HRSA HIV/AIDS Bureau

Ending the HIV Epidemic in the U.S. Initiative

Data Report

2024

HRSA
Ryan White HIV/AIDS Program

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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 five years of the EHE initiative (reporting period varies by data source).

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

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

Acknowledgments

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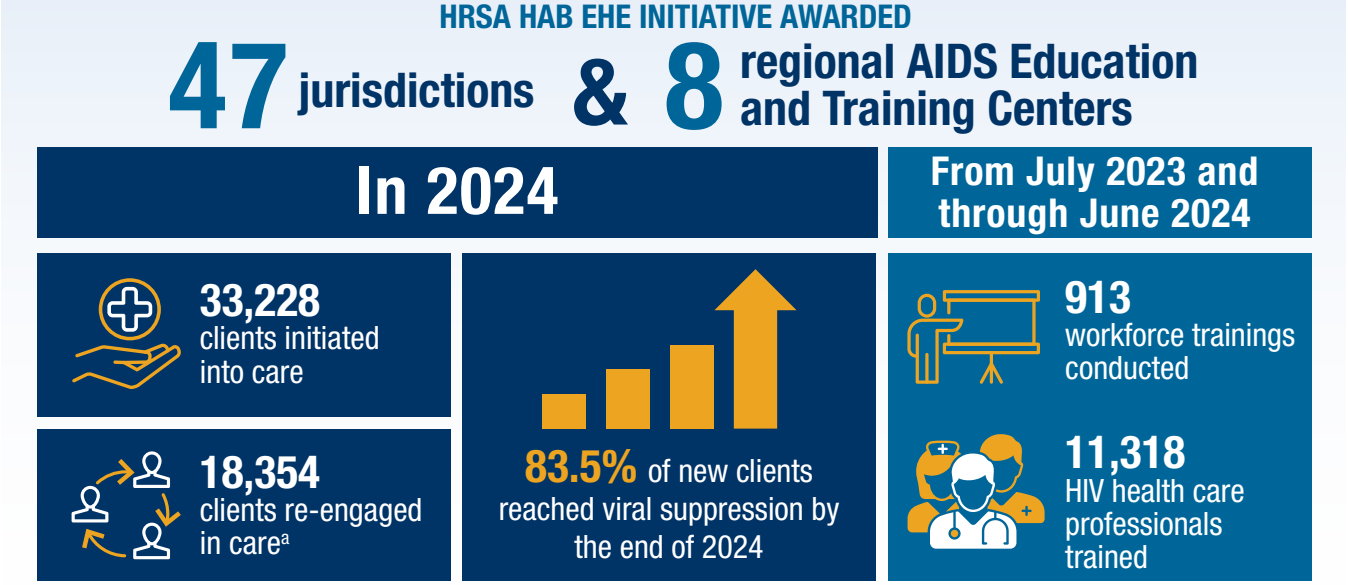
CONTENTS

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 activities build on the Ryan White HIV/AIDS Program's (RWHAP) comprehensive system of care. The initiative focuses 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 supports the RWHAP Part F AIDS Education and Training Center (AETC) Program to increase workforce training and technical assistance in EHE jurisdictions.

In 2024, EHE-funded providers served more than 33,000 new clients (a 24% increase from 2023) and more than 18,000 clients estimated to be re-engaged in care (a 6% increase from 2023). From July 2023 through June 2024, regional AETCs conducted more than 900 EHE-funded trainings (a 19% increase from the prior year) for more than 11,000 HIV health care professionals (a 36% increase from the prior year). **This is the highest number of new and estimated re-engaged clients, trainings, and trainees since the start of the EHE initiative in 2020.** This increase in the number of clients reached, workforce trainings, and HIV health care professionals trained is a result of the increase in HRSA HAB EHE initiative appropriations from $71 million in fiscal year (FY) 2020 to $165 million in FY 2024.

Figure 1
Overview of HRSA HAB's Ending the HIV Epidemic in the U.S. (EHE) Initiative, 2024



[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 2024, 84% of new patients receiving medical care from EHE-funded providers were virally suppressed by the end of the calendar year, compared with 69% 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 essential to ending the HIV epidemic in the United States. Without the EHE initiative, new infections will continue, resulting in more lives lost and contributing to $20 billion annually in direct health expenditures for HIV prevention and care [1].

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 services from EHE-funded providers and understand the impact of HIV care services 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 professionals who participated in regional RWHAP Part F 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 less than 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 participant characteristics and service delivery and employment setting characteristics (Tables 6–7).
  - Summaries of selected EHE-funded training events delivered by regional 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 2024, with additional details for calendar year 2024.
  - Jurisdictional progress report information from March 2024 through February 2025.
- Workforce training:
  - AETC data from March 2020 through June 2024, with additional details for the July 2023 through June 2024 reporting period.
  - AETC progress report information from July 2023 through February 2024.

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 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 reach people with HIV who are not receiving regular care in the United States or U.S. territories. The RWHAP funds HIV medical care, treatment, and support services for more than 600,000 people with HIV—representing more than half of all people with diagnosed HIV in the United States [4]. With RWHAP funding, cities, counties, states, and local clinics/community-based organizations deliver efficient and effective HIV care, treatment, and support services for people with HIV with lower incomes.

Since March 2020, HAB EHE recipients have leveraged their existing RWHAP infrastructure, paired with additional flexibilities of the EHE initiative, to implement evidence-based strategies to reach and engage people with HIV. In fiscal year (FY) 2024, HRSA HAB received $165 million in appropriations, resulting in awards to 60 HRSA HAB EHE recipients:

- The 39 RWHAP Part A recipients and eight Part B recipients that constitute the 47 EHE jurisdictions. The EHE jurisdictions represent 48 counties; Washington, D.C.; San Juan, Puerto Rico; and seven states that have disproportionate occurrences of HIV in their rural areas (see Appendix).
- Three national centers and eight regional RWHAP Part F AIDS Education and Training Center (AETC) Program 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 strengthen funded jurisdictions' EHE work plans, promote coordination of planning activities, and ensure jurisdictions have access to the capacity-building resources they need.

The combination of jurisdiction funding, workforce capacity, and technical assistance provided by the EHE initiative engages more people with HIV in care to reach better health outcomes.

Ryan White Program Moving Forward

Ryan White Program Moving Forward is HRSA HAB's renewed vision for the RWHAP [5]. Ryan White Program Moving Forward builds on the foundation of the RWHAP and innovative, low-barrier strategies employed in the EHE initiative. This framework is designed to sustain high-quality care and treatment for people currently receiving services through the RWHAP while expanding efforts to identify and engage individuals with HIV who are undiagnosed or out of care.

Highlights of Analyses: Clients Served and Services Delivered

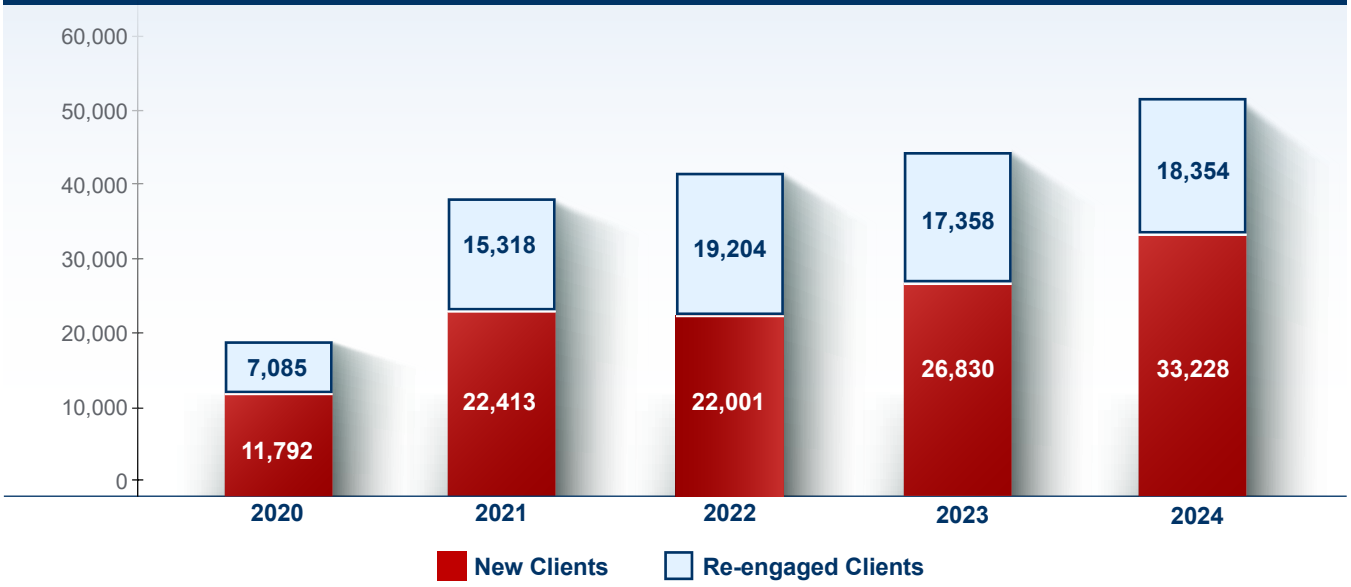
During the fifth year of the EHE initiative, EHE jurisdictional recipients reported significant progress in serving new clients and re-engaging people with HIV into care. The flexibility of EHE funding allowed recipients to deploy tailored approaches to meet the needs of people with HIV in their jurisdictions.

Reaching New and Re-engaged Clients Through Expanded Service Delivery

Since the start of the EHE initiative in 2020, the number of new and re-engaged clients served has nearly tripled. In 2024, EHE-funded providers served 33,228 clients new to care (an increase of more than 6,000 clients from 2023) and 18,354 clients re-engaged in care (an increase of nearly 1,000 clients from 2023) (Figure 2; Tables 1a and 1b). The increase in HRSA HAB EHE initiative appropriations created opportunities for EHE-funded providers to reach and provide services to greater numbers of clients.

Figure 2

New and re-engaged[a] clients served by EHE-funded providers, by year, 2020–2024—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: 2024 HRSA HAB EHE Report (Tables 1a and 1b).

Most Common Service Categories Delivered

EHE-funded providers delivered a variety of services to their clients, including core medical and support services that are allowable under the RWHAP and "EHE initiative services." To provide increased flexibility to meet the goals of the EHE initiative, "EHE initiative services" are services that do not meet the definition of an RWHAP core medical or support service as outlined in Policy Clarification Notice #16-02 Ryan White HIV/AIDS Program Services: Eligible Individuals & Allowable Uses of Funds (PCN 16-02) [6].

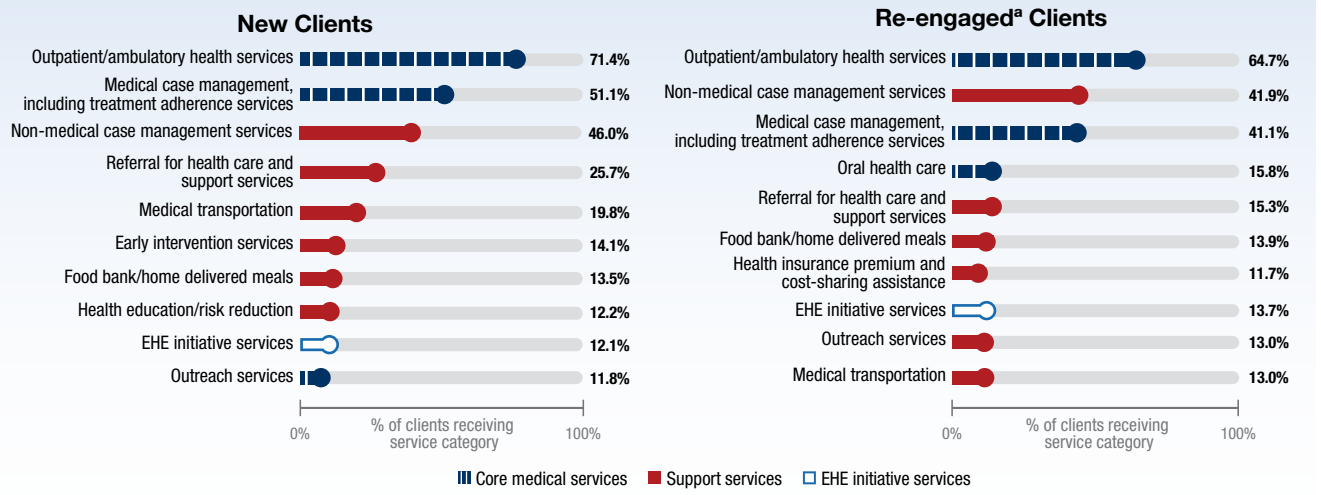
For both new clients and re-engaged clients, the three most common services received in 2024 were outpatient/ambulatory health services (OAHS) (71.4% and 64.7%, respectively), medical case management (51.1% and 41.1%, respectively), and non-medical case management (46.0% and 41.9%, respectively) (Figure 3). This parallels patterns

of service use in the overall RWHAP client population [7]. Among new clients, the next most frequently received services were referrals for health care and support services (25.7%) and medical transportation services (19.8%). Among re-engaged clients, the next most frequently received services were oral health care (15.8%) and referrals for health care and support services (15.3%).

Most of the services received by these clients were from existing RWHAP service categories. However, the EHE initiative services category afforded flexibility and room for innovation. Among new clients, 12.1% received EHE initiative services; among re-engaged clients, 13.7% received EHE initiative services.

Figure 3

The top 10 most common services delivered by EHE-funded providers, by client type, 2024—47 HRSA HAB EHE-funded jurisdictions.



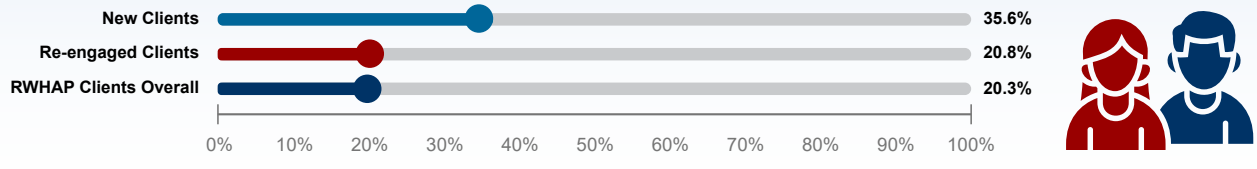
[a] *Estimated re-engaged clients are calculated only among EHE-funded outpatient/ambulatory health services, medical case management, non-medical case management, and EHE initiative service category providers. This is likely an underestimate of all people re-engaged in care across all EHE-funded providers.*

Notes:
- *Figure includes only clients receiving services directly from EHE-funded providers.*
- *Clients that received multiple services are counted in each received RWHAP service.*
- *Core service includes RWHAP clients who are HIV positive or presumed positive.*
- *Percentages for core services and support services are calculated using independent denominators.*

Compared with RWHAP clients overall, new clients of EHE-funded providers are younger. In 2024, more than one-third of the new clients (35.6%) were aged 20–34 years (Figure 4, Tables 1a and 1b). Among re-engaged clients, one-fifth (20.8%) were aged 20–34 years. People aged 50 years and older accounted for 28.3% of new clients and 45.4% of re-engaged clients served by EHE-funded providers, compared with 47.4% in the overall RWHAP population.

Figure 4

New and re-engaged[a] clients aged 20–34 years served by EHE-funded providers, by client type, 2024—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.*

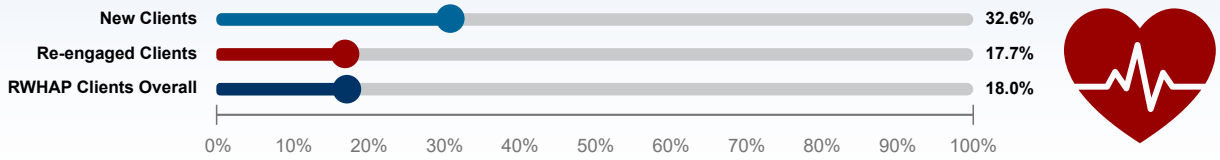
Source: 2024 HRSA HAB EHE Report (Tables 1a and 1b) for new and re-engaged client data; 2024 RWHAP Annual Data Report (Table 1a) for RWHAP overall client data.

In 2024, 43.0% of new clients self-identified as Black/African American, 35.6% as Hispanic/Latino, and 18.1% as White. Among re-engaged clients, 57.9% self-identified as Black/African American, 22.5% as Hispanic/Latino, and 16.5% 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).

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 in 2024, nearly one-third of new clients (32.6%) had no health care coverage, which was nearly double the percentage of the overall RWHAP client population without coverage (18.0%) (Figure 5; Tables 1a and 1b). The percentage of re-engaged clients without health care coverage (17.7%) was consistent with RWHAP overall. Of note, the percentage of new clients who lacked health care coverage decreased from 46.0% in 2020 to 32.6% in 2024, yet the percentage remained higher than among re-engaged clients and RWHAP clients overall. Linking people who lack health care coverage to services from the time of diagnosis ensures early access to care, which increases the likelihood that patients can reach and maintain viral suppression [8].

Figure 5

New and re-engaged[a] clients with no health care coverage served by EHE-funded providers, by client type, 2024—47 HRSA HAB EHE-funded jurisdictions.



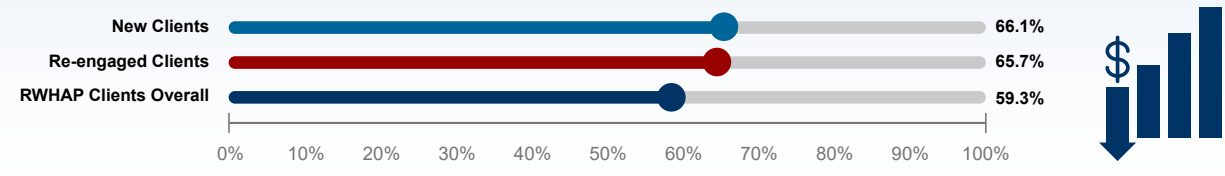
[a] *Estimated re-engaged clients are calculated only among EHE-funded outpatient/ambulatory health services, medical case management, non-medical case management, and EHE initiative service category providers. This is likely an underestimate of all people re-engaged in care across all EHE-funded providers.*

Source: 2024 HRSA HAB EHE Report (Tables 1a and 1b) for new and re-engaged client data; 2024 RWHAP Annual Data Report (Table 1a) for RWHAP overall client data.

Approximately two-thirds of new clients and re-engaged clients served by EHE-funded providers live at or below 100% of the federal poverty level (FPL). Among clients served by EHE-funded providers, 66.1% of new clients and 65.7% of re-engaged clients were living at or below 100% FPL. Among RWHAP clients overall, 59.3% were living at or below 100% FPL (Figure 6; Tables 1a and 1b).

Figure 6

New and re-engaged[a] clients at or below 100% of the federal poverty level served by EHE-funded providers, by client type, 2024—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: 2024 HRSA HAB EHE Report (Tables 1a and 1b) for new and re-engaged client data; 2024 RWHAP Annual Data Report (Table 1a) for RWHAP overall client data.

Strategies to Expand HIV Care Access for People with HIV

EHE jurisdictional recipients applied tailored approaches to overcome barriers to care and meet the specific needs of people with HIV in their jurisdictions who do not successfully access existing care systems. Recipients delivered services beyond traditional hours (e.g., nights, weekends), provided services in new locations, scheduled same-day appointments, and offered drop-in services. Below is a summary of the frequently reported activities that expanded access, along with direct quotations from recipients describing the benefits, outcomes, and impact of EHE funding.

Rapid Antiretroviral Therapy

Recipients leveraged EHE funding to implement rapid antiretroviral therapy (rapid ART) programs. The rapid ART program model involves starting patients on HIV medications (ideally the same day or within seven days of diagnosis or re-engagement in care) and immediately scheduling them for a follow-up appointment. Rapid access to antiretroviral therapy increases the likelihood of viral suppression and helps prevent new HIV transmissions.

One recipient described how EHE funding accelerated treatment initiation, enabling them to distribute starter packs of antiretroviral therapy to newly diagnosed patients immediately.

> *[Our] standard for Rapid ART is linkage to treatment within 72 hours of diagnosis. The only eligibility requirement is a positive HIV diagnosis—there are no geographic requirements. Rapid ART clients receive a starter pack of treatment medication during their first visit following a diagnosis. In the meantime, providers can process clients for [Ryan White Program Part A] eligibility...*

Other recipients described the impact of their EHE-funded rapid ART programs in their local emergency departments in finding undiagnosed people with HIV and linking them to care.

> *We implemented an opt-out HIV testing and rapid ART (antiretroviral therapy) initiation process in the [emergency department (ED)]. This will ensure that every patient presenting to the ED is tested for HIV and, if necessary, rapidly started on treatment. This partnership has been developed with technical assistance from [HRSA's Technical Assistance Provider—Innovation Network].*

Telehealth, Data Sharing, and Technology

Telehealth and technology advancements reduced logistical barriers to care for people who are unable to attend in-person appointments, often due to challenges with work schedules, transportation, and living in rural areas.

> *[We have] new equipment to assist with telehealth including providing some [people with HIV] with limited cell phone services so they can make telehealth appointments and keep in contact with medical providers and case managers. This is a crucial service for [people with HIV] in rural communities, especially those with limited broadband or transportation.*

Telehealth also expanded access to services for clients in clinical settings. Recipients described using telehealth to provide "one-stop-shop" services, enabling clients to address multiple co-occurring conditions with a single clinic visit.

> *[Outpatient/ambulatory health services] and [mental health] services are offered in person and through telehealth, with clients having the option to utilize a technology room for connection to providers.*

Recipients discussed the impact of web-based scheduling in alleviating long call center wait times, ensuring timely client access to book appointments.

> *The establishment of an accessible clinic, supported by web-based scheduling, allows community members to easily book their initial appointments. This system effectively resolves frustrations associated with long call center wait times, ensuring a more streamlined and user-friendly experience.*

The quote below describes how linkage to care specialists leveraged telehealth platforms and applications for virtual appointments, appointment reminders, and frequent client communication.

> *[Our linkage specialists] use telehealth platforms to provide virtual check-ins for patients who have difficulty attending in-person appointments. This helped maintain continuity of care without compromising patient health or comfort, especially for those with limited mobility or living in rural areas. The [linkage specialists] are leveraging mobile apps and text message reminders to ensure patients attend appointments and adhere to medication regimens, using available technology to maintain frequent contact and respond quickly to patient concerns.*

Data sharing partnerships and data to care approaches increased the effective use of data to identify undiagnosed people with HIV and link them to HIV medical care.

> *In partnership with the Surveillance and STD Prevention and Control [teams], we employ a data to care model that [identifies] areas of increased STI prevalence to focus on areas where comorbidities (HIV, hepatitis B virus, and other STDs) trigger a response strategy. This includes testing to identify [people with HIV] and link them to care for the STI, including HIV if needed.*

Mobile Medical Units

Recipients continued the use of mobile medical units, another service delivery approach that reduced transportation barriers and widely expanded access to care. Recipients used mobile medical units to provide accessible services, HIV testing, home visits, and delivery services for medications. Recipients also deployed mobile medical units to areas with demonstrated need for HIV care services to engage more clients in RWHAP services.

> *Five mobile units are still in use, connecting individuals to care, engaging and re-engaging [people with HIV], conducting outreach activities, facilitating testing, and [processing] associated referrals. Expanded access includes weekend and evening operations for several sites.*

Creating New Partnerships

Formalized partnerships enable recipients to provide more services to clients, which is essential for recipients with limited resources in their jurisdictions. Essential to the formative work of the EHE initiative, recipients continued to identify and establish new partnerships to meet evolving needs into this fifth year of the EHE initiative.

> *[We partner to provide patients with] expedited prescribed medication shipment through U.S. Postal Service statewide through the EHE Program's contracted pharmacy.*

One recipient discussed using EHE funding for new partnerships, with formal memorandums of understanding (MOUs) to facilitate expedited service delivery and increase service availability.

> *Agencies that are unable to provide ART have MOUs with others who can, including health departments. These MOUs are also crucial in providing support services...The services include rides to and from medical appointments, short term assistance with rent and utilities, provision of food vouchers or linkage to food pantries. [Services also include] linkage to financial counseling and other agencies that can provide a path to financial stability and permanent housing.*

Client Navigation and HIV Workforce Support

To reach people with HIV who are not accessing services, recipients continued to use EHE funding to hire intervention specialists, medical case managers, and other linkage to care specialists. Recipients described the impact of EHE funding in enabling them to fill these important roles to facilitate linkage, retention, and re-engagement in HIV care.

> *[We have] 13 staff members who regularly travel within [our] county to provide disease intervention and public health follow-up. This follow-up may include field visits to interview newly diagnosed individuals with HIV or syphilis and engage them in linkage and navigation services … Each staff member could have 12 scheduled field visits to provide services daily.*

> *EHE [intensive medical case management] funding has allowed many of our partners to hire additional staff. Increasing staff provided the ability to have smaller caseloads with a more hands-on approach to clients. With additional staffing [we are able to] track areas of patient concern and make community-based referrals as needed.*

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 options, strengthening access to medical and support services.

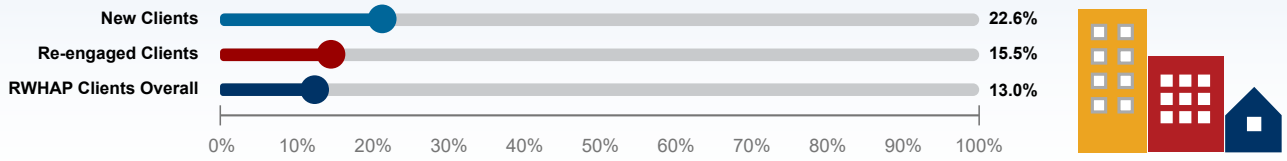
> *1,102 clients utilized EHE Medical Transportation services, completing over 9,887 rides. This service significantly reduced appointment no-shows, improved retention in care, and supported clients in [reaching] viral suppression and overall health goals.*

Housing

Compared with RWHAP clients overall, higher proportions of new and re-engaged clients served by EHE-funded providers were temporarily or unstably housed. Among clients served by EHE-funded providers, a greater proportion of new clients (22.6%) and re-engaged clients (15.5%) were temporarily or unstably housed compared with all RWHAP clients (13.0%). People who lack stable housing are less likely to reach viral suppression and often have multiple complex barriers to care (Figure 7; Tables 1a and 1b).

Figure 7

New and re-engaged[a] clients who are temporarily or unstably housed served by EHE-funded providers, by housing status, 2024—47 HRSA HAB EHE-funded jurisdictions.



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Source: 2024 HRSA HAB EHE Report (Tables 1a and 1b) for new and re-engaged client data; 2024 RWHAP Annual Data Report (Table 1a) for RWHAP overall client data.

Recipients used EHE funding to hire housing specialists, organize housing education summits, provide utility and rental assistance, and address other housing-related needs.

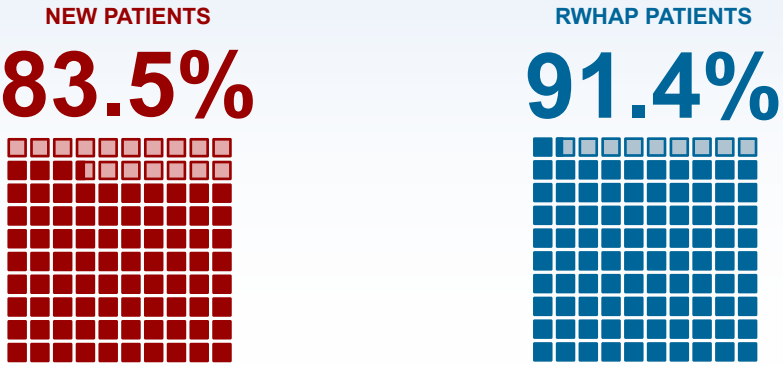
> *The Housing Specialist is forging relationships with multiple housing providers to give the clients the most up to date information. The program provided housing education to 40 [people with HIV] through the housing summits. The Housing Specialist has forged relationships with several property owners who notify him of upcoming vacancies in their properties and will give his clients priority in applying and screening.*

Viral Suppression and EHE Impact

More than 80% of new patients who receive HIV medical care from EHE-funded providers reached viral suppression. By the end of calendar year 2024, 83.5% of 19,929 new patients served by EHE-funded providers who received OAHS reached viral suppression. This is slightly lower than the 91.4% viral suppression among the overall RWHAP patient population but higher than the 68.5% national average for viral suppression of all people diagnosed with HIV in the United States [3] (Figure 8; Tables 2a and 2b).

Figure 8

Viral suppression[a] among new patients served by EHE-funded providers, 2024—47 HRSA HAB EHE-funded jurisdictions.



[a] *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: 2024 HRSA HAB EHE Report (Tables 2a and 2b) for new and re-engaged client data; 2024 RWHAP Annual Data Report (Table 1a) for RWHAP overall client data.

The lower percentage of viral suppression is expected for patients new to care compared with the overall RWHAP population. A person's HIV viral load can take one to six months to reach undetectable levels (i.e., viral suppression) [9]. 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 patients with HIV face multiple and complex needs related to health outcomes, which can negatively affect treatment adherence and viral suppression.

Among new HIV transmissions, 87% come from people who are not aware they have HIV or who are not receiving any HIV care [10]. 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 outcomes and quality of life for people with HIV. The EHE initiative has revealed numerous implementation insights, best practices, and impactful strategies that were key to EHE success in reaching people who are not in care.

One recipient **convened subrecipients to partner for peer-to-peer technical assistance** to share rapid ART best practices. This meeting focused on overcoming challenges to providing rapid ART within 72 hours of diagnosis.

> *… meeting the 3-day window for Rapid stART is a challenge for many providers, often for reasons outside of their control. This can be discouraging for subrecipients who are implementing Rapid stART. One of our biggest lessons learned was that it helped to convene the Rapid stART providers so that they could share their challenges. This helped to identify potential solutions (i.e., Rapid Response pilot with [Communicable Disease Unit]) that are responsive to their challenges and will advance the overall goals of the program.*

EHE funding ensured **timely access to medications for incarcerated clients**, providing a 30-day initial supply while the client's AIDS Drug Assistance Program (ADAP) eligibility was determined.

> *The program has successfully increased the number of inmates receiving antiretroviral medication through the EHE program. This progress has allowed the program to identify those in need and offer necessary support until additional resources, like the Ryan White ADAP program, can be accessed. This approach ensures that inmates in jails throughout the state without funding for medications can still receive the treatment they need. The process remains unchanged and has effectively helped incarcerated individuals obtain their medications, aiming to reduce transmission rates while improving their viral load suppression. The EHE program supplies a 30-day medication supply while eligibility for the ADAP is being determined. Once approved for ADAP, clients can continue to get their medications through the program's pharmacy.*

EHE funding supported an innovative home health program that used **long-acting injectables to improve viral suppression** among clients with complex care needs.

> *[Our home health program] has been providing home-based long-acting injectable HIV medication support with a team of nurses and social workers under the EHE initiative since August 2024. The target population for this work is clients who have a history of not engaging successfully in traditional clinic-based care due to a range of co-occurring issues, such as severe mental health diagnoses, disabling substance use, and physical impairments which leads them to be unable to maintain viral suppression. Some were referred for initiation of Injectable ART due to inability to maintain viral suppression on oral meds while others were referred after repeatedly missing clinic appointments for ART injections, placing them at high risk for developing resistance. In the [home health program], 100% of the clients have [reached] and maintained HIV viral suppression.*

EHE funding **expanded services beyond the scope of other funding sources,** filling critical service gaps.

> *While [our other source of] funding is limited to initial screenings and linkage to a first appointment, EHE funding has enabled [our program] to expand and enhance its services far beyond initial linkage. With this support, we have been able to provide comprehensive care, treatment, and wraparound services, ensuring sustained engagement in care. These expanded services incorporate evidence-based interventions, including Health Education/Risk Reduction (HERR) and Anti-Retroviral Treatment and Access to Services [ARTAS], alongside robust behavioral health support, mental health and substance use counseling, peer support, and increased access to … clinical trials and research opportunities.*

EHE recipients **addressed the importance of client-centered approaches** to increase patient satisfaction and viral suppression.

> *Ending the HIV Epidemic is contingent upon [people] with HIV being in care and virally suppressed. To remain engaged in care requires that persons have their emotional, mental, and physical needs met which allows them to focus on their overall health. The absence of extended waiting periods for care, the availability of non-medical case managers to address for the social needs, the client centered incentives based on what the client has identified as useful are all instrumental in improving patient satisfaction and the improved viral suppression.*

Highlights of Analyses: Workforce Training

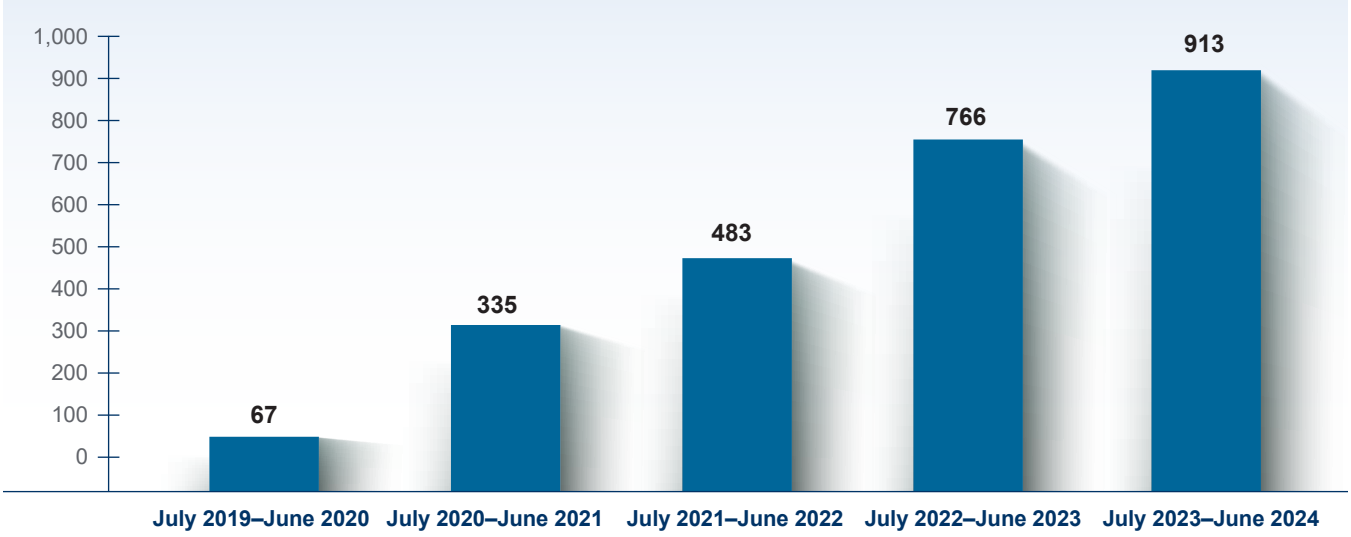
The RWHAP Part F AETC Program's regional training centers support the EHE initiative by expanding workforce capacity in jurisdictions where HIV transmission occurs most frequently. The regional AETCs work to (1) strengthen and expand the skills of the HIV workforce; (2) improve outcomes along the HIV 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 with risk behaviors for 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 2023 through June 2024 reporting period, regional AETCs conducted a total of 913 EHE-funded training events, a steady increase across EHE implementation and nearly 150 more training events than the prior year (Table 5). The reach and impact of EHE-funded AETC training events increased alongside HRSA HAB EHE initiative appropriations.

Figure 9
EHE-funded AETC training events, July 2019 through June 2024



Source: 2024 HRSA HAB EHE Report (Table 5).

Training Topics

The general training content areas most frequently covered in the July 2023 through June 2024 reporting period by EHE-funded AETC training events were HIV prevention (65.0%), engagement and retention in HIV care (44.0%), HIV testing and diagnosis (39.3%), and linkage/referral to HIV care (35.8%) (Table 5).

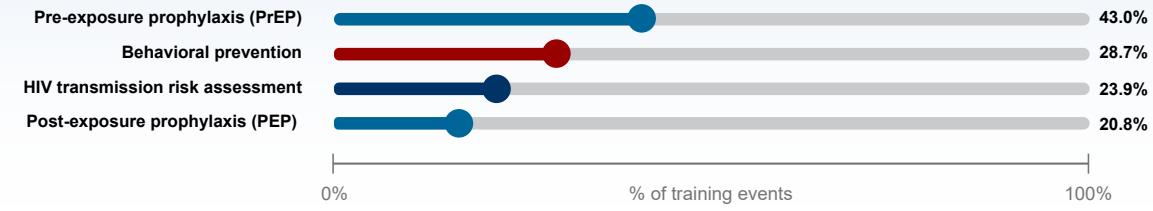
HIV Prevention

The HIV prevention topic most often presented in EHE-funded AETC training events from July 2023 through June 2024 was pre-exposure prophylaxis (PrEP), which was included in 43.0% of the training events. Other HIV prevention topics included behavioral prevention (28.7%), HIV transmission risk assessment (23.9%), and post-exposure prophylaxis (or PEP; 20.8%) (Figure 10 and Table 5).

- The **Northeast/Caribbean AETC** hosted an in-person conference about PrEP in a jurisdiction. This event reached 97 participants and presented the importance of prevention and PrEP to ending the HIV epidemic; the clinical aspects of PrEP; and PrEP implementation, successes, and challenges. One participant shared:

> *This PrEP conference was a great update on the PrEP services being offered in [our jurisdiction] with excellent discussions on how PrEP can be expanded across the [jurisdiction].*

Figure 10
HIV prevention training topics addressed during EHE-funded AETC training events, July 2023 through June 2024



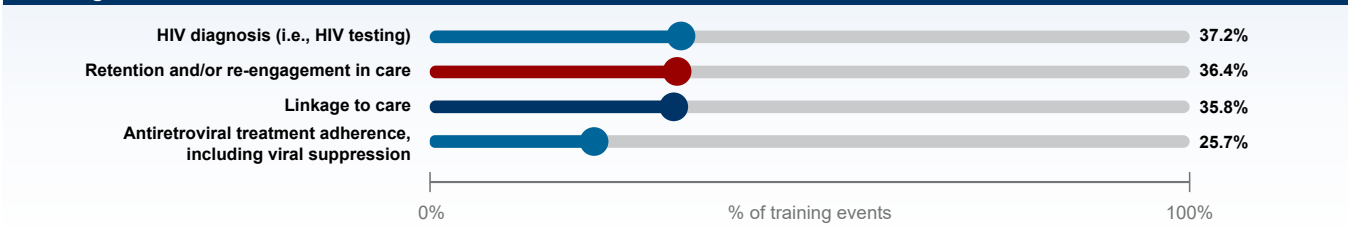
Source: 2024 HRSA HAB EHE Report (Table 5).

HIV Management

HIV management topics—especially those related to diagnosis, linkage to care, and retention and/or engagement in care—were each featured in more than 35% of EHE-funded AETC training events from July 2023 through June 2024. Trainings about treatment adherence were featured in more than one-quarter of the training events (25.7%) (Figure 11 and Table 5).

- The **South Central AETC** local partner implemented the EHE-Rapid stART Community of Practice (CoP) in a jurisdiction. The CoP strengthened clinics' understanding of the jurisdiction's care landscape, provided tailored training, and created a forum for sharing resources to support clients. As a result of this CoP, the number of clients who were newly diagnosed or returning to care and received ART through EHE-Rapid stART increased by 52%.

Figure 11
HIV management training topics addressed during EHE-funded AETC training events, July 2023 through June 2024



Source: 2024 HRSA HAB EHE Report (Table 5).

Primary Care, Chronic Conditions, and Comorbidities

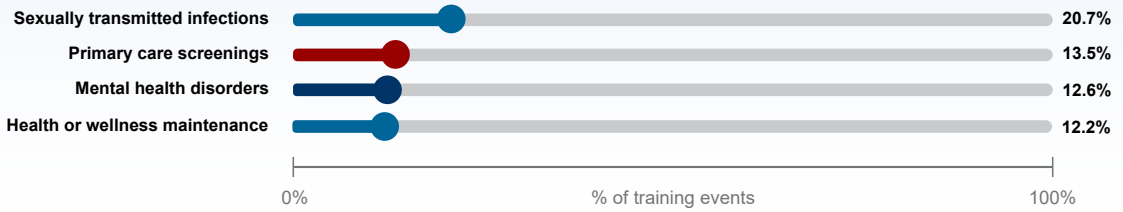
The primary care and comorbidities topics most frequently presented in EHE-funded AETC trainings were sexually transmitted infections (20.7%), substance use disorders (13.5%), primary care screenings (12.6%), and health or wellness maintenance (12.2%) (Figure 12 and Table 5).

- The **MidAtlantic AETC** supported the integration of HIV services into clinical care settings through training and technical assistance. In one jurisdiction, a local partner trained emergency department providers to increase their capacity to offer HIV testing to their patients. In another jurisdiction, a local partner provided peer-to-peer technical assistance to health center staff regarding prior authorizations for long-acting injectables.

> *They were experiencing the same barriers as us with delays in prior authorization for injectable PrEP and injectable ART, but they had eventually streamlined the process. Using their template language for the prior authorization documentation made all the difference.*

Figure 12

Primary care, chronic conditions, and comorbidities training topics addressed during EHE-funded AETC training events, July 2023 through June 2024



Source: 2024 HRSA HAB EHE Report (Table 5).

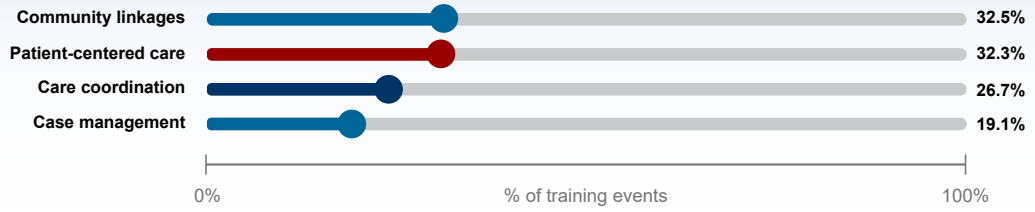
Health Care Organizations or Systems Issues

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 2023 through June 2024 were related to community linkages (32.5%), patient-centered care (32.3%), care coordination (26.7%), and case management (19.1%) (Figure 13 and Table 5).

- **Southeast AETC** uses the Southeast HIV Accelerated Response for Ending the Epidemic (SHARE) project to strengthen clinic capacity. Clinics that participated in the SHARE project reported system improvements, such as linkage to care and PrEP protocols, and were able to expand HIV prevention and treatment services. Through SHARE, a rural clinic in a jurisdiction enrolled six new clients in ADAP.

Figure 13

Health care organizations or systems issues training topics addressed during EHE-funded AETC training events, July 2023 through June 2024



Source: 2024 HRSA HAB EHE Report (Table 5).

Population-Specific Trainings

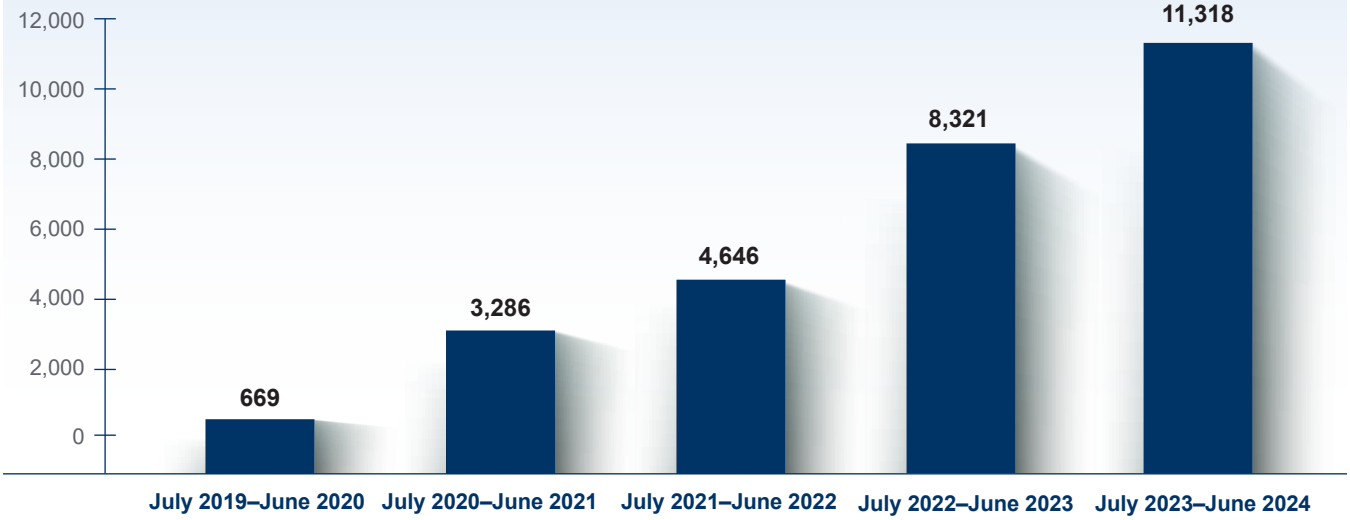
More than one-fifth of training events included the topic of adults aged 50 years and older (22.9%). Approximately 14% EHE-funded AETC training events included the topic of the people who were unstably housed (13.6%). Other communities addressed in training events included people who inject drugs (14.2%), people with legal system involvement (10.6%), and the rural population (5.1%) (Table 5).

- The **Mountain West AETC** engaged community partners to advance HIV prevention among populations disproportionately impacted by HIV, including aging adults. Two interactive workshops in one jurisdiction built the skills of barbers to lead HIV prevention discussions in their work and expanded HIV prevention knowledge among aging adults.

Training Participants

During the July 2023 through June 2024 reporting period, EHE-funded AETC trainings reached 11,318 participants, a steady increase across EHE implementation and nearly 3,000 more participants than the prior year (Figure 14 and Table 6).

Figure 14
EHE-funded AETC training participants, July 2019 through June 2024

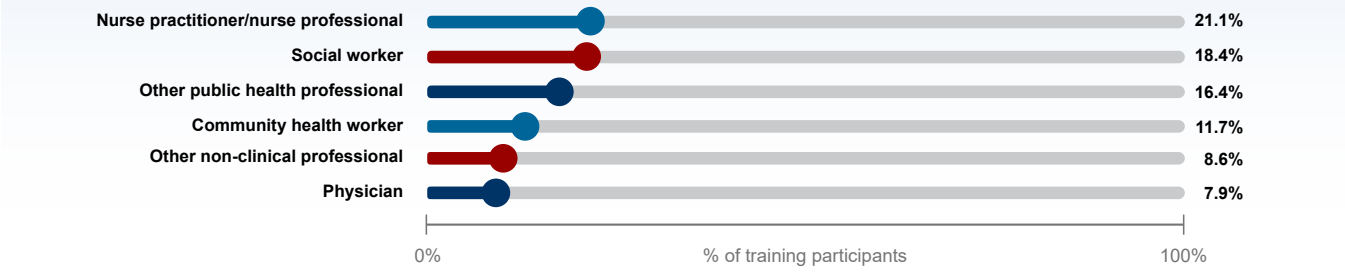


Source: 2024 HRSA HAB EHE Report (Table 7).

Participants' Professional and Employment Characteristics

From July 2023 through June 2024, the most reported professions of EHE-funded RWHAP AETC participants were nurses and nurse practitioners (21.1%), social workers (18.4%), and other public health professionals (16.4%) (Figure 15 and Table 6). Additionally, physicians accounted for 7.9% of all participants, and 0.2% of participants were clergy or faith-based professionals. This information represents the training participant's field and/or discipline; it may not represent their primary functional role in their organization. More than 40% of the participants performed the role of care provider (21.5%) or case manager (18.8%) in their organization.

Figure 15
Professional discipline of participants of EHE-funded AIDS Education and Training Center training events, July 2023 through June 2024

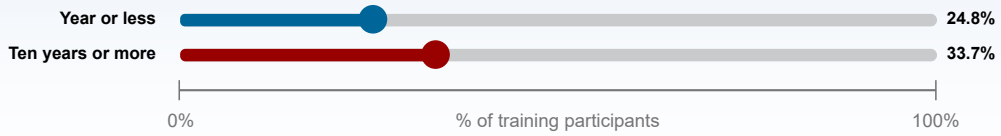


Source: 2024 HRSA HAB EHE Report (Table 6).

Nearly 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) (24.8%), while one-third had more than 10 years of experience (33.7%). More than half of participants provided services to 50 clients or more in a year (57.5%) (Figure 16 and Table 7).

Figure 16

Number of years providing direct services to people with HIV by participants of EHE-funded AIDS Education and Training Center training events, July 2023 through June 2024

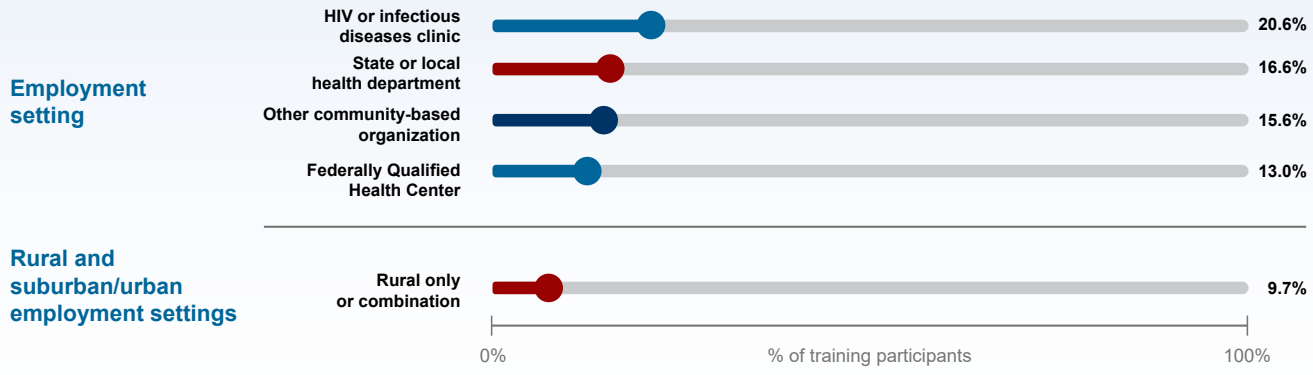


Source: 2024 HRSA HAB EHE Report (Table 7).

The most frequently reported employment setting was HIV or infectious diseases clinic (20.6%), followed by state or local health department (16.6%), Federally Qualified Health Center (13.0%), and other community-based organization (15.6%); 9.7% of the EHE-funded RWHAP AETC participants' employment settings were in a rural area (only or in combination with a suburban/urban area) (Figure 17 and Table 7).

Figure 17

Employment settings of participants of EHE-funded AIDS Education and Training Center training events, July 2023 through June 2024



Source: 2024 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 18.

Figure 18

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**	**AETC EHE Triannual Report, Progress Reports, and Non-competing Continuation Report**	**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 2024	July 2023–June 2024	March 2020–June 2024
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 5–13; Tables 1–4		Page 13–18; 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, and four awards in FY 2024), 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 and Services Administration; RWHAP = Ryan White HIV/AIDS Program

EHE Jurisdictional Progress Reports

This report uses narrative information from EHE progress reports submitted to HRSA HAB during the fifth year of the EHE initiative by each of the 47 HRSA HAB EHE recipients for March 2024 through February 2025. 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.

The highlights section of the report presents a summary of the most-funded activities in the fifth year of the EHE initiative and associated recipient quotes demonstrating the impact of EHE funding. All quotations are direct, de-identified text from EHE recipient progress reports. 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 4, is available in the previously published *HRSA HIV/AIDS Bureau Ending the HIV Epidemic (EHE) Initiative Qualitative Summary of Progress: March 2021–February 2022* and *Ending the HIV Epidemic in the U.S. Initiative Data Report, 2023* [11,12].

Limitations of Findings

EHE progress reports include only the activities, services, and accomplishments that were supported by fiscal year (FY) 2024–2025 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, 2023, and 2024. 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 service delivery, and identify opportunities to improve client HIV-related outcomes.

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 *2024 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 patients served by EHE-funded providers and of 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 2024. 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 during each reporting year. Since data are de-identified when reported, it is not possible to link individual client data across the years. Therefore, it is not known if someone who is estimated to be re-engaged in care in one year is retained in care in subsequent years.

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 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 *2024 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 *2024 Ryan White HIV/AIDS Program (RWHAP) AIDS Education and Training Center (AETC) Program Annual Data Report* [13].

RWHAP AETC Progress Reports

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 2023 through June 2024 reporting period. AETC progress reports were collected through the AETC EHE Triannual Report, 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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13. Health Resources and Services Administration. August 2026. *2024 Ryan White HIV/AIDS Program (RWHAP) AIDS Education and Training Center (AETC) Program Annual Data Report.* Available at https://ryanwhite.hrsa.gov/data/reports.

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 2024, the Health Resources and Services Administration (HRSA) HIV/AIDS Bureau (HAB) awarded Ending the HIV Epidemic in the U.S. (EHE) initiative funds to 47 jurisdictional recipients.

Appendix Table 1. HRSA HAB 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

Section 1. Clients Served and Services Delivered

Section 2. Workforce Training

Table 1a. New clients with HIV served by EHE-funded providers, by year and selected characteristics, 2020–2024— 47 HRSA HAB EHE-funded jurisdictions

	2020		2021		2022		2023		2024	
	N	%	N	%	N	%	N	%	N	%
Age group (yrs)										
<13	7	0.1	32	0.1	18	0.1	18	0.1	21	0.1
13–14	4	<0.1	5	<0.1	5	<0.1	8	<0.1	7	<0.1
15–19	84	0.7	218	1.0	192	0.9	276	1.0	272	0.8
20–24	669	5.7	1,622	7.2	1,664	7.6	1,918	7.1	2,135	6.4
25–29	1,265	10.7	3,118	13.9	3,304	15.0	3,717	13.9	4,153	12.5
30–34	1,571	13.3	3,742	16.7	4,081	18.5	4,785	17.8	5,551	16.7
35–39	1,324	11.2	2,823	12.6	3,154	14.3	3,894	14.5	5,133	15.4
40–44	1,140	9.7	2,308	10.3	2,323	10.6	2,856	10.6	3,694	11.1
45–49	1,070	9.1	1,761	7.9	1,764	8.0	2,296	8.6	2,863	8.6
50–54	1,373	11.6	2,077	9.3	1,682	7.6	2,064	7.7	2,557	7.7
55–59	1,419	12.0	2,063	9.2	1,682	7.6	2,022	7.5	2,569	7.7
60–64	931	7.9	1,380	6.2	1,158	5.3	1,568	5.8	2,201	6.6
≥65	935	7.9	1,264	5.6	974	4.4	1,408	5.2	2,072	6.2
Subtotal	**11,792**	**100.0**	**22,413**	**100.0**	**22,001**	**100.0**	**26,830**	**100.0**	**33,228**	**100.0**
Race/ethnicity										
American Indian/Alaska Native	31	0.3	94	0.4	183	0.9	86	0.3	140	0.4
Asian	127	1.1	299	1.4	704	3.4	317	1.2	481	1.5
Black/African American	6,536	56.2	11,076	50.4	9,347	44.7	11,969	45.8	13,863	43.0
Hispanic/Latino[a]	2,071	17.8	5,408	24.6	6,507	31.1	8,106	31.0	11,465	35.6
Native Hawaiian/Pacific Islander	20	0.2	44	0.2	30	0.1	33	0.1	53	0.2
White	2,776	23.9	4,844	22.0	3,880	18.6	5,261	20.1	5,817	18.1
Multiple races	72	0.6	225	1.0	259	1.2	381	1.5	404	1.3
Subtotal	**11,633**	**100.0**	**21,990**	**100.0**	**20,910**	**100.0**	**26,153**	**100.0**	**32,223**	**100.0**
Sex										
Male	8,912	77.3	17,288	80.1	16,911	80.7	20,172	78.9	24,984	79.4
Female	2,612	22.7	4,307	19.9	4,037	19.3	5,410	21.1	6,475	20.6
Subtotal	**11,524**	**100.0**	**21,595**	**100.0**	**20,948**	**100.0**	**25,582**	**100.0**	**31,459**	**100.0**
Federal poverty level										
0–100%	5,126	68.1	11,563	66.9	12,824	68.9	16,332	68.2	19,493	66.1
101–138%	686	9.1	1,167	6.7	1,286	6.9	1,644	6.9	2,081	7.1
139–250%	1,040	13.8	2,840	16.4	2,663	14.3	3,678	15.4	4,624	15.7
251–400%	500	6.6	1,350	7.8	1,423	7.7	1,824	7.6	2,665	9.0
>400%	172	2.3	370	2.1	404	2.2	467	2.0	636	2.2
Subtotal	**7,524**	**100.0**	**17,290**	**100.0**	**18,600**	**100.0**	**23,945**	**100.0**	**29,499**	**100.0**
Health care coverage										
Private employer	653	8.6	1,679	9.3	1,641	8.7	2,430	9.8	2,859	9.4
Private individual	549	7.2	1,405	7.8	1,225	6.5	2,248	9.1	3,564	11.7
Medicare	342	4.5	759	4.2	789	4.2	1,286	5.2	1,826	6.0
Medicaid	1,558	20.5	4,526	25.1	4,549	24.0	6,610	26.7	8,495	27.9
Medicare and Medicaid	279	3.7	544	3.0	604	3.2	745	3.0	856	2.8
Veterans Administration	14	0.2	33	0.2	44	0.2	33	0.1	48	0.2
Indian Health Service	0	0.0	0	0.0	5	<0.1	4	<0.1	5	<0.1
Other plan	189	2.5	331	1.8	489	2.6	491	2.0	498	1.6
No coverage	3,503	46.0	7,553	41.8	8,300	43.8	9,199	37.1	9,934	32.6
Multiple coverages	530	7.0	1,233	6.8	1,309	6.9	1,746	7.0	2,413	7.9
Subtotal	**7,617**	**100.0**	**18,063**	**100.0**	**18,955**	**100.0**	**24,792**	**100.0**	**30,498**	**100.0**
Housing status										
Stable	5,954	78.1	13,727	78.3	14,166	75.6	18,345	76.8	23,074	77.4
Temporary	1,016	13.3	2,202	12.6	2,806	15.0	3,374	14.1	3,938	13.2
Unstable	650	8.5	1,598	9.1	1,760	9.4	2,169	9.1	2,789	9.4
Subtotal	**7,620**	**100.0**	**17,527**	**100.0**	**18,732**	**100.0**	**23,888**	**100.0**	**29,801**	**100.0**
Total[b]	**11,792**	**100.0**	**22,413**	**100.0**	**22,001**	**100.0**	**26,830**	**100.0**	**33,228**	**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 served by selected EHE -funded providers, by year and selected characteristics, 2020–2024— 47 HRSA HAB EHE-funded jurisdictions

	2020		2021		2022		2023		2024	
	N	%	N	%	N	%	N	%	N	%
Age group (yrs)										
<13	3	<0.1	10	0.1	12	0.1	9	0.1	8	<0.1
13–14	0	0.0	7	<0.1	3	<0.1	5	<0.1	6	<0.1
15–19	15	0.2	32	0.2	48	0.2	46	0.3	48	0.3
20–24	211	3.0	343	2.2	456	2.4	505	2.9	410	2.2
25–29	548	7.7	1,014	6.6	1,344	7.0	1,259	7.3	1,245	6.8
30–34	782	11.0	1,767	11.5	2,380	12.4	2,224	12.8	2,156	11.7
35–39	656	9.3	1,641	10.7	2,206	11.5	2,141	12.3	2,407	13.1
40–44	633	8.9	1,546	10.1	2,116	11.0	1,884	10.9	1,964	10.7
45–49	698	9.9	1,395	9.1	1,863	9.7	1,627	9.4	1,771	9.6
50–54	966	13.6	1,910	12.5	2,262	11.8	1,850	10.7	1,846	10.1
55–59	1,019	14.4	2,165	14.1	2,553	13.3	2,118	12.2	2,117	11.5
60–64	809	11.4	1,691	11.0	2,018	10.5	1,853	10.7	2,075	11.3
≥65	745	10.5	1,797	11.7	1,943	10.1	1,837	10.6	2,301	12.5
Subtotal	**7,085**	**100.0**	**15,318**	**100.0**	**19,204**	**100.0**	**17,358**	**100.0**	**18,354**	**100.0**
Race/ethnicity										
American Indian/Alaska Native	10	0.1	49	0.3	56	0.3	50	0.3	47	0.3
Asian	59	0.9	188	1.3	237	1.3	177	1.0	177	1.0
Black/African American	4,273	61.6	8,288	55.2	9,865	52.8	9,385	54.7	10,531	57.9
Hispanic/Latino[a]	1,351	19.5	3,292	21.9	4,223	22.6	4,112	24.0	4,096	22.5
Native Hawaiian/Pacific Islander	13	0.2	15	0.1	55	0.3	31	0.2	21	0.1
White	1,167	16.8	3,085	20.5	4,064	21.8	3,115	18.2	3,005	16.5
Multiple races	62	0.9	110	0.7	175	0.9	273	1.6	304	1.7
Subtotal	**6,935**	**100.0**	**15,027**	**100.0**	**18,675**	**100.0**	**17,143**	**100.0**	**18,181**	**100.0**
Sex										
Male	4,746	68.9	10,728	72.9	13,599	75.7	12,145	72.6	12,665	73.2
Female	2,143	31.1	3,995	27.1	4,355	24.3	4,579	27.4	4,643	26.8
Subtotal	**6,889**	**100.0**	**14,723**	**100.0**	**17,954**	**100.0**	**16,724**	**100.0**	**17,308**	**100.0**
Federal poverty level										
0–100%	4,177	64.0	7,649	63.4	10,875	64.3	9,649	64.5	9,645	65.7
101–138%	674	10.3	1,073	8.9	1,451	8.6	1,332	8.9	1,190	8.1
139–250%	1,039	15.9	1,919	15.9	2,516	14.9	2,290	15.3	2,183	14.9
251–400%	484	7.4	1,063	8.8	1,410	8.3	1,278	8.5	1,314	8.9
>400%	152	2.3	363	3.0	651	3.9	400	2.7	355	2.4
Subtotal	**6,526**	**100.0**	**12,067**	**100.0**	**16,903**	**100.0**	**14,949**	**100.0**	**14,687**	**100.0**
Health care coverage										
Private employer	811	12.0	1,920	13.5	1,769	9.8	1,689	10.6	1,943	11.6
Private individual	428	6.3	1,249	8.8	957	5.3	1,258	7.9	1,847	11.1
Medicare	804	11.9	1,620	11.4	1,827	10.1	1,649	10.3	1,853	11.1
Medicaid	2,399	35.4	4,414	31.1	6,664	36.8	5,749	36.0	5,436	32.6
Medicare and Medicaid	493	7.3	1,163	8.2	1,054	5.8	1,030	6.5	1,051	6.3
Veterans Administration	4	0.1	21	0.1	20	0.1	30	0.2	20	0.1
Indian Health Service	0	0.0	0	0.0	6	<0.1	0	0.0	1	<0.1
Other plan	124	1.8	246	1.7	881	4.9	204	1.3	178	1.1
No coverage	1,156	17.1	2,109	14.8	2,534	14.0	2,916	18.3	2,951	17.7
Multiple coverages	553	8.2	1,467	10.3	2,401	13.3	1,438	9.0	1,410	8.4
Subtotal	**6,772**	**100.0**	**14,209**	**100.0**	**18,113**	**100.0**	**15,963**	**100.0**	**16,690**	**100.0**
Housing status										
Stable	4,776	75.2	9,985	81.5	14,417	84.8	12,572	83.0	12,666	84.5
Temporary	1,358	21.4	1,774	14.5	1,866	11.0	1,682	11.1	1,562	10.4
Unstable	217	3.4	497	4.1	724	4.3	893	5.9	769	5.1
Subtotal	**6,351**	**100.0**	**12,256**	**100.0**	**17,007**	**100.0**	**15,147**	**100.0**	**14,997**	**100.0**
Total[b]	**7,085**	**100.0**	**15,318**	**100.0**	**19,204**	**100.0**	**17,358**	**100.0**	**18,354**	**100.0**

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

* Clients estimated to be re-engaged in care is calculated among clients served by EHE-funded outpatient/ambulatory health services (or OAHS), 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, 2020–2024—47 HRSA HAB EHE-funded jurisdictions

	2020			2021			2022			2023			2024		
		Viral suppression			Viral suppression			Viral suppression			Viral suppression			Viral suppression	
	Total N	N	%	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	9	69.2
13–14	1	0	0.0	4	4	100.0	3	2	66.7	6	6	100.0	2	2	100.0
15–19	52	38	73.1	153	115	75.2	122	97	79.5	182	143	78.6	187	154	82.4
20–24	442	323	73.1	1,136	866	76.2	1,148	862	75.1	1,267	973	76.8	1,433	1,129	78.8
25–29	821	607	73.9	2,142	1,640	76.6	2,182	1,669	76.5	2,445	1,951	79.8	2,683	2,203	82.1
30–34	939	678	72.2	2,460	1,895	77.0	2,660	2,081	78.2	3,035	2,403	79.2	3,528	2,872	81.4
35–39	741	561	75.7	1,668	1,306	78.3	1,961	1,513	77.2	2,377	1,900	79.9	3,125	2,556	81.8
40–44	527	400	75.9	1,295	1,004	77.5	1,392	1,104	79.3	1,729	1,415	81.8	2,241	1,868	83.4
45–49	421	314	74.6	922	749	81.2	1,034	857	82.9	1,332	1,073	80.6	1,715	1,449	84.5
50–54	453	365	80.6	957	747	78.1	896	724	80.8	1,197	1,004	83.9	1,480	1,256	84.9
55–59	390	328	84.1	871	742	85.2	846	713	84.3	1,052	922	87.6	1,388	1,200	86.5
60–64	214	181	84.6	475	401	84.4	554	473	85.4	798	705	88.3	1,133	1,003	88.5
≥65	126	109	86.5	324	287	88.6	370	328	88.6	633	571	90.2	1,001	948	94.7
Race/ethnicity															
American Indian/Alaska Native	14	10	71.4	39	33	84.6	53	43	81.1	42	32	76.2	79	64	81.0
Asian	81	71	87.7	208	180	86.5	240	200	83.3	210	177	84.3	311	281	90.4
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	8,612	7,001	81.3
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	6,930	5,934	85.6
Native Hawaiian/Pacific Islander	8	7	87.5	28	24	85.7	18	14	77.8	22	15	68.2	41	33	80.5
White	957	746	78.0	2,324	1,873	80.6	2,238	1,809	80.8	3,064	2,579	84.2	3,306	2,786	84.3
Multiple races	51	36	70.6	138	107	77.5	150	117	78.0	179	144	80.4	213	182	85.4
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	15,281	12,775	83.6
Female	993	749	75.4	2,078	1,638	78.8	2,199	1,784	81.1	3,026	2,482	82.0	3,691	3,082	83.5
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	12,843	10,445	81.3
101–138%	432	356	82.4	795	660	83.0	787	656	83.4	1,004	866	86.3	1,266	1,098	86.7
139–250%	661	540	81.7	1,966	1,611	81.9	1,787	1,471	82.3	2,390	2,057	86.1	2,936	2,570	87.5
251–400%	294	240	81.6	893	781	87.5	882	741	84.0	1,163	1,018	87.5	1,652	1,499	90.7
>400%	98	90	91.8	256	232	90.6	254	221	87.0	284	249	87.7	372	337	90.6
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	1,715	1,523	88.8
Private individual	303	258	85.1	781	689	88.2	654	563	86.1	1,274	1,085	85.2	2,173	1,909	87.9
Medicare	160	137	85.6	358	292	81.6	356	301	84.6	628	562	89.5	797	722	90.6
Medicaid	924	698	75.5	2,940	2,241	76.2	2,682	2,044	76.2	3,944	3,118	79.1	4,994	4,079	81.7
Medicare and Medicaid	127	98	77.2	242	203	83.9	265	223	84.2	359	309	86.1	507	451	89.0
Veterans Administration	0	—	—	9	6	66.7	12	10	83.3	9	8	88.9	15	12	80.0
Indian Health Service	0	—	—	0	—	—	0	—	—	3	3	100.0	4	4	100.0
Other plan	92	76	82.6	192	152	79.2	332	254	76.5	329	268	81.5	327	260	79.5
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	7,148	5,725	80.1
Multiple coverages	297	258	86.9	782	670	85.7	907	769	84.8	1,229	1,083	88.1	1,788	1,604	89.7
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	15,346	13,040	85.0
Temporary	675	506	75.0	1,456	1,114	76.5	1,809	1,382	76.4	2,002	1,586	79.2	2,360	1,925	81.6
Unstable	382	243	63.6	971	652	67.1	1,044	723	69.3	1,256	884	70.4	1,553	1,146	73.8
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**	**19,929**	**16,649**	**83.5**

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

Viral suppression was based on data for people with HIV who had at least one outpatient/ambulatory health services (or 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 served by selected EHE-funded providers, by year and selected characteristics, 2020–2024— 47 HRSA HAB EHE-funded jurisdictions

	2020			2021			2022			2023			2024		
		Viral suppression			Viral suppression			Viral suppression			Viral suppression			Viral suppression	
	Total N	N	%	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	3	3	100.0
13–14	0	—	—	0	—	—	1	1	100.0	3	3	100.0	2	1	50.0
15–19	4	3	75.0	10	8	80.0	29	17	58.6	31	26	83.9	33	24	72.7
20–24	137	113	82.5	175	139	79.4	297	234	78.8	338	268	79.3	274	221	80.7
25–29	362	275	76.0	578	438	75.8	908	709	78.1	825	670	81.2	783	621	79.3
30–34	528	410	77.7	1,018	775	76.1	1,675	1,325	79.1	1,442	1,151	79.8	1,290	1,050	81.4
35–39	425	352	82.8	909	726	79.9	1,569	1,253	79.9	1,388	1,117	80.5	1,459	1,162	79.6
40–44	411	344	83.7	803	676	84.2	1,471	1,231	83.7	1,208	993	82.2	1,178	979	83.1
45–49	468	391	83.5	744	629	84.5	1,268	1,086	85.6	1,033	862	83.4	1,020	865	84.8
50–54	693	596	86.0	1,015	887	87.4	1,561	1,358	87.0	1,111	962	86.6	1,017	882	86.7
55–59	719	642	89.3	1,115	997	89.4	1,742	1,553	89.2	1,321	1,167	88.3	1,186	1,061	89.5
60–64	569	511	89.8	879	787	89.5	1,306	1,182	90.5	1,114	1,002	89.9	1,161	1,040	89.6
≥65	554	538	97.1	904	854	94.5	1,260	1,188	94.3	1,089	1,006	92.4	1,239	1,158	93.5
Race/ethnicity															
American Indian/Alaska Native	9	7	77.8	21	16	76.2	27	21	77.8	26	22	84.6	25	20	80.0
Asian	40	38	95.0	101	94	93.1	182	168	92.3	112	103	92.0	93	90	96.8
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	6,607	5,512	83.4
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	2,346	2,076	88.5
Native Hawaiian/Pacific Islander	10	9	90.0	10	10	100.0	44	40	90.9	18	17	94.4	12	11	91.7
White	606	520	85.8	1,423	1,265	88.9	2,447	2,176	88.9	1,691	1,495	88.4	1,410	1,228	87.1
Multiple races	23	21	91.3	37	30	81.1	90	73	81.1	120	108	90.0	102	83	81.4
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	7,384	6,256	84.7
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	2,896	2,511	86.7
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	6,745	5,609	83.2
101–138%	521	468	89.8	662	579	87.5	1,021	899	88.1	905	786	86.9	779	687	88.2
139–250%	751	681	90.7	1,203	1,068	88.8	1,863	1,665	89.4	1,607	1,423	88.6	1,479	1,294	87.5
251–400%	327	306	93.6	694	631	90.9	1,009	914	90.6	808	746	92.3	852	772	90.6
>400%	92	87	94.6	275	264	96.0	527	497	94.3	249	231	92.8	219	203	92.7
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	1,152	1,053	91.4
Private individual	289	271	93.8	480	441	91.9	612	551	90.0	849	766	90.2	963	857	89.0
Medicare	600	565	94.2	897	820	91.4	1,124	1,020	90.7	949	852	89.8	1,035	928	89.7
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	3,547	2,967	83.6
Medicare and Medicaid	364	319	87.6	555	497	89.5	717	622	86.8	693	605	87.3	678	601	88.6
Veterans Administration	1	1	100.0	4	4	100.0	5	4	80.0	10	8	80.0	2	1	50.0
Indian Health Service	0	—	—	0	—	—	3	2	66.7	0	—	—	1	1	100.0
Other plan	75	58	77.3	92	76	82.6	659	633	96.1	108	98	90.7	90	81	90.0
No coverage	847	642	75.8	1,324	986	74.5	1,917	1,433	74.8	2,140	1,648	77.0	2,057	1,591	77.3
Multiple coverages	403	369	91.6	634	564	89.0	1,861	1,701	91.4	1,029	936	91.0	961	845	87.9
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	8,909	7,645	85.8
Temporary	1,042	883	84.7	1,227	1,025	83.5	1,435	1,185	82.6	1,241	1,048	84.4	1,086	921	84.8
Unstable	125	72	57.6	259	162	62.5	464	298	64.2	552	372	67.4	425	309	72.7
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**	**10,645**	**9,067**	**85.2**

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

Viral suppression was based on data for people with HIV who had at least one outpatient/ambulatory health services (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 OAHS, 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, 2020–2024—47 HRSA HAB EHE-funded jurisdictions

Part A jurisdictions			2020	2021	2022	2023	2024
State/territory	**EMA/TGA**	**EHE focus county(ies)**	**N**	**N**	**N**	**N**	**N**
Arizona	Phoenix	Maricopa County	0	567	421	695	743
California	Los Angeles	Los Angeles County	114	1,038	80	106	1,084
	Oakland	Alameda County	106	209	196	206	456
	Sacramento	Sacramento County	0	17	25	56	42
	San Bernardino	Riverside County; San Bernardino County	222	151	253	591	605
	San Diego	San Diego County	0	205	525	147	70
	San Francisco	San Francisco County	229	273	240	310	353
	Santa Ana	Orange County	318	265	344	359	373
District of Columbia	Washington	District of Columbia; Montgomery County, MD; Prince George's County, MD	98	139	152	101	197
Florida	Fort Lauderdale	Broward County	1,322	1,232	1,399	1,618	1,302
	Jacksonville	Duval County	162	349	315	426	339
	Miami	Miami-Dade County	0	299	360	948	776
	Orlando	Orange County	104	564	618	525	518
	Tampa	Hillsborough County; Pinellas County	488	635	627	677	759
	West Palm Beach	Palm Beach County	88	121	192	217	347
Georgia	Atlanta	Cobb County; DeKalb County; Fulton County; Gwinnett County	370	2,086	2,125	2,326	2,439
Illinois	Chicago	Cook County	273	202	134	147	217
Indiana	Indianapolis	Marion County	34	8	184	209	230
Louisiana	Baton Rouge	East Baton Rouge Parish	0	320	339	552	982
	New Orleans	Orleans Parish	0	407	313	342	1,148
Maryland	Baltimore	Baltimore City	10	92	105	220	230
Massachusetts	Boston	Suffolk County	222	27	336	270	137
Michigan	Detroit	Wayne County	219	336	303	958	672
Nevada	Las Vegas	Clark County	0	202	106	39	1,520
New Jersey	Jersey City	Hudson County	55	122	209	121	200
	Newark	Essex County	607	641	624	506	557
New York	New York	Bronx County; Kings County; New York County; Queens County	43	1,375	1,869	2,619	2,817
North Carolina	Charlotte	Mecklenburg County	59	127	257	399	789
Ohio	Cleveland	Cuyahoga County	0	337	210	342	377
	Columbus	Franklin County	62	86	700	993	2,367
Pennsylvania	Philadelphia	Philadelphia County	92	756	292	1,430	1,431
Puerto Rico	San Juan	San Juan Municipio	24	173	20	207	224
Tennessee	Memphis	Shelby County	62	45	32	54	30
Texas	Austin	Travis County	0	352	416	560	558
	Dallas	Dallas County	0	70	1,123	525	1,107
	Fort Worth	Tarrant County	0	449	556	366	541
	Houston	Harris County	1,820	2,010	2,243	2,257	2,487
	San Antonio	Bexar County	1	439	679	973	824
Washington	Seattle	King County	0	261	318	425	456

Part B jurisdictions		2020	2021	2022	2023	2024
State	**EHE focus county or state**	**N**	**N**	**N**	**N**	**N**
Alabama	State	41	414	612	652	511
Arkansas	State	119	150	16	15	13
Kentucky	State	45	42	38	264	612
Mississippi	State	0	0	7	53	57
Missouri	State	168	590	459	560	303
Ohio	Hamilton County	0	190	299	325	813
Oklahoma	State	0	0	58	218	226
South Carolina	State	4,042	3,829	1,130	911	804

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. EMA/TGA geographic boundaries are not limited to the listed EHE focus county(ies).

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 served by selected EHE-funded providers, by year and jurisdiction, 2020–2024— 47 HRSA HAB EHE-funded jurisdictions

Part A jurisdictions			2020	2021	2022	2023	2024
State/territory	**EMA/TGA**	**EHE focus county(ies)**	**N**	**N**	**N**	**N**	**N**
Arizona	Phoenix	Maricopa County	0	11	406	223	216
California	Los Angeles	Los Angeles County	0	349	0	0	22
	Oakland	Alameda County	18	17	134	183	147
	Sacramento	Sacramento County	0	0	0	1	2
	San Bernardino	Riverside County; San Bernardino County	53	63	97	153	152
	San Diego	San Diego County	0	177	259	207	13
	San Francisco	San Francisco County	68	151	76	81	152
	Santa Ana	Orange County	59	52	59	65	154
District of Columbia	Washington	District of Columbia; Montgomery County, MD; Prince George's County, MD	88	399	519	766	1,122
Florida	Fort Lauderdale	Broward County	275	437	464	276	234
	Jacksonville	Duval County	321	1,245	293	312	315
	Miami	Miami-Dade County	0	56	47	117	140
	Orlando	Orange County	0	128	85	53	53
	Tampa	Hillsborough County; Pinellas County	0	0	0	0	0
	West Palm Beach	Palm Beach County	96	48	80	64	63
Georgia	Atlanta	Cobb County; DeKalb County; Fulton County; Gwinnett County	74	452	631	705	635
Illinois	Chicago	Cook County	116	7	0	796	829
Indiana	Indianapolis	Marion County	0	25	190	484	485
Louisiana	Baton Rouge	East Baton Rouge Parish	0	980	177	234	1,383
	New Orleans	Orleans Parish	0	137	178	33	527
Maryland	Baltimore	Baltimore City	39	89	148	273	240
Massachusetts	Boston	Suffolk County	83	40	203	1	117
Michigan	Detroit	Wayne County	341	688	626	433	371
Nevada	Las Vegas	Clark County	0	33	55	831	168
New Jersey	Jersey City	Hudson County	18	34	45	30	61
	Newark	Essex County	3,635	3,567	4,173	2,988	2,842
New York	New York	Bronx County; Kings County; New York County; Queens County	8	1,035	3,893	922	1,288
North Carolina	Charlotte	Mecklenburg County	8	31	112	29	253
Ohio	Cleveland	Cuyahoga County	0	242	311	206	331
	Columbus	Franklin County	977	761	1,697	1,463	502
Pennsylvania	Philadelphia	Philadelphia County	8	1,458	593	1,459	1,555
Puerto Rico	San Juan	San Juan Municipio	10	32	27	46	38
Tennessee	Memphis	Shelby County	0	257	581	675	1,002
Texas	Austin	Travis County	0	326	230	216	228
	Dallas	Dallas County	0	42	46	132	85
	Fort Worth	Tarrant County	0	0	42	56	56
	Houston	Harris County	619	754	957	893	1,014
	San Antonio	Bexar County	1	573	647	426	240
Washington	Seattle	King County	0	163	182	137	159

Part B jurisdictions		2020	2021	2022	2023	2024
State	**EHE focus county or state**	**N**	**N**	**N**	**N**	**N**
Alabama	State	0	7	25	18	30
Arkansas	State	0	56	572	567	543
Kentucky	State	11	3	2	43	41
Mississippi	State	0	0	12	304	280
Missouri	State	0	142	56	94	42
Ohio	Hamilton County	0	17	19	45	19
Oklahoma	State	0	0	57	74	0
South Carolina	State	0	94	80	93	101

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

* Clients estimated to be re-engaged in care is calculated among clients served by EHE-funded outpatient/ambulatory health services (or OAHS), 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.

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. EMA/TGA geographic boundaries are not limited to the listed EHE focus county(ies).

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, 2020–2024—47 HRSA HAB EHE-funded jurisdictions

Part A jurisdictions			2020			2021			2022			2023			2024		
			Total	Viral suppression		Total	Viral suppression		Total	Viral suppression		Total	Viral suppression		Total	Viral suppression	
State/territory	EMA/TGA	EHE focus county(ies)	N	N	%	N	N	%	N	N	%	N	N	%	N	N	%
Arizona	Phoenix	Maricopa County	0	—	—	501	435	86.8	331	276	83.4	584	497	85.1	480	401	83.5
California	Los Angeles	Los Angeles County	0	—	—	678	542	79.9	2	2	100.0	0	—	—	343	262	76.4
	Oakland	Alameda County	56	31	55.4	110	90	81.8	123	93	75.6	126	100	79.4	172	140	81.4
	Sacramento	Sacramento County	0	—	—	15	11	73.3	23	15	65.2	51	27	52.9	41	32	78.0
	San Bernardino	Riverside County; San Bernardino County	84	71	84.5	37	33	89.2	155	95	61.3	474	378	79.7	437	354	81.0
	San Diego	San Diego County	0	—	—	116	97	83.6	342	297	86.8	81	69	85.2	42	37	88.1
	San Francisco	San Francisco County	117	86	73.5	166	126	75.9	132	98	74.2	163	136	83.4	209	168	80.4
	Santa Ana	Orange County	176	155	88.1	198	156	78.8	205	159	77.6	231	191	82.7	254	204	80.3
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	146	120	82.2
Florida	Fort Lauderdale	Broward County	789	572	72.5	603	468	77.6	598	480	80.3	885	705	79.7	619	502	81.1
	Jacksonville	Duval County	68	50	73.5	158	118	74.7	163	130	79.8	184	153	83.2	156	119	76.3
	Miami	Miami-Dade County	0	—	—	182	158	86.8	283	260	91.9	610	554	90.8	710	610	85.9
	Orlando	Orange County	6	5	83.3	139	115	82.7	143	119	83.2	151	126	83.4	150	133	88.7
	Tampa	Hillsborough County; Pinellas County	250	186	74.4	334	270	80.8	315	250	79.4	288	228	79.2	361	299	82.8
	West Palm Beach	Palm Beach County	18	15	83.3	28	23	82.1	52	42	80.8	39	39	100.0	72	62	86.1
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	2,173	1,739	80.0
Illinois	Chicago	Cook County	216	176	81.5	156	134	85.9	98	89	90.8	106	87	82.1	158	134	84.8
Indiana	Indianapolis	Marion County	27	22	81.5	7	7	100.0	160	119	74.4	171	131	76.6	184	148	80.4
Louisiana	Baton Rouge	East Baton Rouge Parish	0	—	—	99	85	85.9	106	87	82.1	134	115	85.8	133	113	85.0
	New Orleans	Orleans Parish	0	—	—	299	211	70.6	233	178	76.4	191	157	82.2	833	736	88.4
Maryland	Baltimore	Baltimore City	1	0	0	53	41	77.4	69	56	81.2	179	148	82.7	172	147	85.5
Massachusetts	Boston	Suffolk County	48	45	93.8	0	—	—	35	30	85.7	20	18	90.0	5	5	100.0
Michigan	Detroit	Wayne County	134	112	83.6	223	177	79.4	209	162	77.5	704	584	83.0	492	390	79.3
Nevada	Las Vegas	Clark County	0	—	—	167	146	87.4	89	77	86.5	23	19	82.6	1,164	1,078	92.6
New Jersey	Jersey City	Hudson County	37	22	59.5	94	69	73.4	161	138	85.7	71	56	78.9	153	125	81.7
	Newark	Essex County	527	422	80.1	551	456	82.8	561	437	77.9	454	362	79.7	456	366	80.3
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	1,192	1,010	84.7
North Carolina	Charlotte	Mecklenburg County	37	35	94.6	74	58	78.4	180	144	80.0	191	137	71.7	357	291	81.5
Ohio	Cleveland	Cuyahoga County	0	—	—	217	170	78.3	141	102	72.3	181	152	84.0	230	179	77.8
	Columbus	Franklin County	26	23	88.5	67	53	79.1	211	182	86.3	432	392	90.7	1,048	984	93.9
Pennsylvania	Philadelphia	Philadelphia County	57	43	75.4	371	289	77.9	230	176	76.5	555	455	82.0	721	600	83.2
Puerto Rico	San Juan	San Juan Municipio	18	13	72.2	140	114	81.4	17	14	82.4	169	137	81.1	180	155	86.1
Tennessee	Memphis	Shelby County	15	9	60	22	17	77.3	21	18	85.7	32	23	71.9	17	12	70.6
Texas	Austin	Travis County	0	—	—	155	125	80.6	302	236	78.1	412	321	77.9	367	299	81.5
	Dallas	Dallas County	0	—	—	21	15	71.4	129	85	65.9	238	188	79.0	473	386	81.6
	Fort Worth	Tarrant County	0	—	—	311	228	73.3	421	321	76.2	239	197	82.4	391	326	83.4
	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	1,636	1,303	79.6
	San Antonio	Bexar County	1	1	100	225	143	63.6	265	182	68.7	386	285	73.8	403	291	72.2
Washington	Seattle	King County	0	—	—	206	179	86.9	262	225	85.9	319	265	83.1	357	312	87.4

Table 4a. Viral suppression among new clients with HIV served by EHE-funded providers, by year and jurisdiction, 2020–2024—47 HRSA HAB EHE-funded jurisdictions *(cont.)*

Part B jurisdictions		2020			2021			2022			2023			2024		
		Total	Viral suppression		Total	Viral suppression		Total	Viral suppression		Total	Viral suppression		Total	Viral suppression	
State	EHE focus county or state	N	N	%	N	N	%	N	N	%	N	N	%	N	N	%
Alabama	State	2	0	0.0	197	162	82.2	499	433	86.8	389	300	77.1	270	212	78.5
Arkansas	State	90	58	64.4	99	72	72.7	5	5	100.0	10	9	90.0	9	8	88.9
Kentucky	State	38	31	81.6	32	28	87.5	30	27	90.0	235	190	80.9	472	372	78.8
Mississippi	State	0	—	—	0	—	—	3	1	33.3	30	24	80.0	35	29	82.9
Missouri	State	82	69	84.1	308	256	83.1	244	207	84.8	274	243	88.7	180	152	84.4
Ohio	Hamilton County	0	—	—	33	26	78.8	123	109	88.6	152	134	88.2	259	237	91.5
Oklahoma	State	0	—	—	0	—	—	36	35	97.2	94	80	85.1	132	112	84.8
South Carolina	State	82	66	80.5	350	292	83.4	346	266	76.9	395	327	82.8	402	354	88.1

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

Viral suppression was based on data for people with HIV who had at least one outpatient/ambulatory health services (or 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. EMA/TGA geographic boundaries are not limited to the listed EHE focus county(ies).

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 4b. Viral suppression among estimated re-engaged* clients with HIV served by selected EHE-funded providers, by year and jurisdiction, 2020–2024— 47 HRSA HAB EHE-funded jurisdictions

Part A jurisdictions			2020			2021			2022			2023			2024		
			Total	Viral suppression		Total	Viral suppression		Total	Viral suppression		Total	Viral suppression		Total	Viral suppression	
State/territory	EMA/TGA	EHE focus county(ies)	N	N	%	N	N	%	N	N	%	N	N	%	N	N	%
Arizona	Phoenix	Maricopa County	0	—	—	1	0	0.0	300	213	71.0	111	79	71.2	117	99	84.6
California	Los Angeles	Los Angeles County	0	—	—	183	131	71.6	0	—	—	0	—	—	0	—	—
	Oakland	Alameda County	6	4	66.7	10	7	70.0	108	104	96.3	116	101	87.1	103	91	88.3
	Sacramento	Sacramento County	0	—	—	0	—	—	0	—	—	0	0	0.0	2	1	50.0
	San Bernardino	Riverside County; San Bernardino County	0	—	—	0	—	—	27	20	74.1	72	47	65.3	53	40	75.5
	San Diego	San Diego County	0	—	—	154	137	89.0	212	183	86.3	182	161	88.5	10	7	70.0
	San Francisco	San Francisco County	27	21	77.8	79	72	91.1	44	36	81.8	43	35	81.4	103	87	84.5
	Santa Ana	Orange County	23	17	73.9	19	12	63.2	32	28	87.5	35	27	77.1	40	36	90.0
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	896	799	89.2
Florida	Fort Lauderdale	Broward County	217	159	73.3	152	112	73.7	416	347	83.4	221	177	80.1	151	118	78.1
	Jacksonville	Duval County	120	92	76.7	273	224	82.1	105	76	72.4	126	97	77.0	125	94	75.2
	Miami	Miami-Dade County	0	—	—	20	16	80.0	19	13	68.4	64	54	84.4	122	104	85.2
	Orlando	Orange County	0	—	—	5	5	100.0	2	1	50.0	2	2	100.0	13	11	84.6
	Tampa	Hillsborough County; Pinellas County	0	—	—	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	25	23	92.0
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	487	354	72.7
Illinois	Chicago	Cook County	32	27	84.4	7	5	71.4	0	—	—	634	569	89.7	702	655	93.3
Indiana	Indianapolis	Marion County	0	—	—	15	14	93.3	85	60	70.6	236	194	82.2	217	189	87.1
Louisiana	Baton Rouge	East Baton Rouge Parish	0	—	—	158	141	89.2	120	106	88.3	179	154	86.0	222	201	90.5
	New Orleans	Orleans Parish	0	—	—	30	25	83.3	77	56	72.7	6	3	50.0	281	229	81.5
Maryland	Baltimore	Baltimore City	7	7	100.0	49	35	71.4	95	76	80.0	176	147	83.5	139	115	82.7
Massachusetts	Boston	Suffolk County	5	5	100.0	0	—	—	7	5	71.4	0	—	—	0	—	—
Michigan	Detroit	Wayne County	187	152	81.3	521	430	82.5	460	337	73.3	316	240	75.9	277	219	79.1
Nevada	Las Vegas	Clark County	0	—	—	32	27	84.4	54	46	85.2	609	512	84.1	93	82	88.2
New Jersey	Jersey City	Hudson County	13	5	38.5	16	13	81.3	28	20	71.4	13	8	61.5	36	32	88.9
	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	2,537	2,292	90.3
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	354	290	81.9
North Carolina	Charlotte	Mecklenburg County	6	5	83.3	27	15	55.6	79	62	78.5	13	11	84.6	77	64	83.1
Ohio	Cleveland	Cuyahoga County	0	—	—	181	146	80.7	141	116	82.3	80	71	88.8	165	145	87.9
	Columbus	Franklin County	405	332	82.0	320	268	83.8	488	432	88.5	587	515	87.7	331	285	86.1
Pennsylvania	Philadelphia	Philadelphia County	1	0	0.0	855	768	89.8	399	330	82.7	741	649	87.6	653	550	84.2
Puerto Rico	San Juan	San Juan Municipio	9	6	66.7	16	9	56.3	26	22	84.6	26	22	84.6	31	21	67.7
Tennessee	Memphis	Shelby County	0	—	—	44	30	68.2	387	285	73.6	422	316	74.9	665	494	74.3
Texas	Austin	Travis County	0	—	—	0	—	—	27	19	70.4	26	21	80.8	51	42	82.4
	Dallas	Dallas County	0	—	—	25	18	72.0	29	19	65.5	99	74	74.7	36	32	88.9
	Fort Worth	Tarrant County	0	—	—	0	—	—	20	13	65.0	26	17	65.4	41	29	70.7
	Houston	Harris County	336	220	65.5	344	232	67.4	441	308	69.8	409	292	71.4	448	348	77.7
	San Antonio	Bexar County	0	—	—	0	—	—	0	—	—	29	20	69.0	58	40	69.0
Washington	Seattle	King County	0	—	—	97	89	91.8	102	94	92.2	76	63	82.9	110	101	91.8

Table 4b. Viral suppression among estimated re-engaged* clients with HIV served by selected EHE-funded providers, by year and jurisdiction, 2020–2024— 47 HRSA HAB EHE-funded jurisdictions *(cont.)*

Part B jurisdictions		2020			2021			2022			2023			2024		
		Total	Viral suppression		Total	Viral suppression		Total	Viral suppression		Total	Viral suppression		Total	Viral suppression	
State	EHE focus county or state	N	N	%	N	N	%	N	N	%	N	N	%	N	N	%
Alabama	State	0	—	—	4	3	75.0	7	6	85.7	7	7	100.0	13	11	84.6
Arkansas	State	0	—	—	24	13	54.2	290	214	73.8	351	299	85.2	349	302	86.5
Kentucky	State	10	8	80.0	3	2	66.7	0	—	—	36	30	83.3	20	18	90.0
Mississippi	State	0	—	—	0	—	—	2	2	100.0	237	207	87.3	166	131	78.9
Missouri	State	0	—	—	17	16	94.1	20	16	80.0	45	36	80.0	20	15	75.0
Ohio	Hamilton County	0	—	—	1	0	0.0	5	4	80.0	14	12	85.7	9	7	77.8
Oklahoma	State	0	—	—	0	—	—	45	41	91.1	36	33	91.7	0	—	—
South Carolina	State	0	—	—	34	26	76.5	48	40	83.3	46	32	69.6	57	50	87.7

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

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

* Clients estimated to be re-engaged in care is calculated among clients served by EHE-funded OAHS, 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.

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. EMA/TGA geographic boundaries are not limited to the listed EHE focus county(ies).

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 2024—United States and 3 territories

	July 2019–June 2020		July 2020–June 2021		July 2021–June 2022		July 2022–June 2023		July 2023–June 2024	
	N	%	N	%	N	%	N	%	N	%
Training content										
Antiretroviral treatment and adherence	7	10.4	210	62.7	174	36.0	325	42.4	357	39.1
Engagement and retention in HIV care	12	17.9	121	36.1	220	45.5	422	55.1	402	44.0
HIV prevention	34	50.7	155	46.3	300	62.1	540	70.5	593	65.0
HIV testing and diagnosis	16	23.9	121	36.1	223	46.2	348	45.4	359	39.3
Linkage/referral to HIV care	16	23.9	156	46.6	204	42.2	333	43.5	327	35.8
Management of comorbid conditions	13	19.4	109	32.5	132	27.3	263	34.3	321	35.2
Rapid ART	—	—	—	—	—	—	44	5.7	67	7.3
Other training content	8	11.9	69	20.6	74	15.3	257	33.6	306	33.5
Training topic										
HIV prevention										
Behavioral prevention	19	28.4	66	19.7	161	33.3	259	33.8	262	28.7
HIV transmission risk assessment	17	25.4	79	23.6	159	32.9	243	31.7	218	23.9
Post-exposure prophylaxis (PEP, occupational and nonoccupational)	8	11.9	36	10.7	52	10.8	131	17.1	190	20.8
Pre-exposure prophylaxis (PrEP)	22	32.8	110	32.8	240	49.7	396	51.7	393	43.0
Prevention of perinatal transmission	2	3.0	25	7.5	41	8.5	95	12.4	107	11.7
Sexual health history taking	—	—	—	—	—	—	115	15.0	129	14.1
Treatment as prevention	7	10.4	85	25.4	131	27.1	180	23.5	177	19.4
Other HIV prevention topics	6	9.0	40	11.9	84	17.4	76	9.9	129	14.1
HIV background and management										
Acute HIV	2	3.0	24	7.2	40	8.3	92	12.0	93	10.2
Adult and adolescent antiretroviral treatment	3	4.5	116	34.6	99	20.5	137	17.9	129	14.1
Aging and HIV	9	13.4	15	4.5	33	6.8	65	8.5	87	9.5
Antiretroviral treatment adherence, including viral suppression	1	1.5	174	51.9	141	29.2	256	33.4	235	25.7
Basic science	5	7.5	30	9.0	54	11.2	109	14.2	108	11.8
Clinical manifestations of HIV disease	0	0.0	15	4.5	42	8.7	87	11.4	106	11.6
HIV diagnosis (i.e., HIV testing)	17	25.4	90	26.9	229	47.4	332	43.3	340	37.2
HIV epidemiology	3	4.5	49	14.6	53	11.0	100	13.1	121	13.3
HIV monitoring and laboratory tests (i.e., CD4 and viral load)	0	0.0	56	16.7	67	13.9	188	24.5	140	15.3
HIV resistance testing and interpretation	0	0.0	24	7.2	29	6.0	23	3.0	26	2.8
Linkage to care	18	26.9	109	32.5	184	38.1	364	47.5	327	35.8
Pediatric HIV management	0	0.0	6	1.8	1	0.2	10	1.3	15	1.6
Retention and/or re-engagement in care	5	7.5	123	36.7	155	32.1	344	44.9	332	36.4
Other HIV background and management topics	3	4.5	12	3.6	10	2.1	50	6.5	34	3.7
Primary care and comorbidities										
Cervical cancer screening, including HPV	0	0.0	4	1.2	26	5.4	10	1.3	6	0.7
Health or wellness maintenance	—	—	—	—	—	—	84	11.0	111	12.2
Hepatitis B	0	0.0	21	6.3	39	8.1	39	5.1	47	5.1
Hepatitis C	9	13.4	40	11.9	54	11.2	77	10.1	73	8.0
Immunization	0	0.0	16	4.8	32	6.6	17	2.2	17	1.9
Influenza	0	0.0	1	0.3	—	—	4	0.5	1	0.1
Malignancies	0	0.0	2	0.6	21	4.3	1	0.1	3	0.3
Medication-assisted therapy for substance use disorders	3	4.5	23	6.9	73	15.1	72	9.4	76	8.3
Mental health disorders	2	3.0	27	8.1	82	17.0	116	15.1	104	11.4
Non-infection comorbidities of HIV or viral hepatitis	4	6.0	14	4.2	39	8.1	31	4.0	20	2.2
Nutrition	0	0.0	4	1.2	2	0.4	6	0.8	5	0.5
Opioid use disorder	3	4.5	15	4.5	38	7.9	34	4.4	55	6.0
Opportunistic infections	1	1.5	24	7.2	38	7.9	36	4.7	37	4.1
Oral health	0	0.0	5	1.5	37	7.7	23	3.0	17	1.9
Osteoporosis	4	6.0	6	1.8	16	3.3	22	2.9	4	0.4
Pain management	0	0.0	3	0.9	5	1.0	4	0.5	2	0.2
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	78	8.5
Primary care screenings	0	0.0	43	12.8	107	22.2	170	22.2	115	12.6
Sexually transmitted infections	7	10.4	46	13.7	111	23.0	183	23.9	189	20.7
Substance use disorders, not including opioid use	2	3.0	28	8.4	62	12.8	94	12.3	123	13.5
Tobacco cessation	0	0.0	—	—	2	0.4	3	0.4	2	0.2
Tuberculosis	0	0.0	1	0.3	2	0.4	1	0.1	4	0.4
Other primary care and morbidities topics	6	9.0	37	11.0	28	5.8	39	5.1	28	3.1
Care of people with HIV										
Health literacy	10	14.9	88	26.3	112	23.2	112	14.6	186	20.4
Stigma	18	26.9	140	41.8	224	46.4	239	31.2	362	39.6
Stress management	—	—	—	—	—	—	26	3.4	49	5.4
Other care of people with HIV topics	2	3.0	6	1.8	3	0.6	35	4.6	61	6.7

Table 5. EHE–funded RWHAP AIDS Education and Training Center (AETC) Program training events by year and training topic, July 2019–June 2024—United States and 3 territories *(cont.)*

	July 2019–June 2020		July 2020–June 2021		July 2021–June 2022		July 2022–June 2023		July 2023–June 2024	
	N	%	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	—	—	—	—
Care coordination	8	11.9	89	26.6	171	35.4	148	19.3	244	26.7
Case management	4	6.0	26	7.8	73	15.1	172	22.5	174	19.1
Community linkages	17	25.4	80	23.9	135	28.0	264	34.5	297	32.5
Confidentiality/HIPAA	1	1.5	17	5.1	10	2.1	19	2.5	23	2.5
Funding or resource allocation	1	1.5	7	2.1	20	4.1	68	8.9	39	4.3
Health care coverage	2	3.0	18	5.4	30	6.2	42	5.5	26	2.8
Legal issues	—	—	10	3.0	46	9.5	58	7.6	56	6.1
Motivational interviewing	5	7.5	64	19.1	110	22.8	28	3.7	48	5.3
Organizational infrastructure	5	7.5	9	2.7	73	15.1	61	8.0	71	7.8
Organizational needs assessment	9	13.4	6	1.8	52	10.8	45	5.9	56	6.1
Patient-centered care	—	—	92	27.5	175	36.2	190	24.8	295	32.3
Patient-centered medical home	0	0.0	23	6.9	48	9.9	46	6.0	50	5.5
Practice transformation	1	1.5	11	3.3	18	3.7	12	1.6	11	1.2
Quality improvement	12	17.9	32	9.6	76	15.7	89	11.6	60	6.6
Team-based care	8	11.9	7	2.1	59	12.2	75	9.8	73	8.0
Telehealth	2	3.0	10	3.0	42	8.7	43	5.6	11	1.2
Use of technology for patient care	2	3.0	5	1.5	15	3.1	36	4.7	37	4.1
Other health care organization or systems issues topics	—	—	—	—	—	—	54	7.0	58	6.4
People affected by HIV										
Children (Ages 0–12)	1	1.5	6	1.8	2	0.4	36	4.7	66	7.2
Adolescents (Ages 13–17)	1	1.5	40	11.9	60	12.4	90	11.7	95	10.4
Young adults (Ages 18–24)	16	23.9	206	61.5	209	43.3	225	29.4	207	22.7
Older adults (Ages 50 and over)	23	34.3	116	34.6	123	25.5	179	23.4	209	22.9
American Indian or Alaska Native	1	1.5	32	9.6	28	5.8	24	3.1	28	3.1
Asian	1	1.5	28	8.4	29	6.0	37	4.8	31	3.4
Black or African American	22	32.8	242	72.2	241	49.9	320	41.8	288	31.5
Hispanic or Latino	6	9.0	174	51.9	144	29.8	204	26.6	198	21.7
Native Hawaiian or Pacific Islander	1	1.5	24	7.2	28	5.8	23	3.0	29	3.2
Other race/ethnicity	0	0.0	0	0.0	1	0.2	2	0.3	1	0.1
Women	16	23.9	222	66.3	207	42.9	256	33.4	258	28.3
People experiencing unstable housing	10	14.9	195	58.2	124	25.7	101	13.2	124	13.6
People who inject drugs	—	—	—	—	—	—	96	12.5	130	14.2
People with legal system involvement	3	4.5	123	36.7	68	14.1	70	9.1	97	10.6
Rural populations	8	11.9	140	41.8	147	30.4	55	7.2	47	5.1
Veterans	—	—	—	—	—	—	3	0.4	11	1.2
Other populations	—	—	—	—	333	69.0	459	59.9	562	4.6
Number of training events held during the year	**67**	**—**	**335**	**—**	**483**	**—**	**766**	**—**	**913**	**—**

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

Note: Participants selected all that apply for the training content and each training topic. The number of training events held during the year is based on training events with information reported for participants and training topics, and it serves as the denominator for percentage calculations. Beginning in the July 2022–June 2023 reporting period, some event topics were collapsed, resulting in variable event counts.

Table 6. EHE–funded RWHAP AIDS Education and Training Center (AETC) Program participants by year and selected characteristics, July 2019–June 2024—United States and 3 territories

	July 2019–June 2020		July 2020–June 2021		July 2021–June 2022		July 2022–June 2023		July 2023–June 2024	
	N	%	N	%	N	%	N	%	N	%
Race/ethnicity										
American Indian/Alaska Native	2	0.3	23	0.8	23	0.5	25	0.3	52	0.5
Asian	27	4.1	161	5.3	239	5.4	372	5.0	555	5.4
Black/African American	236	36.0	999	32.9	1,481	33.7	2,183	29.2	3,102	30.2
Hispanic/Latino[a]	86	13.1	329	10.8	699	15.9	1,895	25.3	2,348	22.8
Native Hawaiian/Pacific Islander	2	0.3	18	0.6	8	0.2	19	0.3	18	0.2
White	271	41.4	1,393	45.9	1,752	39.9	2,756	36.9	3,859	37.5
Multiple races	31	4.7	115	3.8	192	4.4	190	2.5	294	2.9
Other	—	—	—	—	—	—	36	0.5	49	0.5
Subtotal	**655**	**—**	**3,038**	**—**	**4,394**	**—**	**7,476**	**—**	**10,277**	**—**
Professional discipline										
Clergy/faith-based professional	0	0.0	2	0.1	5	0.1	14	0.2	25	0.2
Community health worker	97	14.6	297	9.3	557	12.3	896	11.4	1,268	11.7
Dentist	2	0.3	187	5.8	36	0.8	253	3.2	316	2.9
Dietitian/nutritionist	3	0.5	17	0.5	9	0.2	16	0.2	33	0.3
Mental/behavioral health professional	33	5.0	107	3.3	156	3.4	257	3.3	249	2.3
Midwife	1	0.2	6	0.2	18	0.4	11	0.1	21	0.2
Nurse practitioner/nurse professional (prescriber)	30	4.5	189	5.9	296	6.5	464	5.9	689	6.4
Nurse professional (non-prescriber)	84	12.6	446	13.9	469	10.3	1,082	13.8	1,596	14.7
Pharmacist	18	2.7	185	5.8	277	6.1	350	4.5	473	4.4
Physician	33	5.0	174	5.4	402	8.9	645	8.2	860	7.9
Physician assistant	3	0.5	24	0.7	47	1.0	95	1.2	108	1.0
Practice administrator or leader	16	2.4	41	1.3	104	2.3	174	2.2	243	2.2
Social worker	155	23.3	560	17.5	882	19.4	1,528	19.4	2,001	18.4
Substance abuse professional	16	2.4	74	2.3	101	2.2	109	1.4	167	1.5
Other allied health professional	18	2.7	80	2.5	99	2.2	157	2.0	224	2.1
Other clinical professional	—	—	—	—	—	—	161	2.0	76	0.7
Other dental professional	0	0.0	69	2.2	23	0.5	99	1.3	114	1.1
Other non-clinical professional	80	12.0	289	9.0	403	8.9	678	8.6	937	8.6
Other public health professional	123	18.5	454	14.2	843	18.6	1,207	15.4	1,777	16.4
Number of participants	**666**	**—**	**3,201**	**—**	**4,538**	**—**	**7,861**	**—**	**10,847**	**—**
Role in their organization										
Administrator	98	14.7	330	10.3	597	13.3	870	11.2	1,121	10.3
Agency board member	1	0.2	5	0.2	7	0.2	11	0.1	15	0.1
Care provider/clinician—can or does prescribe HIV treatment	60	9.0	260	8.1	501	11.2	687	8.8	979	9.0
Care provider/clinician—cannot or does not prescribe HIV treatment	62	9.3	416	13.0	563	12.6	985	12.6	1,355	12.5
Case manager	146	21.9	507	15.9	783	17.5	1,508	19.4	2,042	18.8
City, local, state government employee	—	—	—	—	—	—	40	0.5	946	8.7
Client/patient educator (includes navigator)	64	9.6	229	7.2	414	9.2	579	7.4	802	7.4
Clinical/medical assistant	20	3.0	78	2.4	112	2.5	233	3.0	334	3.1
Federal government employee	—	—	—	—	—	—	1,167	15.0	64	0.6
Health care organization non-clinical staff	56	8.4	128	4.0	183	4.1	309	4.0	405	3.7
HIV tester	43	6.5	141	4.4	268	6.0	387	5.0	568	5.2
Intern/resident	2	0.3	153	4.8	102	2.3	108	1.4	107	1.0
Researcher/evaluator	18	2.7	76	2.4	140	3.1	189	2.4	363	3.3
Student/graduate student	18	2.7	233	7.3	110	2.5	501	6.4	528	4.9
Teacher/faculty	31	4.7	85	2.7	143	3.2	158	2.0	240	2.2
Other	106	15.9	551	17.3	817	18.2	497	6.4	1,505	13.9
Number of participants	**666**	**—**	**3,192**	**—**	**4,478**	**—**	**7,790**	**—**	**10,840**	**—**
Total number of participants	**669**	**—**	**3,286**	**—**	**4,646**	**—**	**8,321**	**—**	**11,318**	**—**

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

Note: Participants reporting for July 2019–June 2020 selected all professional disciplines and roles that apply. Since July 2020–June 2021, participants 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 AIDS Education and Training Center (AETC) Program participants by year, selected service delivery characteristics, and employment setting, July 2019–June 2024—United States and 3 territories

	July 2019–June 2020		July 2020–June 2021		July 2021–June 2022		July 2022–June 2023		July 2023–June 2024	
	N	%	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	2,215	24.8
2–4	158	20.3	519	22.3	879	21.2	1,415	22.5	1,912	21.4
5–9	163	20.9	387	16.6	664	16.0	1,179	18.7	1,801	20.1
10–19	188	24.1	391	16.8	761	18.4	1,130	17.9	1,718	19.2
≥20	136	17.4	369	15.8	598	14.4	923	14.7	1,296	14.5
Subtotal	**780**	**100.0**	**2,331**	**100.0**	**4,143**	**100.0**	**6,296**	**100.0**	**8,942**	**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	522	6.2
1–9 per year	107	15.2	428	19.2	602	14.6	1,049	17.7	1,211	14.3
10–19 per year	63	8.9	142	6.4	268	6.5	448	7.6	699	8.3
20–49 per year	134	19.0	277	12.4	674	16.3	913	15.4	1,164	13.8
≥50 per year	399	56.6	1,078	48.3	2,016	48.8	3,225	54.5	4,859	57.5
Subtotal	**705**	**100.0**	**2,230**	**100.0**	**4,128**	**100.0**	**5,922**	**100.0**	**8,455**	**100.0**
Employment setting										
Academic health center	35	5.4	364	11.7	418	9.1	661	8.5	855	8.1
Correctional facility	4	0.6	26	0.8	36	0.8	281	3.6	96	0.9
Dental health facility	—	—	—	—	—	—	214	2.7	169	1.6
Emergency department	2	0.3	11	0.4	13	0.3	58	0.7	58	0.5
Federally Qualified Health Center	92	14.1	412	13.3	647	14.1	1,082	13.9	1,377	13.0
HIV or infectious diseases clinic	114	17.4	452	14.6	864	18.8	1,438	18.4	2,175	20.6
HMO/managed care organization	10	1.5	26	0.8	43	0.9	178	2.3	242	2.3
Hospital-based clinic	43	6.6	139	4.5	260	5.7	422	5.4	444	4.2
Indian Health Service/Tribal clinic	1	0.2	14	0.5	9	0.2	11	0.1	25	0.2
Long-term nursing facility	2	0.3	7	0.2	15	0.3	25	0.3	20	0.2
Maternal/child health clinic	2	0.3	7	0.2	20	0.4	37	0.5	38	0.4
Mental health clinic	6	0.9	37	1.2	63	1.4	72	0.9	98	0.9
Military or veteran's health facility	2	0.3	2	0.1	7	0.2	20	0.3	29	0.3
Pharmacy	11	1.7	106	3.4	142	3.1	164	2.1	170	1.6
Private practice	11	1.7	43	1.4	62	1.4	105	1.3	147	1.4
State or local health department	100	15.3	425	13.7	788	17.2	1,094	14.0	1,756	16.6
STD clinic	15	2.3	57	1.8	137	3.0	251	3.2	374	3.5
Student health clinic	7	1.1	53	1.7	22	0.5	107	1.4	55	0.5
Substance abuse treatment center	17	2.6	73	2.4	107	2.3	121	1.6	173	1.6
Other community-based organization	141	21.6	466	15.0	682	14.9	1,080	13.8	1,649	15.6
Other federal health facility	9	1.4	26	0.8	59	1.3	61	0.8	81	0.8
Other primary care setting	24	3.7	95	3.1	139	3.0	97	1.2	370	3.5
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	401	3.8
Not working	48	7.3	126	4.1	82	1.8	288	3.7	189	1.8
Number of participants	**654**	**100.0**	**3,106**	**100.0**	**4,591**	**100.0**	**7,806**	**100.0**	**10,567**	**100.0**
Rural and suburban/urban employment settings										
Rural settings only	21	3.7	449	14.5	392	9.1	483	7.0	863	8.3
Both rural and suburban/urban settings[a]	14	2.4	62	2.0	77	1.8	78	1.1	138	1.3
Suburban/urban settings only	537	93.9	2,584	83.5	3,857	89.2	6,311	91.8	9,372	90.3
Total	**572**	**100.0**	**3,095**	**100.0**	**4,326**	**100.0**	**6,872**	**100.0**	**10,373**	**100.0**
Total number of participants	**669**	**—**	**3,286**	**—**	**4,646**	**—**	**8,321**	**—**	**11,318**	**—**

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

Note: Participants reporting for July 2019–June 2020 selected all professional disciplines and roles that apply. Since July 2020–June 2021, participants 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] Participants who reported more than one employment setting and reported both rural and suburban/urban settings.