20 Years of Leadership
A LEGACY OF CARE

Daily Updates & Highlights

Ryan White Grantee Meeting and 13th Clinical Conference

8.23.10

IN THIS ISSUE

Welcome: A Cascade of Numbers

A quick glance of what's happening this week—20 events at any moment in the day.

New Pubs: Going Green Lightens Your Load

2010 Ryan White Progress Report, updated fact sheets, new clinical guides on the horizon—and more, like reports on data, AETCs, and HIV testing.

Workshops by Topic

How to find your way through 265 workshops on topics like SPNS, transgender health, ADAP, and more.

Clinical Update

Highlights: accelerated aging complications, ART strategies and the new HHS guidelines, perinatal HIV transmission prevention, and interactive workshops.

10 Workshops to Live Forever

Look your best for video crews recording sessions for later Web viewing—an initiative of HRSA Administrator Dr. Wakefield.

End of Days: Division Meetings

Parts and Divsions come together in special late afternoon sessions the first two days of the conference to talk about funding, grant requirements, and other topics.

What Happened Sunday

HIVQUAL-US Meeting: Around 60 clinicians had a busy Sunday reviewing HIVQUAL activities since the 2008 Grantee Meeting.

HIGHLIGHTS

Two downloads you can't live without—at least for this week:

2010 Ryan White Grantee Meeting: Workshop List

13th Annual Ryan White Clinical Conference: Conference Syllabus Book

LOOKING BACK

25 Years Ago: 1985-1986
HRSA funds its first AIDS Program, the AIDS Service Demonstration Grants—inspired by the San Francisco model of community-based services (versus inpatient care) and the Robert Wood Johnson Foundation AIDS Health Services Program. By year-end, 25,000 Americans died from AIDS.
Learn more: See http://hab.hrsa.gov/livinghistory

Welcome: A Cascade of Numbers

The only quick way to quickly summarize this week's historic Ryan White Grantee Meeting—an occasion to learn and reflect on 20 years of work providing HIV/AIDS care—is to hit you with a deluge of numbers. Here they are:

Over 2,300 people are here. That's just a fraction of the many people back home working away in hundreds of communities, in thousands of Ryan White agencies, providing care to hundreds of thousands of people. The Daily Update team will do its best to bring you highlights from the next 3 ½ days, which will entail:

265	Grantee meeting workshops
160	Poster sessions
100+	CE/CME opportunities
39	Sessions in the 13th Clinical Conference
45	Exhibitors
3	Plenary sessions

To put these numbers in some context, over 20 sessions will take place at any given moment. Choose carefully when deciding what to attend.

In addition to the above, Division director meetings are being held each afternoon, along with special sessions, like a consumer meeting with Dr. Parham Hopson and more. Check the program book, the notice board, and ask the Help Desk as some sessions may be recent additions.

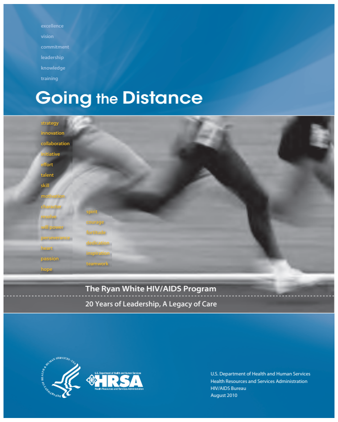
As usual, dedicated time has been set aside to meet with the poster session authors, on Wednesday from 2:30 to 3:30. And, for the first time, we are giving out awards for best posters. Those awards will be announced on Wednesday afternoon.

New Pubs: Going Green Lightens Your Load

There will not be as much stuff to haul back after this year's Grantee meeting as we've gone "green," but don't miss printed versions of these new items or get your pre-orders in for documents coming out later this year or next. All publications will be available online, as noted below.

Going the Distance: Twenty Years of the Ryan White HIV/AIDS Program

In celebration of the 20 year anniversary of the Ryan White HIV/AIDS Program, the 2010 Progress Report describes our work over the past twenty years . . . and the qualities that will guide us into the future. The report features case studies of Ryan White grantees, which show how our program is reaching the underserved, reducing health disparities, and designing ever more effective care delivery frameworks that respond to today's epidemic. Provider, client, and service utilization data from the Ryan White HIV/AIDS Program are also included. Available online, post-meeting, from the HRSA/HIV/AIDS Bureau Web site at http://hab.hrsa.gov or order copies via the HRSA Information Center at http://ask.hrsa.gov.



excellence
vision
commitment
leadership
knowledge
training

Going the Distance

strategy
innovation
collaboration
initiative
effort
talent
skill
motivation
character
resolve
will power
perseverance
heart
passion
hope

spirit
courage
fortitude
dedication
inspiration
teamwork

The Ryan White HIV/AIDS Program

20 Years of Leadership, A Legacy of Care

U.S. Department of Health and Human Services
Health Resources and Services Administration
HIV/AIDS Bureau
August 2010

Fact Sheets: Ryan White HIV/AIDS Program

Included in the folder are one-page fact sheets on the Ryan White HIV/AIDS Program, its Administration, the Division of Training and Technical Assistance, the Division of Science and Policy, and each of the various programs (Parts A – F and the Global AIDS Program). Also included are one page fact sheets on various populations served by the Ryan White HIV/AIDS Program. Available online, post-meeting, from the HRSA/HIV/AIDS Bureau Web site at http://hab.hrsa.gov or order copies via the HRSA Information Center at http://ask.hrsa.gov.

THE RYAN WHITE HIV/AIDS PROGRAM

PROGRAM FACT SHEETS: AUGUST 2010

RYAN WHITE HIV/AIDS PROGRAM OVERVIEW

The AIDS epidemic has taken an enormous toll since its onset in the early 1980s. Approximately 583,000 Americans have died, and many others are living with HIV-related illness and disability or caring for people with the disease.[1] An estimated 56,000 Americans become infected with HIV each year,[2] and more than 1.1 million Americans are living with HIV disease.[3] The epidemic has hit hardest among populations who are poor, lack health insurance, are disenfranchised from the health care system, and are from communities of color.

In response, Congress enacted the Ryan White Comprehensive AIDS Resources Emergency (CARE) Act in 1990 to improve the quality and availability of care for low-income, uninsured, and underinsured individuals and families affected by HIV disease. The CARE Act was amended and reauthorized in 1996, 2000, and 2006; in 2009 it was reauthorized as the Ryan White HIV/AIDS Treatment Extension Act of 2009 (Public Law 111–87).

The Ryan White HIV/AIDS Program is administered by the U.S. Department of Health and Human Services (HHS), Health Resources and Services Administration (HRSA), HIV/AIDS Bureau (HAB).

RYAN WHITE HIV/AIDS PROGRAM CLIENTS

The Ryan White HIV/AIDS Program reaches an estimated 529,000 people each year. People living with HIV disease are, on average, poorer than the general population. For Program clients, the Program is the payor of last resort, because they are un- or underinsured and no other source of payment for services—public or private—is available.

In 2008, more than 70 percent of Ryan White HIV/AIDS Program clients self-identified as members of racial or ethnic minority groups. In the same year, 67 percent of Program clients were male, and 33 percent were female.

THE RYAN WHITE HIV/AIDS PROGRAM WORKS WITH CITIES, STATES, AND LOCAL COMMUNITY-BASED ORGANIZATIONS TO PROVIDE SERVICES TO AN ESTIMATED 529,000 PEOPLE EACH YEAR WHO DO NOT HAVE SUFFICIENT HEALTH CARE COVERAGE OR FINANCIAL RESOURCES TO COPE WITH HIV DISEASE. THE MAJORITY OF RYAN WHITE HIV/AIDS PROGRAM FUNDS SUPPORT PRIMARY MEDICAL CARE AND ESSENTIAL SUPPORT SERVICES. A SMALLER BUT EQUALLY CRITICAL PORTION IS USED TO FUND TECHNICAL ASSISTANCE, CLINICAL TRAINING, AND RESEARCH ON INNOVATIVE MODELS OF CARE. THE RYAN WHITE HIV/AIDS PROGRAM, FIRST AUTHORIZED IN 1990, IS CURRENTLY FUNDED AT $2.29 BILLION.

RYAN WHITE HIV/AIDS PROGRAMS

The Ryan White HIV/AIDS Program is divided into several "Parts," following from the authorizing legislation.

Part A provides grant funding for medical and support services to Eligible Metropolitan Areas (EMAs) and Transitional Grant Areas (TGAs)—population centers that are the most severely affected by the HIV/AIDS epidemic. EMA eligibility requires an area to report more than 2,000 AIDS cases in the most recent 5 years and to have a population of at least 50,000. To be eligible as a TGA, an area must have 1,000 to 1,999 reported new AIDS cases in the most recent 5 years. The FY 2010 Part A appropriation was approximately $679.1 million.

Part B provides grants to States and Territories to improve the quality, availability, and organization of HIV/AIDS health care and support services. Part B grants include a base grant; the AIDS Drug Assistance Program (ADAP) award; funds for the

U.S. Department of Health and Human Services
Health Resources and Services Administration, HIV/AIDS Bureau
5600 Fishers Lane, Room 7-05, Rockville, MD 20857
Tel.: 301.443.1993 Web: hab.hrsa.gov

Using Data to Measure Public Health Performance: A Guide for Ryan White HIV/AIDS Program Grantees

This monograph, released early August 2010, informs Ryan White HIV/AIDS Program grantees, the providers they fund, and consumers the following: why the Ryan White program gathers data, the legislative authority for collecting data, the types of data collected, how the data are used, and the types of questions the data address. See Using Data to Measure Public Health Performance on the HRSA/HAB Web site at http://hab.hrsa.gov or the TARGET Center at http://careacttarget.org.

Using Data to Measure Public Health Performance

A Guide for Ryan White HIV/AIDS Program Grantees

August 2010

U.S. Department of Health and Human Services
Health Resources and Services Administration, HIV/AIDS Bureau
5600 Fishers Lane, Suite 7-90, Rockville, MD 20857
www.hab.hrsa.gov

New Pubs: Going Green Lightens Your Load *(continued)*

Ryan White HIV/AIDS Program 2008-2009 AETC Report

Highlights include a review of AETC training activities, data on the AETC network like the number of clinicians trained and their demographics, and program highlights (e.g., special initiatives). Available online, post-meeting, from the HRSA/HIV/AIDS Bureau Web site at http://hab.hrsa.gov.

Ryan White HIV/AIDS Program
2008-2009 AETC Report

Training HIV/AIDS Clinicians

IN THIS REPORT

HIGHLIGHTS

AETC Program

Mission

Focus of Provider Training

HRSA

CAREAction: A Commitment to Quality Care (August 2010)

The latest issue of the Ryan White HIV/AIDS Program's periodic newsletter covers quality management (QM) topics including treatment guidelines and performance measures and how to integrate them into QM programs.

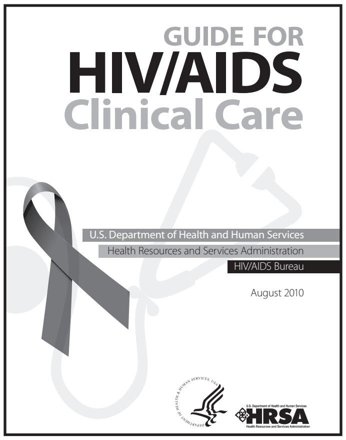
See the CAREAction Newsletter on the HRSA/HAB Web site at http://hab.hrsa.gov.

TARGET Center
Technical Assistance for the Ryan White Community

careacttarget.org

Coming Soon...

Several documents will be out in the coming months or some time next year. Notably are updates of two of HRSA/HAB's popular HIV/AIDS care clinical guides:



GUIDE FOR
HIV/AIDS
Clinical Care

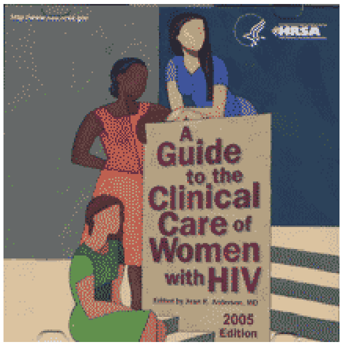
U.S. Department of Health and Human Services
Health Resources and Services Administration
HIV/AIDS Bureau

August 2010

HRSA

Guide for HIV/AIDS Clinical Care

This new and expanded version, a collaborative effort by HRSA and the AETC National Resource Center, is 610 pages covering 93 topics. The Guide is an update of the 2006 version and features new chapters on clinic management, quality improvement, HIV care in correctional settings, and more. Look for pre-order forms at the registration desk. Later this year, the Guide will be available online from the HRSA/HIV/AIDS Bureau Web site at http://hab.hrsa.gov or order copies via the HRSA Information Center at http://ask.hrsa.gov.



HRSA

A Guide to the Clinical Care of Women with HIV

2005 Edition

A Guide to the Clinical Care for Women With HIV: 2011 Edition

An update to the current and wildly popular guide, this version will include new chapters on Family Planning and Preconception Care, Pregnancy and HIV, Palliative and End of Life Care, and Quality Management. Pre-order forms are available at the registration desk at the Clinical Conference. Next year, the Women's Guide will be available online from the HRSA/HIV/AIDS Bureau Web site at http://hab.hrsa.gov or order copies via the HRSA Information Center at http://ask.hrsa.gov.

And From The Field

It's hard to keep track of what grantees are publishing and releasing at the meeting. Below is one we know about. Look for this and other new items on the TARGET Center, which hosts the best tools and training materials being developed by the Ryan White Community.

JAIL: TIME FOR TESTING
INSTITUTE A JAIL-BASED HIV TESTING PROGRAM

Jail: Time for Testing, Institute A Jail-Based HIV Testing Program

This SPNS grantee-developed guide explains how to implement an opt-out HIV testing program in a jail setting and is written for use by persons working within agencies involved with the criminal justice system, public health departments, or AIDS service organizations. Access the guide at the TARGET Center at http://careacttarget.org.

Workshops By Topic

How does one keep abreast of 265 workshops under 7 tracks in time blocks A through J?

The Grantee Meeting Agenda Web page gives you several options. You can find sessions by time block or download the 2010 Workshop List and do a word search of the PDF file for sessions of interest.

If looking for sessions by topic, you'll find at least 6 ADAP workshops, around 20 related to consumer involvement (e.g., peer educators), over 10 on oral health, upwards of 10 on RSR client level data, 5 on transgender issues, and handfuls of others on such topics as testing, rural care, corrections, and more.

HRSA/HAB's SPNS program is presenting 16 workshops, offering a host of insights on lessons learned from research and demonstration projects on a variety of current SPNS Initiatives—oral health, linkages to care in jail settings, and even the newest initiative on access and retention to care for women of color. Below is the SPNS workshop list, followed by select others. See the Full Workshop Listing and search by topic for other issues of interest.

SPNS Workshops

A-9	Enhancing HIV and Mental Health Service Linkage between Jail and Community: An Example of Two HRSA/
A-10	Engaging the Community: Networking to Enhance Linkages for Incarcerated Clients
A-15	AIDS to Cultural Competence: Addressing Health Care Challenges for Women of Color Living with HIV/AIDS
A-23	Identifying, Linking, Engaging, and Retaining Young HIV-Positive MSM of Color: Findings of a SPNS Initiative
B-12	Leveraging SPNS Initiatives to Transform Client-Level Data Collection into Service and Quality Tools
D-1	Building Electronic Capacity among Ryan White-Funded Providers to Achieve Meaningful Use
D -6	Maintaining the Connection: Dental Case Management for the Multi-Diagnosed Marginally Housed
D -7	If You Build It They Will Come: Creating a Dental Home, Access to Care through a SPNS Initiative
E-1	South Carolina Linkage Program for Inmates (SCLPI)
F-28	Using Multi-Media to Recruit and Educate Funders, Providers, and Patients
G-19	Using Electronic Networks of Care across Continuum of HIV Care
G-20	Using HIV Surveillance Data to Prompt Clinical Action: A Novel Electronic Information Exchange
I-4	Process over Product: Navigating across the Four Health Information Technology (HIT) Life Cycles
I-14	If You Build It Will They Come? Increasing Access to HIV Oral Health Care
J-4	Reducing the Burden on HIV Case Managers in Accessing Oral Health Care for HIV Patients
J-9	Notes from the Field: Engaging and Retaining Women of Color in HIV/AIDS Care

Workshops By Topic *(continued)*

Transgender Workshops

A-27	Cultural Competence and Transgender Clients
A-28	A Multi-disciplinary Approach to HIV Care in a Transgender Homeless Population
E-14	Expressions of the Recently Released
G-15	A Program Model for Transgender and HIV Treatment in Adolescents and Young Adults
J-14	Reducing the Burden of HIV Case Managers in Accessing Oral Health Care for HIV Patients
	Clinical Primary Care for Transgender Patients, August 25 at 11 AM

Data: RSR Workshops

Below are highlights from the 10 or so RSR-focused workshops. (Technical assistance in the form of "15 minute clinics" is also available in the Federal Village.)

A-25	RSR Data Submission: Supporting Providers, Meeting Submission Challenges
F-19	Ryan White Services Reporting RSR: New User Training
H1	Working Together to Use and Improve RSR Data
Special	Division of Science and Policy: Update on the Ryan White Data Services Report (Aug 25)

ADAP Workshops

A-22	Effectively Managing ADAP Waiting Lists
B-21	Accessing Medications During an ADAP Waiting List: Experiences from Kentucky
D-27	ADAP Programmatic Management
G-16	Maximizing your 340 B Participation
H-11	The ADAP Semi-Annual Data Report
J-20	Effectively Managing ADAP Waiting Lists

Clinical Update

The 13th Annual Ryan White Clinical Conference will get underway at 11 AM, right after the Opening Plenary. The Conference Syllabus Book lists all clinical sessions, along with submitted slides from speakers.

Registration and most conference sessions will take place in the Thurgood Marshall Ballroom on the Mezzanine level. Attendees can expect 3 days of lectures and interactive workshops presented by 19 nationally recognized experts, who will provide a comprehensive overview of current clinical issues in HIV management.

Highlights of the first day’s program will include discussions of perinatal HIV transmission prevention, the role of accelerated aging in non-AIDS related complications in patients, and antiretroviral therapy strategies based upon the latest HHS guidelines.

Interactive workshops will be held as the last sessions on each conference day.

This year, the Clinical Conference has drawn 635 practitioners from Ryan White Parts A, B, C, and D funded programs, which is a collaborative effort among HRSA/HAB, the Southeast AIDS Training and Education Center (SEATEC), and the International AIDS Society-USA (IAS-USA).

10 Workshops to Live Forever

Video teams will be on hand this week to record 10 workshops for later Web cast viewing. The project is an initiative of HRSA Administrator Dr. Mary Wakefield to bring new life to a limited number of sessions with cross-cutting impact on all of HRSA's programs. Chosen workshops also include those with particular importance to the larger HIV/AIDS community. *(Look your best!)*

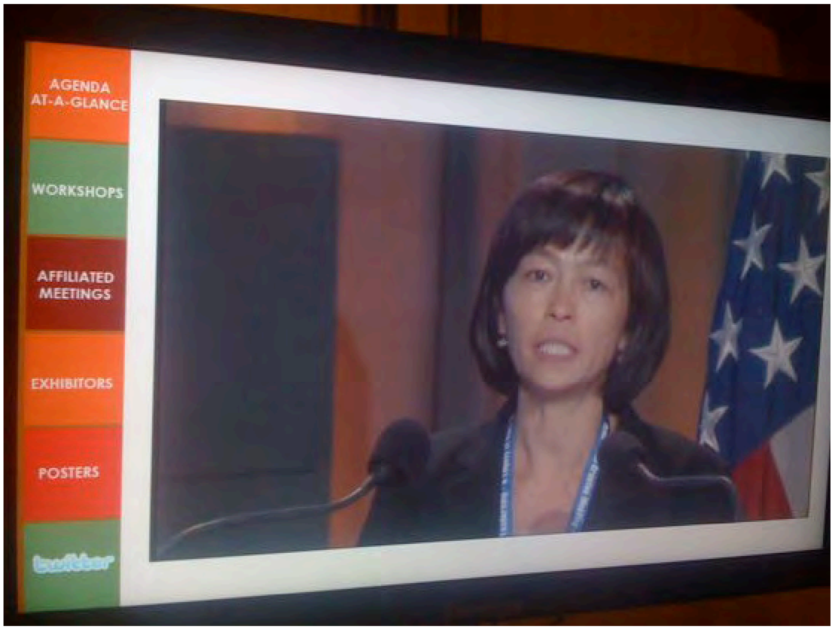
Workshops include the following:

A-04	HRSA Oral Health Programs: Improving Access to Oral Health care for persons Living with HIV/AIDS, Virginia A
B-03	Improving Quality at the Network level: Strategies for Successful QI Partnerships, Maryland C
C-06	Bridging the Gap Between Prevention and Care, Virginia B
D-26	Assessment of Clinician Workforce Capacity Issues in Ryan White HIV/AIDS Program Care Settings, Washington 6
E-7	Lessons Learned Using Technology in Rural Settings, Virginia C
F-24	Expanding Complex Care into Underserved Communities: The ECHO Model, Washington 1
G-19	Using Electronic Networks of Care across the continuum of Care, Washington 1
H-11	The ADAP Semi-Annual Report, Wilson B
I-5	Conversion to Electronic Medical records: One Program's perspective, Maryland C
J-11	The Border AETC Experience: Lessons Learned from 5 Years of Collaboration, Wilson A

Videos of the above workshops will be posted on the TARGET Center at http://careacttarget.org

End of Days: Division Meetings

Parts and Divsions come together in special late afternoon sessions the first two days of the conference to talk about funding, grant requirements, and other topics. On Monday are Part A/DSS, AETC/DTTA, and Parts C and D/DCBP. Tuesday sessions include SPNS/DSP, Part B/DSS, and DTTA/Part D Cooperative Agreements. The AETCs will meet again Wednesday afternoon to talk about expansion of HIV testing in clinical settings and other issues.



DCBP Parts C/D Directors' Meeting

Late Monday afternoon, come meet Division of Community Based Programs (DCBP) staff and get the latest updates! Meet new DCBP staff, including Dr. Margarita Figueroa-Gonzalez (Division Director) and Gary Cook (Deputy Division Director). Short presentations will cover:

- Part F Community Based Dental Partnership Program.
- New streamlined Non-competing Continuation Progress Report process for 2011.
- President Obama's National HIV/AIDS Strategy.
- Quality Management update, by Captain Tracy Matthews.
- Current division activities regarding the evaluation of Models of Care utilized by the Part C and D grantees, by Dr. Figueroa-Gonzalez.

Part C grantees will meet from 4:30 to 5:30 PM on Monday in the Marriott Ballroom. The Part D grantee meeting will follow from 5:30 to 6:30 PM. All interested program staff are invited to attend.

Note: DCBP is actively recruiting for project officers, site visit consultants, and technical assistance consultants.

What Happened Sunday: HIVQUAL-US Meeting

Around 60 clinicians representing a diverse set of Ryan White grantees, joined HIVQUAL consultants and HAB staff for a busy Sunday schedule in reviewing HIVQUAL activities since the 2008 Grantee Meeting. Key presentations at the HIVQUAL-US National Clinical Advisory Committee Meeting included:

- The rollout of eHIVQUAL in June 2010, allowing for Web-based access of the quality management tool.
- A study of longitudinal change in quality of care demonstrating that improvement in quality of care was associated with prolonged performance measurement activities being carried out by the 50 HIVQUAL-participating grantees.
- A proposal to incorporate active HIVQUAL participation as an approved activity for Performance Improvement in the re-certification of physicians by the American Board of Medical Specialties.

careacttarget.org

20 Years of Leadership
A LEGACY OF CARE

Daily Updates & Highlights

Ryan White Grantee Meeting and 13th Clinical Conference

8.24.10

IN THIS ISSUE

Opening Session

Remembering Ryan, his Mom, and other heroes, implementing the Affordable Care Act, and a Clinical Update.

"I Believe in You."

Jeanne White Ginder, Ryan's Mom, recounts her unexpected journey of loss and renewal.

Inspiring Voices

A song, a boy, a history tell our story.

Clinical Updates

First day topics: A novel HIV eradication theory, perinatal transmission, and the debate on premature aging and HIV.

Help Desk

Telling you where to go for a decade.

Updates

Web casts of Clinical Conference plenary lectures will be available, with CME credits, some time in September 2010. Go to the IAS-USA Web site at http://www.iasusa.org/rwprogram2010.

Great Brook Valley Health Center is to be renamed after Edward M. Kennedy Community Health Center on Wednesday, August 25, the anniversary of his death.

WORKSHOP HIGHLIGHTS

A-21, Federal Grants Management:

Understanding and Managing Your HRSA Grant

A-13, Improving Patient Retention by Creating a Trauma-Informed System of HIV/AIDS Care

B-9, Getting the Most Out of Training: Feedback from AETCs

A-9, Enhancing HIV and Mental Health Services Linkage between Jail and Community: An Example of Two HRSA/SPNS Funded Programs

B-16, HIV/STI Screening and Post-Exposure Prophylaxis: Partnering to Improve Care

LOOKING BACK

20 Years Ago: 1990
On August 18, 1990, Congress passes the Ryan White Comprehensive AIDS Resources Emergency (CARE) Act. There are over 150,000 reported AIDS cases in the U.S. Learn more. See: http://hab.hrsa.gov/livinghistory

Opening Session

Remember, Healthcare Reform, HIV Eradication Theory

Opening the Ryan White Grantee Meeting, an historic event marking 20 years of dedication to people, were voices of compassion and humility—a HRSA/HAB soloist (see Inspiring Voices), Ryan White through archival video, Jeanne White Ginder as a featured speaker, and the faces of our history in a video journey.

Talks from top HHS officials ranged from recollections of the program's past and insights ahead, with particular focus on the Affordable Care Act, the health care reform legislation enacted in 2010. A Clinical Panel debate—lively, engaging, sharply funny—rounded out the morning.

Dr. Deborah Parham Hopson, HRSA HIV/AIDS Bureau Associate Administrator and session moderator, spoke of history—20+ years of the Ryan White HIV/AIDS Program—of remembering and looking to the future.

> *"When we began, we were there to help people die with dignity. Today, we are about living….We are here this week, once again, to share those good ideas. And toss out the ones that don't work. For our work is not done…. More people can be reached, and better served, if we keep doing what we've always done, which is to always look for a better path."*

Dr Deborah Parham Hopson, Associate Administrator
HRSA HIV/AIDS Bureau

Opening Session

Words From HHS and HRSA

Presentations by HHS leaders included a video feed by HHS Secretary Sebelius, followed by a keynote speech from HRSA Administrator Mary Wakefield. Secretary Sebelius commemorated decades of dedication and compassion of Ryan White agencies and the long struggle and success of their efforts.

Dr. Wakefield provided a global review of her experience facing gaps in access and her role in heading up the Nation's access agency, HRSA. Wakefield also summarized the expansive role of HRSA in implementing a multitude of Affordable Care Act provisions—from expansion of health centers to workforce development. She also summarized key provisions of health care reform that are intended to bridge many of the most challenging gaps in access to health care, which include:

- High risk pools being established in every state to provide coverage to uninsured people with chronic conditions, including HIV/AIDS.
- Expansion of Medicaid to all lower income individuals earning <$15,000 and < 65 years of age.
- Access to Federal tax credits for those with incomes around $43,000 and the opportunity to pur chase private insurance coverage through competitive insurance exchanges.
- New consumer safeguards to end discrimination based on health status and pre-existing conditions.

> *The ability to "treat the whole patient"—and his or her coexisting conditions—in one place, at one time, is now as integral to Health Reform as it ever has been in Ryan White. With the expansion of the Health Home Model in the years ahead, we would expect many more Health Centers to be in a position to offer these integrated services."*
>
> *"As provisions in the Affordable Care Act take hold in coming years, we will continue to look to the Ryan White program as a shining example of a community-based primary care model that works – one of the most successful in the history of U.S. Public Health."*
>
> Dr. Mary Wakefield, HRSA Administrator

"I Believe in You."

Jeanne White Ginder Speaks at Opening

"I was just a mom," stated Jeanne White Ginder as she reflected on her struggles over a quarter century ago to stare down fear and gain acceptance for her son and herself in the first years of the AIDS epidemic. In her address to meeting participants at the opening session of the Ryan White meeting, Mrs. White Ginder spoke of being approached to serve as a voice for a proposed piece of legislation that would provide desperately-needed HIV/AIDS care. Her son had just died. She was a grieving mother.

"How could I get up and speak in front of people and tell my story. I'd screw up," said White Ginder, saying she had no background in speaking before people, certainly no desire to do so. But she did speak and for the entire world.

Jeanne received multiple requests to speak up in support of the legislation—to put a human face to the epidemic. Among those asking for her voice were Senators Edward Kennedy and Orrin Hatch. "Senator Hatch called and told me that he had lined up 23 Senators for me to talk to," she related. "He said all I had to do is tell them what it was like to watch your son die from AIDS."

Since then, Jeanne has traveled the country as an advocate for HIV services and compassion for people living with HIV/AIDS. As for the meaning of the program named after her son.

Some have written to tell her they were inspired by what happened in those early years and what she did, said White Ginder. In particular is a letter sent many years ago, signed by 100 individuals, which rests on a wall in her home office. She touches it every day. It reads "I believe in you." Those words, said White Ginder, sum up what the Ryan White HIV/AIDS Program means to her. "I believe in you."

Inspiring Voices

How do you energize and inspire 2,500 participants for a 3.5 day conference during the dog days of August in Washington, DC? HRSA looked inward, kicking off the opening plenary with a solo performance by Commander Gettie Audain, followed by a special history video, Living History, recounting the trials and triumphs of the Ryan White Program, spanning the early years of few services delivered by friends and volunteers to a nationwide network of HIV/AIDS care.

Audain performed You Raise Me Up by Josh Groban, prefaced by a photo montage of scenes from Ryan White's life and a video of the front-line work of Ryan White grantees projected across the rooms' three large screens. The Living History video, a 15-minute photo/audio piece, came later in the opening and provided a mix of historic and current day photos along with voice-over perspectives from current and former HRSA employees and people who played a pivotal role in establishing the Ryan White CARE Act.

"I sang the song at HRSA's 2008 World AIDS Day because it was reflective of the theme of unity. I heard from the consumers at the ceremony that it really moved them, really reminded them of their families and loved ones," stated Gettie, the opening plenary soloist. "I also wanted something to reflect the journey of Ryan White. It really sets a united front and shows everyone's place in this journey and this movement."

When not working hard in HRSA/HAB's Division of Science and Policy, Gettie pursues her passion for music, which began at age 5 when she performed in church with her parents and four brothers. Two more recent efforts include organizing a benefit concert for the victims of the 2004 tsunami and performing as part of the Martin Luther King, Jr. Tribute Choir at the Kennedy Center in 2007 and 2008. Despite her long experience singing in public, Gettie put a little extra preparation into today's performance. "It was reviewing the photos that really set the tone for me and allowed me to express the sense of unity at the meeting through song," stated Gettie. (See the Living History Web pages on the HRSA/HAB Web site for more on the Ryan White HIV/AIDS foundation and evolution over two decades.)

Clinical Update

This Day One summary of the Clinical Conference covers three major topics: a debate over when to start antiretroviral therapy, perinatal transmission, and a perspective that evidence is lacking on premature aging in HIV-infected persons. Each is summarized below. Web casts of Clinical Conference plenary lectures will be available, with CME credits, some time in September 2010. Check back on the IAS-USA Web site at http://www.iasusa.org/rwprogram2010.

Topic 1: To Treat or Not to Treat -- A Clinical Debate

The ever-popular clinical panel, moderated again this year by HRSA/HAB Deputy Administrator Dr. Laura Cheever, wrapped up the opening plenary of the Grantee Meeting with a factual yet feisty debate peppered with mentions of Dr. Evil and cost-benefit analyses. Panelists presented the pros and cons of a mathematical theory whose premise is as follows: HIV/AIDS can be eliminated from society if all adults are tested regularly and all infected persons are put on antiretroviral therapy—regardless of CD4 level.

The idea is that virtual elimination of viral load among infected individuals will preclude further transmission, starving the epidemic of new cases. The model was first reported on in The Lancet (Universal Voluntary HIV Testing with Immediate Antiretroviral Therapy as a Strategy for Elimination of HIV Transmission: A Mathematical Model, Granich, et al. Lancet, January 3, 2009) and was subsequently framed as a strategy called TLC+, which stands for:

- Testing to aggressively reduce barriers to universal voluntary testing.
- Linkages to focus on immediate referral to expert medical care for all newly positive and out-of-care PLWHA
- Care+, which entails comprehensive support for patients with a focus on care, including aggressive use of ARV treatment.

The 2,400+ attendees were asked to vote on the pro and con positions in an organized paper-throwing session. You had to be there.

Clinical Update *(continued)*

Yes, Treat Everyone

Arguing for adoption of TLC+ was Dr. Michael Saag, HIV/AIDS clinical expert from the University of Alabama at Birmingham. The essence of the TLC+ position, said Saag, is that the only difference being put forth is to expand treatment to those above 500 CD4 counts, which current HHS antiretroviral treatment guidelines do not endorse. Among his key points:

- Delayed initiation of therapy has many potential harmful outcomes (e.g., destruction of lymphoid-tissue, increased cardiovascular events).
- Waiting to start therapy lets the virus spread as another American becomes HIV-infected every 9 ½ minutes—56,000 new cases each year or 1.1 million available infections over 20 years.

Any concerns over limited resources should be tempered by the fact that lives are being shortened now because of late diagnosis, late presentation, and loss to care.

Dr. Saag even pointed out that a site located at his debating opponent's facility, the San Francisco General Hospital's Positive Health Program, has endorsed treating everyone with HIV, no matter their CD4 level. Their strategy is outlined in Universal Antiretroviral Therapy Initiation: Guideline of the HIV/AIDS Division at San Francisco General Hospital.

No, Don't Do It

Taking the podium at alternative points in the point-counter-point discussion with Dr. Saag (aka Dr. Evil) were Dr. Goldschmidt and Dr. Clanon (aka the mongoose to Dr. Evil's snake). Their key arguments against TLC+:

The science isn't there yet. Test and treat is a mathematical

Clinical Update *(continued)*

model, said Goldschmidt, and its calculations were not likely to work in low prevalence countries. He added that the data for early treatment is based on observational studies and does not account for multiple co-founders, which is typical of such studies.

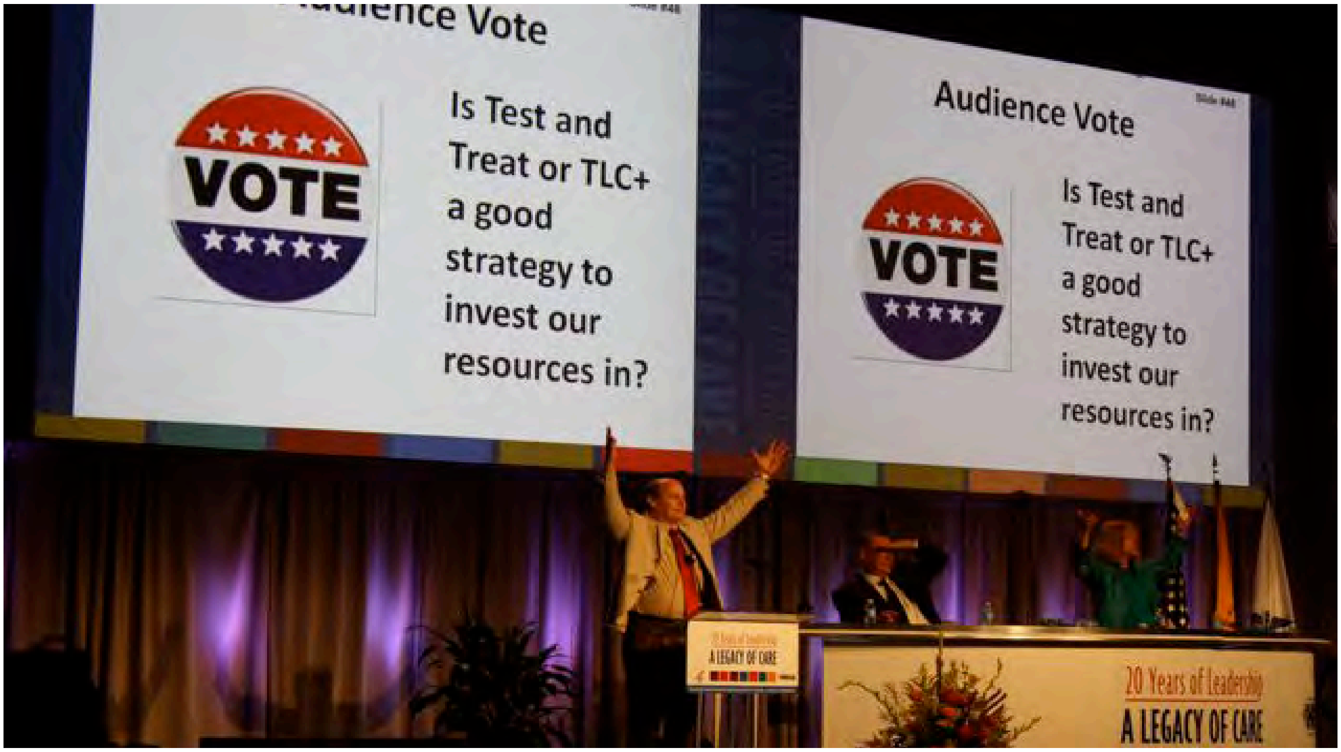
TLC+ assumes too much—the patients are going to be willing and motivated to start and stay on treatment—and overlooks an array of common side effects and toxicities and the difficulty of high levels of medication adherence required to fully suppress viral loads. These challenges are in addition to the risk of development of resistant virus.

The Votes

Two questions were posed to attendees, post-debate:

- In 2010, do we have enough safety and efficacy evidence to encourage individuals to start ARV therapy at any CD4 level?
- Is Test and Treat or TLC+ a good strategy to invest our resources in?

Attendees voted “no” on both questions, overwhelming on the first and less so on the second, suggesting a large degree of skepticism and doubt about the wisdom of launching into an ambitious HIV/AIDS eradication campaign based on antiretroviral treatment.



Clinical Update *(continued)*

Topic 2: FAQs on Prevention of Perinatal HIV Transmission

Do you every feel confused about available contraceptive options for your HIV+ female clients?
Do you feel limited in your options when counseling female clients about contraception and birth control?

In this session, Dr. Jess Folger Waldura provided an overview of top questions clinicians face when managing pregnant and peri-partum patients. Among the answers, which are always available from the Warmline/Hotline service of the National Clinicians Consultation Center, are the following:

- **What antiretrovirals to use during pregnancy.** Federal perinatal treatment guidelines outline antiretroviral options to use when oral contraceptives are also being taken. Said Folger Waldura: do not memorize the options. Look at the guidelines each time as treatment options change and guidelines are continuously updated.
- **Use of hormonal contraceptives in HIV treatment regimens.** A few good safe and efficient options for birth control in HIV+ women are Progestin only oral contraceptive pills, depot medroxyprogesterone, implantable progestin and IUDS. Folger Waldura number one choice for reducing the number of unplanned pregnancies is the IUD because it does not impact the antiretroviral regimen.
- **Dealing with indeterminate HIV tests.** Perinatal HIV transmission has been one of the Nation's most successful accomplishments in HIV care. Continued attention is needed to identify and test pregnant women in both the first and third trimester of pregnancy. The goal is to have an undetectable viral load by the late 3rd trimester and at delivery. Occasionally, clients present with indeterminate HIV test results. If early in their pregnancy, these clients should be retested 4 weeks after the first indeterminate test. Women in "late" pregnancy should be assessed for the likelihood of true HIV infection with consideration given to starting antiretroviral treatment while awaiting confirmation of HIV status. Use of a viral load test to confirm infection status is not an approved diagnostic test and thus should be approached with caution. Women who present in labor with a positive rapid HIV test are to be treated as a true positive, and have a repeat Western Blot and started on treatment immediately.

Topic 3: Non-AIDS Morbidity, Accelerated Aging or Disease-Related Risk Factor?

Dr. Carl Grunfeld tackled the question: Is there premature aging in HIV disease? While some contend that inflammation caused by HIV/AIDS can result in premature aging, Dr. Grunfeld's data suggest that premature aging does not occur, although disease-specific risks (e.g., heart disease) do exist that clinicians need to explain to their patients. Grunfeld shared examples where populations with HIV are, in fact, at decreased risk for certain age-related phenomena, such as the accumulation of organ fat with age. In other words, getting a belly as you age may be less risky in people with HIV/AIDS.

In general, as people age, their immune systems do not work as well, said Grunfeld. PLWHA have the same issues, but the type of immunodeficiency in HIV infected clients differs.

Help Desk: Telling You Where to Go

Here's a piece of helpful history for you: the Help Desk has been pointing Ryan White attendees in the right direction for 10 years, ever since the first all grantee meeting in 2000. This year's booth, set right outside the registration desk area, is staffed by 38 HRSA/HAB volunteers.

Questions don't vary too much from year-to-year, like where do I find a meeting, a person, a lost item, a restaurant. The most serious is helping someone replace forgotten medications by hooking up a local clinician and nearby pharmacy with a back-home doctor.

Below are the most common questions:

- Can you help me find my project officer? This question gets asked more in recent years as HRSA sstaff travel far less frequently these days and have never met their grantees.
- Where's the Clinical Conference and can I register? Tip: Go up the central atrium escalator and be forewarned: attendance is so high this year that three overflow rooms have been set up.
- Can you help me find a special meeting? Suggestion: There are 35 or so such sessions, and they are listed on the touch screens in the common areas around registration.

Among the most popular questions this year: *Can I get one of those tote bags from the quality conference?* Answer: All 500 have been given out. Go to the Exhibit area and see if they have any left, but no guarantees.

Workshop Highlights: Monday, August 23

Federal Grants Management:
Understanding and Managing Your HRSA Grant
A-21 , August 23, 2010

Managing your federal funds can be a task. There's plenty of guidance out there from HRSA and HHS. This session shared a handful of helpful tips, like:

- Read and Understand your NGA Notice of Grant Award (NGA).
- Update addresses and Authorizing Official information.
- Keep up with your due dates for reporting requirements.
- Keep all financial documents for up to three years.

This workshop, geared in part to new grantees, also covered topics like program income, accessing grant funds through Payment Management System (PMS), and other Electronic Handbook (EHB) submissions. The take-home message from this session: "Your Project Officer and Grants Management Specialist are here to support you in managing your grant."

Keep abreast grants management issues by consulting these Web pages:

Grant Information for Current and Prospective HHS Grantees

http://dhhs.gov/asfr/ogapa/aboutog/grantsnet.html

HHS Forms by Number
http://www.hhs.gov/forms/publicuse.html

Workshop Highlights: Monday, August 23

Improving Patient Retention by Creating a Trauma-Informed System of HIV/AIDS Care
A-13, August 23, 2010

A single incident or ongoing exposure to trauma can result in high-risk behaviors, including those that can lead to HIV/AIDS, as well as other behaviors that can be detrimental to health. While helping those suffering from trauma to address the impact can require a specialist, health care providers can take steps to make their services more accessible to people who have experienced trauma.

The Catalyst Foundation in Lancaster, California, a Part C grantee, is dedicated to decreasing the impact of unhealed emotional pain and trauma. It operates the Bartz-Altadonna Memorial Clinic, which provides comprehensive primary medical care for low-income, uninsured, and homeless persons and treatment of all stages of HIV and HCV. The clinic has taken findings from Adverse Childhood Experiences (ACE) study (http://acestudy.org) and applied them to its own services. The ACE study included

17,000 enrollees of Kaiser Permanente in San Diego and is perhaps the largest scientific research study analyzing the relationship between multiple categories of childhood trauma and health and behavioral outcomes later in life.

Key elements of a trauma friendly program include creating an environment that is more welcoming and open and meeting consumers “where they are at.” A non-judgmental staff can encourage trust in therapeutic relationships. Staff (and volunteer) training—for all staff and on an ongoing basis—is essential.

The Bartz-Altadonna clinic uses the 10-question ACE assessment with all consumers and the scores are maintained in consumers’ medical records. A “high” ACE score in an indication of significant trauma.

For those consumers with a high score, their provider will refer them to a specialist in trauma. Steps are also be made to accommodate these consumers’ needs during the provision of health care.

There are some challenges to incorporating a trauma-informed approach. For example, it can be difficult to balance client responsibility with accommodation. Staff, both professional and ancillary, buy in can be difficult to obtain. Finally, self care for staff cannot be overlooked.

While it has only been using this approach for a few months, Bartz-Altadonna has already seen results. The no show rate for consumers with HIV has dropped by 5 percent. The clinic is planning on investigating the relationship between ACE scores and viral load (a marker for adherence) in the future

For more information visit the Catalyst Foundation Web site at http://catalystfdn.org.

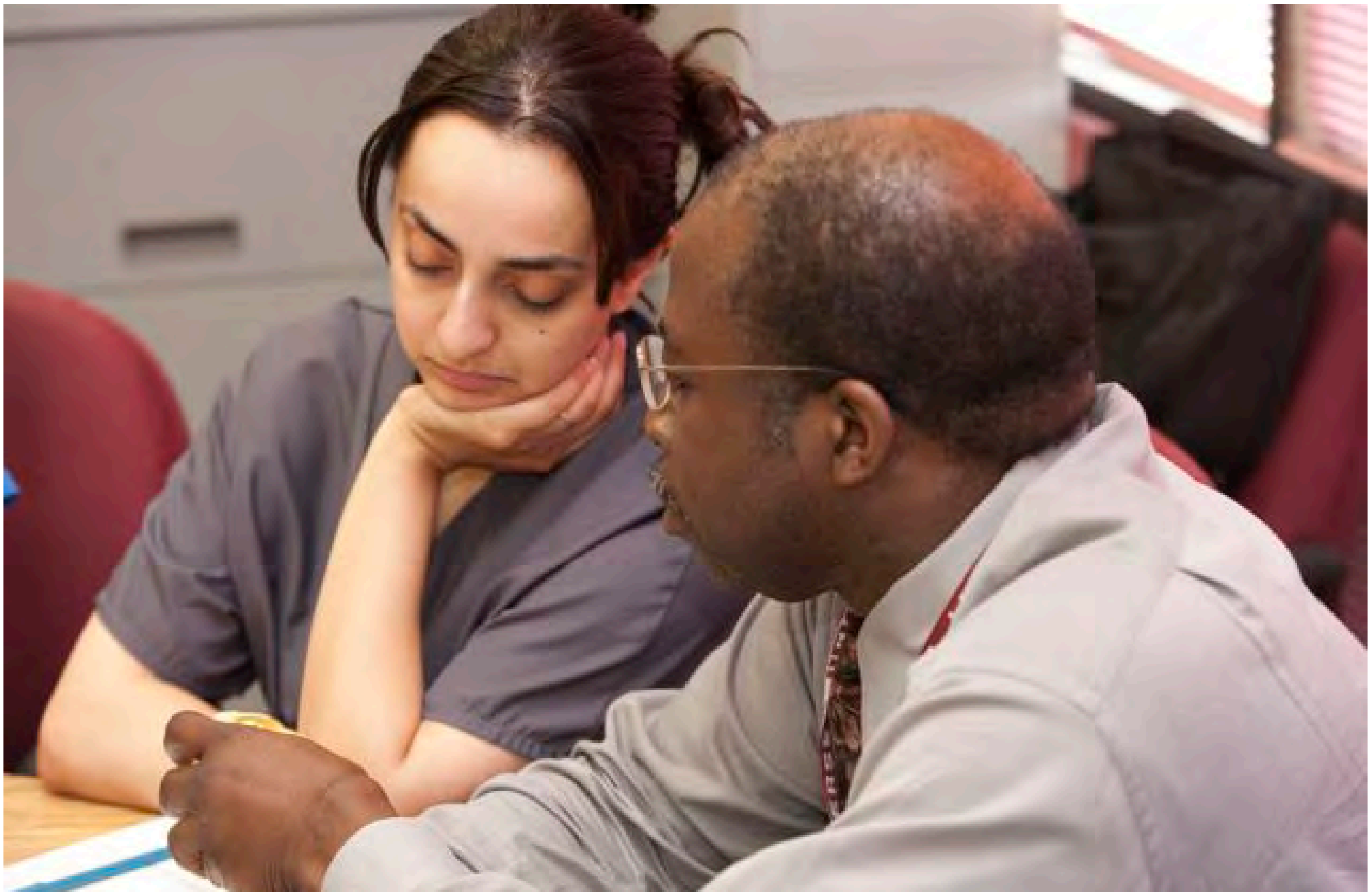
Workshop Highlights: Monday, August 23

Enhancing HIV and Mental Health Services Linkage between Jail and Community: An Example of Two HRSA/SPNS Funded Programs

A-9, August 23, 2010

Jail based mental health and substance abuse counseling and community support can be a significant component to linking incarcerated and previously incarcerated PLWHA to care. This workshop on the work of two SPNS projects included a video panel consisting of consumers, providers, and advocates who discussed best practices for identifying and engaging community partners. Among their tips:

- Develop rapport with corrections staff.
- Appoint a liaison with community partners.
- Communicate often with jail staff, community providers and community case managers.
- Provide continuity of care by continuing the community care plan via discharge planning and coordinating services.



Workshop Highlights: Monday, August 23

Getting the Most Out of Training: Feedback from AETCs
B-9, August 23, 2010

When a group of trainers from the HRSA/HAB-supported AIDS Education and Training Centers (AETCs) gets together to discuss ways to maximize learning and minimize barriers to training in clinical sites, there are likely to be one or two memorable stories. Like the time one trainer showed up at a clinic expecting to find a blank white wall on which she could project her slides, only to have a stuffed deer rump (yes, it was real) mounted in the middle of the wall.

Fortunately, this example is the exception. For the most part, trainers participating in the discussion focused on the importance of working closely with the clinical site to ensure a successful training. While we all understand that time is an extremely precious commodity, a little investment on the part of the clinic can have big pay offs in terms of a successful training.

Assess Before You Train

In planning a training for staff, clinical sites should work with the trainer to conduct a needs assessment. In some cases, a face-to-face meeting can allow the trainer to assess the facility to determine the most appropriate way to set up the training. For example, if the clinic lacks a conference room, small group sessions might be the most appropriate. A visit to the clinic can also allow the trainer to conduct some short, key-informant interviews with staff members to explore their training needs as staff needs may vary from the administrator's or clinical director's perceptions.

Workshop Highlights: Monday, August 23

Getting the Most Out of Training: Feedback from AETCs
B-9, August 23, 2010 (continued)

Think Outside, Yes, the Box

Given the time constraints, clinics should work with trainers to “think outside the box.” Instead of have a single training that lasts all morning, the trainer can conduct a series of shorter trainings over time.

Trainers can also distill information to the bare essentials and design a 20-minute training that could take place during a staff meeting. Another option that was suggested had to do with Web casts and other forms of recorded trainings. The advantage of these are that they often are conducted by highly qualified trainers. However, it can be difficult to engage participants because they are not interactive. Group viewings can be held with a trainer present to answer questions and lead discussion. Providing food is an added inducement. Bottom line, all the trainers participating in the discussion were committed to tailoring their trainings to the needs of the site.

Finally, the AETCs are about building an ongoing training relationship with clinical sites. To ensure that all parties are getting the most out of the relationship, they should share feedback and evaluations. This can lead to better tailored trainings and improved buy-in on the part of staff.

AETC
NATIONAL
RESOURCE
CENTER

Access an array of clinician training resources from the AETC National Resource Center at http://www.aidsetc.org. Also see the TARGET Center’s Clinical Care site at http://careacttarget.org under Topics.

Workshop Highlights: Monday, August 23

HIV/STI Screening and Post-Exposure Prophylaxis: Partnering to Improve Care
B-16, August 23, 2010

This workshop reviewed the benefits of a protocol for HIV screening and prophylaxis for victims of sexual assault. Key elements of the protocol include:

- Offering the patient information.
- Encouraging prophylaxis against HIV and STIs (determined on a case by case basis).
- Encouraging follow-up to HIV/STI exams.

Multidisciplinary collaborations were instrumental in developing the clinic's protocols and algorithms and executing training plans. Key partners included the sexual assault nurse examiner, pharmacy, emergency department social worker, nurse, physician and infectious disease physician, Activities significantly increased the number of sexual assault victims who were screened for HIV/STIs and provided with non-occupational exposure prophylaxis.

20 Years of Leadership
A LEGACY OF CARE

Daily Updates & Highlights

Ryan White Grantee Meeting and 13th Clinical Conference

8.25.10

IN THIS ISSUE

Ryan White 2010 Awards

Acknowledging the accomplishments of seven people with over 100 years of experinece and commitment to HIV/AIDS care.

Past Ryan White Award Winners

Ryan White Awardees over the past 10 years, Part by Part, Title by Title.

SPNS @ the Meeting

Dozens of workshops and posters on modles of HIV/AIDS care -- oral health, coreectional care, technology, and more.

Clinical Update: Day 2

Sessions covered policy, linkage and retention in care, and much more.

WORKSHOP HIGHLIGHTS

C-8, Quality in Hard Times

C-3, Don’t Be Number One: Sliding Fee Scales and Individual Patient Caps

C-2, Medical Care Coordination: Implementing the Medical Home Concept

C-6, Bridging the Gap Between Prevention and Treatment

D-14, Creative Consumer Involvement in System-Level Quality Improvement

E-24, The Financial Impact of New 2009 Department of Health and Human Services (DHHS) Guidelines for the Use of Antiretrovirals

LOOKING BACK

15 Years Ago: 1995
First Protease Inhibitor (saquinavir) is approved by FDA, with later approval that year of its use as combination therapy—the first antiretroviral therapy cocktail. Learn more. See hab.hrsa.gov/livinghistory

Ryan White 2010 Awards

Seven really hard choices get made at each Grantee Meeting: selecting Ryan White Awardees. This year's winners—recognized at the August 24 awards event—collectively have over 100 years experience in HIV/AIDS care. Most are approaching their third decade in the field, with tenures ranging from 29 years to 10.

Their years of contributions were matched by those in the audience—among them some of the staffers who helped put the Ryan White CARE Act in place, like Steven Bowen, Anita Eichler, and June Horner.

2010 Recipients & Awards	**Remarks**
Jeanne White Ginder Associate Administrator's Award	"I'm sure [Ryan] is looking down on me right now."
Jeff Natter Part A Hank Carde Award	"The work we do enobles and enriches us."
Dwayne Haught Part B Dr. Nicholas Rango Award	"Everyone is worthy of care."
Karen Berube, Part C Gabe Kruks Memorial HIV/AIDS Service Award	"I go to work every day and feel good about what I do."
Jane Caruso Part D Rebecca Denison Award	"My new-found-cross-Part collaborative partners have added a whole new dimension to my story."
David Spach AIDS Education & Training Centers Award	"We've been given the opportunity to make a difference in other people's lives."
Howell Strauss SPNS Russell E. Brady Award for Innovative Services Delivery	"More new patients are dropping into our safety net. Can we realistically continue to meet the needs and fulfill the dreams of our patients."

Ryan White 2010 Award Winners

Past Ryan White Award Winners

Associate Administrator’s Award

2008	David Reznik, DDS, Chief of the Dental Service for the Grady Health System in Atlanta, Georgia
2006	Kristen Ries, Clinical Director, University of Utah Hospital Infectious Diseases/HIV Clinic; Salt Lake City, Utah
2004	Kathleen Clanon, NMD, FACP, Director, East Bay AETC Jesse Milan, JR., JD, Analytical Scieneces; Silver Spring, Maryland ActionAIDS; Philadelphia, Pennsylvania National Episcopal AIDS Coalition
2002	Terje Anderson
2000	Carlos Gonzalez, MD

Past Ryan White Award Winners

Part A/Title I Hank Carde Award

2008	Adrienne F. Rogers, TGA Administrator, Sarcramento, CA
2006	Michelle Long, MHA, Director of HIV Health Services, San Francisco Department of Public Health AIDS Office, San Francisco, CA
2004	Charles Henley, LMSW-ACP, Manager of the HIV Services Section, Harris County Public Health and Environmental Services, Houston, Texas
2002	Wilbert C. Jordan, MD, MPH, Director of the OASIS Clinic and AIDS Program in MLK Jr/Drew Medical Center, Los Angeles, CA
2000	Roman Buenrostro

Part B/Title II Dr. Nicholas Rango Award

2008	Stephen George Sherman, Branch Head of North Carolina's HIV/STD Prevention & Care Branch
2006	Victor J. Fox, Manager State of Oregon HIV Client Services Program; Portland, Oregon
2004	James Welsh Title II State AIDS Coordinator; Dover, Delaware
2002	Lois Lux, MS, RNC, Title II administrator, Community and Family Health, Washington State Department of Health, Olympia, WA
2000	Lanny Cross, ADAP Director, New York State

Past Ryan White Award Winners

Part C/Title III Gabe Kruks Memorial HIV/AIDS Service Award

2008	Dr. Cheryl Lynn Besch, Director of the HIV Outpatient Program at the Medical Center of Louisiana
2006	Helena Akua Kwakwa, MD, MPH, Clinical Director HIV Services Philadelphia Department of Public Health; Philadelphia, Pennsylvania
2004	Arlene Bincsik, MS, RNC, CCRN, ACRN, Administrative Director HIV Program Christiana Care Health; Wilmington, Delaware
2002	Montgomery AIDS Outreach; Montgomery, Alabama
2000	Leonard Spinner

Part D/Title IV Rebecca Denison Award

2008	Rolando Jimenez-Mercado, Director of Puerto Rico’s Pediatric AIDS Comprehensive Care and Family Network
2006	Mobeen H. Rathore, MD, Director Rainbow Center, University of Florida; Jacksonville, Florida
2004	Felicia Rodriguez, Program Director Title IV Youth Initiative Adolescent Medicine CORE Center, Stroger Hospital of Cook County; Chicago, Illinois
2002	Sara Abdirahman, Washington, DC
2000	Virginia Ross

Past Ryan White Award Winners

AIDS Education and Training Centers Award

2008	Dr. Ronald Wilcox, Delta AETC Program
2006	Thomas J. Donohoe, MBA, Director UCLA Local Performance Site Pacific AETC
2004	Lucy Bradley-Springer, PhD, RN, ACRN, Director Mountain Plains AETC
2002	Michael E. Reyes, MD, Project Director Pacific AETC
2000	Linda Frank, PhD, MSN, ACRN, Director, Pennsylvania/Mid-Atlantic

SPNS Russell E. Brady Award for Innovative Services Delivery

2008	Allan Rodriguez, MD, University of Miami's Special Projects of National Significance Caribbean Initiative project
2006	Michael A. Kaiser, MD, Associate Chief Medical Officer, LSU Public Hospital System; New Orleans, Louisiana
2004	El Rio Santa Cruz Neighborhood Health Center; Tucson, Arizona
2002	Miriam Hospital; Providence, Rhode Island 2000
2000	Outreach, Inc.

SPNS at the Meeting

The SPNS program has been a proving ground for innovative models of care since the first days of the Ryan White Program. SPNS identifies best practices in care with a focus on the most vulnerable PLWHA and most pressing care issues and does so under topic-specific initiatives. There are 16 workshops at the 2010 Grantee Meeting (see list below) a handful of posters, and even a new publication, Jail: Time for Testing, Institute A Jail-Based HIV Testing Program, a guide explaining how to implement an opt-out HIV testing program in a jail setting..

Each SPNS initiative involves funding a set of demonstration grants and, in most cases, a corresponding evaluation center that directs a multi-site evaluation and delivers technical assistance to the Initiative's grantees. The demonstration sites are required to have a local evaluation as well.

History of Innovation

While SPNS conference offerings are from current SPNS activities, the program has a rich history. The first SPNS initiatives focused on service delivery for Native Americans and youth, in accordance with early CARE Act legislation. Legislative authority for SPNS in the 2009 reauthorization is twofold: address emerging needs of individuals served by the various Ryan White Parts and build the capacity of grantees to report client level data to HRSA.

Initiatives have evolved over the years, along with new care issues. For example, adherence to treatment regimens emerged as a key issue in the mid-to-late 1990s given urgency to ensure correct use of new combination treatments.   Engaging people in care became a focus for SPNS in response to troubling data about the significant number of PLWHA who were not entering care, were entering late, or were falling out of care over time. More recent SPNS include the Oral Health Initiative and the newest: engaging and retaining Women of Color in care.

Highlights of SPNS Workshops

Use of Health Information Technology in care is yet another SPNS focus and reflects the Nation's move toward electronic medical records. One workshop at the meeting, Consumer Rights to Quality Health Care and Privacy: When is Sharing PHI the Right Thing to Do? (A-11), featured several SPNS projects using technology to engage and retain PLWHA in care and improve the quality of the care they receive.

- In Louisiana, a system of care providers is using electronic medical records—specifically, their lab reports—to determine when given patients have not been seen in care. A note can then be sent to whichever provider is seeing that patient so that special efforts can be made to support the person's engagement in the care system. Their system includes all necessary confidentiality and data sharing requirements.

SPNS at the Meeting

- New York City's Presbyterian Hospital has done something similar with electronic medical records but with a twist that empowers clients. Patients can look at their profiles on the electronic system, which includes a listing of every HIV medication they have ever taken. Providers across the system also have access to these data and, as such, can enhance the quality of care delivered in that prior treatment history is readily available as clinicians make future decisions about medications to prescribe.

In another workshop, covering work of another SPNS effort called SPNS Electronic Networks of Care, the City of Paterson (Bergen-Passaic TGA) has linked all of their providers to share client health records with other providers. Efforts are taking place using the Initiative's capacity building funding. The program is also engaging in a bit of cross-program collaboration by working with the Cross-Part Collaborative to improve the quality of care by providing alerts to clinicians in order to address such client needs as STD screening and TB testing (see B-12, Leveraging SPNS Initiatives to Transform Client-Level Data Collection into Service and Quality Tools).

Access SPNS Resources

Learn more about the HRSA/HAB SPNS Initiatives and publications at http://hab.hrsa.gov. SPNS-related publications are also available from the HRSA Information Center at http://ask.hrsa.gov and the TARGET Center at http://careacttarget.org.

20 Years of Leadership
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Clinical Update: Day 2

Day Two plenary presentations the 13th Clinical Conference covered a wide range of topics—policy, linkage and retention in care, and more. Below are highlights and sound bites. See the slide sets in the Clinical Conference Syllabus and look out for Web casts from IAS-USA in the next month.

The National HIV/AIDS Strategy: Highlights for Ryan White Clinicians

Dr. Laura Cheever from HRSA/HAB outlined the strategy—its goals, how it was developed, and steps being taken by HRSA and other Federal agencies to put the plan into action. A late-breaking National HIV/AIDS Listening Strategy was held late Tuesday night. Stay tuned for a summary.

NIH Research Priorities: What HIV Clinicians Need to Know?

Dr. Erbelding from NIH reviewed several upcoming NIH-sponsored studies, including:
Immediate versus deferred antiretroviral therapy. This large study is in the planning stages and will address the issue of immediate versus deferred treatment. Patients at greater than CD4 500 will be enrolled in this much-needed randomized controlled clinical trial.

NIH also plans to conduct a separate study to address research issues in “test-to-treat” studies, such as ethical implications. (To clarify: “test-to-treat” is the idea that you diagnose and get individuals on antiretrovirals as soon a possible , regardless of CD4 count. The difference from the immediate versus deferred issue discussed above is the focus on treating those above the CD4 500 level.

Testing and Linkage to Care

Dr. Elias described HIV/AIDS prevalence in Wahisngton, DC, which she described as a generalized epidemic versus one focused on certain sub-populations. Dr. Elias also described routine testing and linkage to care efforts in the city and various innovative programs. One, a change where clients need to opt-out of testing, resulted in a 20 percent drop in refusals to be tested. In other words, more people are testing under opt-out.

Other studies discussed by Elias included an intensive effort to re-contact persons previously diagnosed and lost to care and special efforts to retain persons in care, especially through improved case management.

Clinical Update: Day 2

Retention in HIV Care: What the Clinician Needs to Know

Dr. Giordano described the strong correlation between retention in care and prognosis. Past intervention studies include SPNS, while a HRSA/CDC collaborative study is underway to examine the impact of variable levels of intervention.

An Update on Resistance Test Interpretation and Diagnostics

In Dr. Shafer's talk, he summarized the following: for initial treatment, genotypic-guided therapy for antiretroviral-naïve patients appears, overall, to be a good approach. However, on occasion, additional undetected minority mutations might be present.

Top 10 Drug-Drug Interactions to Avoid (or NOT): What Every Clinician Needs to Know

As we know, drug interactions with antiretrovirals are complex. Dr. Dong put out a general rule: when drugs have inhibitor or inducer effects, the inhibitor effects are generally stronger. She added: Atazanavir needs an acid environment. Thus, special attention needs to be paid to use of prescription or non-prescription acid agents.

Oral Health in HIV Infection

Dr. Webster described how careful evaluation of the health of the teeth and mouth is a valuable tool in treating oral infections and also identifying and managing early tooth disease. Also, the BK virus is responsible for parotid gland swelling.

HIV and the Nervous System: 3 Decades On

Justin McArthur stated that as many as 45 percent of HIV/AIDS patients may have cognitive impairment. There is mounting evidence of continuing inflammation of the central nervous system (CNS), despite virological control. There is some additional evidence that CNS penetration of various antiretrovirals just might matter toward ongoing CNS disease. Further studies are in progress. Finally, there are still no validated laboratory markers that can be used clinically to diagnose HIV-associated neuro-cognitive disorders.

Workshop Highlights: Tuesday, August 24

Quality in Hard Times: Using Quality to Help Mitigate the Impact of Budget Cuts on Care/Building a Quality Management Program on a Shoestring
C-8, August 24, 2010

Popular excuses for not having time for quality improvement are:

- "With everything else we have to do, we can't afford to dedicate someone to quality."
- " I can barely keep up with patient care as it is."
- "We would like to do quality improvement, but we don't have electronic medical records."
- "We have a quality manager who looks after that, I focus on patient care"

The workshop Quality in Hard Times, revealed ways programs can cut costs and increase revenue through quality improvement. Programs report seeing cost savings from reduction in: lab ordering, no shows, supply costs, duplication of services, and waste of meds by better feedback loop with the pharmacy. Increased revenue was reported from reduction in missing billing sheets, education to doctors about coding, added family planning billing options, and improved application rates for Medicaid.

Other helpful strategies include: not reinventing the wheel, networking with other programs working in similar areas to share experiences and models for success, aligning efforts with QI efforts in other areas of the organization, and leveraging technical support resources offered by HRSA funding and other interest groups.

For more information or to receive resources on building a case for quality improvement in hard economic times, visit the National Quality Center Exhibit table or go to NationalQualityCenter.org.

Go to the TARGET Center and see QUALITY under Topics to access a full range of Quality Management TA and Training resources, including the National Quality Center (http://nationalqualitycenter.org) and HAB's Performance Measures (http://hab.hrsa.gov/special/qualitycare.htm)

Workshop Highlights: Tuesday, August 24

Don’t Be Number One: Sliding Fee Scales and Individual Patient Caps
C-3, August 24, 2010

The number one finding for site visits administered by the DCBP is the grantee’s lack of a sliding fee scale. A close second is lack of a cap on individual charges.

This session, which drew a crowd of over 100 people from all Parts of the Ryan White Program, began with an overview of the Ryan White legislation and HRSA expectations related to sliding fee scale and patient caps. Susan O’Brien followed up with a review of her Part C agency’s policy and how she worked to get it implemented. She described working with middle-management on the organizational level and how she engages clients to take ownership of their care. Karla Burnworth shared how a smaller organization with a much larger service area has been able to implement new fiscal policies. One common theme is engaging both the client and middle-management. An effective way to do this is for the Project Officer to convey the importance of Ryan White Program fiscal policies to middle-management financial staff.
Over 30 questions about sliding fee and cap issues were written down on a flip chart. Presenters will compile answers and send them out to attendees. For more information, contact jfanning@hrsa.gov.

Workshop Highlights: Tuesday, August 24

Medical Care Coordination: Implementing the Medical Home Concept
C-2, August 24, 2010

Major system change can be a challenging and time consuming process. The LA County EMA shared lessons learned in making such a change in shifting from a case management to medical home model—insights they gained in the course of change that was guided by the planning council and grantee.

The multi-year process, LA anticipates it will take about 6 years to implement from the planning stages to finish, brought together a range of stakeholders to engage in a variety of planning and implementation activities.

Consumers were the driving force behind the proposed changes. Through various forms of feedback, including regular needs assessments, consumers emphasized that the psychosocial case management system was not meeting their needs, especially in terms of facilitating access to care. In response, the council took the lead in a planning process that included conducting research to identify possible models. Next steps included development of a framework, standards of care, and principals and priorities, followed by a financial analysis to determine the costs related to the proposed changes.

The grantee headed the implementation process, establishing a transition advisory group (TAG) that included council members, nurses and case managers, consumers, and providers. The grantee also included representatives from other public health care systems, such as chronic disease management and maternal and child health—bringing much-needed insights and experience from those outside of the HIV/AIDS community.

Based on its efforts to bring about major system change, the EMA has several lessons to share.

- Involve stakeholders from the beginning and work toward consensus.
- The larger the change, the greater the resistance will be. Opponents will challenge the data, cost, and the implementation (e.g., will call for pilot testing). When proposing change, it is important to plan for resistance and be prepared (i.e., do your homework).
- The grantee and the council must work together. Opponents will pick up on (and exploit) discord.
- Seek out TA resources. LA County received technical assistance from a HRSA consultant. It helped both in terms of the expertise and having a “neutral” party to guide the process.
- Training will be necessary to support the change. This will need to target all stakeholders including staff, providers, and consumers.
- A comprehensive communication strategy is necessary to let stakeholders, especially consumers,

Workshop Highlights: Tuesday, August 24

know that change is coming. It is also important to keep up the flow of information as people are likely to lose patience with the planning and implementation process as it stretches out.

A variety of tools using during the planning and implementation process are available from the LA HIV Commission. Additional resources on planning and medical case management are available from the TARGET Center at http://careacttarget.org

Bridging the Gap Between Prevention and Treatment
C-6, August 24, 2010

Do your clients have difficulty disclosing their HIV status to family, friends and their partners? Siouxland Community Health Center presented two interventions that have changed behaviors and improved the communication skills of their clients. They include:

- CLEAR: Choosing Life, Empowerment, Action, Result, and
- Healthy Relationships.

These CDC-supported interventions can be accessed at www.effectiveinterventions.org.

Workshop Highlights: Tuesday, August 24

Creative Consumer Involvement in System-Level Quality Improvement
D-14, August 24, 2010

The Seattle Part A TGA explored with participants the benefits of consumer involvement and how to develop creative approaches for partnering with consumers to improve quality.

- The session explored four “Consumer Awareness Campaigns” used to improve on consumer knowledge of lab values, adherence, on-time renewals of insurance, and cervical cancer screening. Participants brainstormed messages and images for use in future campaigns.

- The later part of the workshop focused on the “Consumer Quality Leadership Program” designed to increase the number of consumers who feel prepared and confident in participating in a program and system level groups that affect the quality of HIV care.

Keep an eye out for future TARGET Center (http://careacttarget.org/) posting of this workshop’s resources and tools, which can be modified and replicated in multiple settings.

The Financial Impact of New 2009 Department of Health and Human Services (DHHS) Guidelines for the Use of Antiretrovirals
E-24, August 24, 2010

Dr. Keith Rawlings from the Peabody Health Center in Dallas, Texas, gave a provocative presentation analyzing the additional cost of HAART if the 2009 DHHS Guidelines are applied widely. Analysis of his clinic population as well as those of local HIV providers suggested that 10% (5.6-12%) who were currently not on HAART would be eligible for therapy based on current guidelines (starting when CD4 count < or = 500 cells/cc rather than < or = 350 cells).

For the Dallas EMA, this would involve an estimated 1180 to 2550 persons. The cost of antiretroviral therapy using 340B pricing for preferred ARV regimens would be $16-$35 million annually if 100% of the eligible population were treated, and $8-$17.5 million if 50% were treated. Dr. Rawlings suggested that the resulting questions of financing this expansion, prioritizing Ryan White funds, and the real possibility of establishing disparity in the availability and choice of antiretroviral therapy due to lack of funding needs to be discussed immediately by the Ryan White grantee community and HIV providers.

20 Years of Leadership
A LEGACY OF CARE

Daily Updates & Highlights

Ryan White Grantee Meeting and 13th Clinical Conference

8.26.10

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The final day of the 13th Clinical Conference focused on PEP, transgender health, the very promising future of Hepatitis C treatment, and diagnosing STDs.

Consumers Meet With HRSA/HAB

Wednesday afternoon, 24 consumers met with HRSA/HAB’s Dr. Parham Hopson, covering such wide-ranging topics as consumer involvement in planning and the impact of the Affordable Care Act on the furure of the Ryan White Program.

Oral Health Care and HIV

Dental care was front-and-center at the Ryan White Meeting, with 8 workshops and 13 posters.

HIV and the Transgender Client

A significant proportion of Ryan White providers, over one-fourth, serve transgender clients. A handful of workshops and a clinical conference session covered issues related to transgender HIVAIDS care.

WORKSHOP HIGHLIGHTS

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Special: Health Care Reform: What Ryan White Providers Need to Know

LOOKING BACK

10 Years Ago: 2000

The CARE Act Amendments of 2000 reauthorize the CARE Act.
Learn more. See:
hab.hrsa.gov/livinghistory

And The (Poster) Winners Are...

For the first time, ever, the Ryan White Meeting shined new light on the poster presentations, selecting a total of 15 “best of show” awards. Posters cover such topics as medication adherence, linking clients to services, priority setting and resource allocation, health literacy, and anal cancer screening.

Awards were under three categories: Best Conference Poster Presentation (awarded to one poster from each of the seven tracks), Innovation in Program (again, with awards to one poster from each track), and Innovation in Research (one award). There were 160 submitted posters, but HRSA/HAB authors were deemed not eligible so as to focus on presentations from the Ryan White grantee community.

Selections were made by the Poster Subcommittee panel as follows, according to three criteria: importance, methods, and clarity:

- The Best Conference Poster Presentation was an on-site review of all grantee-submitted posters.
- Awards for Innovation in Research and Innovation in Program entailed a pre-meeting review and scoring of poster abstract submissions. This was followed by an on-site review of the poster submissions of the abstracts that received top scores. The Subcommittee reviewed and score grantee-submitted posters on Monday.

The winning posters are listed below. Posters will be listed online, post meeting, on the TARGET Center. Look for a future HAB Email article to access the posters.

Best Conference Poster Presentations

Photography as a Tool for Developing Positive Life Skills
P-13, Access and Retention

SHOW ME THE MONEY! – Priority Setting and Resource Allocation Process
P-41, Administrative and Fiscal Management

Implementing Case and Technology Based Education Program in Correctional Systems of Care
P-50, Coordination and Linkages

Health Literacy: A Silent Contributor to Health Disparities
P-62, Cultural Competency

Successful Integration of Hepatitis C Treatment into a Primary HIV Clinic
P-81, Prevention/Care Continuum

Transmogrification of an HIV Health Insurance Program
P-102, Program/Agency Development

A Statewide Cross Part Collaborative: The New Jersey Experience
P-141, Quality/Evaluation/Data

And The (Poster) Winners Are...

Innovation in Program

Medication Adherence and Intervention Outcomes in a Ryan White ADAP
P-11, Access and Retention

Optimizing Existing Programs Through Client Audits
P-42, Administrative and Fiscal Management

Linking Existing Services to Provide Smoking Cessation Options to PLWHA
P-49, Coordination and Linkages

Aspects of the Patient Provider Interaction That Influence Quality Medical Care
P-66, Cultural Competency

HIV and EMDR
P-68, Prevention/Care Continuum

Standards of Care: Creating the Fundamentals for a Service Delivery System
P-100, Program/Agency Development

Improving Anal Cancer Screening in an Ambulatory HIV Clinic: A Quality Improvement Initiative
P-113, Quality/Evaluation/Data

Innovation in Research

Long Term Medication Adherence Project
P-92, Program/Agency Development

Clinical Conference Day 3: It’s a Wrap

The final day of the 13th Clinical Conference focused on the following issues:

Occupational Post-Exposure Prophylaxis: Hard Choices and Soft Spots

The big news here is that, since the year 2000—when the PEP guidelines were put into place—there have been no reported cases, worldwide, of occupational exposure to HIV. This probably means the guidelines are working and that, even though we may be over-treating for potential occupational exposure, this is much better than letting a few cases slip through.

Diagnosing Sexually Transmitted Diseases in the HIV Care Setting

Not only are STDs not going way, there seems to be as much STD infection out there as ever. Syphilis, in particular, is prevalent and on the rise, and gonorrhea prevalence continues to be troublesome. The take home message: take a STD history with your patients, and if there’s oral or rectal sex, make sure that those regions of the body are tested specifically for STDs because the urine test will not pick up infection in those regions. To illustrate, Chlamydia typically doesn’t infect the pharynx but does infect the rectum. Nucleic tests are very good at picking up these infections, but can only do so if the tests are conducted. To drive the point home: clinicians: you need to check to know.

The Future of Therapy for Hepatitis C Virus Infection

There is an explosion of new therapies emerging for HCV, with 26 new drugs in development. Some will be available within the next year. So far, newer drugs have not replaced standard therapy. However, when they are added to the standard protocol, these anti-HCV medications either shorten the duration of treatment time or improve overall response rates. This is especially the cases for genotype 1 HCV, the most difficult to treat and most prevalent in the U.S. (A final note on HCV: host genetics has been shown to be the most important predictor to Interferon therapy, with the IL-28 “C/C” homozygous genetic phenotype being most responsive to interferon therapy.)

Primary Care for Transgender Patients

There’s a spectrum of gender identity that often times is mixed between physiological gender and what persons feel they are—their gender identity. Transgender individuals struggle for many years with their gender identity and are seeking understanding from providers in terms of helping them find balance between their physiological gender and gender identity. This is hard for many providers to understand, grasp, and know precisely how to address. Dr. Deutsch outlined how to work with transgender clients.

Clinical Conference Day 3: It's a Wrap

Mental Health: Interventions for Behavioral Issues

The patient who all providers hate is the one who is difficult, demanding, and predominantly driven by their feelings. They typically come into the clinic demanding that their needs get met—immediately. The traditional provider approach is to become confrontational, which is precisely wrong. Instead, providers should try and redirect patient behavior through a system that rewards behaviors that providers want patients to adopt in order to improve their health. For example, say a patient comes in and demands that forms be completed in order to provide an excuse from jury duty. A good provider would not immediately fill out the form but would instead to do so after the patient keeps a series of appoint-

Consumers Meet With HRSA/HAB

Wednesday afternoon, 24 consumers met with HRSA/HAB's Dr. Parham Hopson in this year's consumer listening session, a traditional forum held at every Ryan White Grantee Meeting. Consumers from Los Angeles, Beaumont, Massachusetts, Orange County, New York City, Connecticut, Richmond, San Antonio, Orlando, Sacramento, and many other places.

In a 1.5 hour meeting, the Q/A discussion touched upon consumer involvement at all levels—planning, quality improvement, consumer advisory boards, and education. Below are highlights:

- Consumer involvement in planning—lots of discussion here on challenges such as recruiting new voices, stipends, transportation, and rules around so-called unaffiliated consumers.
- The impact of the Affordable Care Act on the future of the Ryan White program.
- Standards of care and guidelines to help level the quality of care being provided across the Nation.
- Burnout and loss of providers to HIV/AIDS care work.

Oral Health Care and HIV

Dental care was front-and-center with 8 workshops (listed below), 20 posters, and additional coverage of oral health issues at the Clinical Conference (see Oral Health in HIV Infection in the Clinical Conference Syllabus). This focus is reflective of a HRSA-wide focus on oral health (driven by the fact that 20% of the U.S. lacks access to dental care) as well as long-standing Ryan White attention to oral health disease.

Poor oral health is a major problem among persons living with HIV/AIDS and is consistently reported as a top unmet need by consumers in formal needs assessments conducted by Ryan White programs around the country. While dental care is provided by all Ryan White Parts, several programs are focused solely on oral health care. As outlined in a presentation by HRSA/HAB's Dr. Mahyar Mofidi (I-6, Expanding the Dental Safety Net for PLWHA):

- The Part F Dental Reimbursement Program, in operation since 1994, reimbursed dental care pro vided to over 35,000 people in 2008.

- The relatively newer Community Based Dental Partnership Program started operations in Fiscal Year 2002, delivering care to 5,300+ people in 2008 through the work of 1,485 providers—while adeptly spinning a plate and providing training to 824 dental students in that same year.

All Ryan White Parts deliver oral health care. In 2008, over 86,000 Ryan White clients received oral health care from Parts A through D. Additionally the SPNS Innovations in Oral Health Initiative is exploring models of care to deliver these services to PLWHA.

Oral Health Workshops: Highlights. Below are highlights from several oral health workshops, followed by a listing of all the oral health workshops at this year's meeting. Check the TARGET Center, post-meeting, for an online listing of workshop slides and additional resources on this topic.

The Provision of Oral Health Care Services to Children in Ryan White Part D Programs
C-5, August 24, 2010

Dental disease is a critical public health issue whose impact is particularly heaving on children from poor minority households. Early oral diseases can lead to social and other health diseases. Although Medicaid covers dental services for children, this critical health care service is not being accessed by many of those who are eligible for this care.

In this workshop, two Ryan White grantees talked about their work in bringing oral health care services to children eligible for care under Ryan White Part D: the University of Colorado (UC) and the University of California of San Diego (UCSD). Presenters reported challenges faced in delivering dental services to children, such as cultural barriers, fear, transportation, dentists not taking Medicaid, and a shortage of dentists.

They followed up by outlining various activities to address gaps in dental care for children:

Oral Health Care and HIV *(continued)*

- Both California and Colorado have developed public information-type campaigns. Colorado has two: Cavities Free by Three. Another campaign by their School of Dentistry focuses on forming partnerships with internal and family medicine resident programs to conduct dental assessments to reduce access barriers.

- It is one thing to provide dental services. Doing it well is another matter. To determine the impact of dental services to children enrolled in its Part D program, UCSD is using the HAB Performance Measure for Oral Health Care in designing a quality management initiative. The team of providers at UCSD, under the leadership of Dr. Stephen Specter, has developed a program to teach oral health care literacy to enrolled families and staff.

Maintain the Connection: Dental Case Management for the Multi-Diagnosed, Marginally Housed Session Combined With: "If You Build It They Will Come" – Creating a Dental Home: Access to Care through a SPNS Initiative

D-7

Providing Comprehensive Dental Care: Getting Hard-to-Reach Populations to "Open Wide." Not surprising to the "denta-phobes" among us, many people are reluctant to take advantage of dental services, even when provided comprehensive dental care free-of-charge. Two dental programs, one in downtown San Francisco and the other in suburban Chester County, Pennsylvania, shared tips for providing dental care to hard-to-reach populations. Both programs are funded through the SPNS Program Oral Health Care Initiative.

Both programs tried various approaches to make their dental services more accessible to their clients. Most daunting was how to overcome one of the most significant barriers to care: competing challenges faced by clients (e.g., unstable housing, need for food and clothing, lack of transportation). Dental care, even when desperately needed, was often a low priority for clients, many of whom would access available service when in pain but not return for necessary follow-up care.

- The San Francisco program, headed by Tenderloin Health in collaboration with the San Francisco Department of Public Health, Asian and Pacific Islander Wellness Center, and Positive Resource Center, initially hired an oral health coordinator—a mostly administrative position—to schedule appointments. A good number of patients failed to return for follow-up. Many had not been to the dentist in many years and may have been refused care due to stigma and discrimination.

- In response, the program decided to implement a more intensive model of support—the dental case manager (DCM). The DCM carried out eight critical roles, identified by Boston University (also a SPNS grantee). These include: patient recruitment; transportation; accompaniment on visits; explanation of visits (i.e., what to expect); referral and translation; retention support; patient education; and collaboration with HIV case managers. The critical aspect of the DCM is that he or she knows the clients and can help them get to appointments, understand the importance of dental care, and know what to expect.

Oral Health Care and HIV *(continued)*

- The AIDS Care Group had a similar experience in that once established, their services were not an instant draw for the target population. A strategy that worked for them was to reach out to other organizations offering services to PLWHA and take their services on the road. What started as information sessions evolved into on-site screenings. Once patients were identified through the screenings and committed to appointments, AIDS Care Group's supportive services, especially transportation, became critical. Pick-up sites were established in four communities, and patients from those communities are scheduled for the same day. For some of the sites, the twice daily round trips to pick up and return patients required about 400 miles of driving for the shuttle driver (who recommends books on tape). The long drives were made more productive for patients, so to speak, given that AIDS Care Group provided them with access to other services while at the dental clinic.

Despite their different approaches, both programs emphasize the importance of building relationships with clients. While they may only be initially interested in eliminating their pain or receiving a bridge to dramatically improve smiles, over time clients may decide to take the steps necessary to address all their oral health needs. During that time, organizations can be working to meet other needs.

Learn more about HRSA's Ryan White Dental Programs and access TA resources on dental care and HIV/AIDS from the TARGET Center.

Oral Health Workshops

- HRSA Oral Health Programs: Improving Access to Oral Health Care for Persons Living with HIV/AIDS, A-4
- A Grantee and Subgrantee Partnership for Implementing the HAB Oral Health Performance Measures, B-5
- Improving Oral Health Care: Information to Reduce Barriers to Accessing Care, B-6
- Implementing HIV Performance Measures into your Oral Health Program, B-7
- Developing a Successful Network for Endodontic Services for People with HIV/AIDS, C-4
- The Provision of Oral Health Care Services to Children in Ryan White Part D Programs, C-5
- Maintaining the Connection: Dental Case Management for the Multi-Diagnosed Marginally Housed, D-6
- "If You Build It They Will Come": Creating a Dental Home, Access to Care Through a SPNS Initiative, D-7
- Expanding the Dental Safety Net for PLWA, I-6
- Stigma and the Provision of Dental Services to People Living with HIV/AIDS, I-13
- If You Build It, Will They Come? Increasing Access to HIV Oral Health Care, I-14
- Reducing the Burden on HIV Case Managers in Accessing Oral Health Care for HIV Patients, J-4

HIV and the Transgender Client

The size of the transgender population is unknown due primarily to intense social stigma. Data on the percentage of transgender persons who are HIV-infected is also unknown but thought to be among the highest prevalence rates among specific populations. To illustrate, a CDC prevention team meta-analysis on transgender persons and HIV (published in AIDS and Behavior, 2008) looked at 18 studies where transgender women self-reported their HIV status, along with four other studies that actually tested and confirmed the HIV-infection status of transgender participants. In the former analysis, 16% self-reported as HIV-positive. In the latter, 28% actually-tested HIV-positive. This meta-analysis suggests that more than half of HIV-positive transgender women may be unaware of their status.

A significant proportion of Ryan White providers—over one-fourth—serve transgender clients.   The following workshops and clinical conference session covered issues related to transgender HIV/AIDS care.

Cultural Competence and Transgender Clients, A-27
A Multi-disciplinary Approach to HIV Care in a Transgender Homeless Population, A-28
E-14, Expressions of the Recently Released
G-15, A Program Model for Transgender and HIV Treatment in Adolescents and Young Adults
J-14, Primary Care Protocols for Transgender Health
Primary Care for Transgender Patients, Clinical Conference Session, Wednesday, August 25

Below is a highlight of one of these sessions.

A Program Model for Transgender and HIV Treatment in Adolescent and Young Adults
G-15, August 25, 2010

Creating a safe environment for transgender youth and young adults can serve to link them to and retain them in HIV care. The Health and Education Alternatives for Teens (HEAT) program in Brooklyn has found that providing services tailored to the transgender population, most importantly access to hormonal therapy, can draw these high-risk young people into the program and link them to HIV care. Their clients become advocates for the program and are effective in reaching their peers and bringing them into care.

While the draw is the hormonal therapy, there are many benefits for the young people once they enter care. The can be linked to medical services including HIV, STD, and HCV care. Because they regularly return for their hormonal therapy, clinicians can monitor their adherence to antiretroviral therapy.

Clients also can be linked with mental health services, which are important when dealing with issues of gender identity. Other important social services for this population are legal (e.g., to assist with name change) and housing. Getting these young people into care also removes the dangers of getting hormones “on the street” where they can receive unsafe drugs, may engage in unsafe behaviors to earn the money to pay for the drugs, and are not under the supervision of a physician.

Learn more about the HEAT Program at http://www.heatprogram.org/lgbt.html.

Workshop Highlights: Wednesday, August 25

Behavioral Health Workshop: A Closer Look at What Works for Ryan White Programs - News You Can Use
F-16, August 25, 2010

Standing room only was the tone of this session as many were turned away. Andrew Moore from the University of Oklahoma in Oklahoma City discussed their Part C funded behavioral health program. They have been providing mental health services as part of their continuum of care. With the use of the motivational interviewing model, they have provided 799 counseling session and 380 psychiatric appointments in 2009 alone.

So what is motivational interviewing?

- It is a client centered directive method for enhancing intrinsic motivation to change by exploring and resolving ambivalence;
- It creates a non judgmental affirming relationship between client and therapist;
- It allows clients to exercise freedom of choice and self direction
- It utilizes “OARS” techniques: Open ended questions, Affirmations, Reflective listening, and Summarize.
- It works because it utilizes positive reinforcement and empathy; it gives priority to resolving ambivalence; and makes clients responsible for their progress.

Andrew shared barriers to treatment and lessons learned while providing mental health services. For more information and/or questions regarding University of Oklahoma’s behavioral health program, please contact Andrew Moore at andrew-moore@ouhsc.edu

Testing, Referral, and Linkage to Care: Models and Resources for Grantees
F-11, August 25, 2010

An estimated 21% of PLWHA are unaware of their seropositive status, according to national estimates. Additionally, a significant number enter care late: 38% receive an AIDS diagnosis within 12 months. These troubling data have not gone unnoticed by CDC and HRSA, which have been working for a number of years to get more infected persons into care. The need to do so has been reinforced by new legislative requirements in the 2009 Ryan White reauthorization, which put emphasis on identifying and linking infected persons into care. The point is further reinforced by the recently-released National HIV/AIDS Strategy, particularly in the form of a goal to increase the percentage of persons who enter care within 3 months of diagnosis—from current estimates of 65% to 85%. See the National HIV/AIDS Strategy at AIDS.GOV (http://www.aids.gov/).

Workshop Highlights: Wednesday, August 25

This workshop highlighted approaches to better link people into HIV/AIDS care, ranging from specialized case management to expanded HIV testing, along with technical resources available from HRSA and CDC to undertake such work.

ARTAS is an ongoing CDC initiative to explore the efficacy of “linkage case management” in connecting HIV-infected persons to care. Two randomized controlled studies have been conducted—ARTAS I and II—with results indicating that case management linkage support is a highly effective way to get infected persons in case.

CDC speaker Lytt Gardner outlined the following “best practices” agencies should consider if they undertake implementation of a case management linkage to care project:

- Selecting an implementing agency. Most ARTAS sites were community based agencies.
- Establish and strengthen partnerships—with health departments, HIV clinics, etc. This is perhaps the standout best practice because many of the other best practices are unlikely to work if relationships with other agencies are not in place. For example, you will have difficulty maintaining and documenting referrals and transitioning clients to care without cooperation.
- Distinguish ARTAS linkage case management (ALCM) from long term case management, meaning: the role of an ARTAS case manager is to link people to care, not take on the traditional role of case managers. Failing to do so can cause huge problems with case managers and their roles in providing support to clients.
- Communicating the benefits of an ALCM program.
- Maintain referrals; document and track outcomes. Providers need to know whether people were linked to care.
- Transportation. Staff need to be able to meet with clients out of their own offices.
- Transition clients from ALCM to long term case management.
- Provide consistent support and supervision to the linkage case manager. If not given, and given well.

HRSA Activities on Engaging People in Care. Steven Young from HRSA/HAB’s Division of Training and Technical Assistance outlined what has been learned about linking people into care under HRSA-sponsored work, including under SPNS demonstration work.

Workshop Highlights: Wednesday, August 25

Young also outlined resources and technical assistance available to help agencies as they work to link more people into care.

- Training of clinicians in order to expand HIV testing in clinical settings. These activities were carried out under the auspices of the AETC training network under a CDC/HRSA partnership. A wealth of training curricula and other resources are available from the AETC National Resource Center and are also online at the TARGET Center.
- A CDC/HRSA pilot project with Health Centers to expand HIV testing is underway.
- Multiple past and currently ongoing SPNS research and demonstration projects focus on outreach and retention in care. Among these is a SPNS outreach project, Targeted Outreach Initiative:
- Engaging and Retention in HIV Medical Care, documented factors that influence entry to care
- (e.g., ease, access, and availability of care) and techniques that facilitate entry and retention, like frequent contact and activities such as appointment reminders and counseling. The SPNS project also identified key, and well-known, barriers to care entry—competing needs, mental health and substance abuse challenges, and others.
- A series of HRSA/HAB consultations examining aspects of engaging people in care, including one session that looked at the “unmet need” requirement in the Ryan White legislation and the new requirements around testing, referral and linkage to care, as well as another meeting to look at ways to bridge prevention and care through community collaborations. The outcome of this latter consultation is an expected new SPNS Initiative to focus on this topic.

Resources on engaging people in care are available from HRSA at the TARGET Center (http://careact-target.org/). Search terms such as Outreach, Retention, and Linkages. Examples include a document on connecting people to care, a recruitment and retention curriculum, and use of peers/consumers in engaging people in care.

Using Multi-Media to Recruit and Educate Funders, Providers, and Patients
F-28, August 25, 2010

Show, Don’t Tell. Several Ryan White-funded providers shared their experiences using digital stories—made up of photos, voiceovers, and music—as an effective and relatively inexpensive way to communicate with a range of audiences including consumers, staff, other organizations, and the community at large. Stories were developed to demonstrate the value of peers in clinical programs (targeting clinicians) and the importance of dental services for people living with HIV.

Workshop Highlights: Wednesday, August 25

Here are some of their How-to Tips:

- Inexpensive software, such as Vegas and Audacity, are available. It is likely that some of the more "tech savvy" people on your staff are already familiar with this software. If not, it is relatively easy to develop the necessary skill (for ongoing in-house capacity).
- Take time to prepare the script. The intent is to tell a compelling, personal story. Your subjects should spend some time thinking about what they want to say. The script should be in place before you consider the visuals.
- Recycle your photos. Photos of your organizations and events can be reused in other digital stories, cutting down on the time required for your "photo shoots."
- Care should be taken in working with consumers and they should understand that the stories will be shown in public, and even posted online. Producers should spend some time explaining the implications of participation in the project and consent waivers obtained. In recruiting consumers, producers suggested reaching out to more than you need since some may change their minds about participation along the way.

And the benefits of using multimedia videos and peers are extensive:

- Videos are an ongoing way to educate staff and other providers about consumers and their needs.
- Videos are an effective way to conduct outreach to other organizations, planning bodies, and the community at large.
- Videos can leverage the use of consumers in community outreach and education. When you can't coordinate to have someone in-person at a presentation, you still have a powerful way to personalize the epidemic by using the video.
- Consumers that have participated have found the experience to be empowering and have become even more involved in their organizations.

Check out some of their stories online.

- Changing Lives through Good HIV Oral Health (http://echo.hdwg.org/)
- HIV Alliance: Dental Program (http://www.hivalliance.org/support/dental-program)
- AIDS Care Group: HIV/Dental Program (http://www.aidscaregroup.org/news/)
- Peer Education and Evaluation Resource Center videos (http://peer.hdwg.org/)\

Workshop Highlights: Wednesday, August 25

Emerging Concerns in the Treatment of Adolescents: Transitioning Youth from Pediatrics into Adult Care, F-5, August 25, 2010

Transitioning of HIV+ adolescents into adult care is a difficult process for both the adolescent and the pediatric/adolescent provider. This process can be filled with obstacles and barriers and if not handled delicately may negatively impact the adolescent's healthcare.

The following are the "key points of transitioning" as shared in the session: transitioning includes both the process of changing and the actual transition event of moving out of adolescent-focused care; transitioning begins at the day of diagnosis; providers need reminders to let go; adolescents must be involved in decision-making; and coordination across systems is essential.

The important take home tips are that there needs to be a structured plan in place, early discussions about transitioning, options, a selection of appropriate adult providers, and, most importantly, flexibility.

Contact Dr. Ana Garcia at agarcia2@med.miami.edu for a reference list of transition articles.

Institute: Linking Supportive Services with Vocational and Employment Services for People Living with HIV/AIDS, F-9, G-7, H-7

This workshop Institute (3 sessions) covered multiple topics related to employment and PLWHA, including a presentation on data from the National Survey of People with HIV on Employment and Vocational Rehabilitation. The survey examined demographics, knowledge of vocational/employment services; the impact of HIV/AIDS on employment on health and ability to work; and work considerations for PLWHA ages 18 and older living in Arkansas and New York (n=2,538). According to the survey:

- Many unemployed consumers were not aware of laws which protect and/or facilitate employment rights (e.g., Americans with Disabilities Act, Reasonable Accommodations Act, Family, Medical Leave Act and Workforce Investment Act, and State-Federal Vocational Rehabilitation System).
- Employment positively influenced health outcomes of PLWHA. Consumers often said that employment improved self care, medication adherence, CD4 counts, and decreased behavioral risk factors.
- Unemployed consumers perceived loss of benefits, discrimination, and loss of health insurance, disclosure, lack of education and lack of employment services as reasons for unemployment.

Presenters noted employment might not be a healthy option for all PLWHA. More research and analysis to better understand survey findings are forthcoming.

Workshop Highlights: Wednesday, August 25

It's Only Chocolate Chip Cookies: Meeting Patient Needs
F-22, August 25, 2010

This workshop reviewed two established models of care that were combined in a pilot project. The models—Community Behavioral Health Model of 1966 and the Public Health Service Standards Model—were used to develop a system to meet patient and agency needs. The newly-developed model assigns patients a letter, A-D, which indicates where a patient is on his/her level of care.

- Level A indicates that a patient is disconnected from care.
- Level B is a patient that comes to appointments yet still has issues with some aspect of care (adherence, attending referrals).
- Level C is an "average" patient that attends appointments but is not totally invested.
- Level D is a very informed and activated patient.

The level of patients is designed to be a fluid process that allows patients to move to different levels as their characteristics change. This model is thought to work best with patients that are new to the clinic. Pilot project findings suggest that implementing this new client-friendly model will decrease no show appointments, decrease cost of care, and increase access to care.

HIV Testing in the Dental Chair: Needs Assessment and Implementation
H-4, August 25, 2010

The New York/New Jersey AETC conducted a needs assessment on barriers to testing, which identified the major challenges as lack of knowledge and training and reimbursement issues. In response the AETC, in collaboration with state dental associations and the Oral Health Regional Resource Center of the AETC, developed a manual designed to help providers of dental services offer routine HIV testing. The comprehensive manual (publication pending) includes:

- A self assessment form and information on protocol development.
- CLIA/CLEP applications.
- Implementation guidelines.
- Types of test kits available.
- Technical assistance and training resources.
- Necessary forms (informed consent forms for New York State).
- FAQs.

Workshop Highlights: Wednesday, August 25

Health Care Reform: What Ryan White Providers Need to Know
Special Session, August 25, 2010

Room capacity—144 people and completely full at this 8:30 AM session about health care reform. Panelists from national HIV/AIDS associations outlined opportunities, uncertainties, and expansions of coverage in the HIV care system that are likely as a result of the Affordable Care Act.

Directors Andrea Weddle of the HIV Medicine Association, Laura Hanen of the National Alliance of State and Territorial AID Directors, and Carl Schmid of The AIDS Institute addressed issues regarding Affordable Care Act provisions and insurance coverage expansion, highlighting how the bulk of our Ryan White population will benefit from the changes. Said speaker Carl Schmid: "You no longer have to be full blown AIDS, just poor." According to recent ADAP data, about half of Ryan White clients are below the Federal Poverty Level. Health reform improvements include expansion of Medicaid to all persons under 133% of the poverty level and under age 65. Lauren Hanen from NASTAD pointed out how the range of the Federal Premium and Cost-Sharing subsidies under the Affordable Care Act will range from 133% to 400%.