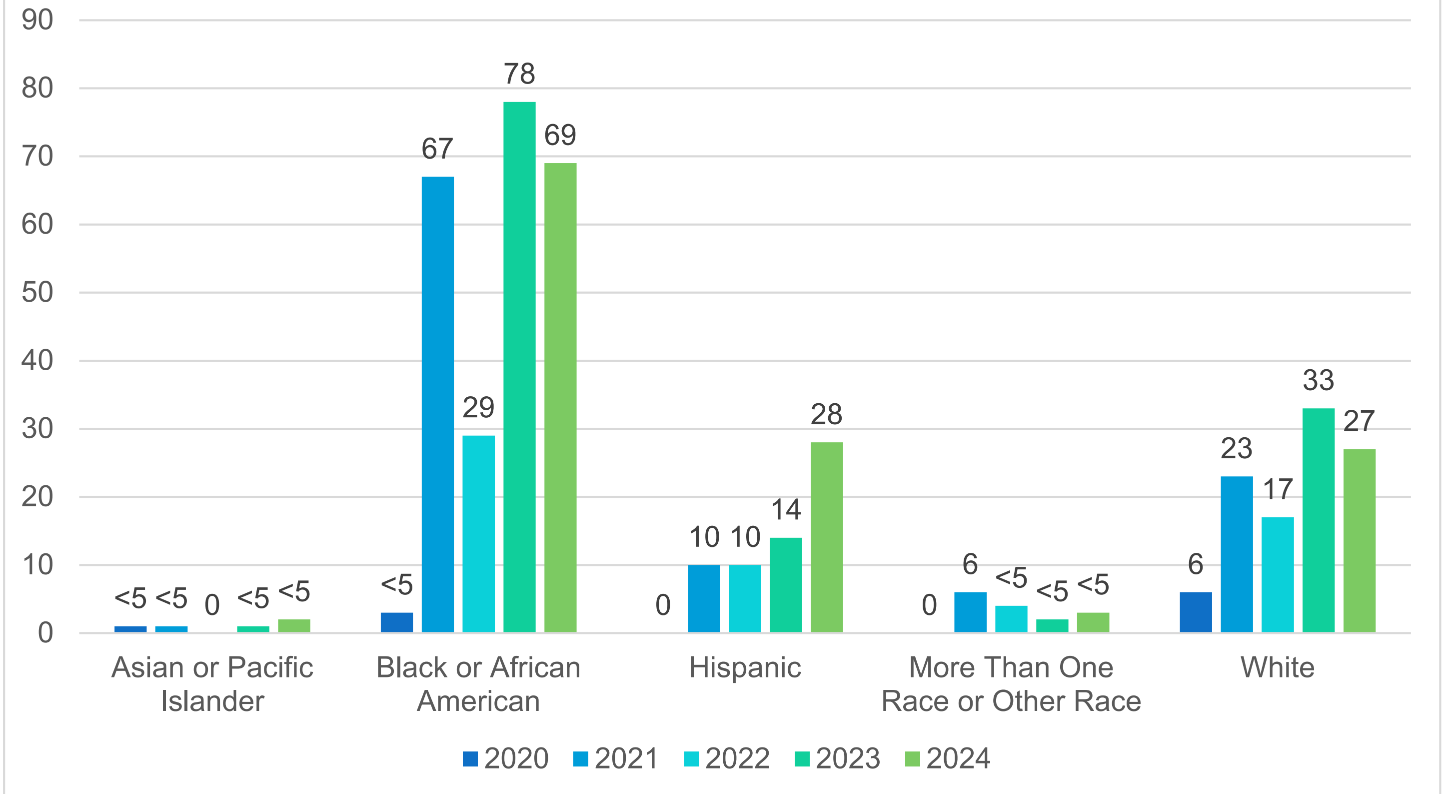
also mitigates barriers, such as transportation, cost, or stigma – this also helps to ensure long-term health management for someone with HIV.



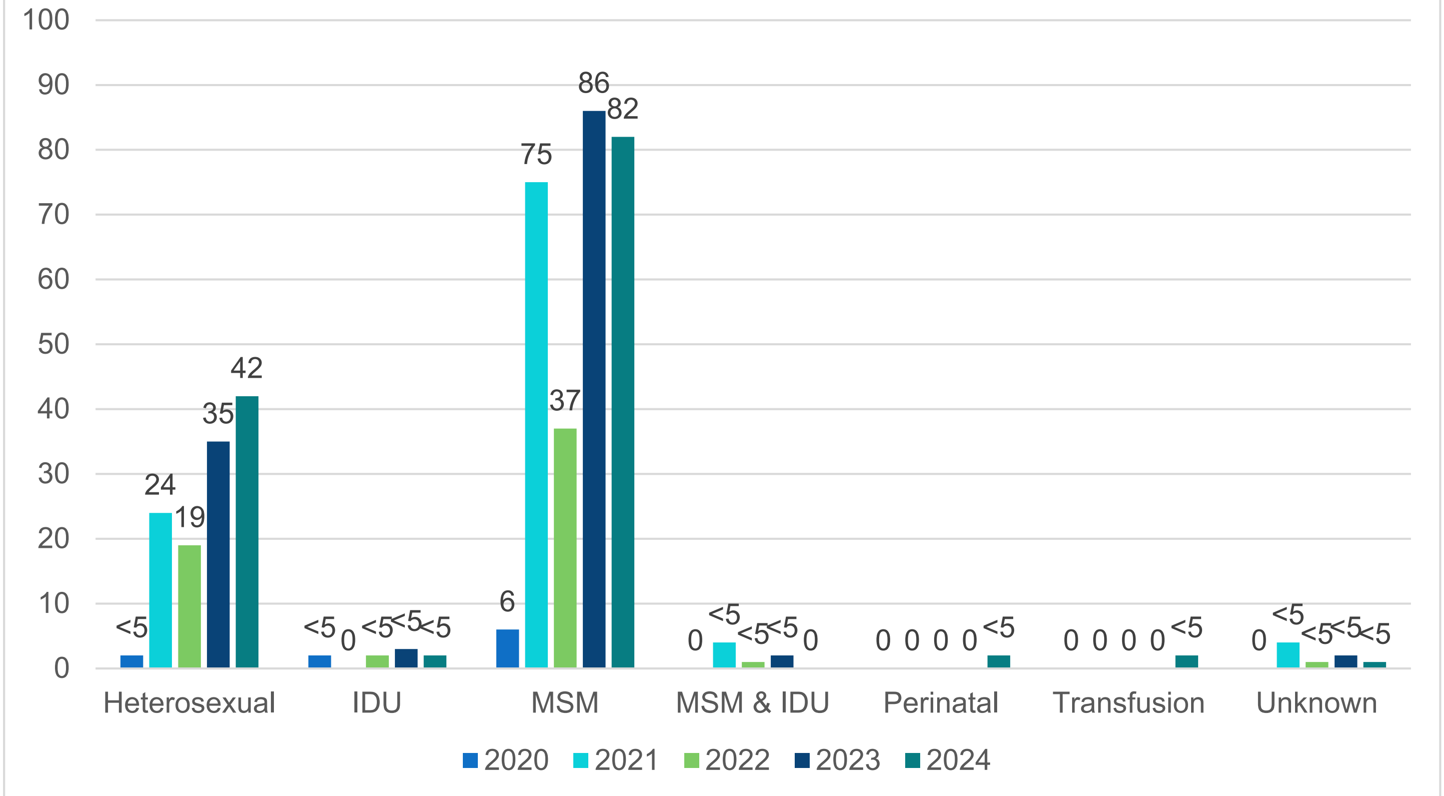
As Phase 1 progressed, the number of clients who were newly diagnosed and enrolled in the program increased. However, the proportion of these clients relative to the total number of clients decreased.



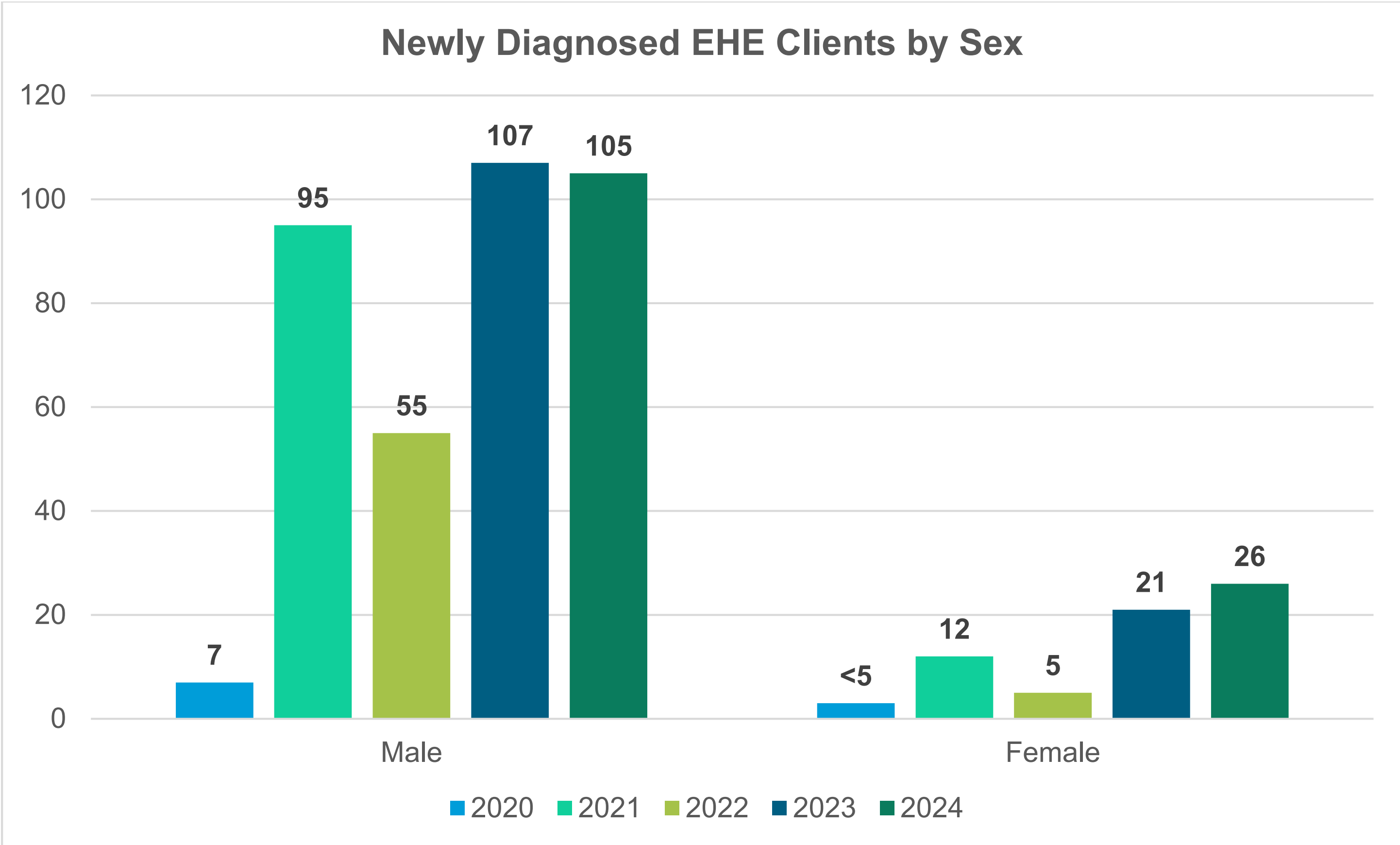
The chart above depicts those who were newly diagnosed and enrolled in EHE compared to the total incidence for Cuyahoga County. While the ratio of newly diagnosed clients compared to total EHE clients was low, the proportion of newly diagnosed EHE clients compared to the total HIV incidence in Cuyahoga County was very high. Although only 5.5% of new diagnoses were enrolled in 2020, just over 90% of the total HIV incidence was enrolled in EHE in 2024 and received at least one service. This speaks to the success of the program recruiting all types of clients with a new diagnosis of HIV in the county and the flexibility of the program to enroll clients from all walks of life.



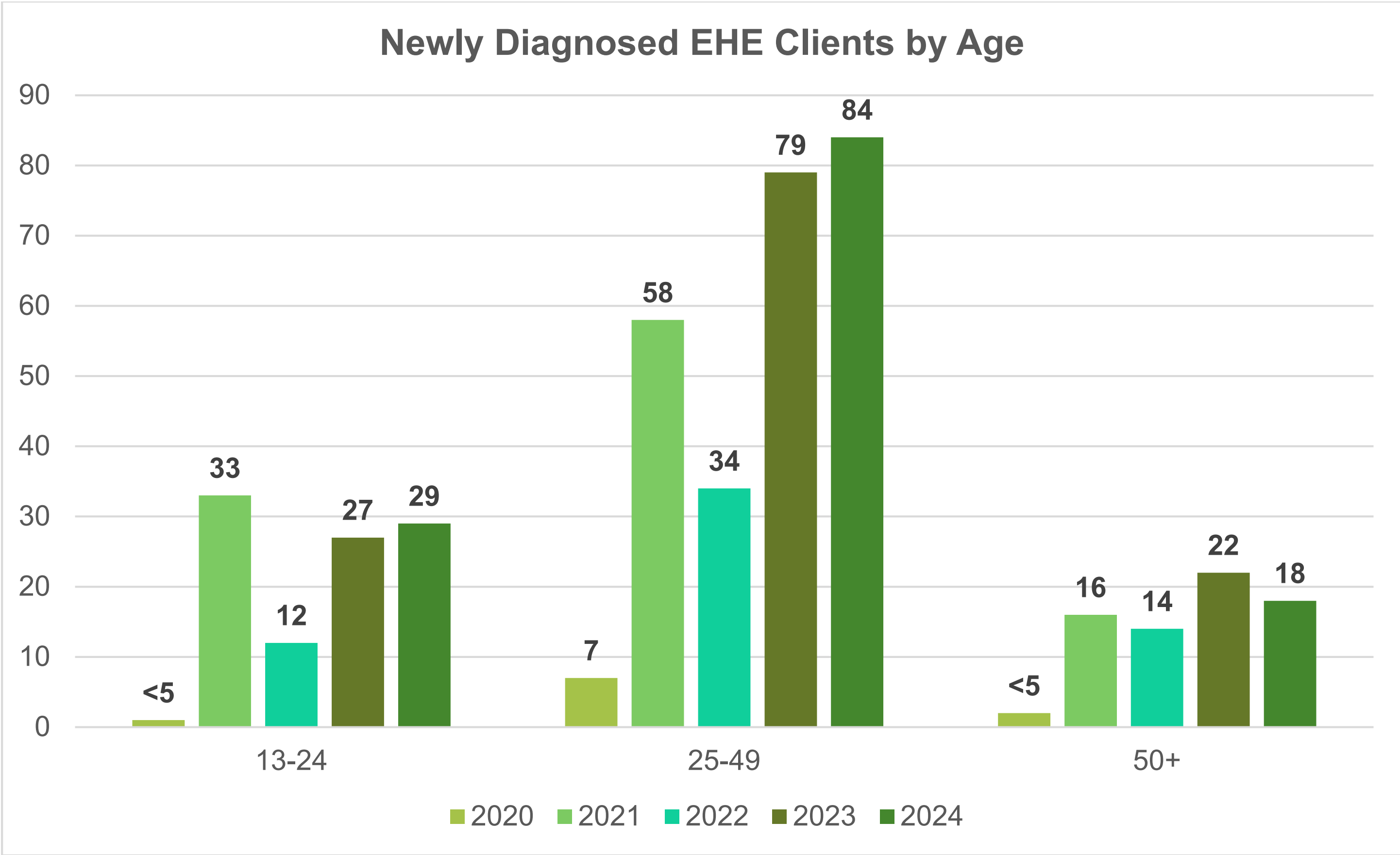
The largest proportion of clients who were enrolled at the time of diagnosis were Black or African American (56%). The number of newly diagnosed and enrolled Hispanic clients increased annually, and more than doubled at the end of Phase 1.



The vast majority of newly diagnosed and enrolled clients were in the MSM transmission category (66%). The number of newly diagnosed and enrolled heterosexual clients also increased annually.



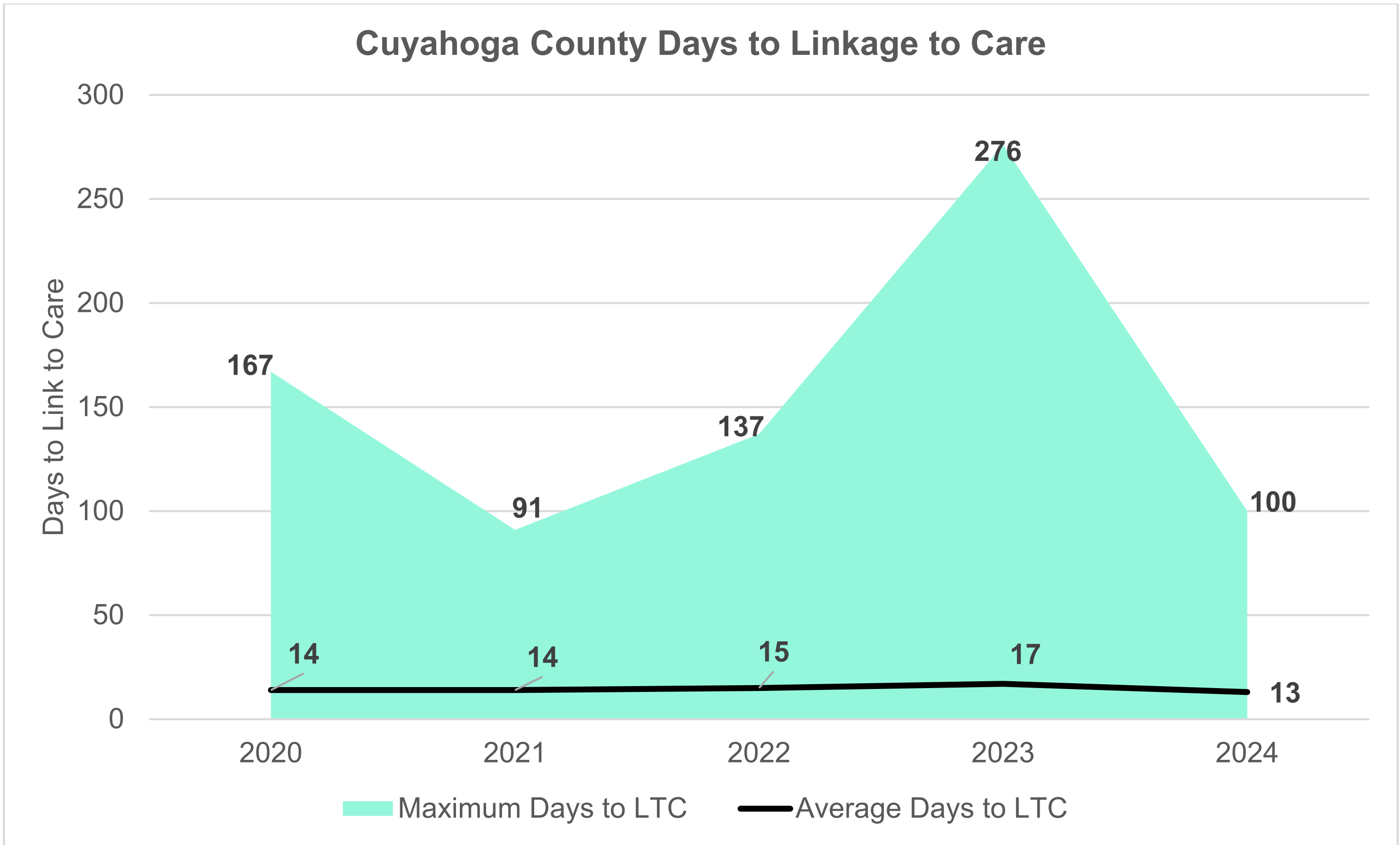
The vast majority of clients who were enrolled at the time of diagnosis were male (85%). However, at the end of Phase 1, the number of newly diagnosed female clients had more than tripled.



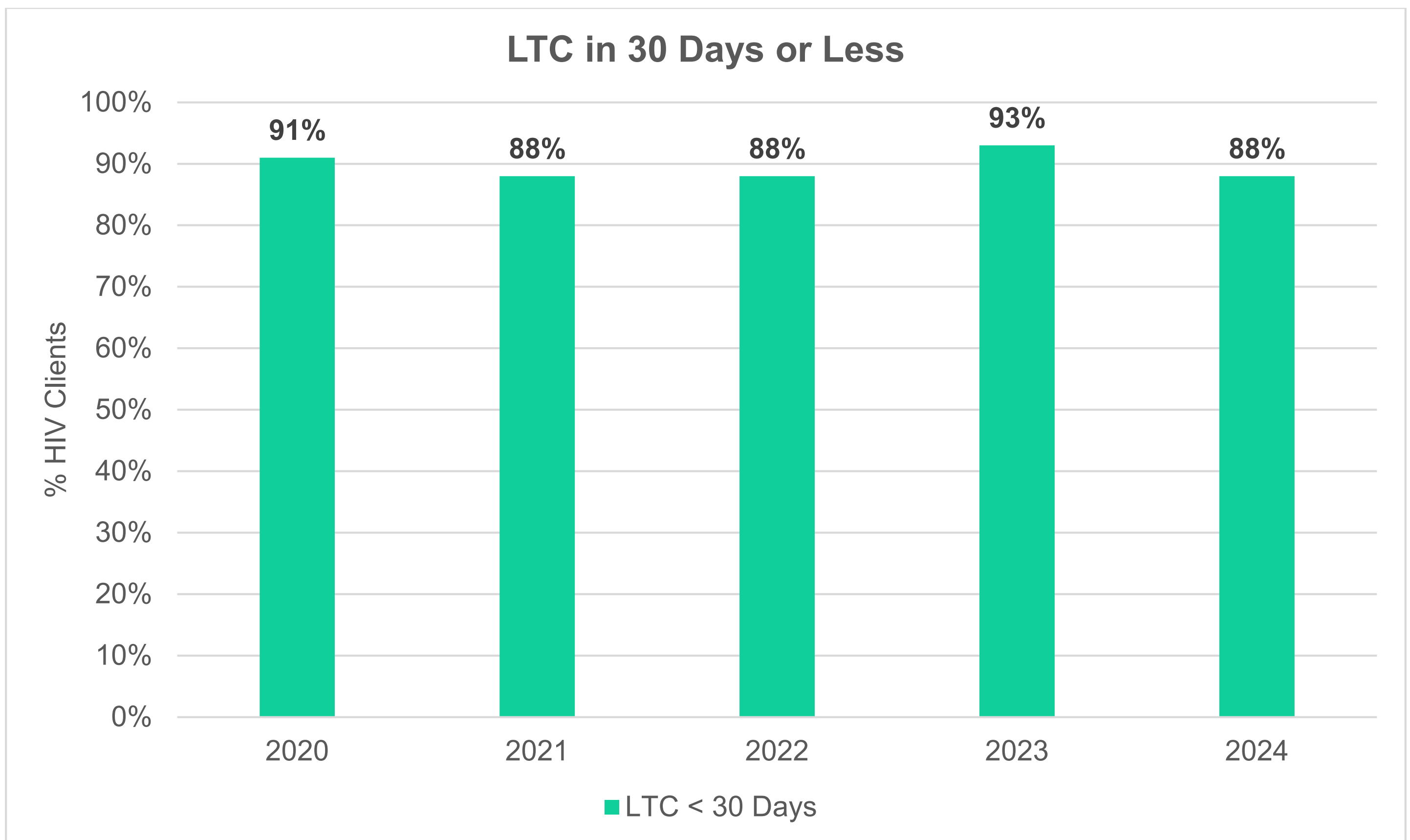
The largest proportion of newly diagnosed enrolled clients were 25-49 years old (60%). Those who were 13-24 years old have remained steady throughout Phase 1.

Time to Linkage to Care

One of the goals of the EHE Initiative is to link people newly diagnosed with HIV to medical care within one month (30 days) of their diagnosis. This rapid target is considered essential to begin ART medication and get clients closer to viral suppression, which in turn improves health outcomes and reduces HIV transmission to partners. It also helps to prevent those who are newly diagnosed from being lost to care, or never entering into treatment.



On average, most of those who were newly diagnosed with HIV in Cuyahoga were linked to care within 2-3 weeks of their diagnosis (average range of 13-17 days during Phase 1). Throughout the course of Phase 1, the number of days those who were newly diagnosed with HIV were linked to care ranged from 0 to 276 days, with the highest numbers of days to linkage occurring in 2023. At the end of Phase 1, the average number of days to linkage to care was at a low of 13 days.



Throughout the course of Phase 1, the vast majority of those newly diagnosed with HIV were linked to care in 30 days or less. Specifically, in 2023, Cuyahoga County linked 93% of those newly diagnosed to care within 30 days, whereas 83% of those newly diagnosed throughout the United States were linked to care in the same time frame (ref: AHEAD Dashboard). On average through Phase 1, 42% of those newly diagnosed with HIV in Cuyahoga County were linked to care within 7 days, which corresponds to Rapid Start goals.

7. Limitations

The data collected through Phase 1 of the EHE Initiative has some potential limitations. One such limitation is that some of the client demographic information is self-reported, such as race/ethnicity, housing status, and HIV risk factor category. Often, self-reported data can introduce bias and must be interpreted with caution. It should also be noted that self-reported data is fluid and can be subject to change. Regarding ethnicity, the United States Office of Management and Budget specifies that race and Hispanic origin (also known as ethnicity) are two separate and distinct concepts; clients who report themselves as being Hispanic/Latinx can be of any or multiple races.

A major limitation of the Phase 1 data is not all providers were inputting data into CAREWare (which is the electronic health and social support services information system for HRSA-funded programs) throughout the course of Phase 1. This results in missing client demographic and care continuum data. While data for a majority of the clients is available, this missing data potentially masks the true effects of the program on the care continuum for clients.

As mentioned above, medication adherence must be interpreted with some caution. While most clients are prescribed ART, it is impossible to know if a client is truly taking their medication(s) as prescribed or picking up refills. Data above also doesn't seem to reflect the full extent of ART use in Cuyahoga County. The discrepancy in ART medication totals could be due to data not being entered into the CAREWare system to reflect the actual medications prescribed to a client. While medication adherence is an important step along the EHE Care Continuum, a more accurate depiction of medication adherence is viral suppression, as this is achieved through ART.

Linkage to care data is only available for all newly diagnosed individuals in Cuyahoga County, which includes those who are not EHE clients. Unfortunately, this functionality is difficult to obtain in the CAREWare system where care continuum data is stored. The true linkage to care time for EHE clients may differ from what is provided for all those who are newly diagnosed.

Lastly, a barrier at the beginning of Phase 1 was the COVID-19 pandemic in Cuyahoga County. With the program beginning in 2020, there were several obstacles to overcome in regards to communications with providers and ensuring clients had access to the care services that were needed. It should be noted totals may be affected by the pandemic due to access to services.

8. Conclusions and Acknowledgements

Phase 1 of the EHE Initiative in Cuyahoga County proved very successful, overcoming barriers from the COVID-19 pandemic at its inception and serving over 7,000 total clients. These clients have consistently higher linkage to care, retention in care, and viral load suppression rates and have improved care outcomes when compared to those who have not accessed EHE services. It is to be hoped that Phase 2 of the EHE Initiative experiences the same successes and has the opportunity to expand to even more service categories.

A huge thank you goes out to the EHE program staff at the Cuyahoga County Board of Health and also their Phase 1 EHE-Care service provider partners. Their dedication to HIV clients is unmatched and truly evident in the quality of care received.

Analysis was completed by the department of Epidemiology, Surveillance, and Informatics at the Cuyahoga County Board of Health. Please direct questions or comments to epi@ccbh.net.

9. Abbreviations

ADAP	AIDS Drug Assistance Program
AIDS	Acquired Immunodeficieny Syndrome
ART	Antiretroviral Medication
CCBH	Cuyahoga County Board of Health
CDC	Centers for Disease Control and Prevention
CHW	Community Health Worker
D2C	Data to Care
EFA	Emergency Financial Assistance
EHE	Ending the HIV Epidemic
EIS	Early Intervention Services
HAB	HIV/AIDS Bureau
HIPAA	Health Insurance Portability and Accountability Act
HIV	Human Immunodeficieny Virus
HRSA	Health Resources and Services Administration
IDU	Injection Drug Use
IMCM	Intensive Medical Case Management
LTC	Linked (or Linkage) to Care
MSM	Men Who Have Sex With Men
MT	Medical Transportation
NMCM	Non-Medical Case Management
OAHS	Outpatient Ambulatory Health Services
PEP	Post-Exposure Prophylaxis
PrEP	Pre-Exposure Prophylaxis
PSS	Psychosocial Support Services
PWH	People With HIV
RIC	Retained (or Retention) in Care
U=U	Undetectable Equals Untransmissible
VLS	Viral Load Suppression