HRSA HIV/AIDS Bureau

Ryan White HIV/AIDS Program
Ending the HIV Epidemic in the U.S. Initiative

Data Report

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HRSA
Ryan White HIV/AIDS Program

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Data presented in this report represent data submitted via the RWHAP Services Report (RSR), the RWHAP Part F AIDS Education and Training Center (AETC) Data System, and the EHE jurisdictional and AETC progress reports. This report includes data for July 2019 through December 2022.

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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

Educational and technical assistance materials about HIV, the EHE Technical Assistance Provider-innovation network, EHE Systems Coordination Provider, and the Ryan White HIV/AIDS Program: TargetHIV.org

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CONTENTS

COMMENTARY

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

The Ryan White HIV/AIDS Program (RWHAP) supports health care and support services for more than half a million people with HIV—representing more than half of all people with diagnosed HIV in the United States [1]. The RWHAP provides funds to and coordinates with cities, counties, states, and local community-based organizations to deliver efficient and effective HIV care, treatment, and support services for people with HIV who have lower incomes. People with HIV who take HIV medication as prescribed and reach and maintain viral suppression cannot sexually transmit the virus to their partner (also known as "U=U" for "Undetectable = Untransmittable") and can live longer and healthier lives. RWHAP services are crucial for attaining optimal HIV health outcomes among people with HIV, preventing further transmission of the virus, and—ultimately—ending the HIV epidemic in the U.S. [1].

The *Ending the HIV Epidemic in the U.S.* (EHE) initiative, which began in fiscal year (FY) 2020, aims to reduce new HIV infections to less than 3,000 per year [2]. The EHE initiative provides the additional expertise, technology, and resources needed to end the HIV epidemic in the United States, with a focus on geographic areas where HIV transmission occurs most frequently. This initiative will reduce new infections, save lives, and reduce costs for HIV prevention, care, and medication in these geographic focus areas, while also driving progress nationwide. The four pillars of the EHE initiative—Diagnose, Treat, Prevent, and Respond—are being implemented by the Centers for Disease Control and Prevention, the Health Resources and Services Administration (HRSA)'s Bureau of Primary Health Care and HIV/AIDS Bureau (HAB), the Indian Health Service, and the National Institutes of Health, in partnership with the U.S. Department of Housing and Urban Development. HRSA HAB's EHE funding was awarded to implement the Treat and Respond pillars of the EHE initiative within the context of the RWHAP.

For HRSA HAB, the EHE initiative expands the RWHAP's comprehensive system of care to focus on reaching many of the more than 150,000 people with HIV who are unaware of their status and the more than 200,000 people with HIV who are not receiving regular care in the United States or U.S. territories, of whom approximately 50% reside in EHE jurisdictions [3]. HAB EHE recipients are leveraging their existing RWHAP infrastructure with additional flexibilities to implement proven and promising strategies and services. HRSA awarded approximately $115 million in total to 60 HRSA HAB EHE recipients in FY 2022 (refer to the Appendix for more details). These funds were awarded to the following:

- The 39 RWHAP Part A recipients and eight Part B recipients that encompass the EHE jurisdictions. The 47 EHE jurisdictions represent 48 counties, Washington, D.C., and San Juan, Puerto Rico, as well as seven states that have a substantial rural HIV burden. In 2022, EHE-funded providers from these jurisdictions served 22,001 clients new to care, which is nearly double the new clients served in 2020, and 19,204 clients estimated to be re-engaged in care.
- Three national centers and eight regional AIDS Education and Training Centers (AETCs) of the RWHAP Part F AETC Program to train and expand the capacity of the HIV health care workforce in EHE jurisdictions. The regional AETCs conducted a total of 483 EHE-funded training events in the July 2021 through June 2022 reporting period, a sevenfold increase compared to July 2019 through June 2020.

- One technical assistance provider and one systems coordination provider, both of which support the 47 EHE jurisdictions funded by HRSA HAB to strengthen their EHE work plans, promote coordination of planning activities, and ensure jurisdictions have access to the expertise and capacity-building resources they need.

Together, these jurisdictional, workforce capacity, and technical assistance EHE activities link and engage people with HIV in care so that they can reach optimal HIV outcomes, which significantly reduces new HIV infections and improves the health of people with HIV in the United States.

Recipient Reporting Overview

This report is the publication of qualitative and quantitative data about clients served by the EHE jurisdictional recipients and EHE-funded training events delivered by regional AETC Program recipients, as explained in **Figure 1**.

Figure 1
HAB-Awarded EHE Initiative Funding

	EHE JURISDICTIONAL RECIPIENTS		AIDS EDUCATION AND TRAINING CENTER (AETC) PROGRAM RECIPIENTS	
Recipients	39 RWHAP Part A[a] recipients and 8 RWHAP Part B[b] recipients		8 Regional AETCs[c]	
Purpose	Direct provision of services to people with HIV in EHE jurisdictions		Training health care providers in EHE jurisdictions to care for people with HIV	
Data Source	Progress Reports	RWHAP Services Report	Progress Reports	AETC Data System
Data Type	Qualitative	Quantitative	Qualitative	Quantitative
Data Submission Frequency	Two to three times per project year	Once per calendar year	Three times per project year	Once per project year
Reporting Periods Included	March 2020–February 2023	January 2020–December 2022	July 2019–June 2022	July 2019–June 2022
Information Presented	Narrative descriptions of services planned, rendered, and successes/challenges faced by EHE-funded jurisdictions in the reporting period	Characteristics and clinical outcomes of clients served by EHE-funded providers	Narrative descriptions of EHE-funded trainings and successes/challenges faced by AETC recipients	Characteristics of EHE-funded trainings and participants
Location of Information in this Report	Pages 3–11; Tables 1–4		Page 11–15; 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 7 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** (3 awards in FY 2020, 4 awards in FY 2021, 3 awards in FY 2022), which do not report quantitative data through the AETC Data System. See the Appendix for additional information about these recipients.

Readers are encouraged to carefully read the technical notes for each section, all figure and table titles, and all footnotes to ensure a complete understanding of the data.

EHE Jurisdictional Progress Reports

Over the first three years of the EHE initiative, EHE jurisdictional recipients reported significant progress toward ending the HIV epidemic using EHE funding. Many recipients reported using EHE funding to provide comprehensive services for high-need individuals and people facing barriers to accessing in-person care through evidence-informed interventions and activities. Furthermore, EHE funding was used to link, engage, and re-engage people with HIV into RWHAP-funded care prior to completion of eligibility determination [4], facilitating rapid initiation of care. EHE funding enabled providers to deliver HIV care services immediately with the knowledge that they would be guaranteed reimbursement for services in the event a client was later not found to meet RWHAP eligibility requirements. Many recipients also made efforts to hire staff with lived experience and medical providers who reflected client demographics—the impact of these and other workforce activities are woven throughout the following descriptions. These important activities increased the reach of care and support services to link and retain more people with HIV in care.

The funding flexibility to expand RWHAP services and provide other services not included in the RWHAP statute enabled recipients to deploy a tailored, local approach to meeting the distinctive needs of people with HIV in their jurisdictions. EHE funding expanded comprehensive services provided by the RWHAP through key flexibilities, such as additional support for traditionally underfunded staff positions (e.g., community health workers), getting clients into care more quickly by allowing providers to deliver care prior to determining clients' RWHAP eligibility, and implementing interventions and services that do not fall within existing RWHAP service categories.

Below is a summary of the most funded activities in Year 3 of the EHE initiative and associated recipient quotations demonstrating the impact of EHE funding on new and out-of-care clients with HIV. Additional information about infrastructure, new partnerships, and community engagement, among other systems-level EHE activities, is available in the previously published *HRSA HIV/AIDS Bureau Ending the HIV Epidemic (EHE) Initiative Qualitative Summary of Progress: March 2021–February 2022* [5].

Expanded Access Activities

EHE recipients increased service delivery by expanding the hours and days that services were provided (e.g., increased hours in mornings, evenings, and weekends), in addition to expanding walk-in services. Additional service expansion activities included delivering interpretation and linguistic services, providing 24-hour crisis counselors, supplying clients with phones to help them engage in telemedicine and other forms of care, and assisting with medical transportation.

> *Extended Operating Hours allow subrecipients to engage clients in care outside of traditional business hours. All of our agencies offer extended hours to provide care to clients at their convenience. EHE funds allow agencies to provide services in the early morning (before 8 a.m.) or evening (until at least 8 p.m.) at least two days per week and to provide services at least one half-day every other weekend. A total of 646 clients were served during extended operating hours.*

EHE recipients also removed barriers and expanded access to care outside of "brick and mortar" locations through the use of mobile medical units, home visits, and telehealth appointments. Services

were also co-located or tailored to enhance access for people who use substances, people with legal system involvement, and people experiencing unstable housing.

One recipient described expanded access activities to remove barriers to care for people experiencing transportation challenges or housing instability:

> *[We] provided mobile service care to clients experiencing extreme challenges involving transportation and/or homelessness to ensure linkage to care. [We] also provided medical transportation assistance in the form of Lyft to allow clients the opportunity to attend intake. Telehealth via phone calls was available to clients. Added computer stations are available to clients for telehealth services.*

One recipient described how EHE funding gave their organization the flexibility to remove barriers to care and address social determinants of health to support people with HIV:

> *This funding is extremely unique as its focus is on virally non-suppressed patients who are experiencing challenges and barriers to care. This program exists to provide an unapologetically enabling approach to care—we are there to help remove any barrier in their way.*

Linkage, Retention, and Re-engagement Activities

EHE efforts were particularly focused on linking to care those who were newly diagnosed and out of care, and to supporting those who faced barriers to staying in care. The information below spotlights recipients' efforts to increase linkage, retention, and re-engagement of people with HIV into care and includes descriptions of activities that expanded service delivery and access to care.

Client Navigation Support and HIV Workforce Expansion

EHE recipients used funding to hire and support a variety of staff specialist positions to assist with linking and retaining people with HIV into care. Many of these staff specialist positions included staff with lived experience or who represented the communities served by the EHE recipients. One recipient described the impact of these specialty positions—such as navigators, community health workers, mental health workers, and linkage-to-care specialists—in facilitating rapid linkage to care in their clinic:

> *We have a dedicated Health Navigator/Community Health Worker, a registered nurse, Mental Health/Social Worker case managers, and a Linkage-to-Care Coordinator (LTC) assisting in linking anyone seeking to establish care in the clinic. They are able [to] successfully refer clients to services, initiate the enrollment process, schedule appointment[s] for an initial visit with a medical provider, and coordinate transportation. Furthermore, the RN [registered nurse] Case Manager is able to place an order on behalf of the medical provider to obtain the initial HIV labs and request medical records prior to clients coming in for their initial visit. As a result [of] … having the staff onsite, we have been able to quickly link patients to care usually within the same week as long as we have a provider in clinic.*

Another recipient described the outcomes of using EHE funding to support staff positions that provide linkage to care services:

> *Data and Linkage to Care (DLTC) personnel are funded through EHE for aiding any person living with HIV in [our area with] accessing care and supportive services … Community Health Workers-Case Manager Supervisor [CHW-CMS] roles were implemented through EHE for expansion of HIV workforce within the state to assist with non-medical case management services. CHW-CMSs are not supported through the [redacted] Ryan White Part B and [AIDS Drug Assistance Program].*

EHE funding also supported the expansion of the local workforce and provided professional development opportunities for people with HIV. Many recipients described training and certifying community members with lived experience to serve their clients as community health workers:

> *The Community Health Worker (CHW) Training Program promotes linkage, engagement, and retention in care by training community members living with HIV as certified CHWs and integrating these CHW graduates into the state certification program. The goal is to expand local HIV workforce for [people with HIV].*

Rapid ART

Linkage to care activities also included starting antiretroviral therapy (ART) immediately (known as Rapid ART or Rapid START), hospital linkage programs, and partnering to accept referrals from other organizations. The goal of Rapid ART/Rapid START programs is to ensure that a newly diagnosed client is scheduled for a medical appointment right away and that they leave their first medical appointment with (or obtain within one week) a filled ART prescription. One recipient described the effects EHE funding flexibility had on improving Rapid ART implementation:

> *EHE funding allows newly diagnosed individuals to be seen very quickly after diagnosis, without ... the eligibility assessment required by the RWHAP. Rapid Start clients are already on ART by the time they see an HIV care provider, which can be up to 30 days later.*

Support Cluster Detection and Response

HIV cluster detection and response efforts use public health data to respond quickly to potential HIV outbreaks to get needed HIV prevention and treatment services to the people who need them. EHE recipients established better coordination with HIV cluster detection and response teams to link new clients to care and support services. One recipient reported using EHE funding to provide housing and food assistance, as a part of cluster response activities, to make it easier for people with newly diagnosed HIV to begin and be retained in care:

> *Two EHE components that have been particularly helpful in linking newly diagnosed HIV clients to care during these cluster events is housing and food assistance. These [RWHAP] EHE supportive services have served as key motivators to link newly diagnosed persons with HIV to care.*

EHE recipients supported online referrals and embraced status-neutral (i.e., equal access for people with HIV and without HIV) and whole-person approaches to facilitate care. One recipient reported developing processes for virtual intakes and newly developed status-neutral forms:

> *In the previous reporting period, the EHE team developed a linkage-to-care process and secure online referral form for people newly diagnosed with HIV. Following the [redacted]'s decision to 'status neutralize' our Plan to End HIV, the team decided to create a status neutral linkage-to-care form [in] our main HIV prevention/care print collateral.*

Data Sharing Agreements

Many recipients enhanced data to care efforts by establishing data sharing agreements and routinely reviewing data to identify clients who were out of care. One recipient stated:

> *[Our program] continues coordinating efforts across funded programs, including data sharing and analyses between Ryan White, [EHE], and HIV Surveillance programming. Similar to last reporting period, during this reporting period HIV Surveillance staff examined state [redacted] data, looking at numbers of HIV+ [county] residents who are out of care; time frames for linkage to care; and viral suppression rates among those newly diagnosed and non-newly diagnosed with HIV. Moving forward, we will meet regularly to compare data, looking at overall outcomes versus Ryan White–specific outcomes, and identify where we can improve services and target outreach and prevention efforts.*

Recipients also worked toward plans to automate data exchanges:

> *A meeting was held statewide in February 2023 to finalize plans between [our organization and the local health department] on next steps and a timeline for 'going live' with automated data exchange … We are currently working with our information and technology team locally and with the [health department's] team to identify programming needs for the various data collection systems involved.*

Overall Impact of EHE Funding

These final selected quotations describe the overarching outcomes of using EHE funding to support jurisdictional-specific approaches to EHE implementation, whether new or expanded, and how these activities increased linkage, retention, and engagement in care:

> *EHE funding delivers in both ways. The funding allows us the ability to create new activities while expanding on some of the core activities that are already funded by RWHAP. The EHE program allows for more people to access services by eliminating income caps and providing greater access to [Affordable Care Act] insurance, Medical Case Management, [Early Intervention Services], and Mental Health which covers more medical care. We also have sites' medical providers that can see patients for medical care that do not qualify for RWHAP due to income requirements.*

Overall, EHE funding was used to fill in gaps in care for people with HIV. One recipient stated:

> *A common component among implemented services is the ability for EHE activities to bridge services between Ryan White, private insurance, and Medicaid ... As the health care landscape continues to change … a lesson learned has been to be flexible with the activities to fill the gaps in care.*

EHE funding supported people with HIV beyond the reach of the RWHAP system of care, often through nontraditional means.

> *[Our organization] has been able to expand their service area to reach clients who were not being served due to geographical constraints … Through the EHE program, [our organization] conducted an in-service presentation for [redacted] case managers … and other local senior centers to continue to outreach beyond the Ryan White network of providers and to continue to focus on elder people living with HIV.*

Context: COVID-19 Impact on Service Delivery

It is important to acknowledge contextual factors that influenced EHE implementation, particularly toward the onset of the initiative. EHE initiative funding was awarded in March 2020, when the COVID-19 emergency measures began to be enacted in the United States. The COVID-19 pandemic caused delays in EHE-funded service delivery implementation. Jurisdictions often had to prioritize the emergency contracts of the COVID-19 response and faced staffing challenges. Staff in many jurisdictions were temporarily reassigned to support COVID-19 response efforts; hiring freezes implemented in many jurisdictions meant additional staff could not be hired to handle the expansion of work. As a result, some EHE-funded recipients reported in 2020 that they either did not deliver services or faced delays in service delivery; some jurisdictions did not serve clients or served only low numbers of clients. These challenges ended by 2022, and all EHE-funded recipients delivered services to clients in 2022.

RWHAP Services Report

The RWHAP Services Report (RSR) contains client-level data on demographic characteristics of and services delivered. This section focuses on the clients with HIV who were served by EHE-funded providers during calendar years 2020, 2021, and 2022, and features information about the following:

- Clients new to care served by EHE-funded providers (“a” tables)
- Clients estimated to be re-engaged[1] in care served by EHE-funded outpatient ambulatory health services, medical case management, non-medical case management, and EHE initiative services providers (“b” tables”).

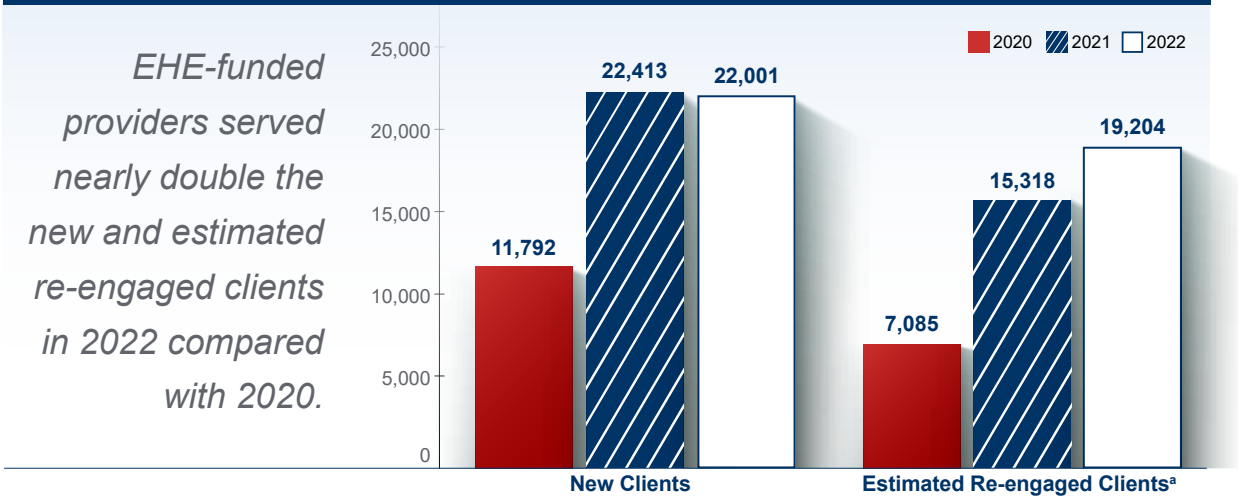
The information presented in the tables includes the number of clients served and their demographic characteristics; socioeconomic factors, such as federal poverty level (FPL), health care coverage, and housing status; and clinical outcomes (i.e., viral suppression). Collectively, this information measures progress toward achieving the goals of the EHE initiative.

[1] 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.

Clients Served by EHE-Funded Providers

In 2022, EHE-funded providers served 22,001 clients new to care and 19,204 clients estimated to be re-engaged in care. This is nearly double the new clients served in 2020, when EHE-funded providers served 11,792 clients new to care and 7,085 clients estimated to be re-engaged in care (**Figure 2; Tables 1a and 1b**).

Figure 2
New and estimated re-engaged[a] clients with HIV served by EHE-funded providers, by year, 2020–2022—47 HRSA HAB EHE-funded jurisdictions.



[a] *Estimated re-engaged clients are only among EHE-funded outpatient ambulatory health services, medical case management, non-medical case management, and EHE initiative service category providers.*

Source: 2022 HRSA HAB EHE Report (Tables 1a and 1b).

Characteristics of Clients Served by EHE-Funded Providers

EHE-funded providers used EHE funding to reach priority populations in their communities. For example, a higher proportion of their new and estimated re-engaged clients were younger, transgender, and people from racial and ethnic minority groups when compared to all clients served by the RWHAP (see **Figure 3**).

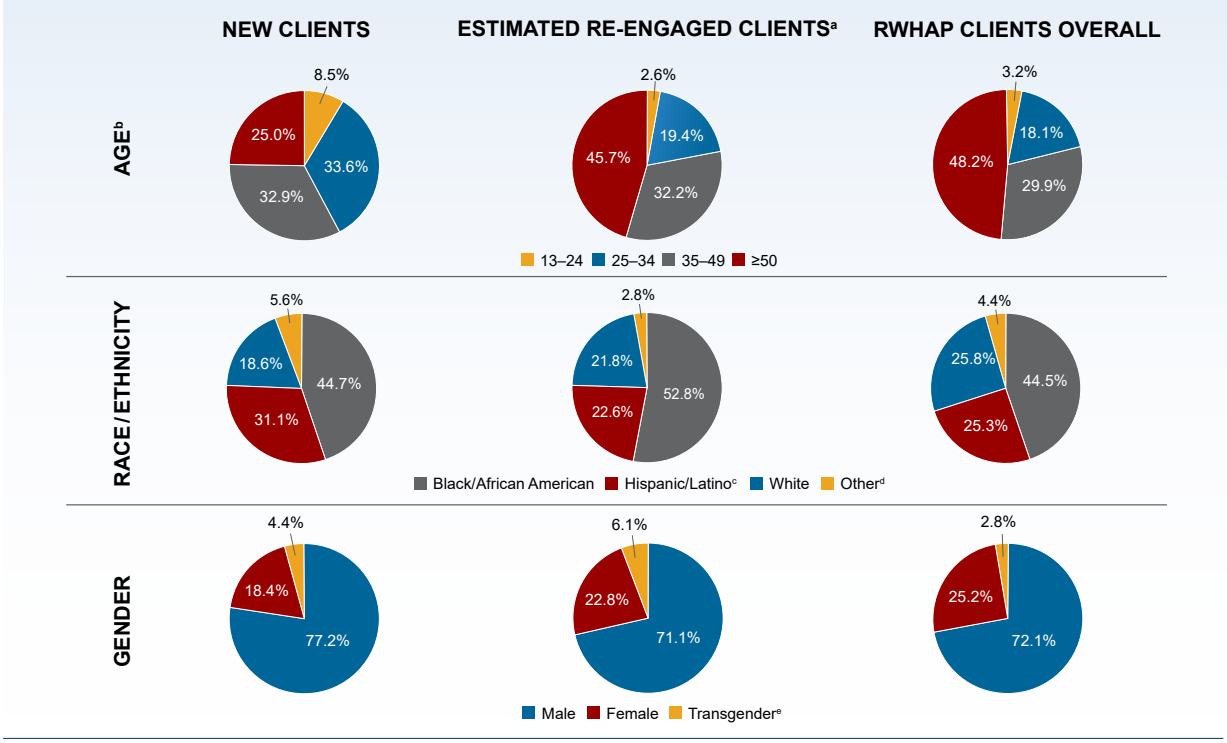
Among clients new to care at EHE-funded providers, 8.5% were aged 13–24 and 33.6% were aged 25–34, higher than the percent of clients in these age groups among all clients served by the RWHAP (3.2% aged 13–24 and 18.1% aged 25–34). Conversely, 25.0% of clients new to care at EHE-funded providers were aged 50 years or older, compared with 48.2% of all clients served by the RWHAP (**Figure 3; Tables 1a and 1b**).

EHE-funded providers had a higher percentage of new clients who were Hispanic/Latino (31.1%) and estimated re-engaged clients who were Black/African American (52.8%) compared to the overall RWHAP client population (Hispanic/Latino: 25.3%; Black/African American: 44.5%; **Figure 3; Tables 1a and 1b**).

Among clients served by EHE-funded providers, 4.4% of new clients and 6.1% of estimated re-engaged clients identified as transgender (new clients: 0.4% transgender male, 3.6% transgender female, 0.3% other gender identity; estimated re-engaged clients: 0.3% transgender male, 5.1% transgender female, 0.6% other gender identity), compared with 2.8% of the overall RWHAP client population (0.3% transgender male, 2.3% transgender female, 0.2% other gender identity; **Figure 3; Tables 1a and 1b**).

Figure 3

New and estimated re-engaged[a] clients with HIV served by EHE-funded providers, by age, race/ethnicity, and gender, 2022—47 HRSA HAB EHE-funded jurisdictions.



[a] *Estimated re-engaged clients are only among EHE-funded outpatient ambulatory health services, medical case management, non-medical case management, and EHE initiative service category providers.*

[b] *Figures do not include clients younger than age 13, as they are less than 1 percent in each category (new clients 0.1%, estimated re-engaged clients 0.1%, and RWHAP overall 0.5%).*

[c] *Hispanics/Latinos can be of any race.*

[d] *"Other" includes American Indian/Alaska Native, Asian, Native Hawaiian/Pacific Islander, and multiple races.*

[e] *Transgender clients include clients who identify as transgender male, transgender female, or other gender identity.*

Source: 2022 HRSA HAB EHE Report (Tables 1a and 1b) for new and estimated re-engaged client data; 2022 RWHAP Annual Data Report (Table 1a) for RWHAP overall client data.

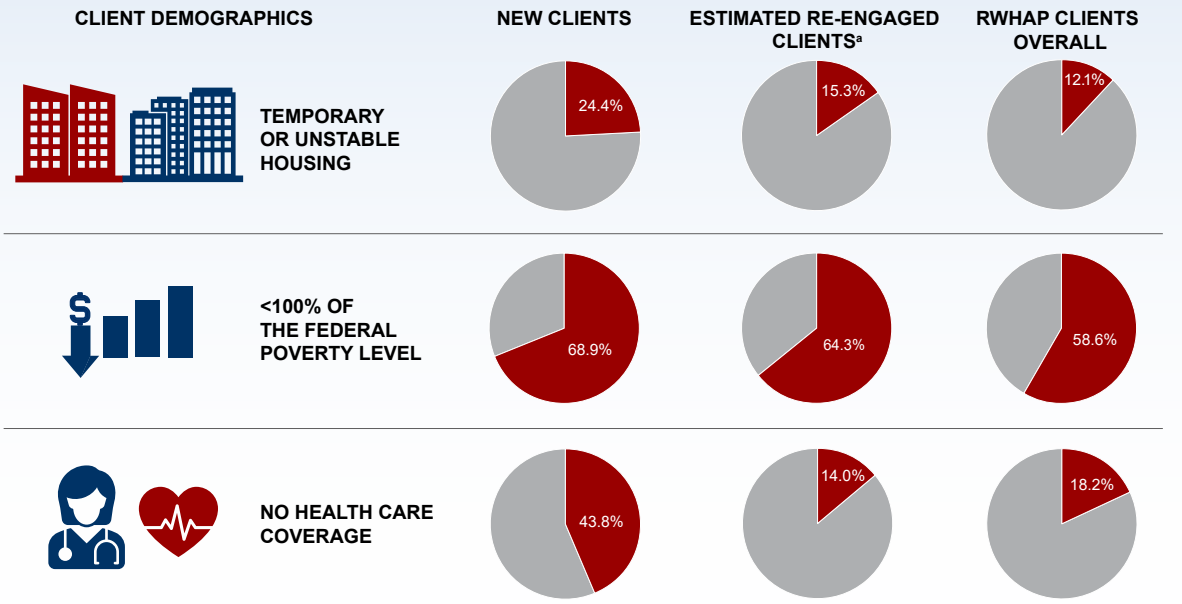
When compared to all RWHAP clients, new and estimated re-engaged clients of EHE-funded providers had higher proportions experiencing unstable or temporary housing, living at or below the FPL, and lacking health care coverage.

Among clients served by EHE-funded providers, nearly one-quarter of new clients and nearly one-sixth of estimated re-engaged clients experienced temporary or unstable housing (new clients: 15.0% temporary housing, 9.4% unstable housing; estimated re-engaged clients: 11.0% temporary housing, 4.3% unstable housing). This is higher than the approximately one-eighth of all clients served by the RWHAP experiencing temporary or unstable housing (6.9% temporary housing, 5.2% unstable housing; **Figure 4; Tables 1a and 1b**).

A higher percentage of new clients and estimated re-engaged clients were living at or below 100% of the FPL (68.9% and 64.3%, respectively) than the overall RWHAP client population (58.6%). Among clients served by EHE-funded providers, 43.8% of new clients had no health care coverage, more than double the percentage of all RWHAP clients without health care coverage (18.2%; **Figure 4; Tables 1a and 1b**).

Figure 4

New and estimated re-engaged[a] clients with HIV served by EHE-funded providers, by sociodemographic characteristics, 2022—47 HRSA HAB EHE-funded jurisdictions.



*In comparison with RWHAP clients overall, a **higher percentage** of **new and estimated re-engaged** clients of EHE-funded providers experienced **temporary or unstable housing** and **were living at or below 100% of the Federal Poverty Level**. Also, nearly half of new clients had **no health care coverage** compared to approximately one-fifth of all RWHAP clients.*

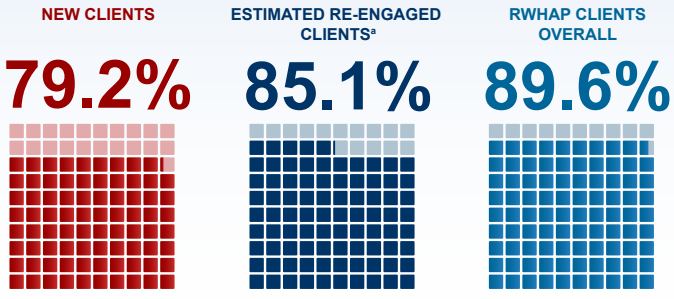
[a] *Estimated re-engaged clients is only among EHE-funded outpatient ambulatory health services, medical case management, non-medical case management, and EHE initiative service category providers.*

Source: 2022 HRSA HAB EHE Report (Tables 1a and 1b) for new and estimated re-engaged client data; 2022 RWHAP Annual Data Report (Table 1a) for RWHAP overall client data.

Figure 5

Viral suppression among new and estimated re-engaged[a] clients with HIV served by EHE-funded providers, 2022—47 HRSA HAB EHE-funded jurisdictions.

New clients and estimated re-engaged clients served by EHE-funded providers had lower viral suppression than RWHAP clients overall.



[a] *Estimated re-engaged clients is only among EHE-funded outpatient ambulatory health services (OAHS), medical case management, non-medical case management, and EHE initiative service category providers.*

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

Source: 2022 HRSA HAB EHE Report (Tables 2a and 2b) for new and estimated re-engaged client data; 2022 RWHAP Annual Data Report (Table 1a) for RWHAP overall client data.

Viral Suppression Among Clients Served by EHE-Funded Providers

By the end of the calendar year, new clients (79.2%) and estimated re-engaged clients (85.1%) who were served by EHE-funded providers and received medical care had lower percentages of viral suppression than RWHAP clients overall (89.6%; **Figure 5; Tables 2a and 2b**). The lower percentage of viral suppression is expected for clients new to or returning to care. Viral loads can take one to six months to reach undetectable levels (i.e., viral suppression) [6]. Because the RWHAP measures viral suppression at the end of the calendar year, some clients new to care or returning to care may not have reached viral suppression by that time. Additionally, people with HIV in priority populations may face multiple and complex needs related to social determinants of health, such as unstable housing, which can negatively affect treatment adherence and viral suppression.

Highlights of Analyses: Workforce Training

The Ryan White HIV/AIDS Program (RWHAP) Part F AIDS Education and Training Center (AETC) Program provides training to health care providers to improve the ability of providers and organizations to counsel, diagnose, treat, and medically manage people with HIV and to help prevent HIV transmission. The regional AETCs provide didactic and clinical training to providers, as well as organizational development activities. The national AETCs provide direct consultation with providers through a 24/7 call center and comprehensive, up-to-date training for providers on an on-demand platform for HIV care and treatment.

The AETC Program supports the EHE initiative by expanding workforce capacity in jurisdictions where HIV transmission occurs most frequently. By increasing the number of health care teams that are educated and motivated to care for people with HIV, the AETC Program aims to increase linkage, engagement, and retention in care for those not yet diagnosed, those diagnosed but not in HIV care, and those who are in HIV care but not yet virally suppressed.

The primary audiences for training events conducted by the regional AETCs are novice and low-volume HIV treatment providers, allied health professionals, and health care support staff who treat both people with HIV and those who may acquire HIV. Training events also are intended for prescribers (e.g., physicians, physician assistants, nurse practitioners) and other health care professionals (e.g., dentists, psychiatrists, pharmacists).

The RWHAP AETC Program recipients developed several strategies and activities to train and support health care team members and students in support of EHE goals. It should be noted that the regional AETC EHE-funded training events may be an underestimate of the AETC Program's full impact on EHE jurisdictions. Additional regional training events supported through other funding streams and the activities of the national AETCs are also available to clinicians and service providers in EHE jurisdictions.

Training Events

During the July 2021 through June 2022 reporting period, regional AETCs conducted a total of 483 EHE-funded training events, a sevenfold increase over the 67 EHE-funded training events conducted from the July 2019 through June 2020 reporting period (**Table 5**).

The general training content areas most frequently covered in the July 2021 through June 2022 reporting period by EHE-funded AETC training events were HIV prevention (62.1%), HIV testing and diagnosis (46.2%), engagement and retention in HIV care (45.5%), and linkage/referral to HIV care (42.2%; **Table 5**).

Training Topics

HIV Prevention

The HIV prevention topic most often presented in EHE-funded AETC training events from July 2021 through June 2022 was pre-exposure prophylaxis (PrEP), which was included in nearly half of the training events (49.7%; **Figure 6** and **Table 5**). Below are three examples of PrEP training events:

- *Micro-Learning PrEP Online Series for Optimal Care:* The Midwest AETC developed a "micro-learning" PrEP online series for prescribers who are interested in PrEP but are unsure how to begin in their practice. Each lesson, lasting 10–15 minutes, equips prescribers with essential knowledge and benchmarks for optimal patient care in PrEP prescription.
- *Community-Led Initiatives for Peer-to-Peer Learning:* The New England AETC established a Suffolk County (Boston, MA) HIV Community Health Worker Advisory Group and a quarterly Suffolk County PrEP Navigator Communities of Practice (CoP). The PrEP Navigator CoP created new pathways for peer-to-peer learning by comparing linkage to care workflows and strategies for PrEP and nPEP (non-occupational post-exposure prophylaxis) in Suffolk County.
- *Engaging Rural Pharmacists to Offer HIV PEP Services:* The University of New Mexico, in partnership with the South Central AETC, developed a statewide pharmacist HIV PEP prescriptive authority protocol. This protocol—approved by the New Mexico Boards of Medicine, Pharmacy, and Nursing—is used to train pharmacists in New Mexico to expand HIV PEP services.

Other HIV prevention topics featured frequently included behavioral prevention (33.3%), HIV transmission risk assessment (32.9%), and U=U (Undetectable = Untransmittable)/treatment as prevention (27.1%; **Figure 6** and **Table 5**).

HIV Background and Management

HIV management topics—especially those related to testing, treatment, and care engagement—were featured in more than 30% of EHE-funded AETC training events from July 2021 through June 2022. Of note, trainings about HIV diagnosis (i.e., HIV testing) were featured in nearly half of the trainings (47.4%; **Figure 6** and **Table 5**).

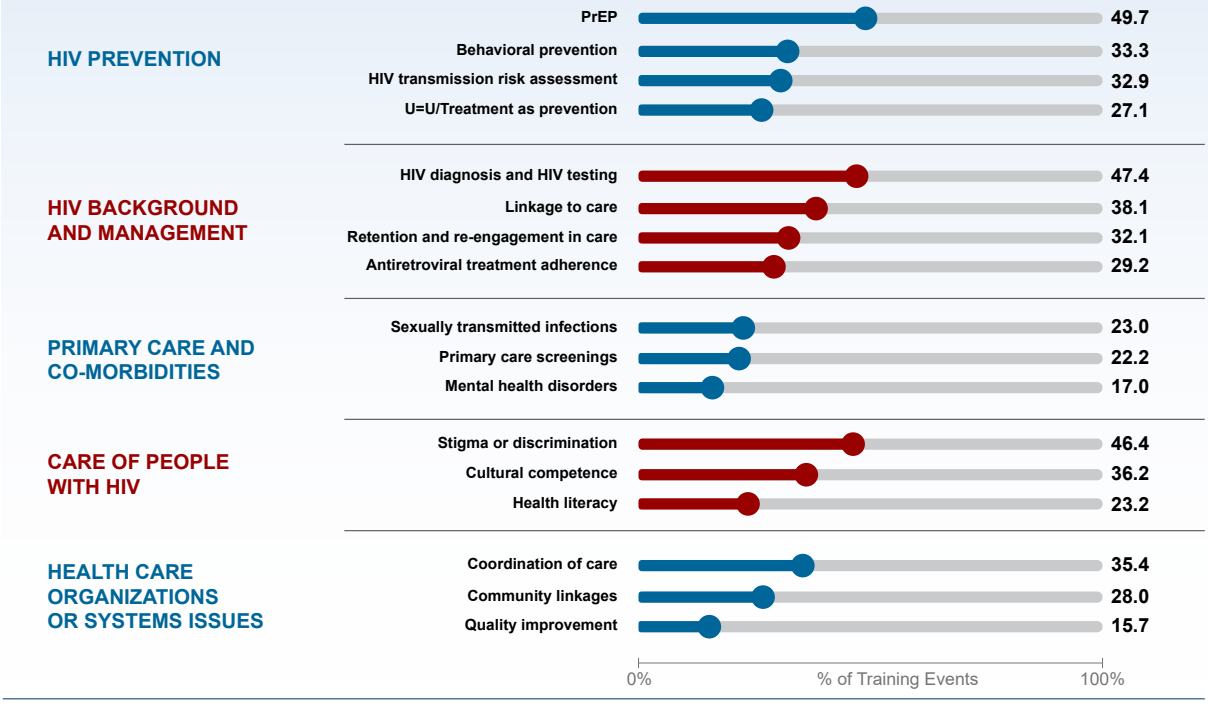
An example of an HIV treatment training event is the End-the-HIV-Epidemic Academy, or END HIV Academy, organized by the Southeast AETC. The Southeast AETC hosted a virtual six-month longitudinal HIV preceptorship training program as a special program in their "END HIV Academy." The project aimed to increase the number of health care team members who provide HIV care and treatment in their jurisdiction. The curriculum consisted of didactic, interactive patient simulations, and facilitated group discussions that covered critical components of HIV prevention, diagnosis, and treatment.

Primary Care and Co-morbidities

The primary care and co-morbidities topics most frequently presented in EHE-funded AETC trainings were sexually transmitted infections (STIs) (23.0%), primary care screenings (22.2%), and mental health disorders (17.0%; **Figure 6** and **Table 5**). An example of a primary care and co-morbidities session is the "Hands-on Skill Building at the STI/HIV Clinical Update" training, a two-day STI capacity-building workshop for HIV and primary care providers offered in Nevada by the Pacific AETC. This training included interactive and didactic components, as well as skill-building components that allowed trainees to participate in four skill-building stations on such topics as STI testing; HIV testing and disclosure; sexual health history taking; and follow-up to HIV testing, care, and treatment.

Figure 6

Top training topics addressed during EHE-funded AIDS Education and Training Center training events, July 2021 to June 2022 (N = 483).



Source: 2022 HRSA HAB EHE Report (Table 5).

Care of People with HIV

Stigma or discrimination was the most frequently presented EHE-funded AETC training event topic related to caring for people with HIV (46.4%), followed by cultural competence (36.2%) and health literacy (23.2%; **Figure 6** and **Table 5**).

An example of a session on the care of people with HIV is the "Culturally Responsive Strategies for Marginalized Populations" training organized by the Pacific AETC – Bay Area, North and Central Coast, or Pacific AETC – BANCC (California). This two-day virtual PrEP symposium offered culturally responsive strategies for providers. During the symposium, providers and people with lived experience shared best practices to address PrEP disparities and medical mistrust.

Health Care Organizations or Systems Issues

The health care organizations or systems topics most frequently presented in EHE-funded AETC trainings from July 2021 through June 2022 were related to coordination of care (35.4%), community linkages (28.0%), and quality improvement (15.7%; **Figure 6** and **Table 5**). Below is an example of regional AETC–organized training events focused on health care organization and system issues:

- *Enhancing Health Care Organizations:* The Southeast AETC's Southeast HIV Accelerated Response for Ending the Epidemic, or SHARE, project was created to provide HIV training and technical assistance to health centers operating in EHE-funded states and jurisdictions. This project partners with clinics lacking in HIV testing and PrEP prescribing, aiming to enhance these services, reduce stigma, develop sexual health protocols, and prepare clinic-specific EHE sustainability plans.

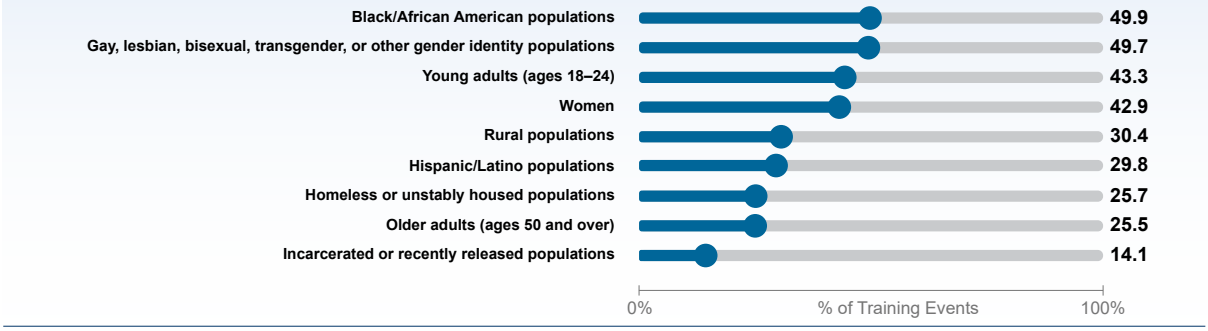
Priority Populations

The AETC Program supports health workforce training to ensure the delivery of quality HIV care and services to all people with HIV, especially priority populations experiencing health disparities [7].

Training topics presented from July 2021 through June 2022 in EHE-funded AETCs focused on several priority populations of people with HIV based on age, race, gender, and the social or community environment. More than two-fifths of training events included the topic of young adults aged 18–24 years (43.3%), and more than a quarter of training events included the topic of older adults aged 50 years and older (25.5%; **Figure 7** and **Table 5**).

Figure 7

Sessions addressing priority populations during EHE-funded AIDS Education and Training Center training events, July 2021 to June 2022 (N = 483).



Source: 2022 HRSA HAB EHE Report (Table 5).

Nearly half of the EHE-funded AETC training events included the Black/African American population as a topic (49.9%), and close to a third of the training events included the Hispanic/Latino population (29.8%). Close to half of the training events featured presentations on HIV and gay, lesbian, bisexual, transgender, or other gender identity populations (49.7%), and two-fifths of the training events included presentations on women (42.9%; **Figure 7** and **Table 5**).

Over a quarter of EHE-funded AETC training events addressed the homeless or unstably housed population (25.7%). Other key priority groups addressed in training events included the rural population (30.4%) and the incarcerated or recently released population (14.1%; **Figure 7** and **Table 5**).

Below are two examples of how priority populations have been featured in training events:

- *Enhancing HIV Care Transition for Legal System–Involved Individuals:* The Mountain West AETC EHE Project in King County, Washington, hosts a weekly “Improving Health Outcomes and Care Transitions for Carcerally Involved People with HIV” meeting that focuses on coordinating and linking to medical care individuals with HIV who are transitioning from the King County jail back into the community. The goal is to ensure continuity of care for people with HIV when they return to communities.
- *HIV Conference With a Focus on Priority Populations:* The Northeast AETC, in collaboration with its regional partners, hosted a conference that included presentations on adapting interventions on housing and food insecurity for people with HIV. Additionally, a series of webinars on intimate partner violence among women with HIV, including engagement and retention strategies, was conducted.

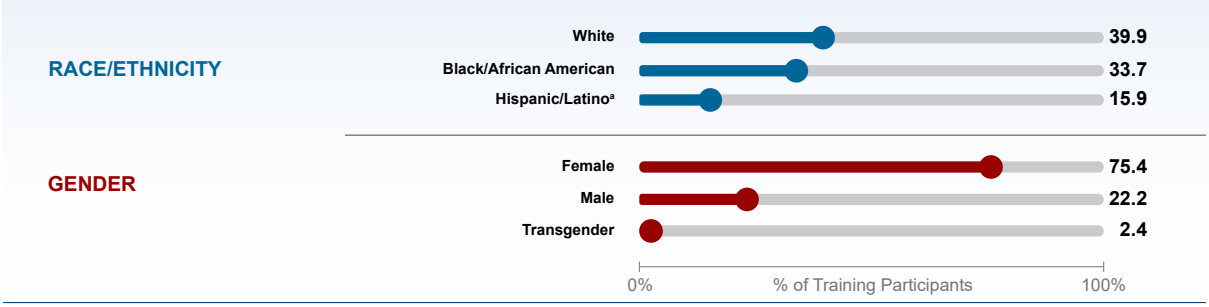
Training Participants

Race/Ethnicity and Gender

During the July 2020 through June 2021 reporting period, nearly two-fifths of the EHE-funded RWHAP AETC participants self-identified as White (39.9%), more than one-third as Black/African American (33.7%), and about 16% as Hispanic/Latino (15.9%). More than three-quarters of EHE-funded RWHAP AETC participants were female (75.4%), about one-fifth were male (22.2%), and less than 3% of participants were transgender (0.3% transgender male, 0.4% transgender female, 1.7% other gender identity; **Figure 8** and **Table 6**).

Figure 8

Demographics of participants of EHE-funded AIDS Education and Training Center training events, July 2021 to June 2022 (N = 4,646).



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

Source: 2022 HRSA HAB EHE Report (Table 6).

Employment Characteristics

From July 2020 through June 2021, the most common professions of EHE-funded RWHAP AETC participants were social workers (19.4%), other public health professionals (18.6%), and nurses and nurse practitioners (16.9%; **Table 6**). Additionally, physicians were 8.9% of all participants and physician assistants were 1.0% of all participants. This information represents the training participant's field and/or discipline; it may not represent their primary functional role in their organization.

In addition to profession, participants reported their primary functional role within their organization to describe their position's activities in their employment setting. The most reported roles were care provider/clinician [prescribing and non-prescribing] (23.8%) and case manager (17.5%; **Table 6**). Care providers/clinicians could be any profession or discipline providing care (e.g., physicians, physician assistants, nurses).

The most frequently reported employment setting was HIV or infectious diseases clinic (18.8%), followed by state or local health department (17.2%), other community-based organization (14.2%), and federally qualified health center (14.1%). About 10% of the EHE-funded RWHAP AETC participants' employment settings were in a rural area only or in combination with a suburban/urban area (10.8%; **Table 7**).

TECHNICAL NOTES

EHE Jurisdictional Progress Reports

This report uses narrative information from *Ending the HIV Epidemic in the U.S.* (EHE) progress reports submitted to the Health Resources and Services Administration (HRSA) HIV/AIDS Bureau (HAB) during Years 1, 2, and 3 of the EHE initiative by each of the 47 HRSA HAB EHE recipients for March 2020 through February 2022. In these EHE progress reports, EHE recipients report on their activities and accomplishments; barriers and challenges faced during EHE implementation; and successes, lessons learned, and best practices. The EHE progress reports complement quantitative data submitted through other mechanisms and provide HRSA HAB with information about the progress made on EHE activities and the contextual factors surrounding EHE implementation. All quotations are direct, deidentified text from EHE recipient progress reports.

Limitations of Findings

These EHE progress reports include only the activities, services, and accomplishments that were supported by fiscal year (FY) 2020–2022 HAB EHE funding and reported by EHE recipients. The reports do not represent the totality of HAB-funded activities and services in these jurisdictions because EHE recipients may use other funding to deliver services and activities, including RWHAP Parts A, B, C, and D funding; Ryan White HIV/AIDS Program (RWHAP) FY 2020 Coronavirus Aid, Relief, and Economic Security (CARES) Act 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, and/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 AIDS Education and Training Center (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 estimated re-engaged clients with HIV served by EHE-funded providers during calendar years 2020, 2021, and 2022. Although the data are limited to these recipients and service providers, all clients receiving care and treatment should be reported, regardless of the funding used for the services. That is, data are not limited to clients served using EHE funding; all clients served receiving RWHAP Parts A–F funding, RWHAP FY 2020 CARES Act–funded services (2020 and 2021), and RWHAP-related funding (i.e., program income or pharmaceutical rebates, etc.) in addition to HAB EHE initiative–funded services (2020–2022) are included in data submissions and in this report.

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

Each year, HRSA HAB requires grant recipients and subrecipients that use RWHAP funds to provide core medical, support, or EHE initiative services during the reporting period to submit data in a specified format. After removing personally identifying information, recipients and subrecipients submit data to HRSA HAB. Beginning in 2019, HRSA HAB encouraged recipients and subrecipients to include RSR data on clients receiving services provided using RWHAP-related funding; this became a reporting requirement for all RWHAP recipients and subrecipients beginning with the 2021 data submission.

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.

Presentation of Data

The data in this report include information received by HRSA HAB for clients served during calendar years 2020 through 2022. Data are organized into two sections:

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

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 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, non-medical case management, 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*. 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.

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 encompass 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 (see the Appendix).

Jurisdiction-level data (i.e., state- and EMA/TGA-level) are delineated based on provider location rather than client location. Jurisdiction-level analyses include data submitted by EHE-funded recipients for all Parts of the RWHAP and EHE funding. That is, all tables include data for all clients served by EHE-funded providers in the jurisdiction, regardless of the source of RWHAP or EHE 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 and/or priority populations in response to shifting jurisdictional, epidemiological, and/or community needs
- Funding activities other than service delivery, including 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 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 *2022 RWHAP Annual Data Report* [1].

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, gender). In addition, information about participants' employment setting(s) is collected (e.g., if the setting is in a rural or suburban/urban area, if the setting receives RWHAP funding).

In March 2020, the EHE initiative began and included funding for expanding workforce capacity through the regional AETCs. 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 *2022 Ryan White HIV/AIDS Program (RWHAP) AIDS Education and Training Center (AETC) Program Annual Data Report* [8].

RWHAP AETC Progress Reports

From July 2019 through June 2022, 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. AETC progress reports were collected through the Non-Competing Continuation Report and the Annual Progress Report.

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

Tables 1–7

Table 1a. New clients with HIV who were served by EHE-funded providers, by year and selected characteristics, 2020–2022—47 HRSA HAB EHE-funded jurisdictions

	2020		2021		2022	
	N	%	N	%	N	%
Age group (yrs)						
<13	7	0.1	32	0.1	18	0.1
13–14	4	<0.1	5	<0.1	5	<0.1
15–19	84	0.7	218	1.0	192	0.9
20–24	669	5.7	1,622	7.2	1,664	7.6
25–29	1,265	10.7	3,118	13.9	3,304	15.0
30–34	1,571	13.3	3,742	16.7	4,081	18.5
35–39	1,324	11.2	2,823	12.6	3,154	14.3
40–44	1,140	9.7	2,308	10.3	2,323	10.6
45–49	1,070	9.1	1,761	7.9	1,764	8.0
50–54	1,373	11.6	2,077	9.3	1,682	7.6
55–59	1,419	12.0	2,063	9.2	1,682	7.6
60–64	931	7.9	1,380	6.2	1,158	5.3
≥65	935	7.9	1,264	5.6	974	4.4
Subtotal	**11,792**	**100.0**	**22,413**	**100.0**	**22,001**	**100.0**
Race/ethnicity						
American Indian/Alaska Native	31	0.3	94	0.4	183	0.9
Asian	127	1.1	299	1.4	704	3.4
Black/African American	6,536	56.2	11,076	50.4	9,347	44.7
Hispanic/Latino[a]	2,071	17.8	5,408	24.6	6,507	31.1
Native Hawaiian/Pacific Islander	20	0.2	44	0.2	30	0.1
White	2,776	23.9	4,844	22.0	3,880	18.6
Multiple races	72	0.6	225	1.0	259	1.2
Subtotal	**11,633**	**100.0**	**21,990**	**100.0**	**20,910**	**100.0**
Gender						
Male	8,912	75.6	17,288	77.1	16,911	77.2
Female	2,612	22.2	4,307	19.2	4,037	18.4
Transgender male	18	0.2	103	0.5	95	0.4
Transgender female	248	2.1	667	3.0	797	3.6
Other gender identity	2	<0.1	45	0.2	69	0.3
Subtotal	**11,792**	**100.0**	**22,410**	**100.0**	**21,909**	**100.0**
Transmission category						
Male client						
Male-to-male sexual contact	5,418	73.1	10,422	75.5	9,984	75.8
Injection drug use	458	6.2	573	4.1	384	2.9
Male-to-male sexual contact and injection drug use	127	1.7	326	2.4	323	2.5
Heterosexual contact[b]	1,342	18.1	2,367	17.1	2,366	18.0
Perinatal	50	0.7	82	0.6	79	0.6
Other[c]	20	0.3	39	0.3	42	0.3
Subtotal[d]	**7,415**	**100.0**	**13,809**	**100.0**	**13,178**	**100.0**
Female client						
Injection drug use	244	12.8	313	10.0	217	7.5
Heterosexual contact[b]	1,603	84.0	2,688	86.2	2,549	87.9
Perinatal	49	2.6	90	2.9	101	3.5
Other[c]	13	0.7	27	0.9	33	1.1
Subtotal[d]	**1,909**	**100.0**	**3,118**	**100.0**	**2,900**	**100.0**
Transgender client						
Sexual contact[e]	195	87.8	484	93.3	623	94.4
Injection drug use	9	4.1	12	2.3	9	1.4
Sexual contact[e] and injection drug use	14	6.3	14	2.7	23	3.5
Perinatal	3	1.4	4	0.8	4	0.6
Other[c]	1	0.5	5	1.0	1	0.2
Subtotal[d]	**222**	**100.0**	**519**	**100.0**	**660**	**100.0**
Federal poverty level						
0–100%	5,126	68.1	11,563	66.9	12,824	68.9
101–138%	686	9.1	1,167	6.7	1,286	6.9
139–250%	1,040	13.8	2,840	16.4	2,663	14.3
251–400%	500	6.6	1,350	7.8	1,423	7.7
>400%	172	2.3	370	2.1	404	2.2
Subtotal	**7,524**	**100.0**	**17,290**	**100.0**	**18,600**	**100.0**
Health care coverage						
Private employer	653	8.6	1,679	9.3	1,641	8.7
Private individual	549	7.2	1,405	7.8	1,225	6.5
Medicare	342	4.5	759	4.2	789	4.2
Medicaid	1,558	20.5	4,526	25.1	4,549	24.0
Medicare and Medicaid	279	3.7	544	3.0	604	3.2
Veterans Administration	14	0.2	33	0.2	44	0.2
Indian Health Service	0	0.0	0	0.0	5	<0.1
Other plan	189	2.5	331	1.8	489	2.6
No coverage	3,503	46.0	7,553	41.8	8,300	43.8
Multiple coverages	530	7.0	1,233	6.8	1,309	6.9
Subtotal	**7,617**	**100.0**	**18,063**	**100.0**	**18,955**	**100.0**

Table 1a. New clients with HIV who were served by EHE-funded providers, by year and selected characteristics, 2020–2022—47 HRSA HAB EHE-funded jurisdictions *(cont.)*

	2020		2021		2022	
	N	%	N	%	N	%
Housing status						
Stable	5,954	78.1	13,727	78.3	14,166	75.6
Temporary	1,016	13.3	2,202	12.6	2,806	15.0
Unstable	650	8.5	1,598	9.1	1,760	9.4
Subtotal	**7,620**	**100.0**	**17,527**	**100.0**	**18,732**	**100.0**
Total[f]	**11,792**	**—**	**22,413**	**—**	**22,001**	**—**

Abbreviations: EHE, Ending the HIV Epidemic; HRSA HAB, Health Resources and Services Administration HIV/AIDS Bureau.

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

[b] Heterosexual contact with a person known to have, or to be at high risk for, HIV infection.

[c] Includes hemophilia and blood transfusion.

[d] Subtotals are reflective of available gender and transmission category information. The values may not sum to the subtotals for gender overall.

[e] Includes any sexual transmission category reported by transgender clients.

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

Table 1b. Estimated re-engaged clients with HIV who were served by selected EHE-funded providers, by year and selected characteristics, 2020–2022—47 HRSA HAB EHE-funded jurisdictions

	2020		2021		2022	
	N	%	N	%	N	%
Age group (yrs)						
<13	3	<0.1	10	0.1	12	0.1
13–14	0	0.0	7	<0.1	3	<0.1
15–19	15	0.2	32	0.2	48	0.2
20–24	211	3.0	343	2.2	456	2.4
25–29	548	7.7	1,014	6.6	1,344	7.0
30–34	782	11.0	1,767	11.5	2,380	12.4
35–39	656	9.3	1,641	10.7	2,206	11.5
40–44	633	8.9	1,546	10.1	2,116	11.0
45–49	698	9.9	1,395	9.1	1,863	9.7
50–54	966	13.6	1,910	12.5	2,262	11.8
55–59	1,019	14.4	2,165	14.1	2,553	13.3
60–64	809	11.4	1,691	11.0	2,018	10.5
≥65	745	10.5	1,797	11.7	1,943	10.1
Subtotal	**7,085**	**100.0**	**15,318**	**100.0**	**19,204**	**100.0**
Race/ethnicity						
American Indian/Alaska Native	10	0.1	49	0.3	56	0.3
Asian	59	0.9	188	1.3	237	1.3
Black/African American	4,273	61.6	8,288	55.2	9,865	52.8
Hispanic/Latino[a]	1,351	19.5	3,292	21.9	4,223	22.6
Native Hawaiian/Pacific Islander	13	0.2	15	0.1	55	0.3
White	1,167	16.8	3,085	20.5	4,064	21.8
Multiple races	62	0.9	110	0.7	175	0.9
Subtotal	**6,935**	**100.0**	**15,027**	**100.0**	**18,675**	**100.0**
Gender						
Male	4,746	67.8	10,728	70.4	13,599	71.1
Female	2,143	30.6	3,995	26.2	4,355	22.8
Transgender male	4	0.1	55	0.4	60	0.3
Transgender female	102	1.5	429	2.8	979	5.1
Other gender identity	2	<0.1	23	0.2	123	0.6
Subtotal	**6,997**	**100.0**	**15,230**	**100.0**	**19,116**	**100.0**
Transmission category						
Male client						
Male-to-male sexual contact	2,056	56.8	4,994	66.0	7,564	68.9
Injection drug use	293	8.1	416	5.5	454	4.1
Male-to-male sexual contact and injection drug use	48	1.3	166	2.2	251	2.3
Heterosexual contact[b]	1,167	32.2	1,883	24.9	2,546	23.2
Perinatal	35	1.0	82	1.1	98	0.9
Other[c]	22	0.6	31	0.4	58	0.5
Subtotal[d]	**3,621**	**100.0**	**7,572**	**100.0**	**10,971**	**100.0**
Female client						
Injection drug use	137	8.0	212	7.5	246	7.0
Heterosexual contact[b]	1,523	88.8	2,475	87.9	3,100	88.7
Perinatal	33	1.9	86	3.1	106	3.0
Other[c]	22	1.3	44	1.6	43	1.2
Subtotal[d]	**1,715**	**100.0**	**2,817**	**100.0**	**3,495**	**100.0**
Transgender client						
Sexual contact[e]	41	91.1	276	94.2	433	96.0
Injection drug use	1	2.2	2	0.7	1	0.2
Sexual contact[e] and injection drug use	1	2.2	9	3.1	11	2.4
Perinatal	0	0.0	3	1.0	3	0.7
Other[c]	2	4.4	3	1.0	3	0.7
Subtotal[d]	**45**	**100.0**	**293**	**100.0**	**451**	**100.0**
Federal poverty level						
0–100%	4,177	64.0	7,649	63.4	10,875	64.3
101–138%	674	10.3	1,073	8.9	1,451	8.6
139–250%	1,039	15.9	1,919	15.9	2,516	14.9
251–400%	484	7.4	1,063	8.8	1,410	8.3
>400%	152	2.3	363	3.0	651	3.9
Subtotal	**6,526**	**100.0**	**12,067**	**100.0**	**16,903**	**100.0**
Health care coverage						
Private employer	811	12.0	1,920	13.5	1,769	9.8
Private individual	428	6.3	1,249	8.8	957	5.3
Medicare	804	11.9	1,620	11.4	1,827	10.1
Medicaid	2,399	35.4	4,414	31.1	6,664	36.8
Medicare and Medicaid	493	7.3	1,163	8.2	1,054	5.8
Veterans Administration	4	0.1	21	0.1	20	0.1
Indian Health Service	0	0.0	0	0.0	6	<0.1
Other plan	124	1.8	246	1.7	881	4.9
No coverage	1,156	17.1	2,109	14.8	2,534	14.0
Multiple coverages	553	8.2	1,467	10.3	2,401	13.3
Subtotal	**6,772**	**100.0**	**14,209**	**100.0**	**18,113**	**100.0**

Table 1b. Estimated re-engaged clients with HIV who were served by selected EHE-funded providers, by year and selected characteristics, 2020–2022—47 HRSA HAB EHE-funded jurisdictions *(cont.)*

	2020		2021		2022	
	N	%	N	%	N	%
Housing status						
Stable	4,776	75.2	9,985	81.5	14,417	84.8
Temporary	1,358	21.4	1,774	14.5	1,866	11.0
Unstable	217	3.4	497	4.1	724	4.3
Subtotal	**6,351**	**100.0**	**12,256**	**100.0**	**17,007**	**100.0**
Total[f]	**7,085**	**—**	**15,318**	**—**	**19,204**	**—**

Abbreviations: EHE, Ending the HIV Epidemic; HRSA HAB, Health Resources and Services Administration HIV/AIDS Bureau.

Selected EHE-funded providers refers to providers of outpatient ambulatory health services, medical case management, non-medical case management, and other EHE initiative services.

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

[b] Heterosexual contact with a person known to have, or to be at high risk for, HIV infection.

[c] Includes hemophilia and blood transfusion.

[d] Subtotals are reflective of available gender and transmission category information. The values may not sum to the subtotals for gender overall.

[e] Includes any sexual transmission category reported by transgender clients.

[f] 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 who were served by EHE-funded providers, by year and selected characteristics, 2020–2022—47 HRSA HAB EHE-funded jurisdictions

	2020			2021			2022		
	Total N	Viral suppression		Total N	Viral suppression		Total N	Viral suppression	
		N	%		N	%		N	%
Age group (yrs)									
<13	3	2	66.7	20	15	75.0	13	10	76.9
13–14	1	0	0.0	4	4	100.0	3	2	66.7
15–19	52	38	73.1	153	115	75.2	122	97	79.5
20–24	442	323	73.1	1,136	866	76.2	1,148	862	75.1
25–29	821	607	73.9	2,142	1,640	76.6	2,182	1,669	76.5
30–34	939	678	72.2	2,460	1,895	77.0	2,660	2,081	78.2
35–39	741	561	75.7	1,668	1,306	78.3	1,961	1,513	77.2
40–44	527	400	75.9	1,295	1,004	77.5	1,392	1,104	79.3
45–49	421	314	74.6	922	749	81.2	1,034	857	82.9
50–54	453	365	80.6	957	747	78.1	896	724	80.8
55–59	390	328	84.1	871	742	85.2	846	713	84.3
60–64	214	181	84.6	475	401	84.4	554	473	85.4
≥65	126	109	86.5	324	287	88.6	370	328	88.6
Race/ethnicity									
American Indian/Alaska Native	14	10	71.4	39	33	84.6	53	43	81.1
Asian	81	71	87.7	208	180	86.5	240	200	83.3
Black/African American	2,664	1,967	73.8	6,015	4,550	75.6	6,054	4,654	76.9
Hispanic/Latino[a]	1,327	1,050	79.1	3,508	2,872	81.9	4,197	3,408	81.2
Native Hawaiian/Pacific Islander	8	7	87.5	28	24	85.7	18	14	77.8
White	957	746	78.0	2,324	1,873	80.6	2,238	1,809	80.8
Multiple races	51	36	70.6	138	107	77.5	150	117	78.0
Gender									
Male	3,979	3,051	76.7	9,844	7,753	78.8	10,468	8,246	78.8
Female	993	749	75.4	2,078	1,638	78.8	2,199	1,784	81.1
Transgender male	12	8	66.7	71	51	71.8	57	44	77.2
Transgender female	145	97	66.9	417	318	76.3	414	325	78.5
Other gender identity	1	1	100.0	17	11	64.7	28	23	82.1
Transmission category									
Male client									
Male-to-male sexual contact	2,697	2,106	78.1	6,535	5,216	79.8	6,958	5,523	79.4
Injection drug use	115	79	68.7	239	174	72.8	208	155	74.5
Male-to-male sexual contact and injection drug use	61	47	77.0	224	185	82.6	215	147	68.4
Heterosexual contact[b]	789	597	75.7	1,479	1,138	76.9	1,713	1,337	78.1
Perinatal	27	17	63.0	48	33	68.8	44	28	63.6
Other[c]	7	6	85.7	27	23	85.2	22	20	90.9
Female client									
Injection drug use	45	35	77.8	97	75	77.3	108	83	76.9
Heterosexual contact[b]	814	626	76.9	1,568	1,258	80.2	1,659	1,368	82.5
Perinatal	21	14	66.7	56	34	60.7	70	51	72.9
Other[c]	6	2	33.3	14	12	85.7	21	19	90.5
Transgender client									
Sexual contact[d]	128	86	67.2	320	240	75.0	323	246	76.2
Injection drug use	4	0	0.0	6	3	50.0	4	3	75.0
Sexual contact[d] and injection drug use	3	2	66.7	8	7	87.5	15	11	73.3
Perinatal	2	2	100.0	2	1	50.0	2	2	100.0
Other[c]	1	0	0.0	3	1	33.3	1	1	100.0

Table 2a. Viral suppression among new clients with HIV who were served by EHE-funded providers, by year and selected characteristics, 2020–2022—47 HRSA HAB EHE-funded jurisdictions *(cont.)*

	2020			2021			2022		
	Total N	Viral suppression		Total N	Viral suppression		Total N	Viral suppression	
		N	%		N	%		N	%
Federal poverty level									
0–100%	3,591	2,654	73.9	8,162	6,223	76.2	8,893	6,904	77.6
101–138%	432	356	82.4	795	660	83.0	787	656	83.4
139–250%	661	540	81.7	1,966	1,611	81.9	1,787	1,471	82.3
251–400%	294	240	81.6	893	781	87.5	882	741	84.0
>400%	98	90	91.8	256	232	90.6	254	221	87.0
Health care coverage									
Private employer	374	315	84.2	1,074	903	84.1	1,055	897	85.0
Private individual	303	258	85.1	781	689	88.2	654	563	86.1
Medicare	160	137	85.6	358	292	81.6	356	301	84.6
Medicaid	924	698	75.5	2,940	2,241	76.2	2,682	2,044	76.2
Medicare and Medicaid	127	98	77.2	242	203	83.9	265	223	84.2
Veterans Administration	0	—	—	9	6	66.7	12	10	83.3
Indian Health Service	0	—	—	0	—	—	0	—	—
Other plan	92	76	82.6	192	152	79.2	332	254	76.5
No coverage	2,830	2,054	72.6	5,927	4,530	76.4	6,534	5,077	77.7
Multiple coverages	297	258	86.9	782	670	85.7	907	769	84.8
Housing status									
Stable	4,051	3,141	77.5	9,730	7,812	80.3	9,888	7,986	80.8
Temporary	675	506	75.0	1,456	1,114	76.5	1,809	1,382	76.4
Unstable	382	243	63.6	971	652	67.1	1,044	723	69.3
Total[e]	**5,130**	**3,906**	**76.1**	**12,427**	**9,771**	**78.6**	**13,181**	**10,433**	**79.2**

Abbreviations: EHE, Ending the HIV Epidemic; HRSA HAB, Health Resources and Services Administration HIV/AIDS Bureau; OAHS, outpatient ambulatory health services.

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

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

[b] Heterosexual contact with a person known to have, or to be at high risk for, HIV infection.

[c] Includes hemophilia and blood transfusion.

[d] Includes any sexual transmission category reported by transgender clients.

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

Table 2b. Viral suppression among estimated re-engaged clients with HIV who were served by selected EHE-funded providers, by year and selected characteristics, 2020–2022— 47 HRSA HAB EHE-funded jurisdictions

	2020			2021			2022		
	Total N	Viral suppression		Total N	Viral suppression		Total N	Viral suppression	
		N	%		N	%		N	%
Age group (yrs)									
<13	2	1	50.0	6	5	83.3	7	7	100.0
13–14	0	—	—	0	—	—	1	1	100.0
15–19	4	3	75.0	10	8	80.0	29	17	58.6
20–24	137	113	82.5	175	139	79.4	297	234	78.8
25–29	362	275	76.0	578	438	75.8	908	709	78.1
30–34	528	410	77.7	1,018	775	76.1	1,675	1,325	79.1
35–39	425	352	82.8	909	726	79.9	1,569	1,253	79.9
40–44	411	344	83.7	803	676	84.2	1,471	1,231	83.7
45–49	468	391	83.5	744	629	84.5	1,268	1,086	85.6
50–54	693	596	86.0	1,015	887	87.4	1,561	1,358	87.0
55–59	719	642	89.3	1,115	997	89.4	1,742	1,553	89.2
60–64	569	511	89.8	879	787	89.5	1,306	1,182	90.5
≥65	554	538	97.1	904	854	94.5	1,260	1,188	94.3
Race/ethnicity									
American Indian/Alaska Native	9	7	77.8	21	16	76.2	27	21	77.8
Asian	40	38	95.0	101	94	93.1	182	168	92.3
Black/African American	3,136	2,644	84.3	4,698	3,871	82.4	6,976	5,713	81.9
Hispanic/Latino[a]	1,010	905	89.6	1,745	1,532	87.8	2,964	2,628	88.7
Native Hawaiian/Pacific Islander	10	9	90.0	10	10	100.0	44	40	90.9
White	606	520	85.8	1,423	1,265	88.9	2,447	2,176	88.9
Multiple races	23	21	91.3	37	30	81.1	90	73	81.1
Gender									
Male	3,225	2,753	85.4	5,810	4,935	84.9	9,200	7,818	85.0
Female	1,585	1,374	86.7	2,122	1,810	85.3	2,964	2,511	84.7
Transgender male	2	2	100.0	13	10	76.9	31	23	74.2
Transgender female	58	45	77.6	204	160	78.4	792	696	87.9
Other gender identity	0	—	—	5	5	100.0	102	92	90.2
Transmission category									
Male client									
Male-to-male sexual contact	1,477	1,255	85.0	3,374	2,869	85.0	5,673	4,851	85.5
Injection drug use	222	200	90.1	286	241	84.3	294	247	84.0
Male-to-male sexual contact and injection drug use	30	23	76.7	88	69	78.4	158	122	77.2
Heterosexual contact[b]	928	797	85.9	1,334	1,127	84.5	1,992	1,674	84.0
Perinatal	23	16	69.6	44	35	79.5	64	46	71.9
Other[c]	15	15	100.0	19	18	94.7	28	27	96.4
Female client									
Injection drug use	105	92	87.6	143	121	84.6	185	152	82.2
Heterosexual contact[b]	1,212	1,059	87.4	1,612	1,388	86.1	2,355	2,013	85.5
Perinatal	26	15	57.7	55	38	69.1	76	47	61.8
Other[c]	13	12	92.3	28	24	85.7	21	17	81.0
Transgender client									
Sexual contact[d]	18	11	61.1	128	103	80.5	305	252	82.6
Injection drug use	1	1	100.0	0	—	—	1	0	0.0
Sexual contact[d] and injection drug use	1	0	0.0	1	0	0.0	8	7	87.5
Perinatal	0	—	—	2	1	50.0	3	2	66.7
Other[b]	1	1	100.0	3	2	66.7	3	3	100.0

Table 2b. Viral suppression among estimated re-engaged clients with HIV who were served by selected EHE-funded providers, by year and selected characteristics, 2020–2022— 47 HRSA HAB EHE-funded jurisdictions *(cont.)*

	2020			2021			2022		
	Total N	Viral suppression		Total N	Viral suppression		Total N	Viral suppression	
		N	%		N	%		N	%
Federal poverty level									
0–100%	2,982	2,475	83.0	5,078	4,184	82.4	8,319	6,860	82.5
101–138%	521	468	89.8	662	579	87.5	1,021	899	88.1
139–250%	751	681	90.7	1,203	1,068	88.8	1,863	1,665	89.4
251–400%	327	306	93.6	694	631	90.9	1,009	914	90.6
>400%	92	87	94.6	275	264	96.0	527	497	94.3
Health care coverage									
Private employer	603	541	89.7	1,285	1,185	92.2	1,166	1,043	89.5
Private individual	289	271	93.8	480	441	91.9	612	551	90.0
Medicare	600	565	94.2	897	820	91.4	1,124	1,020	90.7
Medicaid	1,684	1,406	83.5	2,843	2,315	81.4	4,935	4,063	82.3
Medicare and Medicaid	364	319	87.6	555	497	89.5	717	622	86.8
Veterans Administration	1	1	100.0	4	4	100.0	5	4	80.0
Indian Health Service	0	—	—	0	—	—	3	2	66.7
Other plan	75	58	77.3	92	76	82.6	659	633	96.1
No coverage	847	642	75.8	1,324	986	74.5	1,917	1,433	74.8
Multiple coverages	403	369	91.6	634	564	89.0	1,861	1,701	91.4
Housing status									
Stable	3,510	3,071	87.5	6,524	5,618	86.1	11,108	9,590	86.3
Temporary	1,042	883	84.7	1,227	1,025	83.5	1,435	1,185	82.6
Unstable	125	72	57.6	259	162	62.5	464	298	64.2
Total[e]	**4,872**	**4,176**	**85.7**	**8,156**	**6,921**	**84.9**	**13,094**	**11,144**	**85.1**

Abbreviations: EHE, Ending the HIV Epidemic; HRSA HAB, Health Resources and Services Administration HIV/AIDS Bureau; OAHS, outpatient ambulatory health services.

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

Selected EHE-funded providers refers to providers of outpatient ambulatory health services, medical case management, non-medical case management, and other EHE initiative services.

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

[b] Heterosexual contact with a person known to have, or to be at high risk for, HIV infection.

[c] Includes hemophilia and blood transfusion.

[d] Includes any sexual transmission category reported by transgender clients.

[e] 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 who were served by EHE-funded providers, by year and jurisdiction, 2020–2022—47 HRSA HAB EHE-funded jurisdictions

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

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

Abbreviations: EHE, Ending the HIV Epidemic; EMA, eligible metropolitan area; HRSA HAB, Health Resources and Services Administration HIV/AIDS Bureau; TGA, transitional grant area.

Notes: Data are based on provider location.

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

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

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

Table 3b. Estimated re-engaged clients with HIV who were served by selected EHE-funded providers, by year and jurisdiction, 2020–2022— 47 HRSA HAB EHE-funded jurisdictions

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

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

Abbreviations: EHE, Ending the HIV Epidemic; EMA, eligible metropolitan area; HRSA HAB, Health Resources and Services Administration HIV/AIDS Bureau; TGA, transitional grant area.

Selected EHE-funded providers refers to providers of outpatient ambulatory health services, medical case management, non-medical case management, and other EHE initiative services.

Notes: Data are based on provider location.

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

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

- Changes in funding and/or staffing that impact service delivery and/or data reporting
- Jurisdictional emphasis on new or estimated re-engaged clients (i.e., some jurisdictions may have zero estimated re-engaged clients if their activities focused on clients new to care)
- Early success of direct service activities, leading to fewer new or estimated re-engaged clients not yet engaged in care in subsequent 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 and/or priority populations in response to shifting jurisdictional, epidemiological, and/or community needs
- Funding activities other than service delivery, including 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 who were served by EHE-funded providers, by year and jurisdiction, 2020–2022—47 HRSA HAB EHE-funded jurisdictions

Part A jurisdictions			2020			2021			2022		
			Total N	Viral suppression		Total N	Viral suppression		Total N	Viral suppression	
State/Territory	EMA/TGA	EHE focus county(ies)		N	%		N	%		N	%
Arizona	Phoenix	Maricopa County	0	—	—	501	435	86.8	331	276	83.4
California	Los Angeles	Los Angeles County	0	—	—	678	542	79.9	2	2	100.0
	Oakland	Alameda County	56	31	55.4	110	90	81.8	123	93	75.6
	Sacramento	Sacramento County	0	—	—	15	11	73.3	23	15	65.2
	San Bernardino	Riverside County; San Bernardino County	84	71	84.5	37	33	89.2	155	95	61.3
	San Diego	San Diego County	0	—	—	116	97	83.6	342	297	86.8
	San Francisco	San Francisco County	117	86	73.5	166	126	75.9	132	98	74.2
	Santa Ana	Orange County	176	155	88.1	198	156	78.8	205	159	77.6
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
Florida	Fort Lauderdale	Broward County	789	572	72.5	603	468	77.6	598	480	80.3
	Jacksonville	Duval County	68	50	73.5	158	118	74.7	163	130	79.8
	Miami	Miami–Dade County	0	—	—	182	158	86.8	283	260	91.9
	Orlando	Orange County	6	5	83.3	139	115	82.7	143	119	83.2
	Tampa	Hillsborough County; Pinellas County	250	186	74.4	334	270	80.8	315	250	79.4
	West Palm Beach	Palm Beach County	18	15	83.3	28	23	82.1	52	42	80.8
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
Illinois	Chicago	Cook County	216	176	81.5	156	134	85.9	98	89	90.8
Indiana	Indianapolis	Marion County	27	22	81.5	7	7	100.0	160	119	74.4
Louisiana	Baton Rouge	East Baton Rouge Parish	0	—	—	99	85	85.9	106	87	82.1
	New Orleans	Orleans Parish	0	—	—	299	211	70.6	233	178	76.4
Maryland	Baltimore	Baltimore City	1	0	0	53	41	77.4	69	56	81.2
Massachusetts	Boston	Suffolk County	48	45	93.8	0	—	—	35	30	85.7
Michigan	Detroit	Wayne County	134	112	83.6	223	177	79.4	209	162	77.5
Nevada	Las Vegas	Clark County	0	—	—	167	146	87.4	89	77	86.5
New Jersey	Jersey City	Hudson County	37	22	59.5	94	69	73.4	161	138	85.7
	Newark	Essex County	527	422	80.1	551	456	82.8	561	437	77.9
New York	New York	Bronx County; Kings County; New York County; Queens County	0	—	—	801	621	77.5	824	671	81.4
North Carolina	Charlotte	Mecklenburg County	37	35	94.6	74	58	78.4	180	144	80.0
Ohio	Cleveland	Cuyahoga County	0	—	—	217	170	78.3	141	102	72.3
	Columbus	Franklin County	26	23	88.5	67	53	79.1	211	182	86.3
Pennsylvania	Philadelphia	Philadelphia County	57	43	75.4	371	289	77.9	230	176	76.5
Puerto Rico	San Juan	San Juan Municipio	18	13	72.2	140	114	81.4	17	14	82.4
Tennessee	Memphis	Shelby County	15	9	60	22	17	77.3	21	18	85.7
Texas	Austin	Travis County	0	—	—	155	125	80.6	302	236	78.1
	Dallas	Dallas County	0	—	—	21	15	71.4	129	85	65.9
	Fort Worth	Tarrant County	0	—	—	311	228	73.3	421	321	76.2
	Houston	Harris County	1,350	987	73.1	1,567	1,151	73.5	1,690	1,279	75.7
	San Antonio	Bexar County	1	1	100	225	143	63.6	265	182	68.7
Washington	Seattle	King County	0	—	—	206	179	86.9	262	225	85.9

Table 4a. Viral suppression among new clients with HIV who were served by EHE-funded providers, by year and jurisdiction, 2020–2022—47 HRSA HAB EHE-funded jurisdictions *(cont.)*

Part B jurisdictions		2020			2021			2022		
		Total N	Viral suppression		Total N	Viral suppression		Total N	Viral suppression	
State	EHE focus county or state		N	%		N	%		N	%
Alabama	State	2	0	0.0	197	162	82.2	499	433	86.8
Arkansas	State	90	58	64.4	99	72	72.7	5	5	100.0
Kentucky	State	38	31	81.6	32	28	87.5	30	27	90.0
Mississippi	State	0	—	—	0	—	—	3	1	33.3
Missouri	State	82	69	84.1	308	256	83.1	244	207	84.8
Ohio	Hamilton County	0	—	—	33	26	78.8	123	109	88.6
Oklahoma	State	0	—	—	0	—	—	36	35	97.2
South Carolina	State	82	66	80.5	350	292	83.4	346	266	76.9

Abbreviations: EHE, Ending the HIV Epidemic; EMA, eligible metropolitan area; HRSA HAB, Health Resources and Services Administration HIV/AIDS Bureau; OAHS, outpatient ambulatory health services; TGA, transitional grant area.

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

Notes: Data are based on provider location.

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

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

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

Table 4b. Viral suppression among estimated re-engaged clients with HIV who were served by selected EHE-funded providers, by year and jurisdiction, 2020–2022—47 HRSA HAB EHE-funded jurisdictions

Part A jurisdictions			2020			2021			2022		
			Total N	Viral suppression		Total N	Viral suppression		Total N	Viral suppression	
State/Territory	EMA/TGA	EHE focus county(ies)		N	%		N	%		N	%
Arizona	Phoenix	Maricopa County	0	—	—	1	0	0.0	300	213	71.0
California	Los Angeles	Los Angeles County	0	—	—	183	131	71.6	0	—	—
	Oakland	Alameda County	6	4	66.7	10	7	70.0	108	104	96.3
	Sacramento	Sacramento County	0	—	—	0	—	—	0	—	—
	San Bernardino	Riverside County; San Bernardino County	0	—	—	0	—	—	27	20	74.1
	San Diego	San Diego County	0	—	—	154	137	89.0	212	183	86.3
	San Francisco	San Francisco County	27	21	77.8	79	72	91.1	44	36	81.8
	Santa Ana	Orange County	23	17	73.9	19	12	63.2	32	28	87.5
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
Florida	Fort Lauderdale	Broward County	217	159	73.3	152	112	73.7	416	347	83.4
	Jacksonville	Duval County	120	92	76.7	273	224	82.1	105	76	72.4
	Miami	Miami–Dade County	0	—	—	20	16	80.0	19	13	68.4
	Orlando	Orange County	0	—	—	5	5	100.0	2	1	50.0
	Tampa	Hillsborough County; Pinellas County	0	—	—	0	—	—	0	—	—
	West Palm Beach	Palm Beach County	11	7	63.6	7	6	85.7	19	12	63.2
Georgia	Atlanta	Cobb County; DeKalb County; Fulton County; Gwinnett County	61	45	73.8	346	222	64.2	500	337	67.4
Illinois	Chicago	Cook County	32	27	84.4	7	5	71.4	0	—	—
Indiana	Indianapolis	Marion County	0	—	—	15	14	93.3	85	60	70.6
Louisiana	Baton Rouge	East Baton Rouge Parish	0	—	—	158	141	89.2	120	106	88.3
	New Orleans	Orleans Parish	0	—	—	30	25	83.3	77	56	72.7
Maryland	Baltimore	Baltimore City	7	7	100.0	49	35	71.4	95	76	80.0
Massachusetts	Boston	Suffolk County	5	5	100.0	0	—	—	7	5	71.4
Michigan	Detroit	Wayne County	187	152	81.3	521	430	82.5	460	337	73.3
Nevada	Las Vegas	Clark County	0	—	—	32	27	84.4	54	46	85.2
New Jersey	Jersey City	Hudson County	13	5	38.5	16	13	81.3	28	20	71.4
	Newark	Essex County	3,230	2,923	90.5	3,268	2,987	91.4	3,816	3,464	90.8
New York	New York	Bronx County; Kings County; New York County; Queens County	0	—	—	600	484	80.7	3,523	3,170	90.0
North Carolina	Charlotte	Mecklenburg County	6	5	83.3	27	15	55.6	79	62	78.5
Ohio	Cleveland	Cuyahoga County	0	—	—	181	146	80.7	141	116	82.3
	Columbus	Franklin County	405	332	82.0	320	268	83.8	488	432	88.5
Pennsylvania	Philadelphia	Philadelphia County	1	0	0.0	855	768	89.8	399	330	82.7
Puerto Rico	San Juan	San Juan Municipio	9	6	66.7	16	9	56.3	26	22	84.6
Tennessee	Memphis	Shelby County	0	—	—	44	30	68.2	387	285	73.6
Texas	Austin	Travis County	0	—	—	0	—	—	27	19	70.4
	Dallas	Dallas County	0	—	—	25	18	72.0	29	19	65.5
	Fort Worth	Tarrant County	0	—	—	0	—	—	20	13	65.0
	Houston	Harris County	336	220	65.5	344	232	67.4	441	308	69.8
	San Antonio	Bexar County	0	—	—	0	—	—	0	—	—
Washington	Seattle	King County	0	—	—	97	89	91.8	102	94	92.2

Table 4b. Viral suppression among estimated re-engaged clients with HIV who were served by selected EHE-funded providers, by year and jurisdiction, 2020–2022—47 HRSA HAB EHE-funded jurisdictions *(cont.)*

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

Abbreviations: EHE, Ending the HIV Epidemic; EMA, eligible metropolitan area; HRSA HAB, Health Resources and Services Administration HIV/AIDS Bureau; OAHS, outpatient ambulatory health services; TGA, transitional grant area.

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

Selected EHE-funded providers refers to providers of outpatient ambulatory health services, medical case management, non-medical case management, and other EHE initiative services.

Notes: Data are based on provider location.

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

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

- Changes in funding and/or staffing that impact service delivery and/or data reporting
- Jurisdictional emphasis on new or estimated re-engaged clients (i.e., some jurisdictions may have zero estimated re-engaged clients if their activities focused on clients new to care)
- Early success of direct service activities, leading to fewer new or estimated re-engaged clients not yet engaged in care in subsequent 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 and/or priority populations in response to shifting jurisdictional, epidemiological, and/or community needs
- Funding activities other than service delivery, including 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 Part F AIDS Education and Training Center Program training events, by year and training topic, July 2019–June 2022—United States and 3 territories

	July 2019–June 2020		July 2020–June 2021		July 2021–June 2022	
	N	%	N	%	N	%
Training content						
Antiretroviral treatment and adherence	7	10.4	210	62.7	174	36.0
Engagement and retention in HIV care	12	17.9	121	36.1	220	45.5
HIV prevention	34	50.7	155	46.3	300	62.1
HIV testing and diagnosis	16	23.9	121	36.1	223	46.2
Linkage/referral to HIV care	16	23.9	156	46.6	204	42.2
Management of co-morbid conditions	13	19.4	109	32.5	132	27.3
Coronavirus disease 2019	0	0.0	1	0.3	0	0.0
Other	8	11.9	69	20.6	74	15.3
Training topic						
HIV prevention						
Behavioral prevention	19	28.4	66	19.7	161	33.3
Harm reduction/safe injection	4	6.0	28	8.4	77	15.9
HIV transmission risk assessment	17	25.4	79	23.6	159	32.9
Postexposure prophylaxis (PEP, occupational and nonoccupational)	8	11.9	36	10.7	52	10.8
Preexposure prophylaxis (PrEP)	22	32.8	110	32.8	240	49.7
Prevention of perinatal or mother-to-child transmission	2	3.0	25	7.5	41	8.5
Other biomedical prevention	2	3.0	14	4.2	8	1.7
U=U/Treatment as prevention	7	10.4	85	25.4	131	27.1
HIV background and management						
Acute HIV	2	3.0	24	7.2	40	8.3
Adult and adolescent antiretroviral treatment	3	4.5	116	34.6	99	20.5
Aging and HIV	9	13.4	15	4.5	33	6.8
Antiretroviral treatment adherence, including viral suppression	1	1.5	174	51.9	141	29.2
Basic science	5	7.5	30	9.0	54	11.2
Clinical manifestations of HIV disease	0	0.0	15	4.5	42	8.7
HIV diagnosis (i.e., HIV testing)	17	25.4	90	26.9	229	47.4
HIV epidemiology	3	4.5	49	14.6	53	11.0
HIV monitoring and laboratory tests (i.e., CD4 and viral load)	0	0.0	56	16.7	67	13.9
HIV resistance testing and interpretation	0	0.0	24	7.2	29	6.0
Linkage to care	18	26.9	109	32.5	184	38.1
Pediatric HIV management	0	0.0	6	1.8	1	0.2
Retention and/or re-engagement in care	5	7.5	123	36.7	155	32.1
Other HIV background and management	3	4.5	12	3.6	10	2.1
Primary care and co-morbidities						
Cervical cancer screening, including HPV	0	0.0	4	1.2	26	5.4
Hepatitis B	0	0.0	21	6.3	39	8.1
Hepatitis C	9	13.4	40	11.9	54	11.2
Immunization	0	0.0	16	4.8	32	6.6
Influenza	0	0.0	1	0.3	0	0.0
Malignancies	0	0.0	2	0.6	21	4.3
Medication-assisted therapy for substance use disorders	3	4.5	23	6.9	73	15.1
Mental health disorders	2	3.0	27	8.1	82	17.0
Non-infection comorbidities of HIV or viral hepatitis	4	6.0	14	4.2	39	8.1
Nutrition	0	0.0	4	1.2	2	0.4
Opioid use disorder	3	4.5	15	4.5	38	7.9
Opportunistic infections	1	1.5	24	7.2	38	7.9
Oral health	0	0.0	5	1.5	37	7.7
Osteoporosis	4	6.0	6	1.8	16	3.3
Pain management	0	0.0	3	0.9	5	1.0
Palliative care	0	0.0	0	0.0	1	0.2
Primary care screenings	0	0.0	43	12.8	107	22.2
Reproductive health, including preconception planning	1	1.5	15	4.5	43	8.9
Sexually transmitted infections	7	10.4	46	13.7	111	23.0
Substance use disorders, not including opioid use	2	3.0	28	8.4	62	12.8
Tobacco cessation	0	0.0	0	0.0	2	0.4
Tuberculosis	0	0.0	1	0.3	2	0.4
Other	6	9.0	36	10.7	28	5.8
Issues related to care of people with HIV						
Cultural competence	11	16.4	92	27.5	175	36.2
Health literacy	10	14.9	88	26.3	112	23.2
Low English proficiency	2	3.0	6	1.8	3	0.6
Motivational interviewing	5	7.5	64	19.1	110	22.8
Stigma or discrimination	18	26.9	140	41.8	224	46.4

Table 5. EHE-funded RWHAP Part F AIDS Education and Training Center Program training events, by year and training topic, July 2019–June 2022—United States and 3 territories *(cont.)*

	July 2019–June 2020		July 2020–June 2021		July 2021–June 2022	
	N	%	N	%	N	%
Health care organization or systems issues						
Billing for services and payment models	1	1.5	18	5.4	61	12.6
Case management	4	6.0	26	7.8	73	15.1
Community linkages	17	25.4	80	23.9	135	28.0
Confidentiality/HIPAA	1	1.5	17	5.1	10	2.1
Coordination of care	8	11.9	89	26.6	171	35.4
Funding or resource allocation	1	1.5	7	2.1	20	4.1
Health insurance coverage	2	3.0	18	5.4	30	6.2
Legal issues	0	0.0	10	3.0	46	9.5
Organizational infrastructure	5	7.5	9	2.7	73	15.1
Organizational needs assessment	9	13.4	6	1.8	52	10.8
Patient-centered medical home	0	0.0	23	6.9	48	9.9
Practice transformation	1	1.5	11	3.3	18	3.7
Quality improvement	12	17.9	32	9.6	76	15.7
Team-based care	8	11.9	7	2.1	59	12.2
Telehealth	2	3.0	10	3.0	42	8.7
Use of technology for patient care	2	3.0	5	1.5	15	3.1
Priority populations						
Children (Ages 0–12)	1	1.5	6	1.8	2	0.4
Adolescents (Ages 13–17)	1	1.5	40	11.9	60	12.4
Young adults (Ages 18–24)	16	23.9	206	61.5	209	43.3
Older adults (Ages 50 and over)	23	34.3	116	34.6	123	25.5
American Indian or Alaska Native	1	1.5	32	9.6	28	5.8
Asian	1	1.5	28	8.4	29	6.0
Black or African American	22	32.8	242	72.2	241	49.9
Hispanic or Latino	6	9.0	174	51.9	144	29.8
Native Hawaiian or Pacific Islander	1	1.5	24	7.2	28	5.8
Other race/ethnicity	0	0.0	0	0.0	1	0.2
Women	16	23.9	222	66.3	207	42.9
Gay, lesbian, bisexual, transgender, or other gender identity	19	28.4	251	74.9	240	49.7
Homeless or unstably housed	10	14.9	195	58.2	124	25.7
Immigrant populations	1	1.5	100	29.9	70	14.5
Incarcerated or recently released	3	4.5	123	36.7	68	14.1
Other specific populations	0	0.0	2	0.6	14	2.9
Rural populations	8	11.9	140	41.8	147	30.4
U.S.–Mexico border population	1	1.5	1	0.3	9	1.9
Total number of training events	**67**	**—**	**335**	**—**	**483**	**—**

Abbreviations: EHE, Ending the HIV Epidemic; HIPAA, Health Insurance Portability and Accountability Act; HPV, human papillomavirus; HRSA HAB, Health Resources and Services Administration HIV/AIDS Bureau; U=U, Undetectable = Untransmittable.

Note: Training topics are not mutually exclusive; percentages may not sum to 100%.

Table 6. EHE-funded RWHAP Part F AIDS Education and Training Center Program participants, by year and selected characteristics, July 2019–June 2022—United States and 3 territories

	July 2019–June 2020		July 2020–June 2021		July 2021–June 2022	
	N	%	N	%	N	%
Race/ethnicity						
American Indian/Alaska Native	2	0.3	23	0.8	23	0.5
Asian	27	4.1	161	5.3	239	5.4
Black/African American	237	36.2	999	32.9	1,481	33.7
Hispanic/Latino[a]	86	13.1	329	10.8	699	15.9
Native Hawaiian/Pacific Islander	2	0.3	18	0.6	8	0.2
White	271	41.4	1,393	45.9	1,752	39.9
Multiple races	30	4.6	115	3.8	192	4.4
Subtotal	**655**	**100.0**	**3,038**	**100.0**	**4,394**	**100.0**
Gender						
Male	118	18.0	648	21.0	1,013	22.2
Female	526	80.2	2,371	77.0	3,438	75.4
Transgender male	4	0.6	9	0.3	14	0.3
Transgender female	6	0.9	16	0.5	17	0.4
Other gender identity	2	0.3	37	1.2	76	1.7
Subtotal	**656**	**100.0**	**3,081**	**100.0**	**4,558**	**100.0**
Professional discipline						
Clergy/faith-based professional	0	0.0	2	0.1	5	0.1
Community health worker	97	14.6	297	9.3	557	12.3
Dentist	2	0.3	187	5.8	36	0.8
Dietitian/nutritionist	3	0.5	17	0.5	9	0.2
Mental/behavioral health professional	33	5.0	107	3.3	156	3.4
Midwife	1	0.2	6	0.2	18	0.4
Nurse practitioner/nurse professional (prescriber)	30	4.5	189	5.9	296	6.5
Nurse professional (non-prescriber)	84	12.6	446	13.9	469	10.3
Other allied health professional	18	2.7	80	2.5	99	2.2
Other dental professional	0	0.0	69	2.2	23	0.5
Other non-clinical professional	80	12.0	289	9.0	403	8.9
Other public health professional	123	18.5	454	14.2	843	18.6
Pharmacist	18	2.7	185	5.8	277	6.1
Physician	33	5.0	174	5.4	402	8.9
Physician assistant	3	0.5	24	0.7	47	1.0
Practice administrator or leader	16	2.4	41	1.3	104	2.3
Social worker	155	23.3	560	17.5	882	19.4
Substance abuse professional	16	2.4	74	2.3	101	2.2
Subtotal	**666**	**100.0**	**3,201**	**100.0**	**4,538**	**100.0**
Role in their organization						
Administrator	98	14.7	330	10.3	597	13.3
Agency board member	1	0.2	5	0.2	7	0.2
Care provider/clinician—can or does prescribe HIV treatment	60	9.0	260	8.1	501	11.2
Care provider/clinician—cannot or does not prescribe HIV treatment	62	9.3	416	13.0	563	12.6
Case manager	145	21.8	507	15.9	783	17.5
Client/patient educator (includes navigator)	64	9.6	229	7.2	414	9.2
Clinical/medical assistant	20	3.0	78	2.4	112	2.5
Health care organization non-clinical staff	55	8.3	128	4.0	183	4.1
HIV tester	43	6.5	141	4.4	268	6.0
Intern/resident	2	0.3	153	4.8	102	2.3
Other	106	15.9	551	17.3	817	18.2
Researcher/evaluator	18	2.7	76	2.4	140	3.1
Student/graduate student	18	2.7	233	7.3	110	2.5
Teacher/faculty	30	4.5	85	2.7	143	3.2
Subtotal	**666**	**100.0**	**3,192**	**100.0**	**4,478**	**100.0**
Total number of participants	**669**	**—**	**3,286**	**—**	**4,646**	**—**

Abbreviations: EHE, Ending the HIV Epidemic; HRSA HAB, Health Resources and Services Administration HIV/AIDS Bureau.

Note: Participants reporting for July 2019–June 2020 and July 2020–June 2021 selected all profession/disciplines and primary functional roles that apply. Data for these years are not mutually exclusive; numbers may not sum to the subtotal and percentages may not sum to 100.0%.

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

Table 7. EHE-funded RWHAP Part F AIDS Education and Training Center Program participants, by year and employment setting, July 2019–June 2022—United States and 3 territories

	July 2019–June 2020		July 2020–June 2021		July 2021–June 2022	
	N	%	N	%	N	%
Employment setting						
Academic health center	35	5.4	364	11.7	418	9.1
Correctional facility	4	0.6	26	0.8	36	0.8
Emergency department	2	0.3	11	0.4	13	0.3
Employment setting does not involve the provision of care or services to patients/clients	48	7.3	139	4.5	82	1.8
Family planning clinic	4	0.6	27	0.9	32	0.7
Federally qualified health center	92	14.1	412	13.3	647	14.1
HIV or infectious diseases clinic	114	17.4	452	14.6	864	18.8
HMO/managed care organization	10	1.5	26	0.8	43	0.9
Hospital-based clinic	43	6.6	139	4.5	260	5.7
Indian health services/tribal clinic	1	0.2	14	0.5	9	0.2
Long-term nursing facility	2	0.3	7	0.2	15	0.3
Maternal/child health clinic	2	0.3	7	0.2	20	0.4
Mental health clinic	6	0.9	37	1.2	63	1.4
Military or veteran's health facility	2	0.3	2	0.1	7	0.2
Not working	19	2.9	126	4.1	222	4.8
Other community-based organization	138	21.1	439	14.1	652	14.2
Other federal health facility	9	1.4	26	0.8	59	1.3
Other primary care setting	24	3.7	95	3.1	139	3.0
Pharmacy	11	1.7	106	3.4	142	3.1
Private practice	11	1.7	43	1.4	62	1.4
State or local health department	100	15.3	425	13.7	788	17.2
STD clinic	15	2.3	57	1.8	137	3.0
Student health clinic	7	1.1	53	1.7	22	0.5
Substance abuse treatment center	17	2.6	73	2.4	107	2.3
Subtotal	**654**	**100.0**	**3,106**	**100.0**	**4,591**	**100.0**
Rural and suburban/urban employment settings						
Rural settings only	21	3.7	449	14.5	392	9.1
Both rural and suburban/urban settings[a]	14	2.4	62	2.0	77	1.8
Suburban/urban settings only	537	93.9	2,584	83.5	3,857	89.2
Subtotal	**572**	**100.0**	**3,095**	**100.0**	**4,326**	**100.0**
Total number of participants	**669**	**—**	**3,286**	**—**	**4,646**	**—**

Abbreviations: EHE, Ending the HIV Epidemic; HMO, health maintenance organization; HRSA HAB, Health Resources and Services Administration HIV/AIDS Bureau; STD, sexually transmitted disease.

Note: Participants reporting for July 2019–June 2020 and July 2020–June 2021 selected all employment settings that apply. Data for these years are not mutually exclusive; numbers may not sum to the subtotal and percentages may not sum to 100.0%. The subtotal for employment setting is the number of unique participants who selected at least one employment setting category.

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

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APPENDIX

In fiscal year (FY) 2020, HIV/AIDS Bureau (HAB) awarded $63 million in Ending the HIV Epidemic in the U.S. (EHE) initiative funds to 47 jurisdictions, two technical assistance providers, and 11 Ryan White HIV/AIDS Program (RWHAP) AIDS Education and Training Center (AETC) Program recipients. In FY 2021, $99 million was awarded to these recipients (including one additional AETC recipient). In FY 2022, $115 million was awarded to 60 HRSA HAB EHE recipients (47 HRSA HAB EHE recipients, two technical assistance providers, and 11 RWHAP AETC Program recipients).

Appendix Table 1. HIV/AIDS Bureau EHE Awards

Recipient	Jurisdiction	EHE Focus County(ies) 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

Recipient	Jurisdiction	EHE Focus County(ies) or State
Memphis, TN	Memphis, TN	Shelby County
Oakland, CA	Oakland, CA	Alameda County
Orange County, CA	Santa Ana, CA	Orange County
Riverside–San Bernardino, CA	San Bernardino, CA	Riverside County; San Bernardino County
Sacramento, CA	Sacramento, CA	Sacramento County
San Antonio, TX	San Antonio, TX	Bexar County
Seattle, WA	Seattle, WA	King County
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

Appendix Table 2. HIV/AIDS Bureau EHE Technical Assistance and Systems Coordination Provider Awards, FY 2022

Recipient	Organization
Ending the HIV Epidemic in the U.S. – Technical Assistance Provider, New York, NY	Cicatelli Associates, Inc.
Ending the HIV Epidemic in the U.S. – Systems Coordination Provider, Washington, DC	National Alliance of State & Territorial AIDS Directors (NASTAD)

Appendix Table 3. Ryan White HIV/AIDS Program Part F AIDS Education and Training Center Program EHE Awards, FY 2022

Recipient	AETC
University of California, San Francisco	National Clinician Consultation Center
Rutgers, The State University of New Jersey Biomedical & Health Sciences	National Coordinating Resource Center
University of Washington	National HIV Curriculum e-Learning Platform
University of California, San Francisco	Pacific
University of Pittsburgh	Mid Atlantic
University of Illinois	Midwest
The University of New Mexico	South Central
Vanderbilt University	Southeast
Trustees of Columbia University in the City of New York	Northeast/Caribbean
University of Washington	Mountain West
University of Massachusetts	New England

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

RWHAP Compass Dashboard, a user-friendly, interactive data tool to visualize the reach, impact, and outcomes of the RWHAP: ryanwhite.hrsa.gov/data/dashboard

TargetHIV, tools for the Ryan White HIV/AIDS Program community: targethiv.org