

# welcome

## **Ryan White HIV/AIDS Program Parts C and D Stakeholders Call**

Health Resources and Services Administration | HIV/AIDS Bureau |

Division of Community HIV/AIDS Programs

July 22, 2022





# Ryan White HIV/AIDS Program Parts C and D Stakeholders Call

July 22, 2021

**Mahyar Mofidi, DMD, PhD**  
**Captain, United States Public Health Service**  
**Director, Division of Community HIV/AIDS Programs (DCHAP)**  
**HIV/AIDS Bureau (HAB)**

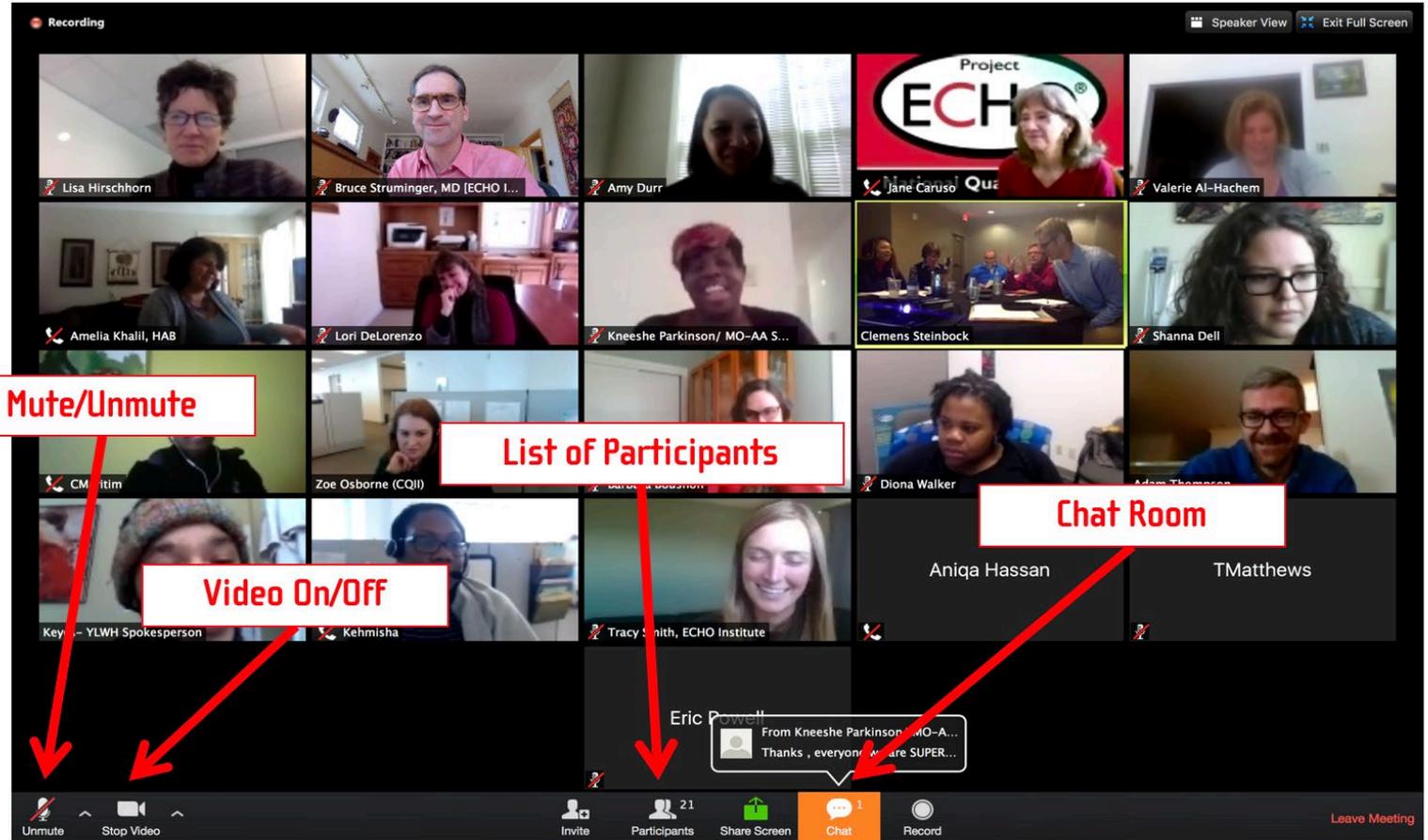
**Vision: Healthy Communities, Healthy People**



# Zoom Platform

## Virtual Etiquette

- Mute your line and stop your video during the presentations
- Chat to ask questions and make comments during the presentations and discussion
- Start your video when you want to speak – we will call on you
- Pair your phone with your computer – to reduce bandwidth



# Meeting Agenda

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- **DCHAP Program Updates**
- **Centering Care for Women, Children, and Adolescents across the HIV Care Continuum**



# HRSA's HIV/AIDS Bureau (HRSA HAB) Vision and Mission



## Vision

Optimal HIV care and treatment for all to end the HIV epidemic in the U.S.

## Mission

Provide leadership and resources to advance HIV care and treatment to improve health outcomes and reduce health disparities for people with HIV and affected communities.



# DCHAP Mission and Core Values

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## Mission

Provide Leadership and resources to assure access to and retention in high quality, comprehensive HIV care and treatment services for vulnerable people with HIV/AIDS, their families, and providers within our nation's communities.

## Core Values

Communication · Integrity · Professionalism · Accountability · Consistency ·  
Respect



# DCHAP Program Updates



# Notice of Award (NoA)

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- RWHAP Part D Supplemental (HRSA-21-059)
  - HRSA HAB is proceeding with the release of funding for RWHAP Part D Supplemental awards.
- RWHAP Part C Capacity Development (HRSA-21-058)
  - HRSA HAB is proceeding with the release of funding for the RWHAP Part C Capacity Development awards.



# Important Dates: Upcoming FFR Deadlines

<b>RWHAP Part C</b>	<b>FY 2020 Budget Period End Date</b>	<b>FY 2020 FFR Due Date</b>
April Start	3/31/2021	7/30/2021
May Start	4/30/2021	7/30/2021

<b>RWHAP Part D</b>	<b>Budget Period Ends...</b>	<b>FY 2020 FFR Due Date</b>
August Start	7/31/2021	10/30/2021



# FY 2020 RWHAP Part C Expenditure Reports

RWHAP Part C	FY 2020 Budget Period End Date	FY 2020 Expenditure Report Due Date
January Start	12/31/2020	4/30/2021
April Start	3/31/2021	7/29/2021
May Start	4/30/2021	7/29/2021



# FY 2021 RWHAP Part C Allocation Reports

RWHAP Part C	FY 2021 Budget Period Start Date	FY 2021 Allocation Report Due Date
January Start	1/1/2021	7/31/2021
April Start	4/1/2021	7/31/2021
May Start	5/1/2021	7/31/2021



# Completing the RWHAP Parts C and D Allocations and Expenditure Reports in GCMS/PTR System

- On **Tuesday, July 13, 2021**, HIV/AIDS Bureau Division of Policy and Data (DPD), in conjunction with the [RWHAP Data Support](#) team at WRMA, hosted a webinar that provided guidance to recipients on completing the Ryan White HIV/AIDS Program (RWHAP) Parts C and D Allocations Report, RWHAP Parts C and D Expenditure Report, and CARES Act Expenditure Reports.
- Step-by-step instructions were presented for accessing, completing, validating, and submitting each of these reports.
- For those unable to attend, and for future review, the link to the recording is available on HAB's [TargetHIV site](#).



# Community Engagement



# Why Is Community Engagement Important?

- The voices of people with HIV, their communities, and the greater communities that support people with HIV have been the cornerstone of the Health Resources and Services Administration's (HRSA) Ryan White HIV/AIDS Program (RWHAP) since its passage by Congress in 1990.
- While the RWHAP has successfully provided care, support and treatment for more than 560,000 people with HIV in 2019, there remains hundreds of thousands of people who have HIV but are not diagnosed or are inconsistently in care.
- With a renewed focus on community engagement to meet the goals for Ending the HIV Epidemic in the U.S., our collective success depends on how well communities are involved in the planning, development, and implementation of HIV care and treatment strategies.



# Background & Guiding Principles

HRSA HAB believes that our collective success depends on how well communities are involved in the ***planning, development, and implementation*** of HIV care and treatment strategies and supports the following guiding principles for community engagement: ***intentional, committed, sustainable, flexible and tailored, and transformational.***

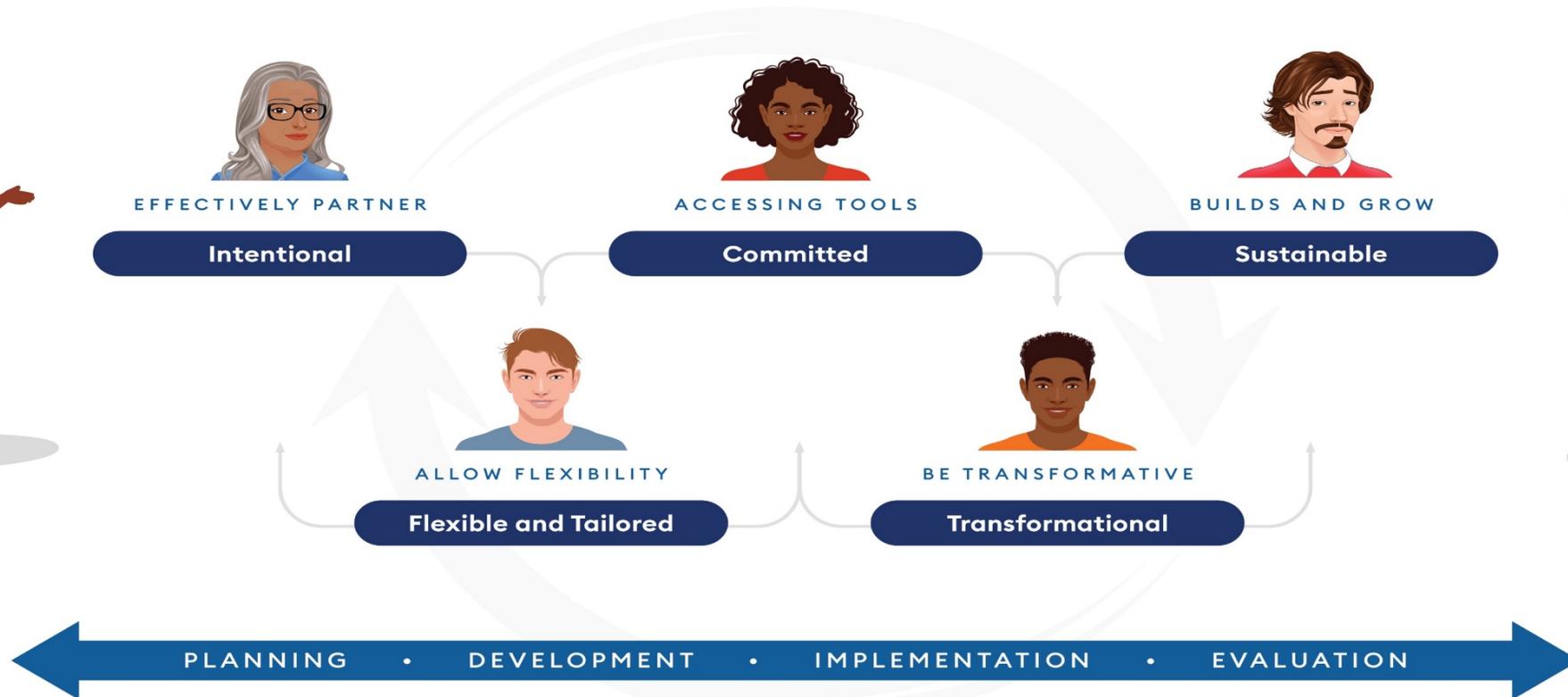


# Community Engagement Framework: Where We Are Today



## Community Engagement Guiding Principles

“voices of the community from beginning to end”



# HRSA HAB 2021 Ending the HIV Epidemic Virtual Community Engagement Listening Session Schedule\*

Region	Schedule	EHE-funded Jurisdictions
<b>Mountain West (Regions 8 &amp; 10)</b>	Public Health Leader Roundtable – August 10, 2021, 2:00-3:30 PM ET Community Listening Session – August 12, 2021, 2:00-3:30 PM ET	Seattle, WA
<b>South Central (Region 6)</b>	Public Health Leader Roundtable – August 17, 2021, 11:00-12:30 PM ET Community Listening Session – August 19, 2021, 11:00-12:30 PM ET	Austin, TX, Baton Rouge, LA, Dallas, TX, Fort Worth, TX, Houston, TX, New Orleans, LA, San Antonio, TX, Arkansas, Oklahoma
<b>Southeast (Region 4)</b>	Public Health Leader Roundtable – September 7, 2021, 11:00-12:30 PM ET Community Listening Session – September 9, 2021, 11:00-12:30 PM ET	Atlanta, GA, Charlotte, NC, Fort Lauderdale, FL, Jacksonville, FL, Memphis, TN, Miami, FL, Orlando, FL, Tampa, FL, West Palm Beach, FL, Alabama, Kentucky, Mississippi, South Carolina

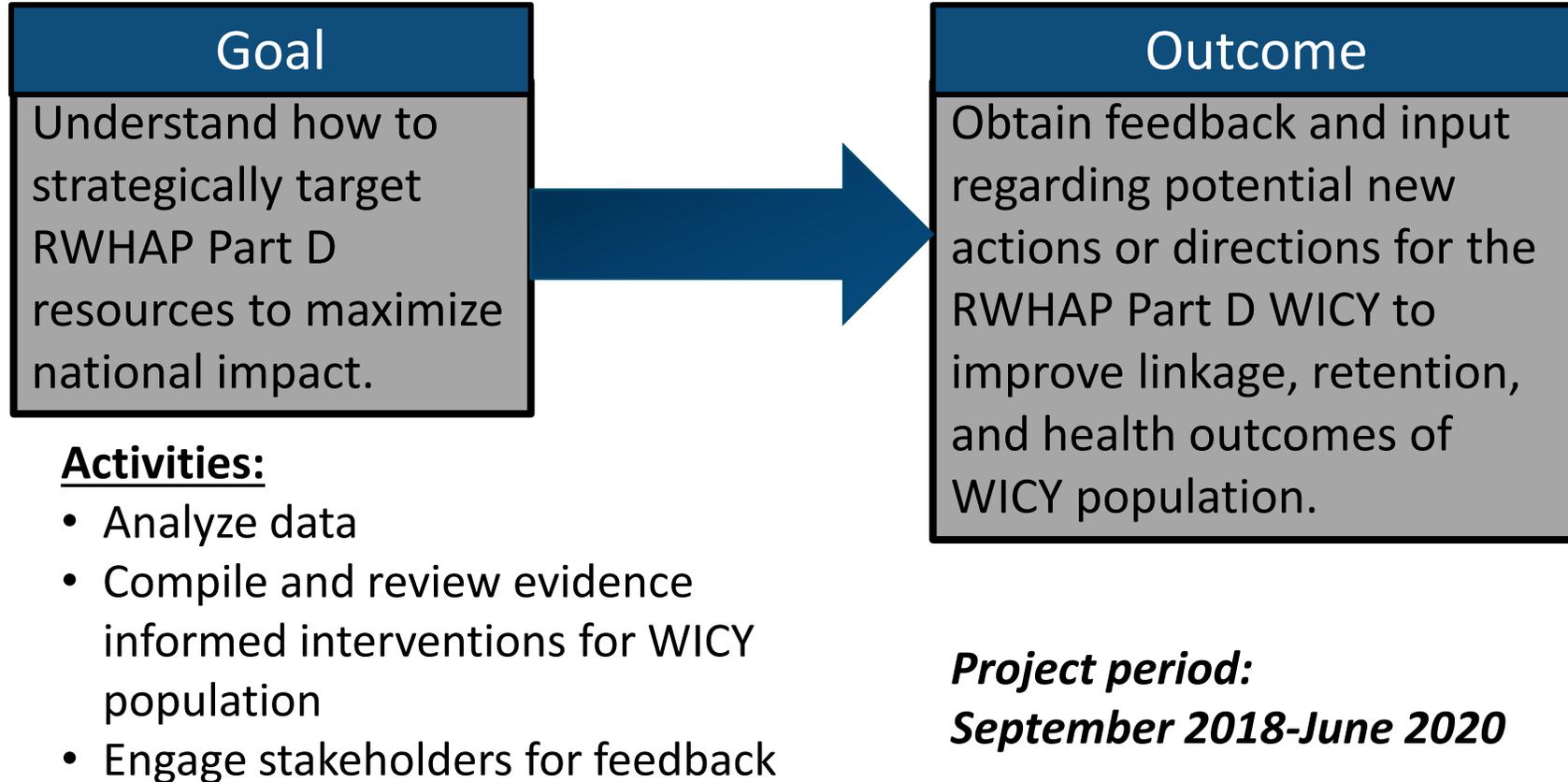


\*Dates subject to change.

# Leveraging RWHAP Part D to Maximize National Impact: FY 2022 Notice of Funding Opportunity



# Leveraging RWHAP Part D to Maximize National Impact



# Leveraging RWHAP Part D

## Key Activities

Timeframe	Activities
Nov. 2018	Presentation to and consultation with CDC/HRSA Advisory Committee on HIV, Viral Hepatitis, and STD Prevention and Treatment (CHAC)
Dec. 2018	Listening session with RWHAP Part D stakeholders
Feb. 2019	Literature review completed
July 2019	Analysis of RWHAP RSR Data for RWHAP Part D recipients, CDC HIV Surveillance Data, RWHAP Part C and D Allocation report, and Geo-mapping completed
FY 2019	Obtained RWHAP Part D stakeholder input during site visits
Oct. 2019	Second listening session with RWHAP Part D stakeholders
Apr. 2020	Conducted all RWHAP Parts HRSA Technical Expert Panel



# Leveraging RWHAP Part D

## Focus Areas for HRSA for FY 2022

- Provide training and technical assistance around RWHAP Part D legislative and program requirements
- Capacity building in high impact areas including:
  - Youth transitioning from youth services to adult care
  - Trauma informed care
  - Pre-conception counseling
  - Behavioral health integration
- Implement a funding allocation methodology to determine FY 2022 RWHAP Part D award funding

If you have any questions, please send an email to the [AskDCHAP@hrsa.gov](mailto:AskDCHAP@hrsa.gov) mailbox with the subject line:  
FY 2022 Part D Re-competition



# New HAB Resources



# New HAB Resources Now Available

**Addressing the Health Care and Social Support Needs of People Aging with HIV**  
Technical Expert Panel Executive Summary

**HRSA**  
Ryan White HIV/AIDS Program

The Health Resources and Services Administration (HRSA) HIV/AIDS Bureau (HAB), which oversees the Ryan White HIV/AIDS Program (RWHP), convened a Technical Expert Panel in November 2020. It explored the health care and social support needs of RWHP's aging population, with a focus on the barriers to and strategies for providing services. Twenty panelists representing people with lived experience, federal partners, state and local health departments, health care providers, researchers, and peer support organizations took part in the discussions.

**Overview of Clients: HRSA's Ryan White HIV/AIDS Program, 2019**  
Population Fact Sheet | June 2021

Below are more details about the Ryan White HIV/AIDS Program (RWHP) client population:

- The majority of clients served by RWHP are low income. Data show that 60.7 percent of clients are living at or below 100 percent of the federal poverty level (FPL), and 89.5 percent of RWHP clients live at or below 250 percent of the FPL. Nearly all clients served have an income at or below 400 percent of the FPL.
- The RWHP serves a diverse population. Nearly three-quarters of clients are from racial/ethnic minority populations, with 46.6 percent of clients identifying as Black/African American and 23.3 percent identifying as Hispanic/Latino.
- The majority of RWHP clients are male. Among all clients served by RWHP, 71.6 percent are male, 26.2 percent are female, and 2.3 percent are transgender.
- The RWHP client population is aging. People aged 50 years and older account for 46.8 percent of all RWHP clients.

Medical care and treatment improve health outcomes and decrease the risk of HIV transmission. People with HIV who take HIV medication daily as prescribed and reach and maintain an undetectable viral load have effectively no risk of sexually transmitting the virus to an HIV-negative partner. Among RWHP clients receiving HIV medical care in 2019, 88.1 percent are virally suppressed,\* which is an increase from the 69.5 percent viral suppression observed in 2010.

RWHP delivers a broad range of services to ensure people with HIV are able to access and remain in care. The most frequently used services are—

- Outpatient ambulatory health services
- Medical case management, including treatment adherence services
- Non-medical case management services
- Oral health care
- Medical transportation
- Referral for health care and supportive services
- Health education/risk reduction
- Food bank/home-delivered meals
- Mental health services
- Health insurance premium and cost sharing assistance for low-income individuals

In addition, the RWHP Part B AIDS Drug Assistance Program provides approximately 265,000 clients with HIV-related medications and/or health care coverage assistance.

\*Viral suppression is defined as a viral load result of less than 200 copies/mL, at most recent test, among people with HIV who had at least one outpatient ambulatory health services visit and one viral load test during the measurement year.

**Ryan White HIV/AIDS Program Fast Facts: Program Clients**

- 73.4% are from Racial/Ethnic Minorities
- 60.7% Live at or Below 100% of the Federal Poverty Level
- 88.1% Are Virally Suppressed (2019)
- 46.8% Are Aged 50+

For more information on HRSA's Ryan White HIV/AIDS Program, visit: [hab.hrsa.gov](https://hab.hrsa.gov).

- New Addressing the Health Care and Social Support Needs of People Aging with HIV Technical Expert Panel Executive Summary
- New Ryan White HIV/AIDS Program population fact sheets highlighting 2019 client-level data
- To access the materials, visit: <https://hab.hrsa.gov/publications/hivaids-bureau-fact-sheets>



# Aging with HIV Technical Assistance Resources

## Aging with HIV

- **HRSA HAB Reference Guides**
  - [Incorporating New Elements of Care](#)
  - [Putting Together the Best Health Care Team](#)
- **Connection to Services**
  - [Eldercare Locator \(U.S. Administration on Aging\)](#)



# Technical Assistance Resources Available on HIV Testing and Rapid ART

## HIV Testing

- [Let's Stop HIV Together – HIV Self-Testing Demonstration Video](#) (CDC)
- [HIV Care Tools- AETC Program App](#) (AETC National Coordinating Resource Center)

## Rapid ART

- [“Rapid Art: An Essential Strategy for Ending the HIV Epidemic”](#) Webinar (Technical Assistance Provider, Ending the HIV Epidemic in the U.S. initiative)



# 2021 Stakeholder Webinar Schedule

## SAVE THE DATE

Health Resources and Services Administration  
HIV/AIDS Bureau  
Division of Community HIV/AIDS Programs  
Stakeholder Webinar

**October 21, 2021 from 2:00 pm - 4:00 pm ET**

**RWHAP Part C and Part D recipient presentations topic:  
Trauma Informed Care**

We will provide the Zoom link and call-in number following this webinar.



# HAB You Heard Webinar



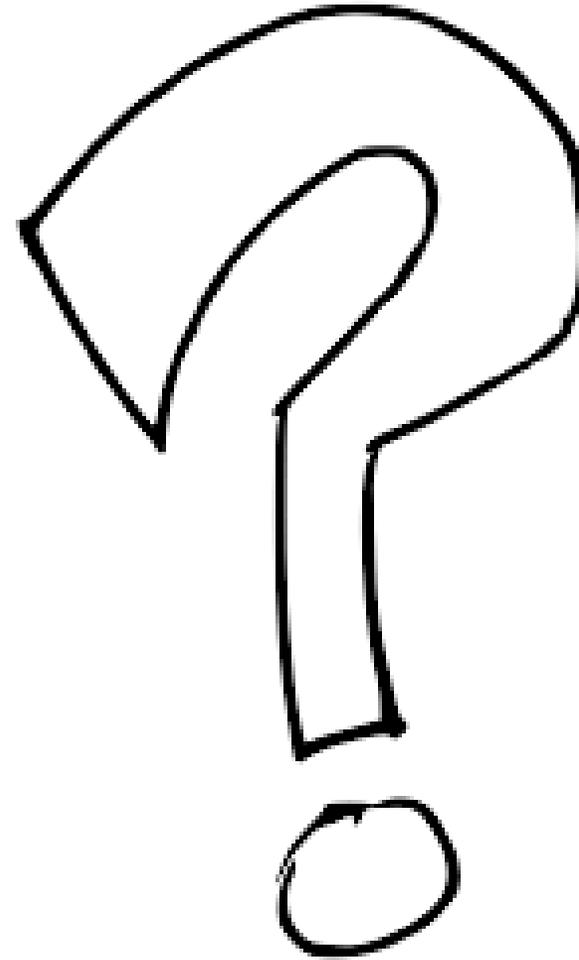
**Mark your calendars for next HAB You Heard webinar will take place August 18, from 2-3 PM ET.**

This monthly update from the HIV/AIDS Bureau (HAB) is hosted on Zoom, and attendees are asked to register to participate.

During the August webinar, HAB You Heard will be commemorating the Ryan White CARE Act 31<sup>st</sup> anniversary. All RWHAP recipients and subrecipients, stakeholders, and federal staff are encouraged to participate in the webinar.

[Register](#) to participate.

# Questions



# Centering Care for Women, Children, and Adolescents across the HIV Care Continuum



# PERINATAL HIV CARE TEAM- WASHINGTON UNIVERSITY SCHOOL OF MEDICINE

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DEBRA COLQUITT, CASE MANAGER

CARRIE SHOUSE, CLINICAL NURSE  
COORDINATOR

# OBJECTIVES

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- Understand how Washington University School of Medicine utilizes staff and clinics to maximize patient care
- Describe the roles and collaboration efforts of Perinatal team members
- Explain how our organization has been able to successfully decrease number of HIV transmissions to babies via mothers

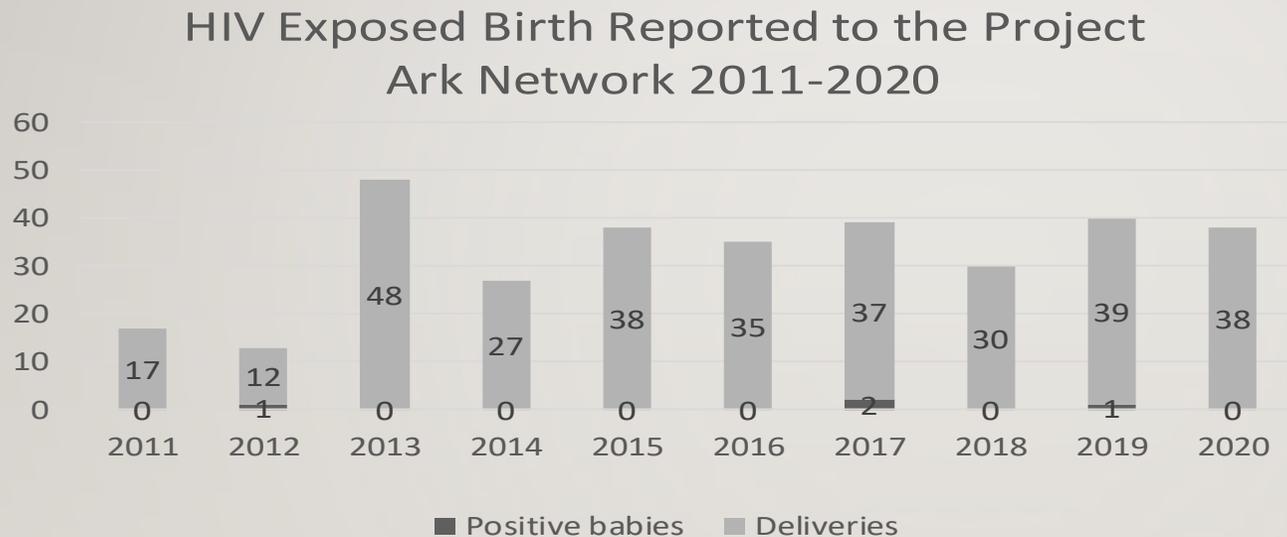
# WASHINGTON UNIVERSITY – ST. LOUIS, MO

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- Multi-Funded/Multi-level Provider
- All RWHAP Parts A-D; F-dental
- 2020 Medical and Support Service total Clients served: N=3,235
- 4 Network Clinical Sites: N=2,575
- Of the 37 mothers\* that gave birth in 2020, 26 (67.6%) are seen by our network providers\*\*.
- All 38 infants are followed at our WUPEDS clinic for HIV Exposure.

Adult Male	1,627
Adult Female	712
Adult Transgender	51
Youth	167
Children	18

# WASHINGTON UNIVERSITY – ST. LOUIS, MO



❖ Of the 37\*\* mothers that gave birth in 2020, 26 (67.6%) are seen at our network providers. Zero MTC Transmission in 2020.

- Between 2011 and 2020, 361 infants have been born to HIV+ mothers.
- 4 infants or 1.1 % Mother to Child (MTC) Transmission 2011-2020.
- All 4 of these Mothers\* and their infants remain in care within the WU network of providers in 2020.

# PERINATAL TEAM

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- **Case Manager**

- Debra

- **Peer Navigator:**

- Sheena

- **Clinical Nurse Coordinator:**

- Carrie

## **Collaborative Group:**

- ID Providers
- OB providers
- Counselors/Therapists
- RW Case Managers

# TRANSMISSION PREVENTION

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- ❖ Be proactive in seeking opportunities to discuss HIV information with ALL women of child-bearing age
- ❖ Recommend planning pregnancies to help reduce perinatal transmission risk
- ❖ Women are encouraged to include partners in the planning process

# MODES FOR PERINATAL TRANSMISSION

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- ❖ Prenatally(in utero)-maternal transmission to fetus(primary HIV infection, illness/high viral load or amniocentesis) during fetal development.
- ❖ Intrapartum(at birth)-through transfer of blood or other secretions between mother and infant during delivery, or invasive procedures such as fetal scalp monitor, forceps delivery or artificial rupture of membranes.
- ❖ Post-partum(after birth)-transmission through breastfeeding has been the only known situation.

# FACTORS INFLUENCING PERINATAL HIV TRANSMISSION

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- ❖ Mother's HIV RNA level (viral load)
- ❖ Sexually transmitted infections (STI)
- ❖ Lack of prenatal care
- ❖ Cigarette smoking and illicit drug use
- ❖ Co-infections: Hepatitis B and C

# ACTIONS TO PREVENT PERINATAL TRANSMISSION

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❖ **Testing**

❖ HAART

❖ Delivery Planning

❖ Discussions about feeding

# CASE MANAGER/PERINATAL NURSE HOSPITAL VISIT REQUIRED TOPICS

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- ❖ Lactation Suppression
- ❖ Medication Adherence  
(mom and baby)
- ❖ Newborn ARV Prophylaxis
- ❖ Disclosure
- ❖ Postpartum Depression
- ❖ Postpartum Care
- ❖ Newborn RNA PCR  
testing
- ❖ Family Support

# MEDICATION ADHERENCE

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- ❖ Remind clients of treatment importance.
- ❖ Assist with communication between client physicians and other medical care givers about treatment concerns.
- ❖ Connect client to treatment support groups/resources.
- ❖ Provide encouragement, support, and reminders as appropriate.

# DISCLOSURE

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- ❖ Legal requirements
- ❖ Disclosure options
- ❖ Benefits of disclosure

# AFTER DELIVERY- CASE MANAGEMENT

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- ❖ Psychosocial issues
- ❖ Baby necessities
- ❖ Housing/utility resources
- ❖ Mental health connection
- ❖ Appointment reminders
- ❖ Medication adherence
- ❖ Support Group

# AFTER DELIVERY- NURSING

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- ❖ Perinatal Nurse contacts client in hospital to arrange baby's Pediatric Infectious Disease (ID) appointment and make sure that baby leaves the hospital with medication
- ❖ Reconfirm contact information and where the woman will be living when she leaves the hospital
- ❖ Make sure that they have a general pediatrician and that they have their shots and visits

# PRIORITY MINIMUM HOME VISIT TOPICS (PRE-COVID)

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- ❖ Identify living conditions and living relationships.
- ❖ View sleeping arrangements.
- ❖ View mother and child relationship.
- ❖ Observe preparation of formula and administration of AZT if possible.
- ❖ Witness mother mental status in home environment (discuss post partum depression).
- ❖ Remind woman of postpartum F/U visit and care.
- ❖ Reinforce medication adherence and instructions.
- ❖ Is case management re-assessment needed?

# POSTPARTUM CARE

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- ❖ Mother's visit to confirm healing process
- ❖ Contraception and primary prevention options reviewed and help schedule as needed
- ❖ STD/STI prevention
- ❖ Pap smear
- ❖ Medication Adherence
- ❖ Two post ID appointments and at least one Obstetric postpartum visit

# POSTPARTUM CHECK-UP

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- ❖ Birth Recovery
- ❖ Lactation suppression breast examination
- ❖ Abdominal
- ❖ Pelvic examination
- ❖ Contraceptive counseling
- ❖ Future Pregnancy planning

# BABY'S FIRST INFECTIOUS DISEASE VISIT

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- ❖ Hearing, vision and reflexes are observed
- ❖ Exam of the organs and body functions
- ❖ Questions about baby's eating and sleeping habits
- ❖ A discussion about home environment
- ❖ Medication adherence make sure parent brings babies medications with them to visit
- ❖ Lab work is completed: RNA PCR testing

# CONTACT INFORMATION

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❖ Carrie Shouse, BSN, RN, Perinatal Nurse Coordinator

314-454-4304

❖ Debra Colquitt, BA, BS, Perinatal Case Manager

314-454-2647

❖ Project ARK 314-535-7275

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# Centering Care for Women, Children, and Adolescents Across the HIV Care Continuum

East Carolina University

Specialty Care

July 22, 2021



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# Objectives

- Who are ECU Physicians?
- Addressing Pre-Conception Counseling with People with HIV
- Following Prenatal and Post-Partum Care of Pregnant People with HIV
- Developing Best Approaches for Transitioning Adolescents to Adult Care

# Introduction

- Located in Greenville, North Carolina
- Receive Parts C and D funding
- 0 babies born with HIV since 2010.
- In 2020
  - Pediatric Specialty Care (PSC) worked with 15 pregnant people with HIV.
  - 100% youth transitioned to Adult Specialty Care (ASC) are still in care.



# Pre-Conception Counseling

Assess current birth control methods.

Discuss and review risks related to potential pregnancy.

Adjust ART regimen as appropriate.

Refer to OBGYN.

# Prenatal Care of People with HIV

Multidisciplinary team known as Maternal-Pediatric Infectious Disease (MPID) team, meets on a monthly basis to review/discuss pregnant people living with HIV, as well as exposed newborns (EN).

Regardless of where pregnant person is receiving their OB care, they will be followed by the MPID.

The PSC Medical Case Manager (MCM) meets with mom in her third trimester to review EN protocol.

Regardless of where EN receives general pediatric care, they will be followed by ECU PSC.

# Prenatal Care of Pregnant People with HIV

Mother is entered into Antiviral Pregnancy Registry [APR].

APR is an epidemiologic collaborative project of pharmaceutical manufacturers with an advisory committee of obstetric [OB] and pediatric practitioners.  
APR collects observational, non-experimental data on antiretroviral (ARV) drug exposure during pregnancy. Information for the APR can be found at: <http://www.apregistry.com/>

In addition to regular OB visits, mother continues to be followed by her HIV provider throughout pregnancy.

Monitor ARV therapy, side effects of ARV therapy, and lab goals.

# Post-Partum Care



Once baby is delivered, MPID continues to follow both mother and EN.



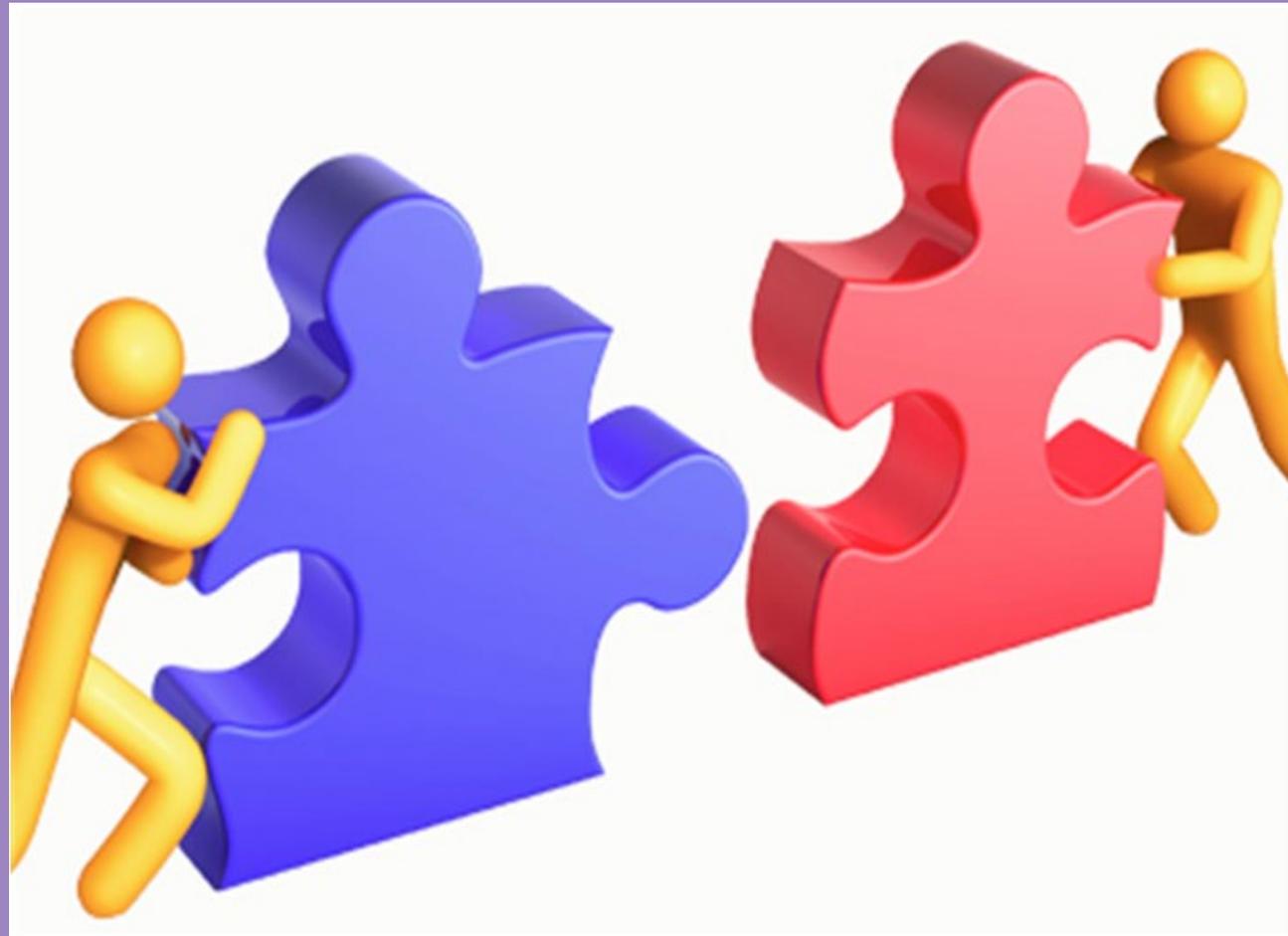
EN is followed at PSC at 2 weeks of age, 4-6 weeks of age, and 4-6 months of age.



Mother continues to be followed by OB and HIV providers.



# Best Approaches for Transitioning Adolescents to Adult Care



# Transition Readiness Discussion

The MCM will start assessing the client's readiness for transition to ASC by age 18.

The MCM will utilize the “Adolescent Transition Checklist” that addresses client's spectrum of abilities.

The MCM will continuously assess and discuss progress with client.

# Transition Checklist

\_\_\_\_ Youth interacts directly with health care team (i.e. asks questions)

\_\_\_\_ Youth is aware of their own HIV/AIDS diagnosis (i.e. disclosure has occurred and is understood)

\_\_\_\_ Youth is able to answer "What is HIV?"

\_\_\_\_ Youth is able to answer "How is HIV transmitted?"

\_\_\_\_ Youth is able to answer "How do you prevent transmission of HIV?"

\_\_\_\_ Youth is able to answer "What are T cells (or CD4) and viral load?"

\_\_\_\_ Youth verbalizes names and dosages of medications

\_\_\_\_ Youth takes medication independently

\_\_\_\_ Youth verbalizes understanding of medication side effects

\_\_\_\_ Youth verbalizes understanding of medication resistance

\_\_\_\_ Youth is able to independently obtain medication refills

\_\_\_\_ Youth is able to identify members of the health care team and how to contact them

\_\_\_\_ Youth verbalizes when/how to call health care provider

\_\_\_\_ Youth is able to independently make appointments

\_\_\_\_ Youth keeps calendar of appointments

\_\_\_\_ Youth verbalizes when to access urgent or emergent medical care

\_\_\_\_ Youth is able to set up transportation for appointments

\_\_\_\_ Youth is able to independently give medical history

\_\_\_\_ Youth knows how to protect partner from HIV transmission

\_\_\_\_ Youth knows how to protect self and partner from transmission of other STIs (sexually-transmitted infections)

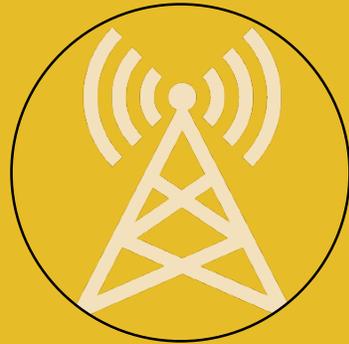
\_\_\_\_ Youth understands contraception options and how to prevent unplanned pregnancies

\_\_\_\_ Youth knows whom to contact for insurance information/concerns

# Transitioning Care



When the client expresses readiness for the transition, the PSC team confirms readiness.



PSC and ASC begin coordinating upcoming transfer of care.



Client's last PSC visit concludes with a tour at ECU ASC.



Client will come to ECU ASC visit at 4-6 weeks for intake.



PSC MCM will work closely with the ASC MCM and the client in facilitating the care transition, as needed.



# Closing

Questions?

Grace K. Wilkins, RN, BSN, MPA, MSN, FNP-BC

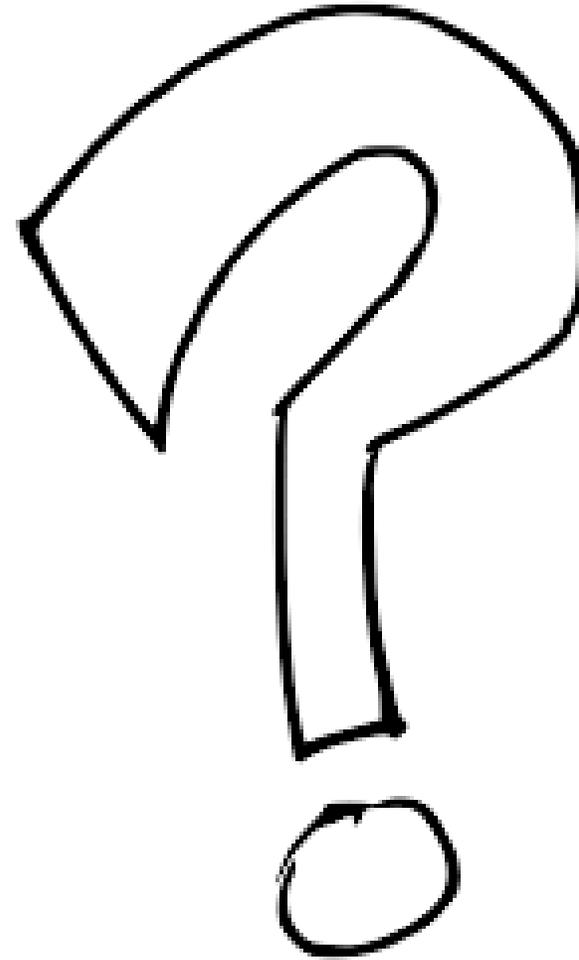
Ryan White Program Director

Phone: 252-744-5724

e-mail: [wilkinsg@ecu.edu](mailto:wilkinsg@ecu.edu)

Thank you!

# Questions



# Contact Information

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