HRSA HIV/AIDS Bureau

Ending the HIV Epidemic in the U.S. Initiative

Data Report

2023

HRSA
Ryan White HIV/AIDS Program

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

Data presented in this report were submitted through the Ryan White HIV/AIDS Program (RWHAP) Services Report (RSR), the RWHAP Part F AIDS Education and Training Center (AETC) Data System, and the EHE jurisdictional and AETC progress reports. The report includes data for the first four years of the EHE initiative (reporting period varies by data source).

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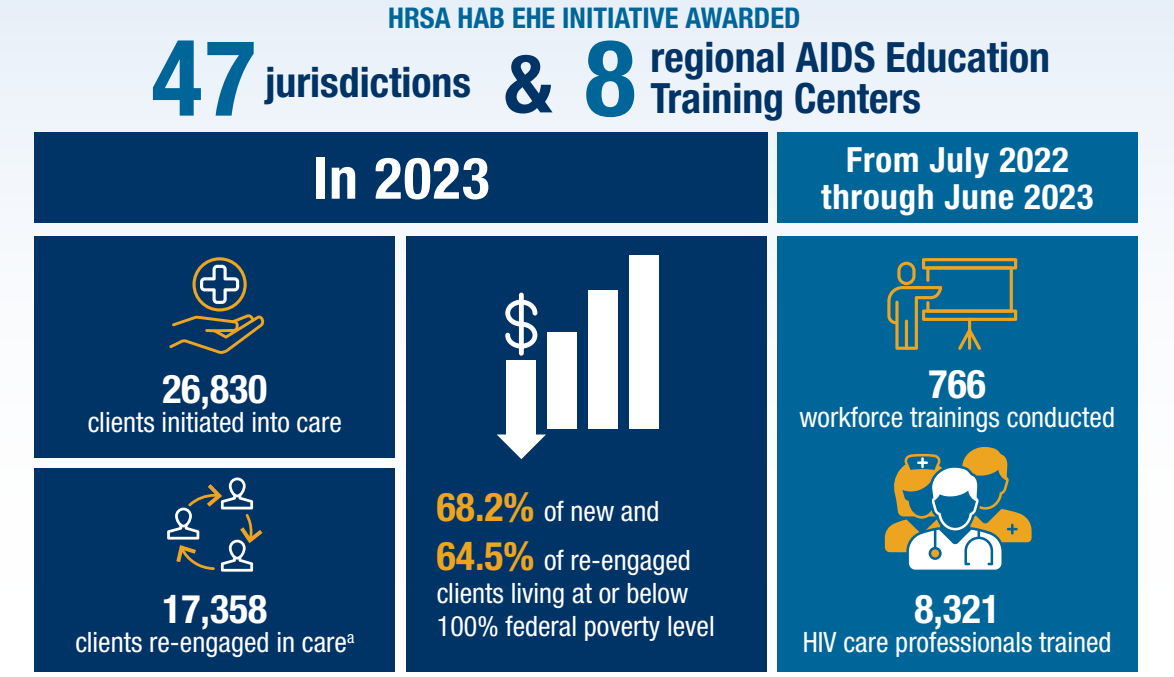
CONTENTS

HRSA HAB EHE DATA REPORT INSIGHTS

The Ending the HIV Epidemic in the U.S. (EHE) initiative focuses on reducing new HIV infections [1]. The Health Resources and Services Administration (HRSA) HIV/AIDS Bureau (HAB) EHE initiative builds on the Ryan White HIV/AIDS Program's (RWHAP) comprehensive system of care to focus on reaching people with HIV who are newly diagnosed (i.e., "new clients") or who are not routinely engaged in HIV care (i.e., "re-engaged clients") in geographic areas with high rates of HIV transmission and rural areas with disproportionate rates of HIV [1,2]. To ensure that the HIV workforce can serve additional clients, EHE funding to the RWHAP AIDS Education and Training Center (AETC) Program increased workforce training and technical assistance in EHE jurisdictions. In 2023, EHE-funded providers served nearly 27,000 new clients and more than 17,000 clients estimated to be re-engaged in care. From July 2022 through June 2023, regional AETCs conducted more than 750 EHE-funded trainings for more than 8,000 HIV health care professionals.

Figure 1
Overview of HRSA HAB's Ending the HIV Epidemic in the U.S. (EHE) Initiative, 2023



[a] *Estimated re-engaged clients are calculated among only EHE-funded outpatient ambulatory health services, medical case management, non-medical case management, and EHE initiative service category providers. This is likely an underestimate of all people re-engaged in care across all EHE-funded providers.*

In 2023, 81.4% of new patients and 84.6% of re-engaged patients receiving medical care from EHE-funded providers were virally suppressed, compared with 67.2% of all people with diagnosed HIV in the United States [3]. People with HIV who take HIV medication as prescribed and reach and maintain viral suppression can manage their HIV as a chronic condition, cannot sexually transmit HIV, and can live longer and healthier lives. Increasing the number of people with HIV who are engaged in medical care and reach and maintain viral suppression is how we will end the HIV epidemic in the United States. Without this EHE initiative, new infections will continue, resulting in more lives lost and costing the U.S. government $20 billion annually in direct medical costs for HIV prevention, care, and medication [1].

To reach people with HIV who are out of care, the RWHAP is building on the foundation of its comprehensive system of care and the lessons learned from the EHE initiative to leverage partnerships, focus interventions, and engage communities to prioritize out of care individuals to advance ending the HIV epidemic.

TECHNICAL NOTES AT-A-GLANCE

Refer to the full Technical Notes for additional information.

WHY does the Health Resources and Services Administration (HRSA) HIV/AIDS Bureau (HAB) produce the Ending the HIV Epidemic in the U.S. (EHE) Initiative Data Report?

- To assess the numbers and demographics of clients receiving EHE-funded services and understand the impact on HIV-related clinical outcomes.
- To understand the reach of EHE-funded workforce training events.
- To highlight important activities, services, and strategies implemented in support of EHE goals.

WHO is included in this report?

- People with HIV served by EHE-funded providers, presented by client type:
  - Clients new to care served by EHE-funded providers ("a" tables).
  - Clients re-engaged in care served by EHE-funded outpatient ambulatory health services, medical case management, non-medical case management, and EHE initiative services providers ("b" tables").
- HIV health care providers who participated in regional RWHAP AIDS Education and Training Center (AETC) Program training events.

WHAT information is presented?

- Clients served and services delivered
  - Client demographic and socioeconomic characteristics (Tables 1a–1b and 3a–3b)
  - Viral suppression data describing how many RWHAP patients who received medical care from EHE funded providers had an HIV RNA test result <200 copies/mL at the end of the calendar year. (Tables 2a–2b and 4a–4b)
  - Summaries of service delivery and best practices and how EHE-funded jurisdictions integrated new systems-level strategies in the reporting period.
- Workforce training
  - Content and topics covered in EHE-funded AETC training events. (Table 5)
  - Training participants characteristics and service delivery and employment setting characteristics. (Tables 6–7)
  - Summaries of selected EHE-funded training events delivered by AETC recipients.

What **GEOGRAPHIC LEVELS** are presented?

- Clients served and services delivered
  - EHE funding was awarded to 39 RWHAP Part A (Eligible Metropolitan Area or Transitional Grant Area) recipients and eight Part B (state) recipients.
  - National data are presented in Tables 1a through 2b.

- EHE jurisdiction data are displayed in Tables 3a through 4b.

- Workforce training
  - EHE funding was awarded to eight regional AETCs of the RWHAP Part F Program.
  - Data are presented across all regional AETCs in aggregate in Tables 5 through 7.

WHICH **TIME PERIODS** are included in this report?

- EHE funding began in March 2020.
- Clients served and services delivered
  - RWHAP Services Report data for calendar years 2020 through 2023, with additional details for calendar year 2023.
  - Jurisdictional progress report information from March 2023 through February 2024.
- Workforce training
  - AETC data and the AETC progress reports from March 2020 through June 2023.

BACKGROUND AND SUMMARY

Building on the Foundation of the Ryan White HIV/AIDS Program Through the Ending the HIV Epidemic in the U.S. Initiative

The Ending the HIV Epidemic in the U.S. (EHE) initiative, which began in fiscal year (FY) 2020, focuses on reducing new HIV infections in geographic areas with high rates of HIV transmission and rural areas with disproportionate rates of HIV. The EHE initiative consists of four key strategies—Diagnose, Treat, Prevent, and Respond. For the Health Resources and Services Administration (HRSA) HIV/AIDS Bureau (HAB), the EHE initiative builds on the foundation of the Ryan White HIV/AIDS Program (RWHAP) comprehensive system of care to focus on reaching the more than 220,000 people with HIV who are not receiving regular care in the United States or U.S. territories [4]. The RWHAP funds health care and support services for more than 570,000 people with HIV—representing more than half of all people with diagnosed HIV in the United States [5]. The RWHAP provides funds to and coordinates with cities, counties, states, and local community-based organizations to deliver efficient and effective HIV care, treatment, and support services for people with HIV who are low income and underserved.

HAB EHE recipients are leveraging their existing RWHAP infrastructure, paired with additional flexibilities provided through the EHE initiative, to implement evidence-based strategies to reach and engage people with HIV. HRSA awarded approximately $147 million in total to 60 HRSA HAB EHE recipients in FY 2023. These funds were awarded to the following:

- The 39 RWHAP Part A recipients and eight Part B recipients that are the EHE jurisdictions. The 47 EHE jurisdictions represent 48 counties; Washington, D.C.; San Juan, Puerto Rico; and seven states that have a disproportionate occurrence of HIV in their rural areas (refer to the Appendix for more details).
- Three national centers and eight regional RWHAP Part F AIDS Education and Training Center (AETC) recipients to train and expand the capacity of the HIV health care workforce in EHE jurisdictions.
- One technical assistance provider and one systems coordination provider to support the EHE jurisdictions to strengthen their EHE work plans, promote coordination of planning activities, and ensure jurisdictions have access to the capacity-building resources they need.

The jurisdiction funding, workforce capacity, and technical assistance supported by EHE engages more people with HIV in care so that they can achieve improved health outcomes.

Highlights of Analyses: Clients Served and Services Delivered

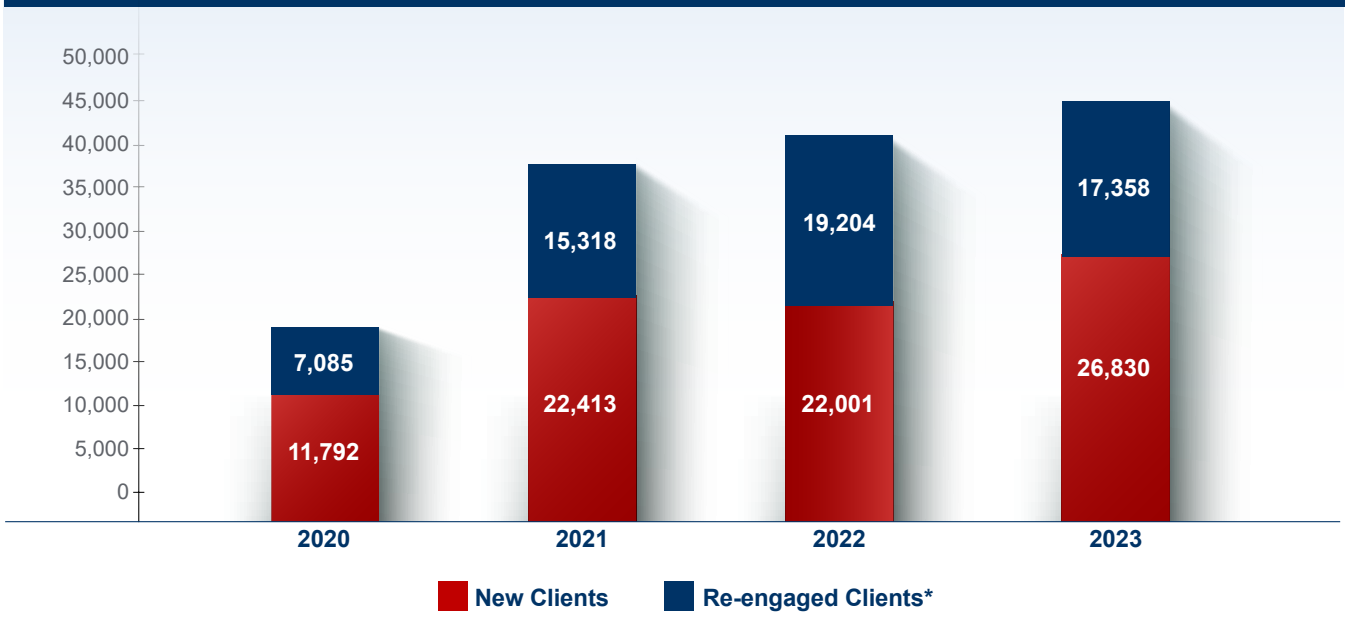
During Year 4 of the EHE initiative, EHE jurisdictional recipients reported significant progress toward reaching new and re-engaged people with HIV. The flexibility of EHE allowed recipients to deploy tailored, localized approaches to meeting the needs of people disproportionately impacted by HIV in their jurisdictions. These high-impact activities centered on increasing providers' capacity to serve more clients, deliver innovative services, and leverage partnerships to facilitate initiation and re-engagement in care. EHE funding was also used to improve service delivery infrastructure, such as telehealth technology, data utilization, and capacity building.

Reaching New and Re-engaged Clients Through Expanded Service Delivery

Since the start of the initiative in 2020, the number of new and re-engaged clients served has more than doubled. In 2023, EHE-funded providers served 26,830 clients new to care and 17,358 clients re-engaged in care, This is an increase compared with the 11,792 new clients and 7,085 re-engaged clients served in 2020. (Figure 2; Tables 1a and 1b).

Figure 2

New and re-engaged clients served by EHE-funded providers, by year, 2020–2023—47 HRSA HAB EHE-funded jurisdictions.



** Estimated re-engaged clients are calculated only among EHE-funded outpatient ambulatory health services, medical case management, non-medical case management, and EHE initiative service category providers. This is likely an underestimate of all people re-engaged in care across all EHE-funded providers.*

Source: 2023 HRSA HAB EHE Report (Tables 1a and 1b).

Expanded Access Activities

EHE jurisdictional recipients successfully reached new clients and people with HIV not consistently engaged in care by strategically directing their EHE funding to expand access to care. Recipients applied tailored approaches to overcome barriers to care and meet the specific needs of people with HIV in their jurisdictions who do not access the existing care systems. In addition to delivering services beyond traditional hours (e.g., nights, weekends), recipients expanded access to health care coverage, locations of service, and other care models. Below is a summary of the most frequently reported activities that expanded access, along with direct quotations from recipients expressing the impact of EHE funding.

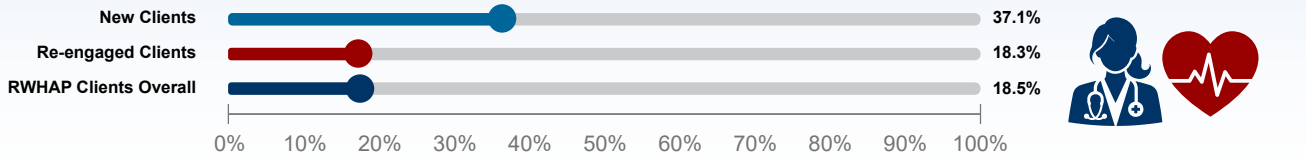
Rapid Antiretroviral Therapy

Recipients utilized EHE funding to support rapid antiretroviral therapy (Rapid ART) programs. The goal of Rapid ART programs is to ensure that patients leave their first appointment with a filled ART prescription, or have it filled within a week, and that they are immediately scheduled for a follow-up appointment. Rapid access to ART increases the likelihood of viral suppression and is important in preventing new potential HIV transmissions. Health care coverage can facilitate the rapid initiation of ART and, subsequently, its health care and public health benefits. For people with HIV who lack health care coverage, overcoming barriers to timely receipt of care and medication is particularly important.

A higher percentage of new clients served by EHE funded providers had no health care coverage compared with the overall RWHAP client population. Among clients served by EHE-funded providers, more than a third of new clients (37.1%) had no health care coverage, more than double the percentage of all RWHAP clients without health care coverage (18.5%). The percentage of re-engaged clients without health care coverage (18.3%) was consistent with RWHAP overall (Figure 3; Tables 1a and 1b). Health care coverage from diagnosis ensures early access to care, which increases the likelihood that patients are able to maintain viral suppression [6].

Figure 3

New and re-engaged[a] clients with no health care coverage served by EHE-funded providers, by client type, 2023—47 HRSA HAB EHE-funded jurisdictions.



[a] *Estimated re-engaged clients are calculated only among EHE-funded outpatient ambulatory health services, medical case management, non-medical case management, and EHE initiative service category providers. This is likely an underestimate of all people re-engaged in care across all EHE-funded providers.*

Source: 2023 HRSA HAB EHE Report (Tables 1a and 1b) for new and re-engaged client data; 2023 RWHAP Annual Data Report (Table 1a) for RWHAP overall client data.

One recipient described how EHE funding allowed them to distribute a 7-day supply of ART to newly diagnosed patients immediately.

> *This project also allows for the distribution of Starter Packs, a 7-day supply of ART at the time of the preliminary positive result. This program links the newly diagnosed person at the same time. The flexibility that EHE provides during enrollment and service delivery is critical for the success of this activity.*

Other recipients described the impact of their EHE-funded Rapid ART programs in hospital settings.

> *Three EHE-funded hospital systems have implemented the Rapid Start ART intervention. Following a confirmatory HIV test and an official diagnosis, these hospital systems' Early Intervention Service teams attend to the patient's needs. HIV doctors begin treatment when appropriate. On average, EHE-funded agencies begin ART within 4–7 days of diagnosis, with most patients receiving ART the same day.*

> *Patients are connected throughout the hospital system, from the Emergency Departments (EDs), to the Infectious Disease Department. [Our subrecipient] reviews CAREWare data to see how many patients are being seen … EHE funding is used in conjunction with other funding (such as the RWHAP) to expand services and provide the appropriate level of care and staffing to the initiative. Our subgrantees delivered the Rapid Start ART initiative and follow-up to 57 clients within the reporting period.*

Telehealth, Data Sharing, and Technology

Telehealth and technology expanded access for people who are unable to make in-person appointments, due to factors such as work schedules, childcare, and transportation issues.

> *New equipment was bought by one of our subrecipients to expand existing telehealth services. This is an important part of the service they provide as they service rural communities and various counties where transportation to their offices can [be] challenging to clients. [Nearly all of our] counties provide telehealth that is accessible to [people with HIV] within their rural communities.*

Additionally, telehealth allowed clinics to provide care for more clients. One recipient described how EHE funding for telehealth visits assisted one clinic with overcoming challenges on clinician availability, ultimately increasing their efficiency in providing care.

> *An identified challenge was clinician availability for patients within the [redacted]clinics. Initially, having a full schedule limited the amount of Rapid ART appointments possible. By introducing the telehealth appointment alternative, patients were able to receive medical attention through telehealth, even when a clinician's in-person schedule was fully booked. This approach has demonstrated remarkable efficiency and requires less time.*

Data sharing was pivotal to outreach and re-engagement efforts, allowing the recipient below to improve the quality of their data about people who are out of care and re-engage more people in care.

> *Due to limited data in the beginning of the reporting period, uptake of [outreach efforts] was slow. Executed data sharing agreements with the [health department] improved the quality of data and allowed us to begin engaging clients that were out of care according to [the health department]. This has resulted in an average of nine successful linkages per week …*

Using technology to allow patients to self-schedule appointments online provided a more convenient option for appointment scheduling.

> *[redacted] HIV clinic has improved patient access by enabling the self-scheduling feature on the [patient portal], simplifying the appointment scheduling process and access to HIV medical providers.*

Mobile Medical Units

Recipients increased the use of mobile medical units (MMUs) in Year 4 of EHE implementation, another service that reduced transportation barriers and widely expanded access to care. Recipients used MMUs to provide convenient walk-in services, HIV testing, home visits, and delivery services for medications. They also offered telehealth services to those without internet access and those with transportation barriers. Recipients deployed MMUs to areas with the greatest need for HIV care services, enabling a focused approach to reaching people with HIV who do not routinely access health care in their jurisdictions.

> *Of the 10 highest-impact zip codes in [redacted] County, the Medical Mobile Unit conducted outreach in all 10 of those. This outreach resulted in 40 new Ryan White clients, an additional 12 patients were scheduled but did not show to their appointment, 13 people living with HIV returned to HIV care at [redacted] Community Health, and 129 people tested for HIV on the unit, of which 6 [tested positive] and [were] referred to the Mobile Medical Unit for services.*

MMUs enabled recipients to reach and engage more clients in RWHAP services who were new to care.

> *This past quarter we significantly increased our efforts in identifying new Ryan White clients and facilitated their access to care. Whereas in the previous quarter we only identified 7 new clients, this quarter we successfully connected 40 new individuals with care through Ryan White Services via the Mobile Medical Unit.*

Creating New Partnerships

Formal organizational partnerships enable recipients to provide more services to clients, which is essential for recipients with limited resources in their jurisdictions. Partnerships not only expand the range of services that a provider can offer through referral but also allow providers to share resources, office space, and staff.

> *... partnerships provide us with invaluable resources to expand our reach and meet the [multiple] needs of our clients. The collaboration with [redacted health organization] is particularly beneficial, as their community health worker assists our team with additional efforts to locate our [underserved people] in the community, including homeless shelters and home visits. This collective approach enhances our ability to connect with and support individuals facing complex barriers to care.*

> *The Early Intervention Services provider has expanded a partnership with the [redacted] HIV/AIDS Surveillance office which takes responsibility of reporting all positive HIV/AIDS cases for [several counties in our jurisdiction]. The expanded partnership enables the Early Intervention Services to share an office space, identify places for community engagement and receive client-level data for newly diagnosed individuals.*

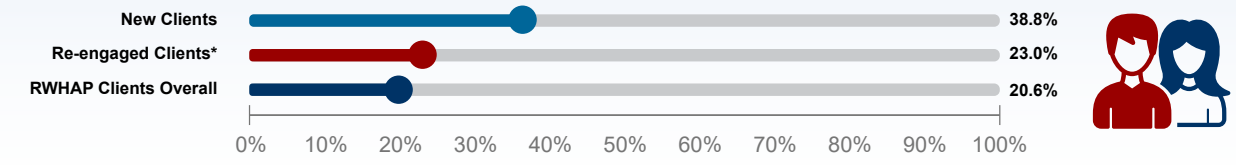
Reaching People with HIV Who Are Underserved

Compared with all RWHAP clients, new and re-engaged clients of EHE-funded providers are younger. In 2023, close to 40% of the new clients (38.8%) were aged 20–34 years (7.1% aged 20–24 years, 31.7% aged 25–34 years). Among re-engaged clients, nearly one-quarter (23.0%) were aged 20–34 years (2.9% aged 20–24 years, 20.1% aged 25–34 years). People aged 50 years and older accounted for 26.2% of new clients and

44.2% of re-engaged clients served by EHE funded providers, which is less than in the overall RWHAP population (47.7%) (Figure 4, Tables 1a and 1b).

Figure 4

New and re-engaged[a] clients between 20–34 years served by EHE-funded providers, by client type, 2023—47 HRSA HAB EHE-funded jurisdictions.



[a] *Estimated re-engaged clients are calculated only among EHE-funded outpatient ambulatory health services, medical case management, non-medical case management, and EHE initiative service category providers. This is likely an underestimate of all people re-engaged in care across all EHE-funded providers.*

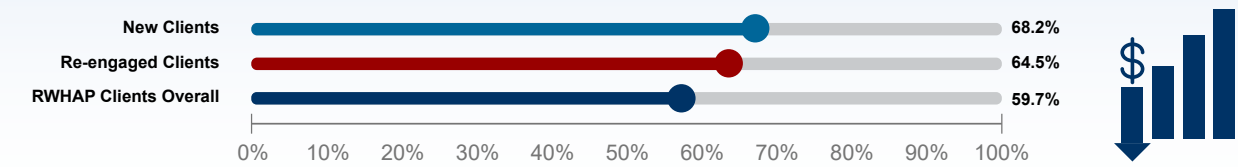
Source: 2023 HRSA HAB EHE Report (Tables 1a and 1b) for new and re-engaged client data; 2023 RWHAP Annual Data Report (Table 1a) for RWHAP overall client data.

In 2023, 45.8% of new clients self-identified as Black/African American, 31.0% as Hispanic/Latino, and 20.1% as White. Among re-engaged clients, 54.7% self-identified as Black/African American, 24.0% as Hispanic/Latino, and 18.2% as White. Among both new and re-engaged clients, less than 2% each self-identified as American Indian/Alaska Native, Asian, Native Hawaiian/Pacific Islander, or people of multiple races (Tables 1a and 1b).

Approximately two-thirds of new clients and re-engaged clients that EHE-funded providers serve live at or below 100% of the federal poverty level (FPL). Among clients served by EHE-funded providers, 68.2% of new clients and 64.5% of re-engaged clients were living at or below 100% FPL. Among RWHAP clients overall, only 59.7% were living at or below 100% FPL (Figure 5; Tables 1a and 1b).

Figure 5

New and re-engaged[a] clients at or below 100% of the federal poverty level served by EHE-funded providers, by client type, 2023—47 HRSA HAB EHE-funded jurisdictions.



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Source: 2023 HRSA HAB EHE Report (Tables 1a and 1b) for new and re-engaged client data; 2023 RWHAP Annual Data Report (Table 1a) for RWHAP overall client data.

Transportation

Particularly for those with lower incomes and in rural areas, lack of transportation is a barrier to health care access. Recipients continued to expand transportation access for medical and support services.

> *[Our jurisdiction] has a contract with the [redacted] transportation company to provide transportation for clients to medical, mental health, or case management appointments, food banks, or any other health related needs. These rides can be scheduled by a case manager, disease intervention specialist, or other service provider directly on the [redacted] online dashboard.*

Some recipients hired dedicated staff to coordinate transportation to appointments.

> *[We are] now utilizing a transportation administrator who has been successful in reaching out to clients with upcoming medical appointments to ensure access to transportation.*

Client Navigation and HIV Workforce Support

Recipients continued to use EHE funding to support community health workers (CHWs), peer navigators, intervention specialists, and other linkage to care specialists. Recipients describe the impact of EHE funding in enabling them to fill these important roles to facilitate linkage, retention, and re-engagement in HIV care.

> *The incorporation of the CHWs (community health workers) to the continuum of care has contributed to increase retention and care and viral load suppression of those clients with significant challenges … The heavy workload of the Medical Case Managers prevents them from providing more continuous and personal follow-up, among other things.*

> *Under this plan [to assist the social worker with their heavy case load], the social worker will refer [underserved] patients to the community health worker, who will spearhead additional outreach efforts to locate and reintegrate them into medical care. These outreach efforts encompass phone calls, home visits, social media searches, and exploration of homeless shelters.*

The quote below describes how health intervention investigators and CHWs work together to provide medical and non-medical case management services for clients.

> *… Health Intervention Investigators (HII) played a critical role in ensuring that all newly diagnosed persons accessed medical care and treatment services within seven to ten business days. These included scheduling medical appointments for the clients and transportation services…The HII would also follow up with the client to assist them with referrals for non-medical case management with an EHE CHW to help promote engagement in care activities, access to supportive services, and other resources … [During the reporting period, HIIs and CHWs] linked more than 146 clients in medical care and treatment services, whether the client was re-engaged or newly diagnosed.*

Recipients also describe the benefits of maintaining a peer navigation program to provide support for people with HIV.

> *This particular program engages individuals through the use of peers who have similar lived experiences. Having peer navigators gives [people with HIV] other options for assistance in care and can provide a support system to those who do not have one. The program being implemented has shown success with clients actively participating in care and achieving viral suppression.*

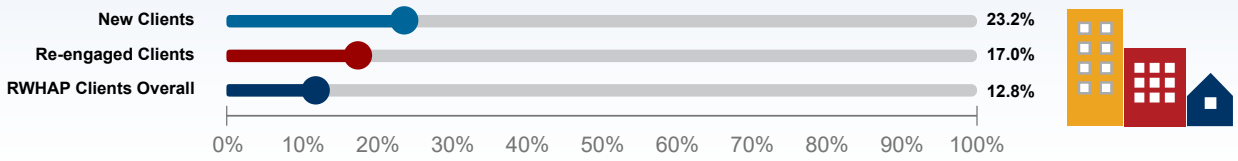
Housing

Compared with RWHAP clients overall, higher proportions of new and re-engaged clients served by EHE-funded providers experience temporary or unstable housing. Among clients served by EHE-funded providers, nearly one-quarter of new clients (23.2%) and more than one-sixth of re-engaged clients (17.0%) experienced temporary or unstable housing. Among all RWHAP clients, only 12.7% experienced temporary or

unstable housing. People experiencing unstable or temporary housing are less likely to reach viral suppression and may have multiple complex barriers to care (Figure 6; Tables 1a and 1b).

Figure 6

New and re-engaged[a] clients who are temporarily or unstably housed served by EHE-funded providers, by housing status, 2023—47 HRSA HAB EHE-funded jurisdictions.



[a] *Estimated re-engaged clients are calculated only among EHE-funded outpatient ambulatory health services, medical case management, non-medical case management, and EHE initiative service category providers. This is likely an underestimate of all people re-engaged in care across all EHE-funded providers.*

Source: 2023 HRSA HAB EHE Report (Tables 1a and 1b) for new and re-engaged client data; 2023 RWHAP Annual Data Report (Table 1a) for RWHAP overall client data.

Recipients used EHE funding to provide short-term and temporary housing, housing location assistance, rental assistance, and homecare starter kits and referral services.

> *... the impact stable housing has on health outcomes is irrefutable. [Our organization] has taken this very seriously as evident in the housing specialist position added to the team and the innovative projects supported through EHE, these new initiatives supported through the [Housing Opportunities for Persons With AIDS] partnership [providing EHE-funded homecare starter kits to newly housed HIV positive persons] is one more way EHE is hoping to impact health through housing.*

Several EHE recipients demonstrated success in addressing clients' stories housing-related needs.

> *A young adult, newly diagnosed in [November] 2022, had been experiencing homelessness on and off for over a year. Upon the referral to [our housing program], her [RWHAP] eligibility had lapsed and she had not been medication adherent due housing instability and lack of general support system. [Our housing program] was able to support her obtaining housing, which allowed her to focus on renewing [RWHAP] eligibility, reconnecting to care and treatment."*

> *[Our Early Intervention Specialist] located and reengaged a client who was homeless on the street and lost to care. Through coordination with [data] staff, the client was connected to an emergency hotel voucher, which is proving increased stability while the client works toward medical stability and finding employment."*

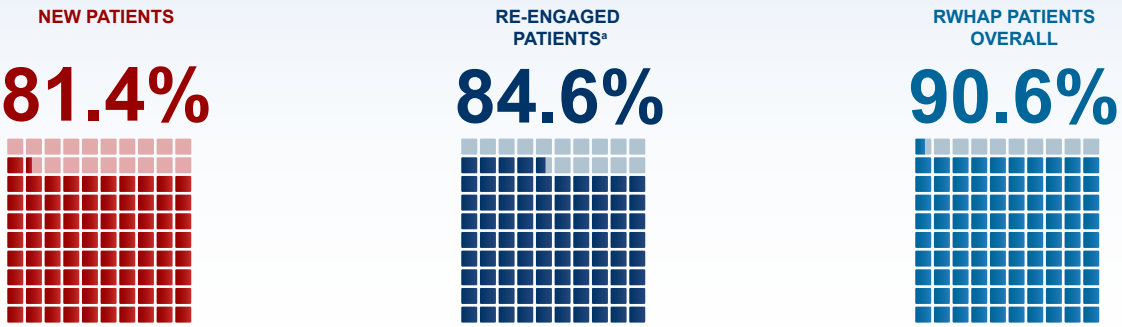
Viral Suppression and EHE Implementation Insights

More than 80% of new and re-engaged patients who receive HIV medical care from EHE-funded providers reached viral suppression, compared with the 67.2% of all people with diagnosed HIV in the United States who reached viral suppression [3]. By the end of calendar year 2023, 81.4% of 16,066 new patients and 84.6% of 10,907 re-engaged patients served by EHE-funded providers who received outpatient ambulatory health services (OAHS) and had a suppressed viral load at their most recent test had reached viral suppression. This is lower than the 90.6% viral suppression among the overall RWHAP patient population but higher than the 67.2%

national average for all people diagnosed HIV in the United States [3] (Figure 7; Tables 2a and 2b). The lower percentage of viral suppression is expected for patients new or returning to care compared with the overall RWHAP population. Viral loads can take one to six months to reach undetectable levels (i.e., viral suppression) [7]. The RWHAP measures viral suppression at the end of the calendar year, and some patients may not have reached viral suppression by that time. Additionally, new and re-engaged patients with HIV face multiple and complex needs related to health outcomes, such as unstable housing, which can negatively affect treatment adherence and viral suppression.

Figure 7

Viral Suppression among new and re-engaged[a] patients served by EHE-funded providers, 2023—47 HRSA HAB EHE-funded jurisdictions.



[a] *Estimated re-engaged patients are calculated only among EHE-funded OAHS, medical case management, non-medical case management, and EHE initiative service category providers. This is likely an underestimate of all people re-engaged in care across all EHE-funded providers.*

HRSA HAB calculates viral suppression among people with HIV who had at least one OAHS visit and at least one viral load test during the measurement calendar year. Viral suppression is defined as a most recent viral load test result of less than 200 copies/mL.

Source: 2023 HRSA HAB EHE Report (Tables 2a and 2b) for new and re-engaged client data; 2023 RWHAP Annual Data Report (Table 1a) for RWHAP overall client data.

Because 87% of all new HIV transmissions come from people who are not aware they have HIV or who are not receiving any HIV care [8], there is a clear need to focus efforts on reaching people who are not in care, both to prevent HIV transmissions and improve the health and quality of life for people with HIV.

The EHE initiative has resulted in numerous implementation insights and best practices that recipients shared as key in their successful EHE efforts:

Responsive interventions tailored to meet the needs of current HIV-related trends in a jurisdiction were extremely impactful. The recipient quoted below used EHE funding to avert 11 perinatal transmissions in a jurisdiction with an uptick in perinatal HIV transmissions.

> *We worked with a total of 24 [pregnant] clients in 2023, with 2 deliveries occurring in August. 11 perinatal transmissions were averted to date. In 2023, we have convened 1 large group meeting, 26 smaller perinatal case conferences, 3 Perinatal HIV Outreach Planning meetings, and 3 outreach meetings with birthing facilities…This effort was developed and implemented after 4 perinatal HIV infections occurred [in our jurisdiction], and has allowed us to ensure we are supporting the most vulnerable communities in our EHE populations to reach the EHE goals.*

Many recipients reported **HRSA technical assistance** as beneficial to their EHE implementation efforts.

> *Throughout the reporting period, EHE program staff continued to benefit from support provided by HRSA's [technical assistance (TA)] partners … including the Recipient's TA request to increase EHE utilization through three focused investments … to 1) expand the HRSA-approved public outreach media campaign by including tailored messaging to reach [people and communities disproportionately impacted by HIV], 2) utilize the County's subcontractor contract provisions to fund linkage-to-care positions in local hospital emergency room departments (ERs) and/or urgent care centers, and 3) implement the use of the [redacted] mobile application (app).*

The recipient below reported that online **virtual navigators** to connect clients to services and support resources are an important offering, assisting both clients and several clinics in their jurisdiction.

> *Virtual navigation—this is a unique addition added this year to offer resources to Ryan White providers who do not have a [specialized] navigator located at their site. The virtual option provides needed support for [RWHAP] clients with barriers to assist in moving them towards becoming undetectable.*

Creating an official **referral tracking protocol** assisted one recipient with ensuring that referrals receive appropriate follow-up.

> *Creating a mechanism to track incoming partner referrals (in contrast to phone calls, faxes, and walk-ins) has allowed us to hold ourselves accountable to follow-through with clients and partners. We have learned that some of our internal processes are inconsistent and [we] have made changes accordingly.*

Recipients also noted that while **telehealth visits** provide important flexibility, there are instances when **in-person visits** are more appropriate and beneficial.

> *Of the 57 clients who received Rapid Start ART, 46 achieved viral load suppression (VLS); a rate of 81%. Sub-grantees have noticed that telehealth services may not be appropriate for Rapid ART. The nature of the visit, type of services provided, and sensitive nature of HIV care may require in-person visits whenever possible. Telehealth, however, if available works best for the patient's needs for follow-up care.*

Finally, recipients also discussed the importance of taking time to **build rapport and trust** with clients dealing with complex concerns.

> *It is vital that staff take their time to build rapport and a relationship with highly complex clients, even if this phase of the staff/client relationship feels slow and without a focused goal—trust and working at a client's pace is essential to success with chronic substance use disorders, serious and persistent mental illness, and complex trauma histories.*

Highlights of Analyses: Workforce Training

The Ryan White HIV/AIDS Program (RWHAP) Part F AETC Program's regional training centers support the EHE initiative by expanding workforce capacity in jurisdictions where HIV transmission occurs most frequently. The regional AETCs work to (1) increase the size and strengthen the skills of the HIV workforce; (2) improve outcomes along the HIV care continuum, including diagnosis, linkage to care, retention in care, and viral suppression; and (3) decrease HIV transmission and, ultimately, reduce HIV incidence by training the frontline workforce.

The primary audiences for training events conducted by the regional AETCs are novice and low-volume HIV treatment providers, allied health professionals, and health care support staff who treat both people with HIV and those who may acquire HIV. Additional regional training events are supported through other funding streams and the activities of the national AETCs, such as the National AETC Support Center, National HIV Curriculum e-Learning Platform, and National Clinician Consultation Center, which also received EHE funding to support clinicians and service providers in EHE jurisdictions.

Training Events

During the July 2022 through June 2023 reporting period, regional AETCs conducted a total of 766 EHE-funded training events, a steady increase since Year 1 of EHE implementation. (Table 5).

The general training content areas most frequently covered in the July 2022 through June 2023 reporting period by EHE-funded AETC training events were HIV prevention (70.5%), engagement and retention in HIV care (55.1%), HIV testing and diagnosis (45.4%), and linkage/referral to HIV care (43.5%) (Table 5).

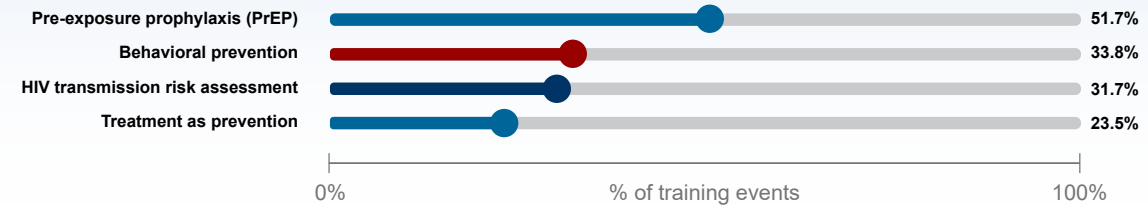
Training Topics

HIV Prevention

The HIV prevention topic most often presented in EHE-funded AETC training events from July 2022 through June 2023 was pre-exposure prophylaxis (PrEP), which was included in more than half of the training events (51.7%). Other HIV prevention topics featured most frequently included behavioral prevention (33.8%), HIV transmission risk assessment (31.7%), and treatment as prevention (23.5%) (Figure 8 and Table 5).

- In Cook County, Illinois, the Midwest AETC conducted "PrEP deserts" educational outreach with prescribers to train on technical evidence and best practices for prescribing and implementing PrEP services. Providers who participated in this program reported an increased intent to prescribe PrEP in their practice and felt more knowledgeable about PrEP treatment recommendations.
- In King County, Washington, the Mountain West AETC and their local partners collaborated with Public Health Seattle King County and the Washington Department of Health on the Pharmacy Initiated PrEP and ART Provision and Retention (PIPAR) project to integrate PrEP access into pharmacies. This project led to the implementation of pharmacist-led PrEP programs in pharmacy chains in Washington and other local pharmacies.

Figure 8
HIV Prevention training topics addressed during EHE-funded AETC training events, July 2022 to June 2023 (N=766)



Source: 2023 HRSA HAB EHE Report (Table 5).

HIV Management

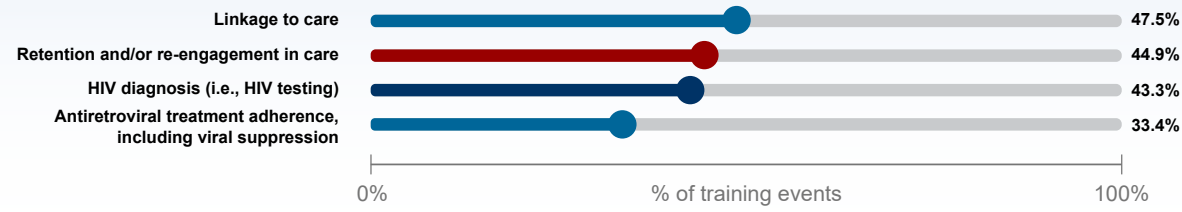
HIV management topics—especially those related to diagnosis, treatment, linkage to care, and care engagement—were featured in more than 30% of EHE-funded AETC training events from July 2022 through June 2023. Trainings about linkage to care were featured in nearly half of the training events (47.5%) (Figure 9 and Table 5).

- The Southeast AETC implemented the End-the-HIV-Epidemic Academy (END HIV), a longitudinal HIV preceptorship training program for prescribers. The virtual academy uses the National HIV Curriculum (NHC), live case-based group discussion, and tele-simulated patient encounters to cover critical components of HIV prevention, diagnosis, and treatment. One END HIV graduate reported:

> *I am a much better provider as a result of this program. I started working in HIV in August and started the Academy in September. I feel it helped get me up to speed much faster and filled in gaps I didn't realize I had.*

- In Harris County, Texas, the South Central AETC supported the EHE-Rapid stART Community of Practice using the ECHO (Extension for Community Healthcare Outcomes) model. This series meets monthly and includes health professionals from five Ryan White Part A clinics that care for the majority of people with HIV in the Houston/Harris County area. This collaboration has demonstrated an increase in participant self-knowledge, skills, and cross-agency collaboration.

Figure 9
HIV Management training topics addressed during EHE-funded AETC training events, July 2022 to June 2023 (N=766)



Source: 2023 HRSA HAB EHE Report (Table 5).

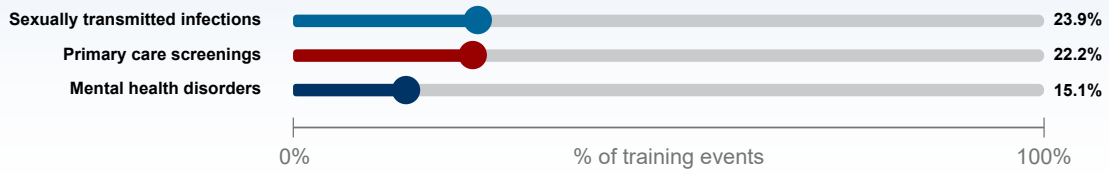
Primary Care, Chronic Conditions, and Comorbidities

The primary care and comorbidities topics most frequently presented in EHE-funded AETC trainings were sexually transmitted infections (23.9%), primary care screenings (22.2%), and mental health disorders (15.1%) (Figure 10 and Table 5).

- MidAtlantic AETC's regional partners hosted an ongoing series of HCV and HIV preceptorship trainings, which expanded in 2022 and 2023 to include content on integrating PrEP into primary care and substance use treatment settings.

Figure 10

Primary Care, Chronic Conditions, and Comorbidities training topics addressed during EHE-funded AETC training events, July 2022 to June 2023 (N=766)



Source: 2023 HRSA HAB EHE Report (Table 5).

Health Care Organizations or Systems Issues

AETC recipients trained health workers on enhancing clinical care capacity of health care organizations. The health care organizations or systems topics most frequently presented in EHE-funded AETC trainings from July 2022 through June 2023 were related to community linkages (34.5%), patient-centered care (24.8%), and case management (22.5%) (Figure 11 and Table 5).

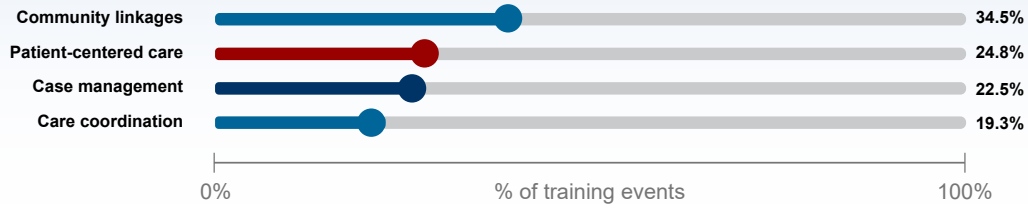
- The Southeast AETC's Southeast HIV Accelerated Response for Ending the Epidemic (SHARE) project partnered with clinics with limited HIV testing and PrEP prescription capacity, including those in rural areas, to strengthen these essential services. Several clinics that participated in the SHARE Project reported increased HIV testing rates during follow-up. One provider in the SHARE program stated:

> *This training increased confidence in my ability to provide the best quality of care to people with HIV, [I am] more aware of what kinds of questions to ask and how to ask them.*

- The Northeast/Caribbean AETC, in collaboration with regional partners located in EHE jurisdictions, convened an in-person conference on strengthening organizational structures and policies to improve patient health outcomes.

Figure 11

Health Care Organizations or Systems issues training topics addressed during EHE-funded AETC training events, July 2022 to June 2023 (N=766)



Source: 2023 HRSA HAB EHE Report (Table 5).

People and Communities Disproportionately Impacted by HIV

Nearly one-quarter of training events included the topic of adults aged 50 years and older (23.4%). Approximately one out of every seven EHE-funded AETC training events included the topic of the people experiencing housing instability (13.2%). Other communities addressed in training events included people who inject drugs (12.5%), people with legal system involvement (9.1%), and the rural population (7.2%) (Table 5).

- The New England AETC and local partners delivered a two-part training series on aging with HIV to strengthen relationship between HIV services and the elder care system. Sessions covered Massachusetts' shifting demographics, home-care considerations, medication adherence, neurocognitive and mental health issues, and the psychosocial complexity of growing older with HIV. One participant described the impact of the session:

  > *There is a lot of stigma and misinformation around HIV, and any learning which treats HIV like another chronic illness while also addressing the stigma is very valuable.*

- The South Central AETC local partner collaborated with the Arkansas Department of Health to develop the state's EHE plan which resulted in a mini learning conference and the launch of monthly "HIV 101 Overview" sessions that cover key strategies, testing, prevention, and PrEP.

Training Participants

Race/Ethnicity

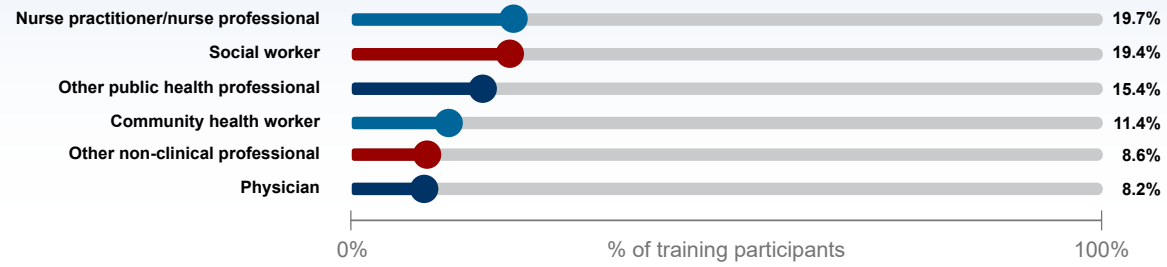
During the July 2022 through June 2023 reporting period, more than a third of the EHE-funded RWHAP AETC participants self-identified as White (36.9%), close to one-third as Black/African American (29.2%), and 25.3% as Hispanic/Latino (Table 6).

Professional and Employment Characteristics

From July 2022 through June 2023, the most reported professions of EHE-funded RWHAP AETC participants were nurses and nurse practitioners (19.7%), social workers (19.4%), and other public health professionals (15.4%) (Figure 12 and Table 6). Additionally, physicians accounted for 8.2% of all participants. This information represents the training participant's field and/or discipline; it may not represent their primary functional role in their organization.

Figure 12

Professional discipline of participants of EHE-funded AIDS Education and Training Center training events, July 2022 to June 2023 (N=8,321).

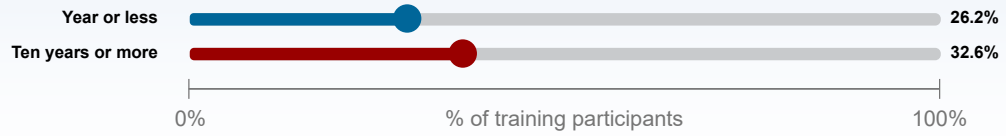


Source: 2023 HRSA HAB EHE Report (Table 6).

More than one-quarter of the participants were new to serving people with HIV (i.e., less than a year of direct service provision to people with HIV; 26.2%) while nearly one-third had more than 10 years of experience (32.6%). More than half of participants had a large client load of more than 50 clients a year (54.5%) (Figure 13 and Table 7).

Figure 13

Number of years providing direct services to people with HIV by participants of EHE-funded AIDS Education and Training Center training events, July 2022 to June 2023 (N = 8,321).

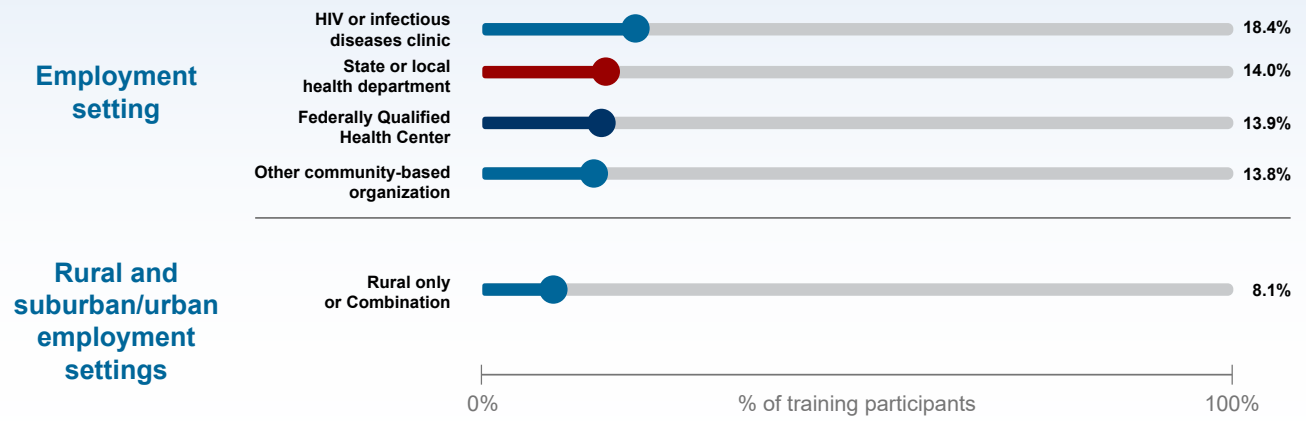


Source: 2023 HRSA HAB EHE Report (Table 7).

The most frequently reported employment setting was HIV or infectious diseases clinic (18.4%), followed by state or local health department (14.0%), Federally Qualified Health Center (13.9%), and other community-based organization (13.8%); 8.2% of the EHE-funded RWHAP AETC participants' employment settings were in a rural area (only or in combination with a suburban/urban area) (Figure 14 and Table 7).

Figure 14

Employment settings of participants of EHE-funded AIDS Education and Training Center training events, July 2022 to June 2023 (N = 8,321)



Source: 2023 HRSA HAB EHE Report (Table 7).

TECHNICAL NOTES

Recipient Reporting Overview

This report is the publication of qualitative and quantitative data about clients served by the Ending the HIV Epidemic in the U.S. (EHE) initiative jurisdictional recipients and EHE-funded training events delivered by regional AIDS Education and Training Center (AETC) program recipients, as explained in Figure 15.

Figure 15. HRSA HAB EHE Initiative Funding

	EHE JURISDICTIONAL RECIPIENTS		AETC PROGRAM RECIPIENTS	
Recipients	39 RWHAP Part A[a] recipients and 8 RWHAP Part B[b] recipients		8 Regional AETCs[c]	
Purpose	Direct provision of services to people with HIV in EHE jurisdictions		Training health care providers in EHE jurisdictions to care for people with HIV	
Data Source	**Progress Reports**	**RWHAP Services Report**	**Progress Reports**	**AETC Data System**
Data Type	Qualitative	Quantitative	Qualitative	Quantitative
Data Submission Frequency	Two times per project year	Once per calendar year	Three times per project year	Once per project year
Reporting Periods Included	March 2023–February 2024	January 2020–December 2023	March 2020–June 2023	March 2020–June 2023
Information Presented	Narrative descriptions of activities and implementation successes/challenges	Characteristics and clinical outcomes of clients and patients served by EHE-funded providers	Narrative descriptions of EHE-funded trainings and successes/challenges	Characteristics of EHE-funded trainings and participants
Location of Information in This Report	Pages 6–15; Tables 1–4		Page 16–20; Tables 5–7	

[a] **RWHAP Part A** provides funding to Eligible Metropolitan Areas and Transitional Grant Areas that are most severely affected by the HIV epidemic to support HIV care and treatment services. HRSA HAB awarded EHE funding to Part A recipients that encompass the EHE county jurisdictions.

[b] **RWHAP Part B** provides funding to states and territories to support HIV care and treatment services. HAB awarded funding to seven states with large rural epidemics. In addition, Ohio's Part B received funding to serve Hamilton County, one of the EHE priority county jurisdictions.

[c] Additional EHE funding was awarded to **national AETCs** (three awards in FY 2020, four awards in FY 2021, three awards each in FY 2022 and FY 2023), which do not report quantitative data through the AETC Data System.

Key: AETC = AIDS Education and Training Center; EHE = Ending the HIV Epidemic in the U.S.; HAB = HIV/AIDS Bureau; HRSA = Health Resources Services Administration; RWHAP = Ryan White HIV/AIDS Program

EHE Jurisdictional Progress Reports

This report uses narrative information from EHE progress reports submitted to the Health Resources and Services Administration (HRSA) HIV/AIDS Bureau (HAB) during Year 4 of the EHE initiative by each of the 47 HRSA HAB EHE recipients for March 2023 through February 2024. In these progress reports, EHE recipients report on their activities and accomplishments; barriers and challenges faced during EHE implementation; and successes, lessons learned, and best practices. The EHE progress reports complement quantitative data submitted through other mechanisms and provide HRSA HAB with information about the progress made on EHE activities and

the contextual factors surrounding EHE implementation. All quotations are direct, deidentified text from EHE recipient progress reports.

The highlights section of the report presents a summary of the most-funded activities in Year 4 of the EHE initiative and associated recipient quotes demonstrating the impact of EHE funding. HAB revises quotes for contextual clarity and to redact sensitive information. Additional information about infrastructure, new partnerships, and community engagement, among other systems-level EHE activities from Years 1 through 3, is available in the previously published *HRSA HIV/AIDS Bureau Ending the HIV Epidemic (EHE) Initiative Qualitative Summary of Progress: March 2021–February 2022* [9].

Limitations of Findings

EHE progress reports include only the activities, services, and accomplishments that were supported by fiscal year (FY) 2023–2024 HAB EHE funding and reported by EHE recipients. The reports do not represent the totality of HAB-funded activities and services in these jurisdictions because EHE recipients may use other funding to deliver services and activities, including Ryan White HIV/AIDS Program (RWHAP) Parts A, B, C, and D funding and other RWHAP-related funding (e.g., program income, pharmaceutical rebates). Additionally, these activities do not represent the totality of EHE-supported activities in these jurisdictions because EHE jurisdictional recipients may have received EHE funding from HRSA's Bureau of Primary Health Care, the Centers for Disease Control and Prevention, or other federal agencies (e.g., National Institutes of Health) to implement specific EHE interventions and activities. EHE jurisdictional recipients also may have received support from EHE-funded AETC recipients or technical assistance providers. Information provided by EHE recipients on their EHE activities through other mechanisms (e.g., monitoring calls with project officers) is not captured in this report.

RWHAP Services Report Data

The report includes data reported in the RWHAP Services Report (RSR) for new and re-engaged clients with HIV served by EHE-funded providers during calendar years 2020, 2021, 2022, and 2023. Although the data are limited to these recipients and service providers, all clients receiving care and treatment are included, regardless of the funding used for the services. That is, data are not limited to clients served using EHE funding; all clients served by EHE-funded providers are included in data submissions and in this report. The information presented in Tables 1a–4b includes the number of new and re-engaged clients served and their demographic characteristics and socioeconomic factors.

The RSR is HRSA HAB's primary source of annual client-level data reported by more than 2,000 grant recipients and subrecipients, including those funded for EHE. These data allow HRSA HAB and its stakeholders to assess the numbers and demographics of clients receiving services, understand client HIV-related outcomes, and identify and address HIV-related disparities.

RSR data do not include information about the AIDS Drug Assistance Program (ADAP), which is reported through another data system. Although data presented in this report are "non-ADAP," many clients included in the RSR data also receive ADAP services.

For additional information about RSR reporting, please refer to the Technical Notes section of the *2023 RWHAP Annual Data Report* [4].

Presentation of Data

Data are organized into two sections:

- Section 1 **(Tables 1a–2b)**: National-level numbers and percentages of both patients served by EHE-funded providers and viral suppression, presented by patient type (new and re-engaged) and selected demographic characteristics.
- Section 2 **(Tables 3a–4b)**: Jurisdiction—state- and eligible metropolitan area (EMA)– and transitional grant area (TGA)–level numbers of patients served by EHE-funded providers and viral suppression among patients served by EHE-funded providers, presented by patient type (new and re-engaged).

Tables 1a and 1b display subtotals for each subpopulation, as well as the overall total. Subtotals are displayed to reflect the denominator used for the percentage calculation of each subpopulation. Because of missing data, the values in each column may not sum to the column total.

The data in this report include information received by HRSA HAB for clients served during calendar years 2020 through 2023. RSR data are submitted once per calendar year.

Client Type

Beginning in 2020, EHE-funded providers were required to report two new data elements in the RSR to identify clients who were new to care and estimate the clients who were re-engaged in care.

- New clients ("a" tables): A client was reported as "new" if they were new to care at the reporting service provider (i.e., the client had never received care at the HIV service provider for any service category). After deduplication across providers, the client was identified as a "new client" if they were new to care to all reporting service providers. In this report, these are the clients defined as clients new to HIV care ("new clients").
- Received a service in the previous year: EHE-funded outpatient ambulatory health services (OAHS), medical case management (MCM), non-medical case management (non-MCM), and EHE initiative service providers were also required to report if a client received at least one service in the previous reporting year.

These two data elements were used to estimate whether a client was previously "out of care" and became re-engaged in HIV care ("b" tables). In this report, if a client was neither reported as a new client nor received a service in the previous year, that client would be considered re-engaged in care. This estimation of re-engaged clients across all service providers is an approximation and should not be interpreted as a precise application of a formal definition of re-engagement in care. Because the re-engaged clients are only calculated for providers that deliver OAHS, MCM, non-MCM, and EHE initiative services, this is likely an underestimate of all people re-engaged in care across all EHE-funded providers.

HIV Status

RSR data in this report include de-identified client-level information about people who received services from EHE-funded providers. The data presented in this report include only people with HIV.

Jurisdictions

HRSA HAB awarded EHE funds to the 39 RWHAP Part A recipients and eight Part B recipients that compose the EHE jurisdictions (i.e., 48 counties; Washington, D.C.; San Juan, Puerto Rico; and the seven rural states).

Part A of the RWHAP provides emergency assistance to EMAs and TGAs that are most severely affected by the HIV epidemic. EMAs and TGAs range in size from one city or county to more than 26 different geographic entities; 11 include parts of more than one state. For EHE funding, the EHE jurisdictions were associated with existing RWHAP Part A EMAs/TGAs with one exception; EHE funding to Hamilton County, Ohio, was awarded to the Ohio Part B (see the Appendix).

Jurisdiction-level data (i.e., state- and EMA/TGA-level) are delineated based on provider location rather than client location. Jurisdiction-level analyses include data submitted by EHE-funded recipients for all Parts of the RWHAP and EHE funding. That is, all tables include data for all clients served by EHE- funded providers in the jurisdiction, regardless of the source of funding. Jurisdiction level data are displayed in Tables 3a–4b.

It is important to note that data shown for jurisdictions are not mutually exclusive; clients may have received services from providers in multiple EMAs and TGAs.

At the jurisdictional level, year-to-year fluctuations in the number of new or estimated re-engaged clients are to be expected. These fluctuations could be attributed to any of the following:

- Changes in funding and/or staffing that impact service delivery and/or data reporting
- Jurisdictional emphasis on new or estimated re-engaged clients (i.e., some jurisdictions may have zero estimated re-engaged clients if their activities focused on clients new to care)
- Early success of direct service activities, leading to fewer new or estimated re-engaged clients not yet engaged in care in later years, with funding directed to maintaining these clients in care and increasing treatment adherence
- Changes in direct service activities, approaches, or geographic areas of focus in response to shifting jurisdictional, epidemiological, and/or community needs
- Funding activities other than service delivery, such as clinical quality management, recipient administration, development and expansion of data systems, and planning and evaluation, including stakeholder engagement and process and outcome evaluation activities
- Improved quality, accuracy, and validity of data reported to HRSA HAB

Viral Suppression

Viral suppression was calculated based on data for people with HIV who had at least one OAHS visit and at least one viral load test during the measurement year. Viral suppression was defined as the most recently reported HIV RNA test result of <200 copies/mL.

Other Variables

For information on other variables presented in the RSR section of this report, please refer to the Technical Notes section of the *2023 RWHAP Annual Data Report* [4].

RWHAP Regional AETC Training Events

Eight regional AETCs were awarded EHE funding to deliver training events to respond to the needs of health care professionals in EHE jurisdictions. EHE-funded trainings are defined as training events supported by AETC EHE funding.

Each year, regional AETCs are required to report quantitative data to HRSA HAB about their training events and the participants who attended those events in the United States, Guam, Puerto Rico, and the U.S. Virgin Islands. The yearly AETC data reporting period is July 1 to June 30.

Information collected on training events via Event Record (ER) data forms includes the topics covered, names of collaborating organizations, types of funds used from special initiatives, type and length of sessions, training modalities or technologies used, the total number of participants in attendance, and the total number of Participant Information Forms (PIFs) collected from participants.

Information collected on participants via PIF data forms includes demographic information (e.g., profession, functional role, race/ethnicity). In addition, information about participants' employment setting(s) is collected (e.g., if the setting is in a rural or suburban/urban area).

A new funding source was added to the ER data collection form to reflect the use of EHE funds for training events. Training content and topics related to EHE appear throughout the current training content/topic variables; there is not a separate variable for EHE training content/topics.

For information on variables presented in the AETC portion of this report, please refer to the Technical Notes section of the *2023 Ryan White HIV/AIDS Program (RWHAP) AIDS Education and Training Center (AETC) Program Annual Data Report* [10].

RWHAP AETC Progress Reports

From March 2020 through June 2023, HRSA HAB collected narrative information from the eight regional AETCs detailing their activities and achievement of project goals for each program component and funding stream. AETC Progress Report findings in this report include only the activities and accomplishments that were supported by HAB EHE funding during the July 2022 through June 2023 reporting period. AETC progress reports were collected through the Non-Competing Continuation Report and the Annual Progress Report.

Please note that this report provided examples of the most common training topics provided; every EHE-funded AETC training event was not described.

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ADDITIONAL RESOURCES

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

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

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

APPENDIX

In fiscal year 2023, the Health Resources and Services Administration HIV/AIDS Bureau awarded Ending the HIV Epidemic in the U.S. (EHE) initiative funds to 47 jurisdictional recipients.

Appendix Table 1. HIV/AIDS Bureau EHE Awards

Recipient	Jurisdiction	EHE Focus Counties or State
Atlanta, GA	Atlanta, GA	Cobb County; DeKalb County; Fulton County; Gwinnett County
Baltimore, MD	Baltimore, MD	Baltimore City
Boston, MA	Boston, MA	Suffolk County
Chicago, IL	Chicago, IL	Cook County
Dallas, TX	Dallas, TX	Dallas County
Detroit, MI	Detroit, MI	Wayne County
Ft. Lauderdale, FL	Ft. Lauderdale, FL	Broward County
Houston, TX	Houston, TX	Harris County
Los Angeles, CA	Los Angeles, CA	Los Angeles County
Miami, FL	Miami, FL	Miami–Dade County
New Orleans, LA	New Orleans, LA	Orleans Parish
New York, NY	New York, NY	Bronx County; Kings County; New York County; Queens County
Newark, NJ	Newark, NJ	Essex County
Orlando, FL	Orlando, FL	Orange County
Philadelphia, PA	Philadelphia, PA	Philadelphia County
Phoenix, AZ	Phoenix, AZ	Maricopa County
San Diego, CA	San Diego, CA	San Diego County
San Francisco, CA	San Francisco, CA	San Francisco County
San Juan, PR	San Juan, PR	San Juan Municipio
Tampa–St. Petersburg, FL	Tampa, FL	Hillsborough County; Pinellas County
Washington, DC	Washington, DC	District of Columbia; Montgomery County, MD; Prince George's County, MD
West Palm Beach, FL	West Palm Beach, FL	Palm Beach County
Austin, TX	Austin, TX	Travis County
Baton Rouge, LA	Baton Rouge, LA	East Baton Rouge Parish
Charlotte, NC/Gastonia, SC	Charlotte, NC	Mecklenburg County, NC
Cleveland–Lorain–Elyria, OH	Cleveland, OH	Cuyahoga County
Columbus, OH	Columbus, OH	Franklin County
Ft. Worth, TX	Ft. Worth, TX	Tarrant County
Indianapolis, IN	Indianapolis, IN	Marion County
Jacksonville, FL	Jacksonville, FL	Duval County
Jersey City, NJ	Jersey City, NJ	Hudson County
Las Vegas, NV	Las Vegas, NV	Clark County
Memphis, TN	Memphis, TN	Shelby County
Oakland, CA	Oakland, CA	Alameda County

Recipient	Jurisdiction	EHE Focus Counties or State
Orange County, CA	Santa Ana, CA	Orange County
Riverside–San Bernardino, CA	San Bernardino, CA	Riverside County; San Bernardino County
Sacramento, CA	Sacramento, CA	Sacramento County
San Antonio, TX	San Antonio, TX	Bexar County
Seattle, WA	Seattle, WA	King County
Alabama	Alabama	State
Arkansas	Arkansas	State
Kentucky	Kentucky	State
Mississippi	Mississippi	State
Missouri	Missouri	State
Ohio	Ohio	Hamilton County
Oklahoma	Oklahoma	State
South Carolina	South Carolina	State

Tables 1–7

Table 1a. New clients with HIV served by EHE-funded providers, by year and selected characteristics, 2020–2023— 47 HRSA HAB EHE-funded jurisdictions

	2020		2021		2022		2023	
	N	%	N	%	N	%	N	%
Age group (yrs)								
<13	7	0.1	32	0.1	18	0.1	18	0.1
13–14	4	<0.1	5	<0.1	5	<0.1	8	<0.1
15–19	84	0.7	218	1.0	192	0.9	276	1.0
20–24	669	5.7	1,622	7.2	1,664	7.6	1,918	7.1
25–29	1,265	10.7	3,118	13.9	3,304	15.0	3,717	13.9
30–34	1,571	13.3	3,742	16.7	4,081	18.5	4,785	17.8
35–39	1,324	11.2	2,823	12.6	3,154	14.3	3,894	14.5
40–44	1,140	9.7	2,308	10.3	2,323	10.6	2,856	10.6
45–49	1,070	9.1	1,761	7.9	1,764	8.0	2,296	8.6
50–54	1,373	11.6	2,077	9.3	1,682	7.6	2,064	7.7
55–59	1,419	12.0	2,063	9.2	1,682	7.6	2,022	7.5
60–64	931	7.9	1,380	6.2	1,158	5.3	1,568	5.8
≥65	935	7.9	1,264	5.6	974	4.4	1,408	5.2
Subtotal	**11,792**	**100.0**	**22,413**	**100.0**	**22,001**	**100.0**	**26,830**	**100.0**
Race/ethnicity								
American Indian/Alaska Native	31	0.3	94	0.4	183	0.9	86	0.3
Asian	127	1.1	299	1.4	704	3.4	317	1.2
Black/African American	6,536	56.2	11,076	50.4	9,347	44.7	11,969	45.8
Hispanic/Latino[a]	2,071	17.8	5,408	24.6	6,507	31.1	8,106	31.0
Native Hawaiian/Pacific Islander	20	0.2	44	0.2	30	0.1	33	0.1
White	2,776	23.9	4,844	22.0	3,880	18.6	5,261	20.1
Multiple races	72	0.6	225	1.0	259	1.2	381	1.5
Subtotal	**11,633**	**100.0**	**21,990**	**100.0**	**20,910**	**100.0**	**26,153**	**100.0**
Sex								
Male	8,912	77.3	17,288	80.1	16,911	80.7	20,172	78.9
Female	2,612	22.7	4,307	19.9	4,037	19.3	5,410	21.1
Subtotal	**11,524**	**100.0**	**21,595**	**100.0**	**20,948**	**100.0**	**25,582**	**100.0**
Federal poverty level								
0–100%	5,126	68.1	11,563	66.9	12,824	68.9	16,332	68.2
101–138%	686	9.1	1,167	6.7	1,286	6.9	1,644	6.9
139–250%	1,040	13.8	2,840	16.4	2,663	14.3	3,678	15.4
251–400%	500	6.6	1,350	7.8	1,423	7.7	1,824	7.6
>400%	172	2.3	370	2.1	404	2.2	467	2.0
Subtotal	**7,524**	**100.0**	**17,290**	**100.0**	**18,600**	**100.0**	**23,945**	**100.0**
Health care coverage								
Private employer	653	8.6	1,679	9.3	1,641	8.7	2,430	9.8
Private individual	549	7.2	1,405	7.8	1,225	6.5	2,248	9.1
Medicare	342	4.5	759	4.2	789	4.2	1,286	5.2
Medicaid	1,558	20.5	4,526	25.1	4,549	24.0	6,610	26.7
Medicare and Medicaid	279	3.7	544	3.0	604	3.2	745	3.0
Veterans Administration	14	0.2	33	0.2	44	0.2	33	0.1
Indian Health Service	0	0.0	0	0.0	5	<0.1	4	<0.1
Other plan	189	2.5	331	1.8	489	2.6	491	2.0
No coverage	3,503	46.0	7,553	41.8	8,300	43.8	9,199	37.1
Multiple coverages	530	7.0	1,233	6.8	1,309	6.9	1,746	7.0
Subtotal	**7,617**	**100.0**	**18,063**	**100.0**	**18,955**	**100.0**	**24,792**	**100.0**
Housing status								
Stable	5,954	78.1	13,727	78.3	14,166	75.6	18,345	76.8
Temporary	1,016	13.3	2,202	12.6	2,806	15.0	3,374	14.1
Unstable	650	8.5	1,598	9.1	1,760	9.4	2,169	9.1
Subtotal	7,620	100.0	17,527	100.0	18,732	100.0	23,888	100.0
Total[b]	**11,792**	**100.0**	**22,413**	**100.0**	**22,001**	**100.0**	**26,830**	**100.0**

Abbreviation: EHE, Ending the HIV Epidemic in the U.S. initiative.

[a] Hispanics/Latinos can be of any race.

[b] Subtotals for each subpopulation are displayed to reflect the denominator used for the percentage calculation of each subpopulation; due to missing data, the values in each column may not sum to the column total.

Table 1b. Estimated re-engaged* clients with HIV who were served by selected EHE-funded providers, by year and selected characteristics, 2020–2023—47 HRSA HAB EHE-funded jurisdictions

	2020		2021		2022		2023	
	N	%	N	%	N	%	N	%
Age group (yrs)								
<13	3	<0.1	10	0.1	12	0.1	9	0.1
13–14	0	0.0	7	<0.1	3	<0.1	5	<0.1
15–19	15	0.2	32	0.2	48	0.2	46	0.3
20–24	211	3.0	343	2.2	456	2.4	505	2.9
25–29	548	7.7	1,014	6.6	1,344	7.0	1,259	7.3
30–34	782	11.0	1,767	11.5	2,380	12.4	2,224	12.8
35–39	656	9.3	1,641	10.7	2,206	11.5	2,141	12.3
40–44	633	8.9	1,546	10.1	2,116	11.0	1,884	10.9
45–49	698	9.9	1,395	9.1	1,863	9.7	1,627	9.4
50–54	966	13.6	1,910	12.5	2,262	11.8	1,850	10.7
55–59	1,019	14.4	2,165	14.1	2,553	13.3	2,118	12.2
60–64	809	11.4	1,691	11.0	2,018	10.5	1,853	10.7
≥65	745	10.5	1,797	11.7	1,943	10.1	1,837	10.6
Subtotal	**7,085**	**100.0**	**15,318**	**100.0**	**19,204**	**100.0**	**17,358**	**100.0**
Race/ethnicity								
American Indian/Alaska Native	10	0.1	49	0.3	56	0.3	50	0.3
Asian	59	0.9	188	1.3	237	1.3	177	1.0
Black/African American	4,273	61.6	8,288	55.2	9,865	52.8	9,385	54.7
Hispanic/Latino[a]	1,351	19.5	3,292	21.9	4,223	22.6	4,112	24.0
Native Hawaiian/Pacific Islander	13	0.2	15	0.1	55	0.3	31	0.2
White	1,167	16.8	3,085	20.5	4,064	21.8	3,115	18.2
Multiple races	62	0.9	110	0.7	175	0.9	273	1.6
Subtotal	**6,935**	**100.0**	**15,027**	**100.0**	**18,675**	**100.0**	**17,143**	**100.0**
Gender								
Male	4,746	68.9	10,728	72.9	13,599	75.7	12,145	72.6
Female	2,143	31.1	3,995	27.1	4,355	24.3	4,579	27.4
Subtotal	**6,889**	**100.0**	**14,723**	**100.0**	**17,954**	**100.0**	**16,724**	**100.0**
Federal poverty level								
0–100%	4,177	64.0	7,649	63.4	10,875	64.3	9,649	64.5
101–138%	674	10.3	1,073	8.9	1,451	8.6	1,332	8.9
139–250%	1,039	15.9	1,919	15.9	2,516	14.9	2,290	15.3
251–400%	484	7.4	1,063	8.8	1,410	8.3	1,278	8.5
>400%	152	2.3	363	3.0	651	3.9	400	2.7
Subtotal	**6,526**	**100.0**	**12,067**	**100.0**	**16,903**	**100.0**	**14,949**	**100.0**
Health care coverage								
Private employer	811	12.0	1,920	13.5	1,769	9.8	1,689	10.6
Private individual	428	6.3	1,249	8.8	957	5.3	1,258	7.9
Medicare	804	11.9	1,620	11.4	1,827	10.1	1,649	10.3
Medicaid	2,399	35.4	4,414	31.1	6,664	36.8	5,749	36.0
Medicare and Medicaid	493	7.3	1,163	8.2	1,054	5.8	1,030	6.5
Veterans Administration	4	0.1	21	0.1	20	0.1	30	0.2
Indian Health Service	0	0.0	0	0.0	6	<0.1	0	0.0
Other plan	124	1.8	246	1.7	881	4.9	204	1.3
No coverage	1,156	17.1	2,109	14.8	2,534	14.0	2,916	18.3
Multiple coverages	553	8.2	1,467	10.3	2,401	13.3	1,438	9.0
Subtotal	**6,772**	**100.0**	**14,209**	**100.0**	**18,113**	**100.0**	**15,963**	**100.0**
Housing status								
Stable	4,776	75.2	9,985	81.5	14,417	84.8	12,572	83.0
Temporary	1,358	21.4	1,774	14.5	1,866	11.0	1,682	11.1
Unstable	217	3.4	497	4.1	724	4.3	893	5.9
Medicaid	6,351	100.0	12,256	100.0	17,007	100.0	15,147	100.0
Total[b]	**7,085**	**100.0**	**15,318**	**100.0**	**19,204**	**100.0**	**17,358**	**100.0**

Abbreviations: EHE, Ending the HIV Epidemic in the U.S. initiative; OAHS, outpatient ambulatory health services.

* Clients estimated to be re-engaged in care is calculated among clients served by EHE-funded outpatient ambulatory health services, medical case management, non-medical case management, and EHE initiative services providers. This estimation of re-engaged clients is an approximation and should not be interpreted as a precise application of a formal definition of re-engagement in care.

[a] Hispanics/Latinos can be of any race.

[b] Subtotals for each subpopulation are displayed to reflect the denominator used for the percentage calculation of each subpopulation; due to missing data, the values in each column may not sum to the column total.

Table 2a. Viral suppression among new clients with HIV served by EHE-funded providers, by year and selected characteristics, 2020–2023—47 HRSA HAB EHE-funded jurisdictions

	2020			2021			2022			2023		
		Viral suppression			Viral suppression			Viral suppression			Viral suppression	
	Total N	N	%	Total N	N	%	Total N	N	%	Total N	N	%
Age group (yrs)												
<13	3	2	66.7	20	15	75.0	13	10	76.9	13	9	69.2
13–14	1	0	0.0	4	4	100.0	3	2	66.7	6	6	100.0
15–19	52	38	73.1	153	115	75.2	122	97	79.5	182	143	78.6
20–24	442	323	73.1	1,136	866	76.2	1,148	862	75.1	1,267	973	76.8
25–29	821	607	73.9	2,142	1,640	76.6	2,182	1,669	76.5	2,445	1,951	79.8
30–34	939	678	72.2	2,460	1,895	77.0	2,660	2,081	78.2	3,035	2,403	79.2
35–39	741	561	75.7	1,668	1,306	78.3	1,961	1,513	77.2	2,377	1,900	79.9
40–44	527	400	75.9	1,295	1,004	77.5	1,392	1,104	79.3	1,729	1,415	81.8
45–49	421	314	74.6	922	749	81.2	1,034	857	82.9	1,332	1,073	80.6
50–54	453	365	80.6	957	747	78.1	896	724	80.8	1,197	1,004	83.9
55–59	390	328	84.1	871	742	85.2	846	713	84.3	1,052	922	87.6
60–64	214	181	84.6	475	401	84.4	554	473	85.4	798	705	88.3
≥65	126	109	86.5	324	287	88.6	370	328	88.6	633	571	90.2
Race/ethnicity												
American Indian/Alaska Native	14	10	71.4	39	33	84.6	53	43	81.1	42	32	76.2
Asian	81	71	87.7	208	180	86.5	240	200	83.3	210	177	84.3
Black/African American	2,664	1,967	73.8	6,015	4,550	75.6	6,054	4,654	76.9	7,369	5,801	78.7
Hispanic/Latino[a]	1,327	1,050	79.1	3,508	2,872	81.9	4,197	3,408	81.2	4,962	4,147	83.6
Native Hawaiian/Pacific Islander	8	7	87.5	28	24	85.7	18	14	77.8	22	15	68.2
White	957	746	78.0	2,324	1,873	80.6	2,238	1,809	80.8	3,064	2,579	84.2
Multiple races	51	36	70.6	138	107	77.5	150	117	78.0	179	144	80.4
Sex												
Male	3,979	3,051	76.7	9,844	7,753	78.8	10,468	8,246	78.8	12,369	10,053	81.3
Female	993	749	75.4	2,078	1,638	78.8	2,199	1,784	81.1	3,026	2,482	82.0
Federal poverty level												
0–100%	3,591	2,654	73.9	8,162	6,223	76.2	8,893	6,904	77.6	10,816	8,593	79.4
101–138%	432	356	82.4	795	660	83.0	787	656	83.4	1,004	866	86.3
139–250%	661	540	81.7	1,966	1,611	81.9	1,787	1,471	82.3	2,390	2,057	86.1
251–400%	294	240	81.6	893	781	87.5	882	741	84.0	1,163	1,018	87.5
>400%	98	90	91.8	256	232	90.6	254	221	87.0	284	249	87.7
Health care coverage												
Private employer	374	315	84.2	1,074	903	84.1	1,055	897	85.0	1,508	1,305	86.5
Private individual	303	258	85.1	781	689	88.2	654	563	86.1	1,274	1,085	85.2
Medicare	160	137	85.6	358	292	81.6	356	301	84.6	628	562	89.5
Medicaid	924	698	75.5	2,940	2,241	76.2	2,682	2,044	76.2	3,944	3,118	79.1
Medicare and Medicaid	127	98	77.2	242	203	83.9	265	223	84.2	359	309	86.1
Veterans Administration	0	—	—	9	6	66.7	12	10	83.3	9	8	88.9
Indian Health Service	0	—	—	0	—	—	0	—	—	3	3	100.0
Other plan	92	76	82.6	192	152	79.2	332	254	76.5	329	268	81.5
No coverage	2,830	2,054	72.6	5,927	4,530	76.4	6,534	5,077	77.7	6,638	5,231	78.8
Multiple coverages	297	258	86.9	782	670	85.7	907	769	84.8	1,229	1,083	88.1
Housing status												
Stable	4,051	3,141	77.5	9,730	7,812	80.3	9,888	7,986	80.8	12,460	10,342	83.0
Temporary	675	506	75.0	1,456	1,114	76.5	1,809	1,382	76.4	2,002	1,586	79.2
Unstable	382	243	63.6	971	652	67.1	1,044	723	69.3	1,256	884	70.4
Total[b]	**5,130**	**3,906**	**76.1**	**12,427**	**9,771**	**78.6**	**13,181**	**10,433**	**79.2**	**16,066**	**13,075**	**81.4**

Abbreviations: EHE, Ending the HIV Epidemic in the U.S. initiative; OAHS, outpatient ambulatory health services.

Viral suppression was based on data for people with HIV who had at least one OAHS visit during the measurement year and whose most recent viral load test result was <200 copies/mL.

[a] Hispanics/Latinos can be of any race.

[b] Because column totals were calculated independently of the values for the subpopulations, the values in each column may not sum to the column total.

Table 2b. Viral suppression among estimated re-engaged* clients with HIV who were served by selected EHE-funded providers, by year and selected characteristics, 2020–2023— 47 HRSA HAB EHE-funded jurisdictions

	2020			2021			2022			2023		
		Viral suppression			Viral suppression			Viral suppression			Viral suppression	
	Total N	N	%	Total N	N	%	Total N	N	%	Total N	N	%
Age group (yrs)												
<13	2	1	50.0	6	5	83.3	7	7	100.0	4	4	100.0
13–14	0	—	—	0	—	—	1	1	100.0	3	3	100.0
15–19	4	3	75.0	10	8	80.0	29	17	58.6	31	26	83.9
20–24	137	113	82.5	175	139	79.4	297	234	78.8	338	268	79.3
25–29	362	275	76.0	578	438	75.8	908	709	78.1	825	670	81.2
30–34	528	410	77.7	1,018	775	76.1	1,675	1,325	79.1	1,442	1,151	79.8
35–39	425	352	82.8	909	726	79.9	1,569	1,253	79.9	1,388	1,117	80.5
40–44	411	344	83.7	803	676	84.2	1,471	1,231	83.7	1,208	993	82.2
45–49	468	391	83.5	744	629	84.5	1,268	1,086	85.6	1,033	862	83.4
50–54	693	596	86.0	1,015	887	87.4	1,561	1,358	87.0	1,111	962	86.6
55–59	719	642	89.3	1,115	997	89.4	1,742	1,553	89.2	1,321	1,167	88.3
60–64	569	511	89.8	879	787	89.5	1,306	1,182	90.5	1,114	1,002	89.9
≥65	554	538	97.1	904	854	94.5	1,260	1,188	94.3	1,089	1,006	92.4
Race/ethnicity												
American Indian/Alaska Native	9	7	77.8	21	16	76.2	27	21	77.8	26	22	84.6
Asian	40	38	95.0	101	94	93.1	182	168	92.3	112	103	92.0
Black/African American	3,136	2,644	84.3	4,698	3,871	82.4	6,976	5,713	81.9	6,315	5,222	82.7
Hispanic/Latino[a]	1,010	905	89.6	1,745	1,532	87.8	2,964	2,628	88.7	2,521	2,186	86.7
Native Hawaiian/Pacific Islander	10	9	90.0	10	10	100.0	44	40	90.9	18	17	94.4
White	606	520	85.8	1,423	1,265	88.9	2,447	2,176	88.9	1,691	1,495	88.4
Multiple races	23	21	91.3	37	30	81.1	90	73	81.1	120	108	90.0
Sex												
Male	3,225	2,753	85.4	5,810	4,935	84.9	9,200	7,818	85.0	7,599	6,408	84.3
Female	1,585	1,374	86.7	2,122	1,810	85.3	2,964	2,511	84.7	3,006	2,581	85.9
Federal poverty level												
0–100%	2,982	2,475	83.0	5,078	4,184	82.4	8,319	6,860	82.5	6,927	5,692	82.2
101–138%	521	468	89.8	662	579	87.5	1,021	899	88.1	905	786	86.9
139–250%	751	681	90.7	1,203	1,068	88.8	1,863	1,665	89.4	1,607	1,423	88.6
251–400%	327	306	93.6	694	631	90.9	1,009	914	90.6	808	746	92.3
>400%	92	87	94.6	275	264	96.0	527	497	94.3	249	231	92.8
Health care coverage												
Private employer	603	541	89.7	1,285	1,185	92.2	1,166	1,043	89.5	1,113	1,007	90.5
Private individual	289	271	93.8	480	441	91.9	612	551	90.0	849	766	90.2
Medicare	600	565	94.2	897	820	91.4	1,124	1,020	90.7	949	852	89.8
Medicaid	1,684	1,406	83.5	2,843	2,315	81.4	4,935	4,063	82.3	3,876	3,200	82.6
Medicare and Medicaid	364	319	87.6	555	497	89.5	717	622	86.8	693	605	87.3
Veterans Administration	1	1	100.0	4	4	100.0	5	4	80.0	10	8	80.0
Indian Health Service	0	—	—	0	—	—	3	2	66.7	0	—	—
Other plan	75	58	77.3	92	76	82.6	659	633	96.1	108	98	90.7
No coverage	847	642	75.8	1,324	986	74.5	1,917	1,433	74.8	2,140	1,648	77.0
Multiple coverages	403	369	91.6	634	564	89.0	1,861	1,701	91.4	1,029	936	91.0
Housing status												
Stable	3,510	3,071	87.5	6,524	5,618	86.1	11,108	9,590	86.3	8,972	7,693	85.7
Temporary	1,042	883	84.7	1,227	1,025	83.5	1,435	1,185	82.6	1,241	1,048	84.4
Unstable	125	72	57.6	259	162	62.5	464	298	64.2	552	372	67.4
Total[b]	**4,872**	**4,176**	**85.7**	**8,156**	**6,921**	**84.9**	**13,094**	**11,144**	**85.1**	**10,907**	**9,231**	**84.6**

Abbreviations: EHE, Ending the HIV Epidemic in the U.S. initiative; OAHS, outpatient ambulatory health services.

Viral suppression was based on data for people with HIV who had at least one OAHS visit during the measurement year and whose most recent viral load test result was <200 copies/mL.

* Clients estimated to be re-engaged in care is calculated among clients served by EHE-funded outpatient ambulatory health services, medical case management, non-medical case management, and EHE initiative services providers. This estimation of re-engaged clients is an approximation and should not be interpreted as a precise application of a formal definition of re-engagement in care.

[a] Hispanics/Latinos can be of any race.

[b] Because column totals were calculated independently of the values for the subpopulations, the values in each column may not sum to the column total.

Table 3a. New clients with HIV served by EHE-funded providers, by year and jurisdiction, 2020–2023—47 HRSA HAB EHE-funded jurisdictions

Part A jurisdictions			2020	2021	2022	2023
State/Territory	**EMA/TGA**	**EHE focus county(ies)**	**N**	**N**	**N**	**N**
Arizona	Phoenix	Maricopa County	0	567	421	695
California	Los Angeles	Los Angeles County	114	1,038	80	106
	Oakland	Alameda County	106	209	196	206
	Sacramento	Sacramento County	0	17	25	56
	San Bernardino	Riverside County; San Bernardino County	222	151	253	591
	San Diego	San Diego County	0	205	525	147
	San Francisco	San Francisco County	229	273	240	310
	Santa Ana	Orange County	318	265	344	359
District of Columbia	Washington	District of Columbia; Montgomery County, MD; Prince George's County, MD	98	139	152	101
Florida	Fort Lauderdale	Broward County	1,322	1,232	1,399	1,618
	Jacksonville	Duval County	162	349	315	426
	Miami	Miami-Dade County	0	299	360	948
	Orlando	Orange County	104	564	618	525
	Tampa	Hillsborough County; Pinellas County	488	635	627	677
	West Palm Beach	Palm Beach County	88	121	192	217
Georgia	Atlanta	Cobb County; DeKalb County; Fulton County; Gwinnett County	370	2,086	2,125	2,326
Illinois	Chicago	Cook County	273	202	134	147
Indiana	Indianapolis	Marion County	34	8	184	209
Louisiana	Baton Rouge	East Baton Rouge Parish	0	320	339	552
	New Orleans	Orleans Parish	0	407	313	342
Maryland	Baltimore	Baltimore City	10	92	105	220
Massachusetts	Boston	Suffolk County	222	27	336	270
Michigan	Detroit	Wayne County	219	336	303	958
Nevada	Las Vegas	Clark County	0	202	106	39
New Jersey	Jersey City	Hudson County	55	122	209	121
	Newark	Essex County	607	641	624	506
New York	New York	Bronx County; Kings County; New York County; Queens County	43	1,375	1,869	2,619
North Carolina	Charlotte	Mecklenburg County	59	127	257	399
Ohio	Cleveland	Cuyahoga County	0	337	210	342
	Columbus	Franklin County	62	86	700	993
Pennsylvania	Philadelphia	Philadelphia County	92	756	292	1,430
Puerto Rico	San Juan	San Juan Municipio	24	173	20	207
Tennessee	Memphis	Shelby County	62	45	32	54
Texas	Austin	Travis County	0	352	416	560
	Dallas	Dallas County	0	70	1,123	525
	Fort Worth	Tarrant County	0	449	556	366
	Houston	Harris County	1,820	2,010	2,243	2,257
	San Antonio	Bexar County	1	439	679	973
Washington	Seattle	King County	0	261	318	425

Part B jurisdictions		2020	2021	2022	2023
State	**EHE focus county or state**	**N**	**N**	**N**	**N**
Alabama	State	41	414	612	652
Arkansas	State	119	150	16	15
Kentucky	State	45	42	38	264
Mississippi	State	0	0	7	53
Missouri	State	168	590	459	560
Ohio	Hamilton County	0	190	299	325
Oklahoma	State	0	0	58	218
South Carolina	State	4,042	3,829	1,130	911

Abbreviations: EHE, Ending the HIV Epidemic in the U.S. initiative; EMA, eligible metropolitan area; TGA, transitional grant area.

Notes: Data are based on provider location.

EMAs/TGAs are listed according to the primary state in which the jurisdiction is located. Data shown for EMAs and TGAs are not mutually exclusive; clients may have received services from providers in multiple EMAs and/or TGAs.

At the jurisdictional level, year-to-year fluctuations in the number of new or estimated re-engaged clients are to be expected. These fluctuations could be attributed to any of the following:

- Changes in funding and/or staffing that impact service delivery and/or data reporting
- Jurisdictional emphasis on new or estimated re-engaged clients (i.e., some jurisdictions may have zero estimated re-engaged clients if their activities focused on clients new to care)
- Early success of direct service activities, leading to fewer new or estimated re-engaged clients not yet engaged in care in later years, with funding directed to maintaining these clients in care and increasing treatment adherence
- Changes in direct service activities, approaches, or geographic areas of focus in response to shifting jurisdictional, epidemiological, and/or community needs
- Funding activities other than service delivery, like clinical quality management, recipient administration, development and expansion of data systems, and planning and evaluation, including stakeholder engagement and process and outcome evaluation activities
- Improved quality, accuracy, and validity of data reported to HRSA HAB

Table 3b. Estimated re-engaged clients with HIV who were served by selected EHE-funded providers, by year and jurisdiction, 2020–2023— 47 HRSA HAB EHE-funded jurisdictions

Part A jurisdictions			2020	2021	2022	2023
State/Territory	**EMA/TGA**	**EHE focus county(ies)**	**N**	**N**	**N**	**N**
Arizona	Phoenix	Maricopa County	0	11	406	223
California	Los Angeles	Los Angeles County	0	349	0	0
	Oakland	Alameda County	18	17	134	183
	Sacramento	Sacramento County	0	0	0	1
	San Bernardino	Riverside County; San Bernardino County	53	63	97	153
	San Diego	San Diego County	0	177	259	207
	San Francisco	San Francisco County	68	151	76	81
	Santa Ana	Orange County	59	52	59	65
District of Columbia	Washington	District of Columbia; Montgomery County, MD; Prince George's County, MD	88	399	519	766
Florida	Fort Lauderdale	Broward County	275	437	464	276
	Jacksonville	Duval County	321	1,245	293	312
	Miami	Miami-Dade County	0	56	47	117
	Orlando	Orange County	0	128	85	53
	Tampa	Hillsborough County; Pinellas County	0	0	0	0
	West Palm Beach	Palm Beach County	96	48	80	64
Georgia	Atlanta	Cobb County; DeKalb County; Fulton County; Gwinnett County	74	452	631	705
Illinois	Chicago	Cook County	116	7	0	796
Indiana	Indianapolis	Marion County	0	25	190	484
Louisiana	Baton Rouge	East Baton Rouge Parish	0	980	177	234
	New Orleans	Orleans Parish	0	137	178	33
Maryland	Baltimore	Baltimore City	39	89	148	273
Massachusetts	Boston	Suffolk County	83	40	203	1
Michigan	Detroit	Wayne County	341	688	626	433
Nevada	Las Vegas	Clark County	0	33	55	831
New Jersey	Jersey City	Hudson County	18	34	45	30
	Newark	Essex County	3,635	3,567	4,173	2,988
New York	New York	Bronx County; Kings County; New York County; Queens County	8	1,035	3,893	922
North Carolina	Charlotte	Mecklenburg County	8	31	112	29
Ohio	Cleveland	Cuyahoga County	0	242	311	206
	Columbus	Franklin County	977	761	1,697	1,463
Pennsylvania	Philadelphia	Philadelphia County	8	1,458	593	1,459
Puerto Rico	San Juan	San Juan Municipio	10	32	27	46
Tennessee	Memphis	Shelby County	0	257	581	675
Texas	Austin	Travis County	0	326	230	216
	Dallas	Dallas County	0	42	46	132
	Fort Worth	Tarrant County	0	0	42	56
	Houston	Harris County	619	754	957	893
	San Antonio	Bexar County	1	573	647	426
Washington	Seattle	King County	0	163	182	137

Part B jurisdictions		2020	2021	2022	2023
State	**EHE focus county or state**	**N**	**N**	**N**	**N**
Alabama	State	0	7	25	18
Arkansas	State	0	56	572	567
Kentucky	State	11	3	2	43
Mississippi	State	0	0	12	304
Missouri	State	0	142	56	94
Ohio	Hamilton County	0	17	19	45
Oklahoma	State	0	0	57	74
South Carolina	State	0	94	80	93

Abbreviations: EHE, Ending the HIV Epidemic in the U.S. initiative; EMA, eligible metropolitan area; OAHS, outpatient ambulatory health services; TGA, transitional grant area.

Notes: Data are based on provider location.

EMAs/TGAs are listed according to the primary state in which the jurisdiction is located. Data shown for EMAs and TGAs are not mutually exclusive; clients may have received services from providers in multiple EMAs and/or TGAs.

* Clients estimated to be re-engaged in care is calculated among clients served by EHE-funded outpatient ambulatory health services, medical case management, non-medical case management, and EHE initiative services providers. This estimation of re-engaged clients is an approximation and should not be interpreted as a precise application of a formal definition of re-engagement in care.

At the jurisdictional level, year-to-year fluctuations in the number of new or estimated re-engaged clients are to be expected. These fluctuations could be attributed to any of the following:

- Changes in funding and/or staffing that impact service delivery and/or data reporting
- Jurisdictional emphasis on new or estimated re-engaged clients (i.e., some jurisdictions may have zero estimated re-engaged clients if their activities focused on clients new to care)
- Early success of direct service activities, leading to fewer new or estimated re-engaged clients not yet engaged in care in later years, with funding directed to maintaining these clients in care and increasing treatment adherence
- Changes in direct service activities, approaches, or geographic areas of focus in response to shifting jurisdictional, epidemiological, and/or community needs
- Funding activities other than service delivery, like clinical quality management, recipient administration, development and expansion of data systems, and planning and evaluation, including stakeholder engagement and process and outcome evaluation activities
- Improved quality, accuracy, and validity of data reported to HRSA HAB

Table 4a. Viral suppression among new clients with HIV served by EHE-funded providers, by year and jurisdiction, 2020–2023—47 HRSA HAB EHE-funded jurisdictions

Part A jurisdictions			2020			2021			2022			2023		
				Viral suppression			Viral suppression			Viral suppression			Viral suppression	
State/Territory	EMA/TGA	EHE focus county(ies)	Total N	N	%	Total N	N	%	Total N	N	%	Total N	N	%
Arizona	Phoenix	Maricopa County	0	—	—	501	435	86.8	331	276	83.4	584	497	85.1
California	Los Angeles	Los Angeles County	0	—	—	678	542	79.9	2	2	100.0	0	—	—
	Oakland	Alameda County	56	31	55.4	110	90	81.8	123	93	75.6	126	100	79.4
	Sacramento	Sacramento County	0	—	—	15	11	73.3	23	15	65.2	51	27	52.9
	San Bernardino	Riverside County; San Bernardino County	84	71	84.5	37	33	89.2	155	95	61.3	474	378	79.7
	San Diego	San Diego County	0	—	—	116	97	83.6	342	297	86.8	81	69	85.2
	San Francisco	San Francisco County	117	86	73.5	166	126	75.9	132	98	74.2	163	136	83.4
	Santa Ana	Orange County	176	155	88.1	198	156	78.8	205	159	77.6	231	191	82.7
District of Columbia	Washington	District of Columbia; Montgomery County, MD; Prince George's County, MD	72	59	81.9	70	56	80.0	126	105	83.3	61	53	86.9
Florida	Fort Lauderdale	Broward County	789	572	72.5	603	468	77.6	598	480	80.3	885	705	79.7
	Jacksonville	Duval County	68	50	73.5	158	118	74.7	163	130	79.8	184	153	83.2
	Miami	Miami–Dade County	0	—	—	182	158	86.8	283	260	91.9	610	554	90.8
	Orlando	Orange County	6	5	83.3	139	115	82.7	143	119	83.2	151	126	83.4
	Tampa	Hillsborough County; Pinellas County	250	186	74.4	334	270	80.8	315	250	79.4	288	228	79.2
	West Palm Beach	Palm Beach County	18	15	83.3	28	23	82.1	52	42	80.8	39	39	100.0
Georgia	Atlanta	Cobb County; DeKalb County; Fulton County; Gwinnett County	334	255	76.3	1,780	1,379	77.5	1,767	1,342	75.9	1,987	1,567	78.9
Illinois	Chicago	Cook County	216	176	81.5	156	134	85.9	98	89	90.8	106	87	82.1
Indiana	Indianapolis	Marion County	27	22	81.5	7	7	100.0	160	119	74.4	171	131	76.6
Louisiana	Baton Rouge	East Baton Rouge Parish	0	—	—	99	85	85.9	106	87	82.1	134	115	85.8
	New Orleans	Orleans Parish	0	—	—	299	211	70.6	233	178	76.4	191	157	82.2
Maryland	Baltimore	Baltimore City	1	0	0	53	41	77.4	69	56	81.2	179	148	82.7
Massachusetts	Boston	Suffolk County	48	45	93.8	0	—	—	35	30	85.7	20	18	90.0
Michigan	Detroit	Wayne County	134	112	83.6	223	177	79.4	209	162	77.5	704	584	83.0
Nevada	Las Vegas	Clark County	0	—	—	167	146	87.4	89	77	86.5	23	19	82.6
New Jersey	Jersey City	Hudson County	37	22	59.5	94	69	73.4	161	138	85.7	71	56	78.9
	Newark	Essex County	527	422	80.1	551	456	82.8	561	437	77.9	454	362	79.7
New York	New York	Bronx County; Kings County; New York County; Queens County	0	—	—	801	621	77.5	824	671	81.4	1,028	822	80.0
North Carolina	Charlotte	Mecklenburg County	37	35	94.6	74	58	78.4	180	144	80.0	191	137	71.7
Ohio	Cleveland	Cuyahoga County	0	—	—	217	170	78.3	141	102	72.3	181	152	84.0
	Columbus	Franklin County	26	23	88.5	67	53	79.1	211	182	86.3	432	392	90.7
Pennsylvania	Philadelphia	Philadelphia County	57	43	75.4	371	289	77.9	230	176	76.5	555	455	82.0
Puerto Rico	San Juan	San Juan Municipio	18	13	72.2	140	114	81.4	17	14	82.4	169	137	81.1
Tennessee	Memphis	Shelby County	15	9	60	22	17	77.3	21	18	85.7	32	23	71.9
Texas	Austin	Travis County	0	—	—	155	125	80.6	302	236	78.1	412	321	77.9
	Dallas	Dallas County	0	—	—	21	15	71.4	129	85	65.9	238	188	79.0
	Fort Worth	Tarrant County	0	—	—	311	228	73.3	421	321	76.2	239	197	82.4
	Houston	Harris County	1,350	987	73.1	1,567	1,151	73.5	1,690	1,279	75.7	1,565	1,224	78.2
	San Antonio	Bexar County	1	1	100	225	143	63.6	265	182	68.7	386	285	73.8
Washington	Seattle	King County	0	—	—	206	179	86.9	262	225	85.9	319	265	83.1

Table 4a. Viral suppression among new clients with HIV served by EHE-funded providers, by year and jurisdiction, 2020–2023—47 HRSA HAB EHE-funded jurisdictions *(cont.)*

Part B jurisdictions		2020			2021			2022			2023		
			Viral suppression			Viral suppression			Viral suppression			Viral suppression	
State	EHE focus county or state	Total N	N	%	Total N	N	%	Total N	N	%	Total N	N	%
Alabama	State	2	0	0.0	197	162	82.2	499	433	86.8	389	300	77.1
Arkansas	State	90	58	64.4	99	72	72.7	5	5	100.0	10	9	90.0
Kentucky	State	38	31	81.6	32	28	87.5	30	27	90.0	235	190	80.9
Mississippi	State	0	—	—	0	—	—	3	1	33.3	30	24	80.0
Missouri	State	82	69	84.1	308	256	83.1	244	207	84.8	274	243	88.7
Ohio	Hamilton County	0	—	—	33	26	78.8	123	109	88.6	152	134	88.2
Oklahoma	State	0	—	—	0	—	—	36	35	97.2	94	80	85.1
South Carolina	State	82	66	80.5	350	292	83.4	346	266	76.9	395	327	82.8

Abbreviations: EHE, Ending the HIV Epidemic in the U.S. initiative; EMA, eligible metropolitan area; OAHS, outpatient ambulatory health services; TGA, transitional grant area.

Viral suppression was based on data for people with HIV who had at least one OAHS visit during the measurement year and was defined as the most recently reported HIV RNA test result of <200 copies/mL.

Notes: Data are based on provider location.

EMAs/TGAs are listed according to the primary state in which the jurisdiction is located. Data shown for EMAs and TGAs are not mutually exclusive; clients may have received services from providers in multiple EMAs and/or TGAs.

At the jurisdictional level, year-to-year fluctuations in the number of new or estimated re-engaged clients are to be expected. These fluctuations could be attributed to any of the following:

- Changes in funding and/or staffing that impact service delivery and/or data reporting
- Jurisdictional emphasis on new or estimated re-engaged clients (i.e., some jurisdictions may have zero estimated re-engaged clients if their activities focused on clients new to care)
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- Changes in direct service activities, approaches, or geographic areas of focus in response to shifting jurisdictional, epidemiological, and/or community needs
- Funding activities other than service delivery, like clinical quality management, recipient administration, development and expansion of data systems, and planning and evaluation, including stakeholder engagement and process and outcome evaluation activities
- Improved quality, accuracy, and validity of data reported to HRSA HAB

Table 4b. Viral suppression among estimated re-engaged* clients with HIV who were served by selected EHE-funded providers, by year and jurisdiction, 2020–2023— 47 HRSA HAB EHE-funded jurisdictions

Part A jurisdictions			2020			2021			2022			2023		
				Viral suppression			Viral suppression			Viral suppression			Viral suppression	
State/Territory	EMA/TGA	EHE focus county(ies)	Total N	N	%	Total N	N	%	Total N	N	%	Total N	N	%
Arizona	Phoenix	Maricopa County	0	—	—	1	0	0.0	300	213	71.0	111	79	71.2
California	Los Angeles	Los Angeles County	0	—	—	183	131	71.6	0	—	—	0	—	—
	Oakland	Alameda County	6	4	66.7	10	7	70.0	108	104	96.3	116	101	87.1
	Sacramento	Sacramento County	0	—	—	0	—	—	0	—	—	0	0	0.0
	San Bernardino	Riverside County; San Bernardino County	0	—	—	0	—	—	27	20	74.1	72	47	65.3
	San Diego	San Diego County	0	—	—	154	137	89.0	212	183	86.3	182	161	88.5
	San Francisco	San Francisco County	27	21	77.8	79	72	91.1	44	36	81.8	43	35	81.4
	Santa Ana	Orange County	23	17	73.9	19	12	63.2	32	28	87.5	35	27	77.1
District of Columbia	Washington	District of Columbia; Montgomery County, MD; Prince George's County, MD	34	29	85.3	59	49	83.1	102	67	65.7	270	235	87.0
Florida	Fort Lauderdale	Broward County	217	159	73.3	152	112	73.7	416	347	83.4	221	177	80.1
	Jacksonville	Duval County	120	92	76.7	273	224	82.1	105	76	72.4	126	97	77.0
	Miami	Miami–Dade County	0	—	—	20	16	80.0	19	13	68.4	64	54	84.4
	Orlando	Orange County	0	—	—	5	5	100.0	2	1	50.0	2	2	100.0
	Tampa	Hillsborough County; Pinellas County	0	—	—	0	—	—	0	—	—	0	—	—
	West Palm Beach	Palm Beach County	11	7	63.6	7	6	85.7	19	12	63.2	16	14	87.5
Georgia	Atlanta	Cobb County; DeKalb County; Fulton County; Gwinnett County	61	45	73.8	346	222	64.2	500	337	67.4	577	421	73.0
Illinois	Chicago	Cook County	32	27	84.4	7	5	71.4	0	—	—	634	569	89.7
Indiana	Indianapolis	Marion County	0	—	—	15	14	93.3	85	60	70.6	236	194	82.2
Louisiana	Baton Rouge	East Baton Rouge Parish	0	—	—	158	141	89.2	120	106	88.3	179	154	86.0
	New Orleans	Orleans Parish	0	—	—	30	25	83.3	77	56	72.7	6	3	50.0
Maryland	Baltimore	Baltimore City	7	7	100.0	49	35	71.4	95	76	80.0	176	147	83.5
Massachusetts	Boston	Suffolk County	5	5	100.0	0	—	—	7	5	71.4	0	—	—
Michigan	Detroit	Wayne County	187	152	81.3	521	430	82.5	460	337	73.3	316	240	75.9
Nevada	Las Vegas	Clark County	0	—	—	32	27	84.4	54	46	85.2	609	512	84.1
New Jersey	Jersey City	Hudson County	13	5	38.5	16	13	81.3	28	20	71.4	13	8	61.5
	Newark	Essex County	3,230	2,923	90.5	3,268	2,987	91.4	3,816	3,464	90.8	2,709	2,479	91.5
New York	New York	Bronx County; Kings County; New York County; Queens County	0	—	—	600	484	80.7	3,523	3,170	90.0	425	322	75.8
North Carolina	Charlotte	Mecklenburg County	6	5	83.3	27	15	55.6	79	62	78.5	13	11	84.6
Ohio	Cleveland	Cuyahoga County	0	—	—	181	146	80.7	141	116	82.3	80	71	88.8
	Columbus	Franklin County	405	332	82.0	320	268	83.8	488	432	88.5	587	515	87.7
Pennsylvania	Philadelphia	Philadelphia County	1	0	0.0	855	768	89.8	399	330	82.7	741	649	87.6
Puerto Rico	San Juan	San Juan Municipio	9	6	66.7	16	9	56.3	26	22	84.6	26	22	84.6
Tennessee	Memphis	Shelby County	0	—	—	44	30	68.2	387	285	73.6	422	316	74.9
Texas	Austin	Travis County	0	—	—	0	—	—	27	19	70.4	26	21	80.8
	Dallas	Dallas County	0	—	—	25	18	72.0	29	19	65.5	99	74	74.7
	Fort Worth	Tarrant County	0	—	—	0	—	—	20	13	65.0	26	17	65.4
	Houston	Harris County	336	220	65.5	344	232	67.4	441	308	69.8	409	292	71.4
	San Antonio	Bexar County	0	—	—	0	—	—	0	—	—	29	20	69.0
Washington	Seattle	King County	0	—	—	97	89	91.8	102	94	92.2	76	63	82.9

Table 4b. Viral suppression among estimated re-engaged* clients with HIV who were served by selected EHE-funded providers, by year and jurisdiction, 2020–2023—47 HRSA HAB EHE-funded jurisdictions *(cont.)*

Part B jurisdictions		2020			2021			2022			2023		
			Viral suppression			Viral suppression			Viral suppression			Viral suppression	
State	EHE focus county or state	Total N	N	%	Total N	N	%	Total N	N	%	Total N	N	%
Alabama	State	0	—	—	4	3	75.0	7	6	85.7	7	7	100.0
Arkansas	State	0	—	—	24	13	54.2	290	214	73.8	351	299	85.2
Kentucky	State	10	8	80.0	3	2	66.7	0	—	—	36	30	83.3
Mississippi	State	0	—	—	0	—	—	2	2	100.0	237	207	87.3
Missouri	State	0	—	—	17	16	94.1	20	16	80.0	45	36	80.0
Ohio	Hamilton County	0	—	—	1	0	0.0	5	4	80.0	14	12	85.7
Oklahoma	State	0	—	—	0	—	—	45	41	91.1	36	33	91.7
South Carolina	State	0	—	—	34	26	76.5	48	40	83.3	46	32	69.6

Abbreviations: EHE, Ending the HIV Epidemic in the U.S. initiative; EMA, eligible metropolitan area; OAHS, outpatient ambulatory health services; TGA, transitional grant area.

Viral suppression was based on data for people with HIV who had at least one OAHS visit during the measurement year and was defined as the most recently reported HIV RNA test result of <200 copies/mL.

Notes: Data are based on provider location.

EMAs/TGAs are listed according to the primary state in which the jurisdiction located. Data shown for EMAs and TGAs are not mutually exclusive; clients may have received services from providers in multiple EMAs and/or TGAs.

* Clients estimated to be re-engaged in care is calculated among clients served by EHE-funded outpatient ambulatory health services, medical case management, non-medical case management, and EHE initiative services providers. This estimation of re-engaged clients is an approximation and should not be interpreted as a precise application of a formal definition of re-engagement in care.

At the jurisdictional level, year-to-year fluctuations in the number of new or estimated re-engaged clients are to be expected. These fluctuations could be attributed to any of the following:

- Changes in funding and/or staffing that impact service delivery and/or data reporting
- Jurisdictional emphasis on new or estimated re-engaged clients (i.e., some jurisdictions may have zero estimated re-engaged clients if their activities focused on clients new to care)
- Early success of direct service activities, leading to fewer new or estimated re-engaged clients not yet engaged in care in later years, with funding directed to maintaining these clients in care and increasing treatment adherence
- Changes in direct service activities, approaches, or geographic areas of focus in response to shifting jurisdictional, epidemiological, and/or community needs
- Funding activities other than service delivery, like clinical quality management, recipient administration, development and expansion of data systems, and planning and evaluation, including stakeholder engagement and process and outcome evaluation activities
- Improved quality, accuracy, and validity of data reported to HRSA HAB

Table 5. EHE-funded RWHAP AIDS Education and Training Center (AETC) Program training events by year and training topic, July 2019–June 2023—United States and 1 territory

	July 2019–June 2020		July 2020–June 2021		July 2021–June 2022		July 2022–June 2023	
	N	%	N	%	N	%	N	%
Training content								
Antiretroviral treatment and adherence	7	10.4	210	62.7	174	36.0	325	42.4
Engagement and retention in HIV care	12	17.9	121	36.1	220	45.5	422	55.1
HIV prevention	34	50.7	155	46.3	300	62.1	540	70.5
HIV testing and diagnosis	16	23.9	121	36.1	223	46.2	348	45.4
Linkage/referral to HIV care	16	23.9	156	46.6	204	42.2	333	43.5
Management of comorbid conditions	13	19.4	109	32.5	132	27.3	263	34.3
Rapid ART	—	—	—	—	—	—	44	5.7
Other training content	8	11.9	69	20.6	74	15.3	257	33.6
Training topic								
HIV prevention								
Behavioral prevention	19	28.4	66	19.7	161	33.3	259	33.8
HIV transmission risk assessment	17	25.4	79	23.6	159	32.9	243	31.7
Postexposure prophylaxis (PEP, occupational and nonoccupational)	8	11.9	36	10.7	52	10.8	131	17.1
Preexposure prophylaxis (PrEP)	22	32.8	110	32.8	240	49.7	396	51.7
Prevention of perinatal transmission	2	3.0	25	7.5	41	8.5	95	12.4
Sexual health history taking	—	—	—	—	—	—	115	15.0
Treatment as prevention	7	10.4	85	25.4	131	27.1	180	23.5
Other HIV prevention topics	6	9.0	42	12.6	85	17.6	78	10.2
HIV background and management								
Acute HIV	2	3.0	24	7.2	40	8.3	92	12.0
Adult and adolescent antiretroviral treatment	3	4.5	116	34.6	99	20.5	137	17.9
Aging and HIV	9	13.4	15	4.5	33	6.8	65	8.5
Antiretroviral treatment adherence, including viral suppression	1	1.5	174	51.9	141	29.2	256	33.4
Basic science	5	7.5	30	9.0	54	11.2	109	14.2
Clinical manifestations of HIV disease	0	0.0	15	4.5	42	8.7	87	11.4
HIV diagnosis (i.e., HIV testing)	17	25.4	90	26.9	229	47.4	332	43.3
HIV epidemiology	3	4.5	49	14.6	53	11.0	100	13.1
HIV monitoring and laboratory tests (i.e., CD4 and viral load)	0	0.0	56	16.7	67	13.9	188	24.5
HIV resistance testing and interpretation	0	0.0	24	7.2	29	6.0	23	3.0
Linkage to care	18	26.9	109	32.5	184	38.1	364	47.5
Pediatric HIV management	0	0.0	6	1.8	1	0.2	10	1.3
Retention and/or re-engagement in care	5	7.5	123	36.7	155	32.1	344	44.9
Other HIV background and management topics	3	4.5	12	3.6	10	2.1	50	6.5
Primary care and co-morbidities								
Cervical cancer screening, including HPV	0	0.0	4	1.2	26	5.4	10	1.3
Health or wellness maintenance	—	—	—	—	—	—	84	11.0
Hepatitis B	0	0.0	21	6.3	39	8.1	39	5.1
Hepatitis C	9	13.4	40	11.9	54	11.2	77	10.1
Immunization	0	0.0	16	4.8	32	6.6	17	2.2
Influenza	0	0.0	1	0.3	0	0.0	4	0.5
Malignancies	0	0.0	2	0.6	21	4.3	1	0.1
Medication-assisted therapy for substance use disorders	3	4.5	23	6.9	73	15.1	72	9.4
Mental health disorders	2	3.0	27	8.1	82	17.0	116	15.1
Non-infection comorbidities of HIV or viral hepatitis	4	6.0	14	4.2	39	0.1	31	4.0
Nutrition	0	0.0	4	1.2	2	0.4	6	0.8
Opioid use disorder	3	4.5	15	4.5	38	7.9	34	4.4
Opportunistic infections	1	1.5	24	7.2	38	7.9	36	4.7
Oral health	0	0.0	5	1.5	37	7.7	23	3.0
Osteoporosis	4	6.0	6	1.8	16	3.3	22	2.9
Pain management	0	0.0	3	0.9	5	1.0	4	0.5
Palliative care	0	0.0	0	0.0	1	0.2	5	0.7
Preconception planning	1	1.5	15	4.5	43	8.9	61	8.0
Primary care screenings	0	0.0	43	12.8	107	22.2	170	22.2
Sexually transmitted infections	7	10.4	46	13.7	111	23.0	183	23.9
Substance use disorders, not including opioid use	2	3.0	28	8.4	62	12.8	94	12.3
Tobacco cessation	0	0.0	0	0.0	2	0.4	3	0.4
Tuberculosis	0	0.0	1	0.3	2	0.4	1	0.1
Other primary care and morbidities topics	6	9.0	37	11.0	28	5.8	39	5.1
Care of people with HIV								
Health literacy	10	14.9	88	26.3	112	23.2	112	14.6
Stigma	18	26.9	140	41.8	224	46.4	239	31.2
Stress management	—	—	—	—	—	—	26	3.4
Other care of people with HIV topics	2	3.0	6	1.8	3	0.6	35	4.6

Table 5. EHE-funded RWHAP AIDS Education and Training Center (AETC) Program training events by year and training topic, July 2019–June 2023—United States and 1 territory *(cont.)*

	July 2019–June 2020		July 2020–June 2021		July 2021–June 2022		July 2022–June 2023	
	N	%	N	%	N	%	N	%
Health care organization or systems issues								
Billing for services and payment models	1	1.5	18	5.4	61	12.6	0	0.0
Care coordination	8	11.9	89	26.6	171	35.4	148	19.3
Case management	4	6.0	26	7.8	73	15.1	172	22.5
Community linkages	17	25.4	80	23.9	135	28.0	264	34.5
Confidentiality/HIPAA	1	1.5	17	5.1	10	2.1	19	2.5
Funding or resource allocation	1	1.5	7	2.1	20	4.1	68	8.9
Health care coverage	2	3.0	18	5.4	30	6.2	42	5.5
Legal issues	0	0.0	10	3.0	46	9.5	58	7.6
Motivational interviewing	5	7.5	64	19.1	110	22.8	28	3.7
Organizational infrastructure	5	7.5	9	2.7	73	15.1	61	8.0
Organizational needs assessment	9	13.4	6	1.8	52	10.8	45	5.9
Patient-centered care	—	—	92	27.5	175	36.2	190	24.8
Patient-centered medical home	0	0.0	23	6.9	48	9.9	46	6.0
Practice transformation	1	1.5	11	3.3	18	3.7	12	1.6
Quality improvement	12	17.9	32	9.6	76	15.7	89	11.6
Team-based care	8	11.9	7	2.1	59	12.2	75	9.8
Telehealth	2	3.0	10	3.0	42	8.7	43	5.6
Use of technology for patient care	2	3.0	5	1.5	15	3.1	36	4.7
Other health care organization or systems issues topics	—	—	—	—	—	—	54	7.0
Priority populations								
Children (Ages 0–12)	1	1.5	6	1.8	2	0.4	36	4.7
Adolescents (Ages 13–17)	1	1.5	40	11.9	60	12.4	90	11.7
Young adults (Ages 18–24)	16	23.9	206	61.5	209	43.3	225	29.4
Older adults (Ages 50 and over)	23	34.3	116	34.6	123	25.5	179	23.4
American Indian or Alaska Native	1	1.5	32	9.6	28	5.8	24	3.1
Asian	1	1.5	28	8.4	29	6.0	37	4.8
Black or African American	22	32.8	242	72.2	241	49.9	320	41.8
Hispanic or Latino	6	9.0	174	51.9	144	29.8	204	26.6
Native Hawaiian or Pacific Islander	1	1.5	24	7.2	28	5.8	23	3.0
Other race/ethnicity	0	0.0	0	0.0	1	0.2	2	0.3
Women	16	23.9	222	66.3	207	42.9	256	33.4
People experiencing unstable housing	10	14.9	195	58.2	124	25.7	101	13.2
People who inject drugs	—	—	—	—	—	—	96	12.5
People with legal system involvement	3	4.5	123	36.7	68	14.1	70	9.1
Rural populations	8	11.9	140	41.8	147	30.4	55	7.2
Veterans	—	—	—	—	—	—	3	0.4
Other populations	—	—	—	—	333	69.0	459	59.9
Number of training events held during the year	**67**	**—**	**335**	**—**	**483**	**—**	**766**	**—**

Abbreviations: EHE, Ending the HIV Epidemic in the U.S. initiative; RWHAP, Ryan White HIV/AIDS Program; ART, antiretroviral therapy; HIPAA, Health Insurance Portability and Accountability Act; HPV, human papillomavirus.

Note: Participants selected all that apply for the training content and each training topic. The number of training sessions held during the year is based on training sessions with information reported for participants and training topics and it serves as the denominator for percentage calculations.

Table 6. EHE–funded RWHAP AIDS Education and Training Center (AETC) Program participants by year and selected characteristics, July 2019–June 2023—United States and 1 territory

	July 2019–June 2020		July 2020–June 2021		July 2021–June 2022		July 2022–June 2023	
	N	%	N	%	N	%	N	%
Race/ethnicity								
American Indian/Alaska Native	2	0.3	23	0.8	23	0.5	25	0.3
Asian	27	4.1	161	5.3	239	5.4	372	5.0
Black/African American	236	36.0	999	32.9	1,481	33.7	2,183	29.2
Hispanic/Latino[a]	86	13.1	329	10.8	699	15.9	1,895	25.3
Native Hawaiian/Pacific Islander	2	0.3	18	0.6	8	0.2	19	0.3
White	271	41.4	1,393	45.9	1,752	39.9	2,756	36.9
Multiple races	31	4.7	115	3.8	192	4.4	190	2.5
Other	—	—	—	—	—	—	36	0.5
Subtotal	**655**	**100.0**	**3,038**	**100.0**	**4,394**	**100.0**	**7,476**	**100.0**
Professional discipline								
Clergy/faith-based professional	0	0.0	2	0.1	5	0.1	14	0.2
Community health worker	97	14.6	297	9.3	557	12.3	896	11.4
Dentist	2	0.3	187	5.8	36	0.8	253	3.2
Dietitian/nutritionist	3	0.5	17	0.5	9	0.2	16	0.2
Mental/behavioral health professional	33	5.0	107	3.3	156	3.4	257	3.3
Midwife	1	0.2	6	0.2	18	0.4	11	0.1
Nurse/advanced practice nurse (non-prescriber)	—	—	—	—	—	—	—	—
Nurse practitioner	—	—	—	—	—	—	—	—
Nurse practitioner/nurse professional (prescriber)	30	4.5	189	5.9	296	6.5	464	5.9
Nurse professional (non-prescriber)	84	12.6	446	13.9	469	10.3	1,082	13.8
Pharmacist	18	2.7	185	5.8	277	6.1	350	4.5
Physician	33	5.0	174	5.4	402	8.9	645	8.2
Physician assistant	3	0.5	24	0.7	47	1.0	95	1.2
Practice administrator or leader	16	2.4	41	1.3	104	2.3	174	2.2
Social worker	155	23.3	560	17.5	882	19.4	1,528	19.4
Substance abuse professional	16	2.4	74	2.3	101	2.2	109	1.4
Other allied health professional	18	2.7	80	2.5	99	2.2	157	2.0
Other clinical professional	—	—	—	—	—	—	161	2.0
Other dental professional	0	0.0	69	2.2	23	0.5	99	1.3
Other non-clinical professional	80	12.0	289	9.0	403	8.9	678	8.6
Other public health professional	123	18.5	454	14.2	843	18.6	1,207	15.4
Number of participants	**666**	**—**	**3,201**	**—**	**4,538**	**—**	**7,861**	**—**
Role in their organization								
Administrator	98	14.7	330	10.3	597	13.3	870	11.2
Agency board member	1	0.2	5	0.2	7	0.2	11	0.1
Care provider/clinician—can or does prescribe HIV treatment	60	9.0	260	8.1	501	11.2	687	8.8
Care provider/clinician—cannot or does not prescribe HIV treatment	62	9.3	416	13.0	563	12.6	985	12.6
Case manager	146	21.9	507	15.9	783	17.5	1,508	19.4
City, local, state governnment employee	—	—	—	—	—	—	40	0.5
Client/patient educator (includes navigator)	64	9.6	229	7.2	414	9.2	579	7.4
Clinical/medical assistant	20	3.0	78	2.4	112	2.5	233	3.0
Federal government employee	—	—	—	—	—	—	1,167	15.0
Health care organization non-clinical staff	56	8.4	128	4.0	183	4.1	309	4.0
HIV tester	43	6.5	141	4.4	268	6.0	387	5.0
Intern/resident	2	0.3	153	4.8	102	2.3	108	1.4
Researcher/evaluator	18	2.7	76	2.4	140	3.1	189	2.4
Student/graduate student	18	2.7	233	7.3	110	2.5	501	6.4
Teacher/faculty	31	4.7	85	2.7	143	3.2	158	2.0
Other	106	15.9	551	17.3	817	18.2	497	6.4
Number of participants	**666**	**—**	**3,192**	**—**	**4,478**	**—**	**7,790**	**—**
Total number of participants	**669**	**—**	**3,286**	**—**	**4,646**	**—**	**8,321**	**—**

Abbreviations: EHE, Ending the HIV Epidemic in the U.S. initiative; RWHAP, Ryan White HIV/AIDS Program.

Note: Participants reporting for July 2018–June 2019 and July 2019–June 2020 selected all professional disciplines and roles that apply. Participants reporting for July 2020–June 2021, July 2021–June 2022, and July 2022 –June 2023 could report more than one professional discipline and/or role if they participated in more than one training during the year and their discipline and/or role changed. Professional discipline and role data for all years are not mutually exclusive; numbers may not sum to the number of participants and percentages may not sum to 100.0%.

[a] Hispanics/Latinos can be of any race.

Table 7. EHE-funded RWHAP Part F AIDS Education and Training Center Program participants, by year and employment setting, July 2019–June 2023—United States and 1 territory

	July 2019–June 2020		July 2020–June 2021		July 2021–June 2022		July 2022–June 2023	
	N	%	N	%	N	%	N	%
Number of years providing direct services to people with HIV								
≤1	135	17.3	665	28.5	1,241	30.0	1,649	26.2
2–4	158	20.3	519	22.3	879	21.2	1,415	22.5
5–9	163	20.9	387	16.6	664	16.0	1,179	18.7
10–19	188	24.1	391	16.8	761	18.4	1,130	17.9
≥20	136	17.4	369	15.8	598	14.4	923	14.7
Subtotal	**780**	**100.0**	**2,331**	**100.0**	**4,143**	**100.0**	**6,296**	**100.0**
Estimated number of clients with HIV per year								
None per year	2	0.3	305	13.7	568	13.8	287	4.8
1–9 per year	107	15.2	428	19.2	602	14.6	1,049	17.7
10–19 per year	63	8.9	142	6.4	268	6.5	448	7.6
20–49 per year	134	19.0	277	12.4	674	16.3	913	15.4
≥50 per year	399	56.6	1,078	48.3	2,016	48.8	3,225	54.5
Subtotal	**705**	**100.0**	**2,230**	**100.0**	**4,128**	**100.0**	**5,922**	**100.0**
Employment setting								
Academic health center	35	5.4	364	11.7	418	9.1	661	8.5
Correctional facility	4	0.6	26	0.8	36	0.8	281	3.6
Dental health facility	—	—	—	—	—	—	214	2.7
Emergency department	2	0.3	11	0.4	13	0.3	58	0.7
Federally Qualified Health Center	92	14.1	412	13.3	647	14.1	1,082	13.9
HIV or infectious diseases clinic	114	17.4	452	14.6	864	18.8	1,438	18.4
HMO/managed care organization	10	1.5	26	0.8	43	0.9	178	2.3
Hospital-based clinic	43	6.6	139	4.5	260	5.7	422	5.4
Indian health services/tribal clinic	1	0.2	14	0.5	9	0.2	11	0.1
Long-term nursing facility	2	0.3	7	0.2	15	0.3	25	0.3
Maternal/child health clinic	2	0.3	7	0.2	20	0.4	37	0.5
Mental health clinic	6	0.9	37	1.2	63	1.4	72	0.9
Military or veteran's health facility	2	0.3	2	0.1	7	0.2	20	0.3
Pharmacy	11	1.7	106	3.4	142	3.1	164	2.1
Private practice	11	1.7	43	1.4	62	1.4	105	1.3
State or local health department	100	15.3	425	13.7	788	17.2	1,094	14.0
STD clinic	15	2.3	57	1.8	137	3.0	251	3.2
Student health clinic	7	1.1	53	1.7	22	0.5	107	1.4
Substance abuse treatment center	17	2.6	73	2.4	107	2.3	121	1.6
Other community-based organization	141	21.6	466	15.0	682	14.9	1,080	13.8
Other federal health facility	9	1.4	26	0.8	59	1.3	61	0.8
Other primary care setting	24	3.7	95	3.1	139	3.0	97	1.2
Employment setting does not involve the provision of care or services to patients/clients	19	2.9	139	4.5	222	4.8	344	4.4
Not working	48	7.3	126	4.1	82	1.8	288	3.7
Number of participants	**654**	**100.0**	**3,106**	**100.0**	**4,591**	**100.0**	**7,806**	**100.0**
Rural and suburban/urban employment settings								
Rural settings only	21	3.7	449	14.5	392	9.1	483	7.0
Both rural and suburban/urban settings[a]	14	2.4	62	2.0	77	1.8	78	1.1
Suburban/urban settings only	537	93.9	2,584	83.5	3,857	89.2	6,311	91.8
Total	**572**	**100.0**	**3,095**	**100.0**	**4,326**	**100.0**	**6,872**	**100.0**
Total number of participants	**669**	**—**	**3,286**	**—**	**4,646**	**—**	**8,321**	**—**

Abbreviations: EHE, Ending the HIV Epidemic in the U.S. initiative; RWHAP, Ryan White HIV/AIDS Program; HMO, health maintenance organization; STD, sexually transmitted disease.

Note: Participants reporting for July 2018–June 2019 and July 2019–June 2020 selected all employment settings that apply. Participants reporting for July 2020–June 2021, July 2021–June 2022, and July 2022—June 2023 could report more than one employment setting if they participated in more than one training during the year and their employment setting changed. Employment setting data for all years are not mutually exclusive; numbers may not sum to the number of participants and percentages may not sum to 100.0%.

[a] Participants who reported more than one employment setting and reported both rural and suburban/urban settings.