



**Improving HIV Service Delivery:
Policy Recommendations for HRSA's HIV/AIDS Bureau &
CDC's National Center for HIV, Viral Hepatitis, STD, and TB Prevention
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The Ryan White HIV/AIDS Program (RWP) has been at the forefront of delivering comprehensive, person-centered health care services and improving health care outcomes for people with HIV regardless of their insurance or socioeconomic status. The sustained investment in the program, along with important new administrative policy guidance, has played an important role in the 29% [increase in viral suppression rates](#) among people receiving RWP services, from 69.5% in 2010 to 89.7% in 2021. While important progress has been made, inequities in viral suppression rates remain for people who are unstably housed, Black/African American and American Indian/Alaskan Native individuals, adolescents, and transgender youth and adults. An important policy change was the [2021 guidance for determining eligibility and payer of last resort requirements](#) recommending that grantees facilitate rapid access to HIV services, including antiretroviral treatment, and streamline eligibility certification requirements to avoid care and treatment disruptions. However, some states still need greater incentives and encouragement to bring their processes in line with the guidance.

To sustain progress in improving health outcomes for people with HIV in the context of the currently constrained federal funding environment, we must identify strategies and policies to do more and do better with fewer resources to make progress to end HIV as an epidemic. In response to this urgent need, this brief outlines recommendations from RWP providers for how to optimize care, harmonize data reporting and grow and diversify the HIV workforce in order to fully leverage existing program resources and improve service delivery and outcomes.

In addition to the recommendations in this brief, it also is important to support clinics with implementing innovations in care and treatment, such as telehealth, mobile service delivery or street medicine and long-acting injectables, and to develop guidance and facilitate partnerships with other agencies to address critical issues impacting health, including food security, emergency financial assistance and affordable housing.

OPTIMIZE CARE THROUGH EARLY TREATMENT INITIATION AND EXPANDING ACCESS TO STATUS NEUTRAL CLINICS THAT BUNDLE SERVICES, INCLUDING GENDER-AFFIRMING CARE AND HIV TREATMENT

Early access and initiation to HIV care and treatment is recommended to improve health outcomes and reduce HIV transmission, but health care access, coverage and grant requirements continue to create barriers that delay or prevent access to care and treatment. The status neutral clinic is an exciting new model that holds promise for some clinics to expand and improve access by offering whole person care for HIV treatment and prevention services through a holistic, non-stigmatizing approach to providing

HIV services. We recommend the following policy and programmatic changes to facilitate implementation of status neutral clinics for clinics in a position to do so.

- **Expedite entry into care by allowing clinics greater flexibility to use RWP funds to address barriers to linkage to care and to support early initiation of HIV care and treatment by:**
 - Allowing or providing guidance to grantees for covering services for time-limited periods in situations, such as:
 - When patients in unstable housing situations are unable to document their in-state residency;
 - When there are significant, e.g., weeks long, delays in securing prior authorization approvals for initial laboratory testing, medical visits or medications;
 - When treatment is initiated before confirmatory HIV tests for a newly diagnosed person due to significant delays in receiving confirmatory test results (e.g., it can take more than seven days in Missouri if processed through the state lab) so that these patients do not incur significant out-of-pocket costs if they are seen in the RWP clinic and the confirmatory test is negative; and
 - When people are unable to complete their RWP enrollment before being released from the hospital, to allow them to obtain medicines and complete their enrollment.
 - Allowing grantees to, at a minimum, cover medical transportation and early intervention case management in absence of required program eligibility documentation.
- **Facilitate service integration for status neutral syndemic service delivery by braiding funding from CDC, HRSA's HIV/AIDS Bureau (HAB) and Bureau of Primary Health Care, Substance Abuse and Mental Health Services Administration (SAMHSA) and potentially other federal agencies by:**
 - Developing Funding Opportunity Announcements that braid grant funding from multiple federal agencies to help improve services for syndemic issues and to reduce the administrative burden on providers and grantees to braid funding themselves;
 - Harmonizing grant application requirements and data reporting requirements across agencies when grantees are applying for braided funding so they are not required to write separate grant applications and to generate reports with duplicative information and different formatting;
 - Facilitating the bundling of HIV and other sexually transmitted infection (STI) services to support service integration at HIV clinic sites to avoid high out-of-pocket costs for patients who test negative for HIV and thus would not be eligible for Ryan White Program support for their STI screening; and
 - Developing a joint CDC and HAB funding opportunity to evaluate the role of low barrier clinics and street medicine programs in improving access to HIV prevention and care to populations not well served by traditional brick-and-mortar clinics, including adolescents, people experiencing homelessness and others.
- **Provide resources to respond to HIV outbreaks in real time by instituting flexibility to distribute Ending the HIV Epidemic (EHE) funds to programs working in jurisdictions with burgeoning HIV epidemics.**

HARMONIZE DATA REPORTING ACROSS RYAN WHITE HIV/AIDS PROGRAM PARTS AND WITH OTHER FEDERAL PROGRAMS TO IMPROVE ACCURACY AND THE UTILITY OF DATA IN SUPPORTING SYNDEMIC APPROACHES TO CARE

Grantee data reporting and quality improvement and evaluation activities have been a key tenet of the RWP program and have been critical to the program's success. However, most RWP clinics increasingly rely on funding from multiple RWP parts, the federal EHE initiative and other federal agencies, including CDC and SAMHSA. Streamlining data reporting across these programs is important to reduce administrative burden, preserve limited staff time and increase the utility of the data to improve prevention and care delivery and facilitate a syndemic approach to service delivery. We urge HRSA to partner with CDC and SAMHSA to:

- Simplify data reporting requirements and the systems used to submit data by:
 - Reducing the amount of data that clinics and providers are required to capture and report;
 - Exploring partnerships with electronic health record (EHR) vendors to automate reporting and reduce administrative burden; and
 - Reducing cost barriers by providing supplemental grant funds or negotiating discounts to using streamlined solutions that are available.
- Reduce redundancies in data reporting across RWP parts so that clinics do not need to report the same data through different systems for each part.
- Release data and comparative data back to grantees in a timely manner so that clinics can use it to improve services and programming and to justify funding for continuing services or offering new services.
- Provide increased support to rural and other under-resourced clinics to facilitate data reporting, including:
 - Developing HRSA-trained data and technology teams to help clinics with fewer resources to more easily complete data reporting;
 - Providing additional technical assistance as needed to these clinics to help them increase capacity and meet program goals; and
 - Providing individualized training to clinics that do not have the resources to purchase EHR systems, such as EPIC.
- Adjust reporting requirements to allow grantees to use different metrics for differentiated service delivery or street medicine models designed to tailor services to individual needs and preferences. This will ensure that grantees are not penalized for serving people who may not engage with the traditional health system.
- Collaborate with other federal partners to encourage and promote the integration of ID syndemic care into health care professional training leveraging the [National HIV Curriculum](#), [Hepatitis C Curriculum](#) and [National STD Curriculum](#).

INCREASE EFFORTS TO GROW AND DIVERSIFY THE HIV WORKFORCE AND PROMOTE CULTURALLY RESPONSIVE SERVICES

Without a robust HIV workforce that reflects the populations disproportionately affected by HIV, efforts to end HIV as an epidemic will be stymied. Nearly 80% of U.S. counties do not have a single ID physician. In the Southern U.S., where more than 52% of new HIV infections occur, it is estimated that 80% of the counties in at least 14 Southern states do not have a single experienced HIV clinician, with the disparities being greatest in rural areas. The HIV/AIDS Bureau's AIDS Education and Training Centers (AETC) Program also plays a critical role in supporting HIV training and continuing education programs targeted

to the local needs of the community. Funding for the program has remained largely flat for years, despite its important role in the HIV response as well as growing HIV workforce challenges and increasing administrative requirements for grantees. We recommend the following to better leverage limited AETC resources:

- Optimize funding support for, and capacity of, AETC programs to increase their reach and impact by:
 - Allowing greater flexibility with AETC funding to better meet local workforce needs by allowing AETCs to direct limited resources to where they can have the greatest impact within their region or state. As an example, the requirement for regional offices to work with pharmacy, medicine, nursing and behavioral health schools is time and labor intensive because of the need to work across institutions – with limited immediate impact in some regions;
 - Reducing AETC mandatory data reporting requirements to help focus programming to meet local workforce needs and reduce the costs associated with administrative burden; and
 - Providing guidance to states and other RWP grantees on innovative ways to use program income to support workforce development.
- Enhance programming to increase the diversity of the comprehensive HIV care team to better reflect populations served by the RWP by:
 - Sharing best practices for outreach, recruitment and training of health care professionals that reflect and/or possess the lived experiences of populations disproportionately affected by HIV, including individuals who are transgender or nonbinary;
 - Normalizing gender-affirming care and treatment for substance use disorders by supporting providers in regions where they face challenges and restrictions to providing routine quality care and encouraging the integration of substance use disorder screening and treatment into routine HIV care;
 - Deploying AETC funding to support AETC-sponsored trainings that include translation so that team members who do not speak English as their first language can more fully engage; and
 - Identifying additional resources for culturally responsive translation and adaptation services that ideally also have HIV knowledge and expertise and to support trainings and resources that enable clinics to be antiracist and trauma-informed in their approach to care.
- Partner with the Bureau of Health Workforce to support implementation of the Bio-Preparedness Workforce Pilot Program and consider innovative ways to fund the program – which would draw more health care professionals to RWP clinical sites by offering loan repayment in exchange for service at the clinics in addition to other medically underserved areas and settings.

From 2010 to 2021, required data fields for regional AETC programs **increased by 463%, from 181 to 1,019 fields**, to reflect the new required programming. *This was in addition to the data reporting for the Ending the HIV Epidemic initiative and the Ending the HIV Epidemic-Primary Care HIV Prevention activities.*

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