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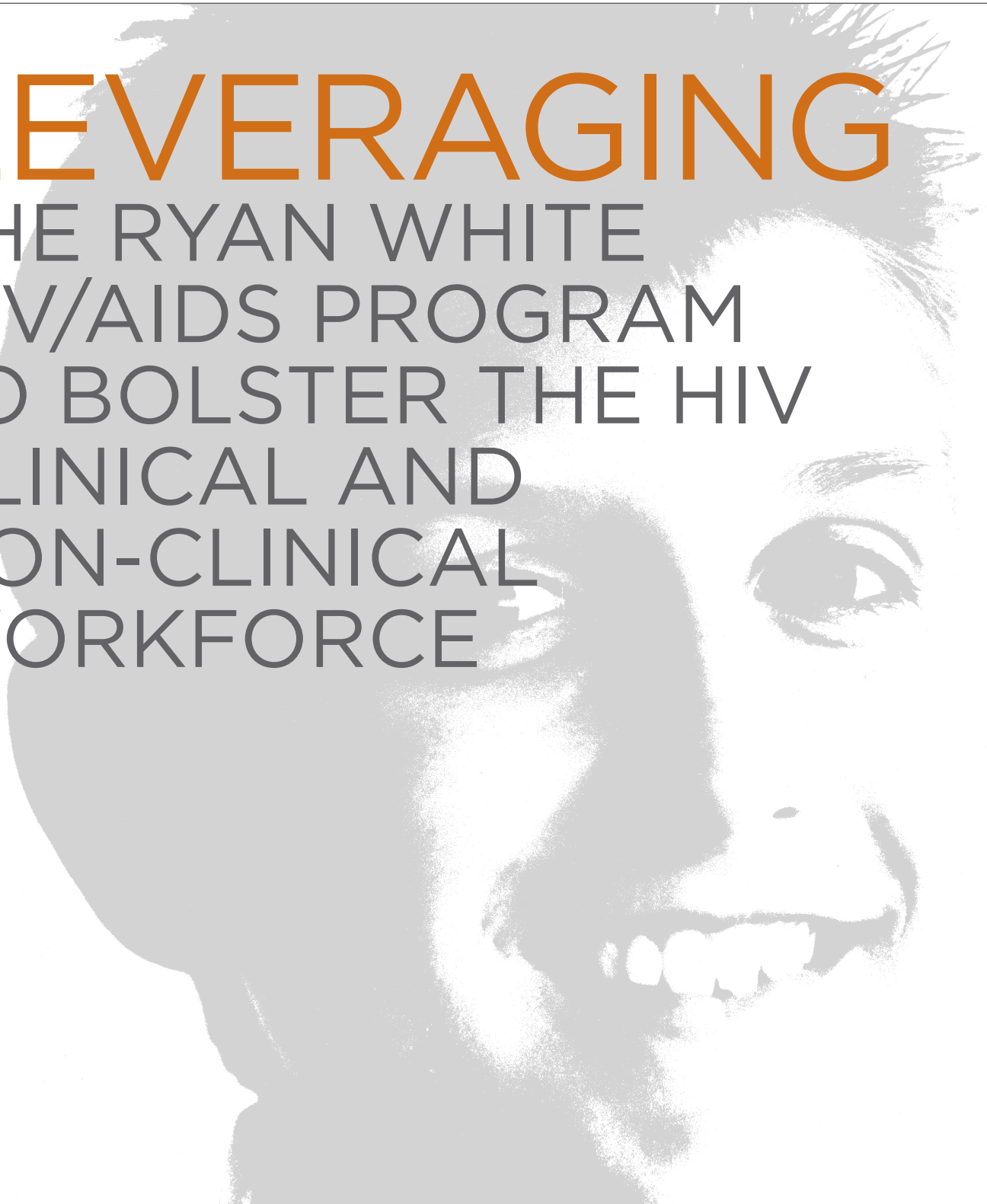
REIMAGINING THE
RYAN WHITE
HIV/AIDS PROGRAM

JUNE 2015

PROTECTING THE LEGACY – IMPROVING HIV HEALTH OUTCOMES

LEVERAGING

THE RYAN WHITE
HIV/AIDS PROGRAM
TO BOLSTER THE HIV
CLINICAL AND
NON-CLINICAL
WORKFORCE



JUNE 2015

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This issue brief was developed independently of, but informed by an expert consultation held in Washington, DC in December 2014 of approximately 30 diverse stakeholders, including people with HIV, HIV medical and non-medical providers, Ryan White grantees, and federal HIV policy and program staff. The project is guided by an advisory group consisting of:

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THE RYAN WHITE POLICY PROJECT

seeks to generate and evaluate ideas for adapting the Ryan White HIV/AIDS program to be maximally effective in a changing health system.

Some might question whether we need a dedicated HIV care and treatment program now that the Affordable Care Act (ACA) has prohibited discrimination on the basis of health status and expanded access to insurance coverage.

Yes. Continuing the Ryan White HIV/AIDS program is necessary to maintain twenty-five years of investment that has saved lives and improved HIV health outcomes. It has yielded a nationwide system of clinical and non-clinical providers equipped to meet the complex and specialized needs of people with HIV in a manner that is culturally relevant and effective. In addition, the Ryan White program provides an extraordinary example of the effectiveness of an integrated care model in decreasing the morbidity and mortality of what would otherwise be a terminal illness.

While the Ryan White program was created in the early years of the epidemic as an “exceptional” response to a national crisis, this focused response to HIV remains important because of the continuing serious public health aspects of HIV. If we do not address the care and treatment needs of people with HIV, the epidemic will spread and increase the costs it imposes on the Nation. The Ryan White program sits alongside other programs such as those that serve people with mental health and substance abuse disorders at the Substance Abuse and Mental Health Services Administration (SAMHSA), programs for people with developmental disabilities and seniors within the Administration for Community Living, and special eligibility options for specific populations within certain Federal programs. All of these were designed by past Congresses and Administrations to provide cost-effective responses to specific health threats facing the American people.

People with HIV who are in care, on treatment, and virally suppressed are unlikely to transmit HIV to others. Recent data indicate that more than 60% of HIV transmissions in the United States occur among people with HIV who have been diagnosed, but are not in regular care compared to fewer than 10% of

transmissions among people diagnosed and in care (*JAMA*, Skarbinski, 2015). The Ryan White program supports people to remain engaged in care. New analyses from CDC and HRSA show that uninsured people with HIV receiving Ryan White services are more likely to be virally suppressed than people with HIV who have insurance, but no access to Ryan White services (CROI 2015 Abstract 1064, Bradley). Further, the same study found that people with HIV with private insurance or Medicaid who receive supplemental coverage from Ryan White were more likely to be prescribed antiretroviral therapy (ART) and people with HIV in Medicaid and Medicare with supplemental coverage from Ryan White were more likely to be virally suppressed than if they did not receive supplemental Ryan White services. In 2010, more than 70% of Ryan White program clients had Medicaid, Medicare, or private insurance, yet they turned to the Ryan White program because insurance, on its own, does not meet all of their health care needs. Moreover, some people with HIV remain ineligible for insurance coverage.

Early experience with the ACA coverage expansions demonstrates that gaps remain. For example, many health plans have placed all HIV medications in the highest cost tiers. A study in 12 states found that when people with HIV enrolled in these plans, their costs were three times higher than in plans with different formulary structures. Even factoring in lower premiums and the annual out-of-pocket limit, researchers concluded that persons enrolled in such plans paid about \$3,000 more each year than if they had enrolled in a plan with a different formulary structure (*NEJM*, Jacobs and Sommers, 2015). The Ryan White program serves as the essential backstop payer of last resort for HIV health services.

For background on the Ryan White HIV/AIDS Program, see the Kaiser Family Foundation issue brief developed as a collaboration between the Foundation and the O’Neill Institute: *Updating The Ryan White HIV/AIDS Program For A New Era: Key Issues & Questions For The Future*. (Available at kff.org)

The US economy depends on a strong infrastructure of roads and bridges, modern information technology, and a well-trained and productive workforce to sustain itself; these are also critical elements of a vibrant response to the Nation's HIV epidemic.

We need to maintain systems of care in clinics and communities; we need to develop and improve systems to integrate, collect and use data; and we need to reward a spirit of innovation and a willingness to adapt to an evolving epidemic with new opportunities to better support people with HIV in systems of care. To accomplish these things, we need an energized, diverse, and qualified HIV workforce.

This workforce consists of physicians, nurses, physician assistants, nurse practitioners, pharmacists, and other health professionals working in clinical settings. It also includes social workers, case managers, peer counselors, insurance navigators, community health workers, rehabilitation counselors, and others performing critical roles that support people to engage and stay engaged in HIV care, working in both clinical and community settings. Importantly, people living with HIV are often both clients of HIV programs and workforce contributors, whether as paid staff or volunteers. The Ryan White HIV/AIDS Program, our primary federal program dedicated to responding to the care and treatment needs of people with HIV, is also the main federal program dedicated to maintaining and growing the HIV workforce.

Once patients are retained in regular clinical care, the health system, with the support of the Ryan White program, does a fairly good job of getting people with HIV onto treatment and virally suppressed. The weak link, however, is that once diagnosed, too many are not linked to HIV clinical care or are unable to maintain an ongoing relationship with an HIV care provider. To do better, we need a broad range of paid clinical and non-clinical providers, as well as community volunteers.

Responding to HIV requires providers who have the knowledge and expertise to manage a complex and rapidly changing medical condition. Indeed, the science of HIV evolves continuously and requires more regular training and updating of providers than for many other conditions, making the need to attain and maintain current knowledge of clinical standards and practices a continuing challenge. Moreover, responding to HIV requires a workforce of professionals who can overcome the structural barriers that keep people out of care, including poverty, persistent stigma and discrimination, and high rates of co-existing medical conditions and mental health and substance abuse disorders. Further, it also requires a diverse workforce equipped to mitigate large disparities that exist in access to care and health outcomes.

Many people went into providing HIV care and services early in the epidemic when HIV was an emerging and frightening health problem. There is a whole generation of people (health professionals, social services providers, and community members alike) who have labored heroically to bring us to the place where we are. Just as we are poised for so much progress, we are starting to witness a turnover where many of these individuals are approaching the end of their careers.

Today, we need to rejuvenate and re-energize the workforce by retaining and supporting existing workers and attracting new people to engage in HIV care, whether as a primary professional focus or as part of broader efforts to meet community health care needs.

To assist policymakers in thinking about how the Ryan White program can most effectively support the HIV workforce today and build the workforce for the future, this brief examines three issues:

1

IDENTIFYING AND RESPONDING
to the needs of the HIV non-clinical workforce

2

**RECRUITING, SUPPORTING,
AND RETAINING**
clinical care providers

3

BETTER INTEGRATING
people with HIV as critical contributors to the HIV workforce

IDENTIFYING AND RESPONDING TO THE NEEDS OF THE HIV NON-CLINICAL WORKFORCE

For purposes of this brief, when we talk about the non-clinical workforce, we are referencing a diverse workforce typically employed by community based organizations or other entities that do not provide HIV primary care or specialty care services, as well as clinics, hospitals, and other health care entities. The types of professionals included include social workers, case managers, test counselors, peer navigators, benefits counselors, re-engagement specialists, rehabilitation counselors, and others. Ideally, these individuals do not operate independently as social services providers, but are either directly or indirectly working in support of an integrated care team. The next phase of development of the Ryan White program and the development of new HIV models of care more generally will likely involve better integrating HIV prevention and care providers and strengthening the integration of non-clinical professionals within clinical care teams. This is needed to support people with HIV to access health

care services, navigate the health system, initiate antiretroviral therapy (ART), adhere to ART, take steps to maintain health, and re-engage people who have stopped participating in regular health care.

The need for non-clinical professionals is not new. What may be new, however, is an increased focus on prioritizing specific roles for these providers, such as (a) benefits counselors who are needed as more people gain access to insurance and struggle with navigating new and changing health systems, and (b) re-engagement specialists who are trained to identify and work with clients who have stopped engaging in HIV care in order to bring people back into regular and appropriate HIV health care.

We often look to community based organizations to provide leadership in linking people to care, re-engaging people who have fallen out of care, and supporting people to navigate the health system and remain adherent to treatment. The most effective programs, however, often are those where these community functions are tightly integrated with the medical care team.

Our workforce training efforts need to reflect this reality and provide training that facilitates greater integration.

POLICY RECOMMENDATIONS FOR THE RYAN WHITE PROGRAM

ENCOURAGE

FURTHER INTEGRATION AND CO-LOCATION OF NON- CLINICAL PROVIDERS IN CLINICAL CARE TEAMS

A legacy of the Ryan White program and an ongoing part of the structure of the program is that community-based non-clinical providers often are funded independently of clinical providers. While some models exist or are being tested to bring more of these functions into the clinical setting, that is not always the best approach. Policymakers may wish to consider structural changes to how funding is awarded and grant outcomes are established to better align responsibilities and incentives of clinical and non-clinical providers so that they work to achieve the same outcomes, benefit from collaboration, and minimize competition between agencies providing these essential functions. As part of this type of exercise, consideration should be given to task shifting, and potentially strengthening the role of nurse practitioners to play an enhanced role as clinical providers and non-clinical providers to take on expanded roles in supporting engagement and re-engagement in care.¹

ASSESS

THE NEED FOR SPECIFIC TYPES OF NON-CLINICAL PROVIDERS AND EXPAND STAFFING CAPACITY

As we seek to improve engagement in care along the HIV care continuum (which encompasses stages of care from HIV diagnosis to viral suppression) and as there is growing enthusiasm for more integrated care delivery models, policymakers should assess specific workforce needs and prioritize training and capacity building for specific functions. As more people gain access to insurance coverage, they often have challenges navigating insurance systems, filing complaints or appeals when services are denied, and troubleshooting billing or access issues. Trained and experienced benefits counselors and insurance navigators can also support the best, most effective use of limited Ryan White resources by ensuring full access to insurance benefits and other payment sources. Therefore, expanding capacity to provide trained benefits counselors or insurance navigators may be important.

Another critically important role that directly supports engagement in care is that of re-engagement specialists. Building the system wide capacity to support re-engagement in care by training re-engagement specialists is likely to be among the most critically important roles of the Ryan White program over the coming years.

ENHANCE

COLLABORATION AMONG THE SEPARATE RYAN WHITE PROGRAMS IN THE TRAINING OF NON-CLINICAL PROFESSIONALS

The AIDS Education and Training Center (AETC) program, and grantees under Ryan White Parts A-D and the Special Projects of National Significance (SPNS) program could all play a role in supporting the training and capacity building of non-clinical providers. Consideration should be given to how to prioritize workforce training and professional development for the positions most likely to help retain and re-engage people in care. While the AETC program may have a lead responsibility, other parts of Ryan White partner can be effective partners to support the work of AETC programs. Improved coordination across different parts of the Ryan White program also could help to reduce duplication of effort and facilitate using the AETCs to disseminate model programs and best practices developed through the SPNS program or other parts of the Ryan White program.

POLICY RECOMMENDATIONS FOR OUTSIDE OF THE RYAN WHITE PROGRAM

UTILIZE

MEDICAID AND MEDICARE INNOVATIONS, INCLUDING THE DEPLOYMENT OF COMMUNITY HEALTH WORKERS AND THE ADOPTION OF ACCOUNTABLE CARE ORGANIZATIONS (ACOS)

Health centers often have relied on community health workers and the ACA has expanded funding for them. While not focused on HIV, CMS and HRSA should explore ways that Medicaid programs can leverage community health worker programs to help address the comprehensive needs of people with HIV. More work could be done to create licensure programs and to take other steps to standardize the training and the roles and responsibilities of community health workers in order to reduce barriers to their employment and deployment as critical contributors to the HIV health care workforce.

Accountable Care Organizations (ACOs) are provider-run organizations that exist in Medicaid, Medicare, and among private insurance plans in which the participating providers are collectively responsible for the care of an enrolled population and may share in any savings associated with improvements in the

quality and efficiency of the care they provide.² To date, the emphasis of these programs has been on broader populations, such as persons that use long-term services and supports and the HIV population has received limited attention. Given the prevalence of overlapping mental health, substance use, and other conditions among people living with HIV, this type of model offers the potential to yield important improvements in engagement in HIV care and improvements in overall health if such programs are appropriately designed and evaluated to work effectively for people with HIV. The ACO model for people with HIV also can better engage primary care physicians in early identification and referral to the appropriate care system. The adoption of ACOs for people with HIV merits more consideration.

RECRUITING, SUPPORTING AND RETAINING CLINICAL CARE PROVIDERS

As HIV has become more manageable with numerous effective ART regimens, it continues to require clinicians to learn the complexities of managing ART in conjunction with treatment for co-occurring conditions common in people with HIV and staying current with the latest HIV treatment standards. There is ongoing dialogue over the care and medical management of HIV within primary care settings. Some would like to push for a greater role for primary care to manage the care of people with HIV, while others assert that we need to focus more on sustaining and expanding access to HIV specialty care. The likely answer is that we need to move forward in both of these directions, although factors such as primary care provider productivity standards, poor reimbursement and stigma challenge widespread integration of HIV into typical primary care settings, including community health centers that do not receive Ryan White funding. Even in primary care settings, however, our ultimate success depends on ensuring an adequate supply of clinical providers with the capacity to medically manage HIV. This requires that primary care providers maintain either a minimum HIV caseload and expertise in addition to staying current on evolving HIV care and treatment standards or it calls for a strong system for maintaining easy and routine access to consultative services from HIV specialists. Additionally, it will be important to ensure that health centers and other primary care sites that seek to serve people with HIV have funding for the full range of needed support services, starting with effective case management services.

Sustaining our current system of HIV clinical providers has multiple challenges. These include: (a) creating interest in HIV care when health professionals are in medical school or during their residency programs; (b) addressing structural barriers (including poor reimbursement) that prevent physician, nurse, physician assistant, and other trainees from focusing on HIV care; (c) training about and engaging in practice transformation so that a variety of specialists and other professionals who interact and serve people with HIV on an occasional basis are comfortable with managing unique manifestations related to HIV; and, (d) investing in ongoing education and peer-interactions to keep the existing workforce up-to-date on treatment advances, evolving clinical issues, and changes in health care financing and delivery systems. We also need to address HIV stigma and discrimination that also exists within the clinical and medical community. In addition, we need to rejuvenate the passion in new and young clinicians just beginning their medical careers that drew the first generation of HIV providers to the field.

POLICY RECOMMENDATIONS FOR THE RYAN WHITE PROGRAM

ALLOCATE

MORE RYAN WHITE RESOURCES FOR THE AETC PROGRAM

The AIDS Education and Training Center (AETC) program is not the only component of the Ryan White program with important responsibility for supporting the workforce, but it is the component of the program that has primary responsibility for providing education support for the HIV workforce (See insert on the new direction of the AETC program). Funded at around \$33 million per year, Congress and the Administration may need to consider whether the program has adequate funding to achieve the multiple roles assigned to it.³ In HRSA's most recent funding announcement, the maximum award for the regional AETC with the smallest award is \$2.5 million per year for the New England AETC, which covers six states. The largest award, which has a maximum of \$4.7 million, goes to the Southeast AETC, which covers 8 states, many of which are high HIV prevalence states. It is reasonable to ask whether this is sufficient funding for all of the education and workforce development needs placed on these centers. While people who have engaged with the AETC network have always acknowledged their commitment, some have questioned whether the program has been adequately focused. The recent funding announcement from HRSA, however, has added a significant new orientation for the AETC program that will likely ensure that the AETC network is more focused and better equipped to support the HIV clinical and non-clinical workforce going forward. It will be important to evaluate the impact of the re-direction of the program and consider appropriate funding levels to reach HIV workforce capacity targets. It is also worth noting that funding for the program has been flat over many years while the clinical competencies required to successfully care for people with HIV have changed dramatically, and in many cases have become more complex. Since a well-trained high quality workforce is the underpinning of an effective Ryan White program, even within a level-funded Ryan White program, it may be time to consider perhaps doubling or tripling funding for practice transformation and workforce development support through the AETC network, even if it means allocating funds from other parts of the Ryan White program.

ESTABLISH

A CORE SET OF INDICATORS TO MONITOR PROGRAM OUTCOMES AND PROGRESS TOWARD MAINTAINING ADEQUATE NUMBERS OF HIV-TRAINED CLINICAL PROVIDERS

One of the challenges for the AETC program is reporting on meaningful metrics that can be used to assess whether the program and the individual centers are having the necessary impact. HRSA reports that in the 2012-2013 grant year, the AETC program conducted 15,670 trainings and reached 115,680 participants.⁴ While this shows that the program is reaching a certain level of volume, it tells us nothing about whether the trainings are sufficient for individual health professionals. Indeed, as HRSA's new direction recognizes in requiring a focus on practice transformation, a one-time training is not likely adequate to meet the needs of many individuals. They seek to renew the focus on whole health care teams by utilizing longitudinal, long-term skills building, mentoring, and professional development. Further, reporting on the number of trainings tells us nothing about which types of providers are receiving training and the overall pool of providers who need training. More attention may be needed on measuring how AETC programs and services lead to improvements in practice.

Going forward, HRSA is encouraged to be more proactive in analyzing and sharing workforce data that it currently maintains. Further, policymakers may want to give more thought to how to assess the community's need for AETC services and how to effectively monitor progress and measure impact. It should be noted that there are no obvious indicators that the program should be using. The lack of effective metrics to-date does not stem from a resistance to effective measurement, as much as the difficulties of identifying appropriate and effective measures. Across the HIV service system, there is a growing focus on both streamlining the number of indicators that are reported and ensuring that the metrics that programs use are valuable. The AETC program needs to be part of this policy dialogue working to develop and implement performance standards that are consistent with best practices for other workforce training programs and that effectively demonstrate the value of the AETC program when public resources are limited.

CHARTING A NEW COURSE FOR THE AIDS EDUCATION AND TRAINING CENTER (AETC) PROGRAM

The AETC program is the component of the Ryan White program with lead responsibility for workforce training and capacity building. Funded under the Ryan White Part F program with an FY 2014 appropriation of \$33.6 million, the AETC program supports 6 national centers or initiatives and a regional network of 8 regional AETCs in FY 2015 (A reduction from a network of 11 regional AETCs in prior years).

WHAT IS THE AETC'S MISSION? The program exists to increase the number of health care professionals who are educated to counsel, diagnose, treat, and medically manage people living with HIV and to help prevent high-risk behaviors that lead to HIV transmission. As part of this effort, the goal of the Regional AETCs is to increase the size and strengthen the skills of the current and novice HIV clinical workforce, improve outcomes along the care continuum, in alignment with the National HIV/AIDS Strategy, and reduce HIV incidence by improving the achievement and maintenance of HIV viral load suppression.

WHO DOES THE PROGRAM SERVE? The AETCs target health care providers and allied health professionals, but they do not need to be HIV experts. Allied health professionals include positions such as medical case managers, social workers, and others who assist people with HIV to adhere to treatment, learn about and practice secondary prevention, and receive appropriate social support. Allied health professionals do not need to be employed in a clinical setting. Therefore, community based organizations whose staff participate on an integrated care team with a clinical partner organization are eligible to receive AETC services.

HOW HAS HRSA UPDATED ITS PROGRAM GUIDANCE? In 2015, HRSA updated its guidance for the AETC program with its Funding Opportunity Announcement (FOA) for regional AETCs for the next four years:

- **Fewer Regions:** The new FOA has reduced the number of regions from 11 to 8. They match the geographic areas covered by HHS's 10 regions, with HHS regions 8 and 10 making up the Frontier AETC region and HHS regions 5 and 7 making up the Midwest AETC region.

- **Emphasizes the HIV care continuum:** The program requires AETCs to align their efforts with the National HIV/AIDS Strategy and focus on improving outcomes along the care continuum.
- **Practice Transformation:** For established providers, the regional AETCs are to focus on practice transformation that integrates the principles of the patient-centered medical home model and integrating HIV care and behavioral health services. AETCs must identify at least three community health centers (CHCs) that are not Ryan White grantees or sub-grantees and at least three sub-grantees of Ryan White Parts A or B to work together on a four-year longitudinal project.
- **HIV Interprofessional Education (IPE) Projects:** The FOA formalizes a common AETC practice by requiring all regional AETCs to establish an HIV Interprofessional Education (IPE) project. This involves partnering with accredited schools of medicine, nursing, and pharmacy (and, if they choose, schools of dentistry, behavioral health, social work, public health and allied health) to incorporate integrated, interprofessional hands-on clinical learning and team building skills.
- **Collaboration across the AETC network:** The AETCs also are required to work together to enhance their performance and reduce duplication across the network.
- **Cooperative agreements instead of grants:** HRSA has changed the funding mechanism for the regional AETCs from a grant program to cooperative agreements that allow HRSA to work more closely with the AETCs to develop trainings that have both impact at the local, regional, and national levels. HRSA also will be able to work with the AETCs to more effectively emphasize a set of core competencies for the HIV workforce, emphasize new and effective teaching modalities using e-learning, and continue AETC efforts to expand the use of tele-health to improve access to services and technical assistance.

Sources: Information about the AETC program was taken from the Ryan White HIV/AIDS Program Fact Sheet (October 2014) available at <http://hab.hrsa.gov/about/hab/parteducation.html> and the Regional AETC Funding Opportunity Announcement for FY 2015 (HRSA-15-032) released in January 2015, available at <http://www.grants.gov>.

POLICY RECOMMENDATIONS FOR THE RYAN WHITE PROGRAM

ESTABLISH PARTNERSHIPS WITH PROFESSIONAL ASSOCIATIONS TO DEFINE AND STANDARDIZE HIV CLINICAL COMPETENCIES

HRSA has recognized the need to define core HIV clinical competencies for different professionals serving on an integrated health care team. In fact, the new AETC policy direction will likely lead to greater standardization. At the same time, more comprehensive efforts may be needed and it will be important to both minimize duplication of effort and avoid the development of competing standards. Already, various professional associations including the American Academy for HIV Medicine, the Association of Nurses in AIDS Care, the National Alliance for HIV Education and Workforce Development, HealthHIV, the HIV Medicine Association and others are doing important work in this area. Policymakers could consider whether new collaborations are needed or whether existing collaborations require more funding in order to clearly define clinical competencies and then prepare the workforce to meet these competencies. Further, attention may need to be paid to clinics, hospitals, and other facilities to ensure that they are held accountable for preparing their workforces to support engagement in care and improve health outcomes. As will be discussed in the next section, it is important to extend this work beyond health professionals to include allied professionals and peers.

POLICY RECOMMENDATIONS FOR **OUTSIDE** OF THE RYAN WHITE PROGRAM

DEEM RYAN WHITE PART C AND D GRANTEEES AS ELIGIBLE ENTITIES WITHIN HEALTH PROFESSIONAL SHORTAGE AREAS (HPSAs) IN THE SAME MANNER AS COMMUNITY HEALTH CENTERS (CHCs)

The National Health Service Corps is the primary federal program for preparing physicians and other health care providers to serve in underserved communities. It offers new health professionals access to loan repayment in exchange for serving in primary care settings in underserved communities. While its focus is on broadly extending access to primary care, dental care, and mental and behavioral health care in health professional shortage areas (HPSAs), it can be an effective avenue for placing new professionals in HIV clinics. Clinics can apply to be designated a site, but this can be a cumbersome process and there is no guarantee that they will be approved. All Federally Qualified Health Centers and Rural Health Clinics that provide access to care regardless of ability to pay, however, receive automatic HPSA facility designation.⁵ Policymakers could extend the same designation to all Ryan White Parts C and D grantees as a way to expand the capacity to use loan repayment as a tool for recruiting additional HIV providers. A related issue is that several years ago, HRSA considered additional changes to its medically underserved areas (MUA) and medically underserved populations (MUP) designations, but apparently has not taken recent action in this regard. It may be time to take a fresh look at how these designations are determined and whether further refinements are merited.

BETTER INTEGRATING PEOPLE WITH HIV AS CRITICAL CONTRIBUTORS TO THE HIV WORKFORCE

With support from the Ryan White program, the health system does a fairly good job of getting most people who are retained in care to start treatment and achieve viral suppression. More concentrated efforts and new approaches are needed, however, to engage those people who are aware of their HIV status, but unengaged in care. Many people believe that people living with HIV and members of affected communities have a unique and special role to play in supporting people to come to terms with their HIV diagnosis, help them navigate a confusing health system, and overcome structural barriers that prevent them from engaging in care. Indeed, because peers have their own experiences with stigma and discrimination, both in their personal lives and when accessing health care, many individuals find that they are more able to openly discuss questions, concerns, and barriers to care

with a person with HIV rather than with some clinical providers. Many organizations also express support for developing models that use peers in clinical and community settings to support engagement in care. The next phase of the Ryan White program, however, may require HRSA, working alongside the Centers for Disease Control and Prevention (CDC), the Substance Abuse and Mental Health Services Administration (SAMHSA), and other agencies to do even more to evaluate effective peer-based programs, and to better identify optimal approaches to integrating peers within health care teams.

POLICY RECOMMENDATIONS FOR THE RYAN WHITE PROGRAM

IDENTIFY

ROLES, TRAINING
NEEDS, AND CAREER
PATHS FOR PEERS TO SERVE
ON HEALTH CARE TEAMS

Many people who work in HIV care can point to special people with HIV who are incredibly helpful and trusted by other people living with HIV. The challenge comes when clinics and community-based organizations try to scale up peer models beyond one or two exceptional people. HRSA, working with CDC, SAMHSA, and other agencies may consider collaborations to define roles for peers that includes both specific responsibilities and hand-off points to social workers or others with more specialized training. This would also entail developing career paths, with particular attention to vocational rehabilitation, so that people with HIV with deep community roots are able to develop skills over time and rise in the levels of responsibility and scope of activities they perform. Policymakers should consider what level of patient data they can access, as some people have expressed concern regarding accessing care at sites where other community members can see their personal health information. Further consideration also should be given to the role of unpaid community volunteers. As policymakers consider the role of task shifting, attention should be paid to how to effectively use paid and unpaid peers in such approaches.

EXAMINE

AND ADDRESS
REIMBURSEMENT
AND CREDENTIALING
BARRIERS THAT LIMIT
THE DEPLOYMENT
OF PEERS

If peers are to be widely incorporated in health care teams to support retention and engagement in care, organizations will need to have clear mechanisms for paying them. Legal and credentialing issues may need to be addressed in order for Medicaid, Medicare, and private insurers to pay for critical functions when performed by peers. Therefore, HRSA, working with CDC, vocational rehabilitation, one-stops, and other agencies, should provide national guidance and technical assistance to support the expanded role of peers.

ADDRESS

EMPLOYMENT BARRIERS
FOR PERSONS IN RECOVERY,
PERSONS WITH A HISTORY
OF INCARCERATION, AND
PERSONS CONVICTED OF
SEX-RELATED OFFENSES

Many people with HIV have been marginalized by the health system and have experienced deep and traumatic stigma and discrimination. These individuals may be especially receptive to peer-based models that can help them overcome barriers to retention and engagement in care. State laws designed to protect vulnerable populations, such as those that require criminal background checks and make convicted felons ineligible for employment or that limit the ability of persons with a history of substance use or mental illness to serve in certain roles, may create barriers to employing peers for populations facing the greatest stigmatization and with the most distrust of the health system. Policymakers could review existing laws and identify appropriate solutions that protect vulnerable individuals, yet which also allow for the employment of these types of peers. This also may entail working with the Department of Justice to ascertain whether civil rights laws, such as the Americans with Disabilities Act (ADA) can be used to remove such employment barriers.

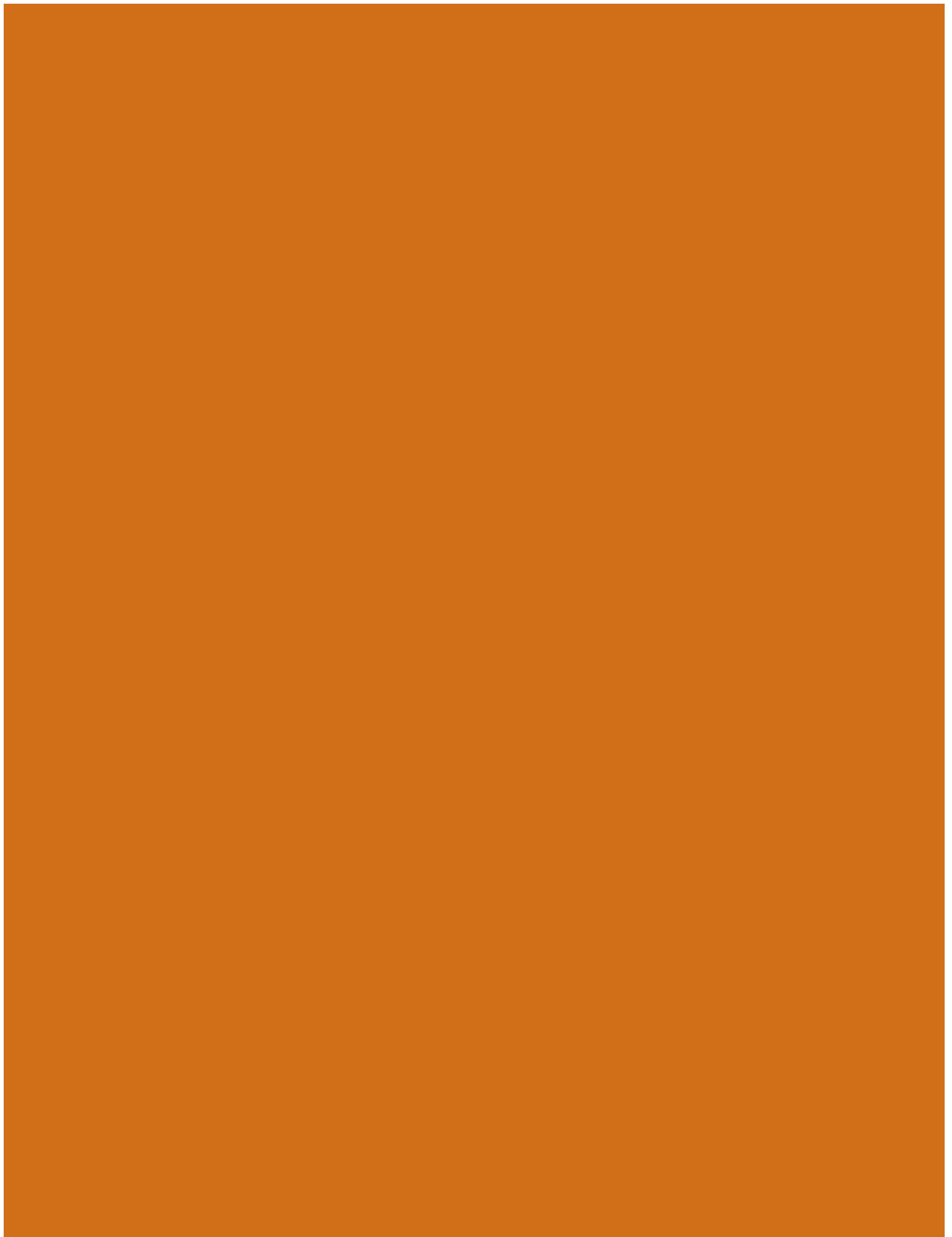
CONCLUSION

The Nation is poised to make significant progress at reducing the scope of the HIV epidemic in the United States if we can take advantage of new science and expanded access to insurance to ensure that all people with HIV are well supported in systems of care. We can get there, but this will require renewing our commitment to building and supporting a workforce of clinical and non-clinical providers that can engage people with HIV in care, re-engage them if they have interruptions in care, and address social, financial, and other barriers that prevent people from being fully engaged in care.

The Ryan White HIV/AIDS Program, working with other federal agencies, can help providers achieve practice transformation. Indeed, HRSA has already taken important steps to better support the HIV workforce now and in the future. We need policymakers to build on HRSA's effort and to ensure that both policies and financial resources are available to keep a vibrant and strong HIV workforce that is fully integrated into the broader health system.

ENDNOTES

- 1 Task shifting is a strategy that has been identified to ameliorate workforce shortages across the health system, but it may have particular relevance to improving HIV care. For background, see “Task shifting: rational redistribution of tasks among health workforce teams: global recommendations and guidelines,” World Health Organization, 2008. Available at <http://www.who.int/healthsystems/TTR-TaskShifting.pdf>.
- 2 See, for example, “Emerging Medicaid Accountable Care Organizations: The Role of Managed Care,” Kaiser Commission on Medicaid and the Uninsured, May 2012. Available at <https://kaiserfamilyfoundation.files.wordpress.com/2013/01/8319.pdf>.
- 3 As one example of the challenges and deficiencies of current efforts to train the HIV workforce, see the recent report on HIV/AIDS science and treatment literacy among the HIV workforce, “When We Know Better, We Do Better: The State of HIV/AIDS Science and Treatment Literacy in the HIV/AIDS Workforce,” Black AIDS Institute, February 2015. Available at <https://www.blackaids.org/images/reports/15-know.pdf>.
- 4 “Ryan White HIV/AIDS Program Fact Sheet: Part F: AIDS Education and Training Centers Program,” HRSA HIV/AIDS Bureau, October 2014. Available at <http://hab.hrsa.gov/abouthab/files/partfaetcfacts2014.pdf>.
- 5 HRSA, see <http://bhpr.hrsa.gov/shortage/hpsas/designationcriteria/index.html>. Accessed on June 7, 2015.



RYAN WHITE WAS AN INDIANA TEENAGER



with hemophilia who was diagnosed with HIV in 1984. He was an object of fear and he faced extreme discrimination when he attempted to attend school in the early years of the HIV epidemic. He was one of the first people that the Nation came to know as living with HIV and he was a prominent champion for an inclusive response toward all persons living with the virus. Ryan died of AIDS in 1990 before he was able to complete

high school. His mother, Jeanne White Ginder continues to advocate for HIV/AIDS issues and educate the public about the impact of this disease.

Later in 1990 when the Congress enacted the first comprehensive national response to HIV, pulling together a few smaller and more targeted initiatives, they named the law the Ryan White Comprehensive AIDS Resources Emergency (CARE) Act. The program has had bipartisan support and has been reauthorized in 1996, 2000, 2006, and 2009. Today, the program works with cities, states, and local community-based organizations to provide services to an estimated 536,000 people living with HIV.

The passion, perseverance, and dedication to providing a caring response to all people in the United States living with HIV as embodied by the Ryan White HIV/AIDS Program is a lasting legacy of Ryan White and the many other people living with HIV and their friends, families, and care providers over the course of the epidemic. Twenty-five years later, the program has become the indispensable linchpin in the Nation's response to the HIV epidemic in the United States.