

# HIV Prevention and Treatment Challenges in Rural America from the National Advisory Committee on Rural Health and Human Services – 10/06/20

**Kristine Sande:**

Welcome everybody. I'm Kristine Sande, and I'm the Program Director of the Rural Health Information Hub. And I'd like to welcome you to today's webinar, HIV Prevention and Treatment Challenges in Rural America. We're happy to be collaborating with the National Advisory Committee on Rural Health and Human Services on today's webinar. Before we begin, I'll quickly run through a few housekeeping items.

We hope to have time for your questions at the end of today's webinar. If you have questions for our presenters, we ask that you submit those near the end of the webinar using the Q&A button on the bottom of the screen. We've provided a PDF copy of the presentation on the RHI Hub website, and that's accessible through the URL on your screen. And we'll also put that in the chat function, so you can have a clickable link to it. If you have technical issues during the webinar, please visit the Zoom help center at [support.zoom.us](https://support.zoom.us).

And now it's my pleasure to introduce our first speaker, Dr. Jeff Colyer. He currently serves as the Chair of the National Advisory Committee on Rural Health and Human Services. He is also a Board Certified Craniofacial and Plastic Surgeon with a special interest in craniofacial and pediatric plastic surgery at KU and the Mid-America Craniofacial Teams. Dr. Colyer brings a wealth of experience in public and private sector leadership. He was the 47th governor of Kansas and has started or helped manage small companies, healthcare entities, large organizations, and complex international projects, and has served on a variety of boards. Please welcome Dr. Colyer, who will give an overview of the committee as well as introducing our other speakers for today. Dr. Colyer.

**Jeff Colyer:**

Thank you Kristine, and thank you everyone for joining us today. I'd like to take this opportunity to welcome you to our webinar on HIV Prevention and Treatment Challenges in Rural America, sponsored by the National Advisory Committee on Rural Health and Human Services. In this webinar, we will provide an overview of the Committee, highlight some recent increases in new HIV infections in rural areas, discuss barriers to HIV prevention and treatment services, and hear about the Committee site visit and policy recommendations. I would now like to provide some brief background on the committee, especially for those joining today's webinar who may not know who the National Advisory Committee is.

The Committee is a federally chartered independent citizens' panel, whose charge is to advise the secretary of HHS on health challenges that affect rural America. The Committee consists of 21 members, including myself, the Chair, and the experiences and expertise they bring reflects wide variety of rural issues in public health, medicine, nursing, human service delivery, hospital administration, childcare, research, finance, law and business. The Committee was formed in the late 1980s in response to a large number of rural hospital closures. Since then the Committee has continued its work to address and examine pertinent issues that affect the health and wellbeing of rural Americans, and to also hear directly from rural stakeholders.

Following the meetings, the Committee produces policy briefs to the HHS Secretary with recommendations on policy or regulatory matters under the Secretary's purview. For its 87th convening at the beginning of March 2020, the Committee met at an obscure place you've never heard of in Atlanta, Georgia called the CDC. During the meeting, the Committee examined the challenges to access and quality HIV prevention and treatment services in rural communities, in addition to some of the federal programs currently being leveraged to address this issue. Over a two and a half day meeting, the Committee first heard from subject matter experts, two of

whom you will hear from during this webinar. The subcommittee tasked with the issue then visited Hobson City, Alabama, to meet with staff from their Health Services Center and other HIV service organizations throughout the state of Alabama. We have hyperlinked to the brief if you click on the cover of this policy brief. You can also find it along with other briefs, at the link provided at the bottom of this slide. Recent increases of HIV cases in rural areas led the Committee to focus on the issue during its March 2020 convening. In early 2019, the president announced the ending the HIV epidemic, A Plan for America Initiative. It aims to reduce new HIV infections by 75% in the next five years, and by 90% in the next 10 years. There are several states and localities identified in the initiative that are partly or majority rural, especially in the south, which counts for just over 50% of the new HIV cases nationwide. An understanding of the current challenges affecting the HIV prevention and treatment delivery in rural communities is helpful for the Federal Office of Rural Health Policy of Health and Human Services. It's helpful for other stakeholders to address HIV and related public health challenges.

To transition us into learning more about rural HIV challenges, I want to briefly introduce the rest of the team presenting on today's webinar. First, we will hear from Captain Mahyar Mofidi for a national level perspective. Captain Mofidi was appointed Director of the Division of Community HIV Programs in the HIV/AIDS Bureau, the Health Resources and Human Services Administration in November 2015. As the Director, he is responsible for leading the development, implementation and evaluation of the Ryan White HIV/AIDS Part C, D and F dental programs. He ministers a portfolio of \$300 million in federal funds to support over 600 community based organizations to provide comprehensive healthcare and support services to more than 400,000 low income people with HIV.

Before joining HRSA, Captain Mofidi was a faculty member at the University of North Carolina School of Dentistry and a Research Associate at the Cecil Shep's Center for Health Services Research at UNC Chapel Hill. He has a deep passion for serving the underserved populations and towards his lifelong commitment. He also volunteers as a dentist in rural Kentucky, providing oral health services for people with HIV. Captain Mofidi received his dental degree from the University of Louisville, and his doctorate in health behavior from UNC Chapel Hill School of Public Health.

Then we will hear from Michael Murphree for a state level perspective. Michael Murphree is currently the CEO of Medical AIDS Outreach of Alabama. A lifelong resident of Alabama, Mike is a graduate of Auburn University at Montgomery and the University of Alabama. He received his Master Social Worker degree in 1989 and is licensed at the LCSW level. Prior to his hire at MAO of Alabama, he served as the Interim Executive Director of the Southern AIDS Coalition. Having grown up in rural Alabama, it helped instill an extra sensitivity to the special specific needs and cultural differences that rural communities present. This background was particularly helpful in the expansion of HIV specific medical care to rural communities in South East and West Alabama during the service and Montgomery AIDS Outreach in Montgomery, Alabama.

A frequently requested presenter on social work, case management, mental health, and HIV issues at national state and local conferences and programs, his work and life experiences have been invaluable in learning ways to teach people both professionally and personally. Following Michael Murphree, will be Dr. Ben Taylor, a former committee member. Dr. Taylor received a Master of Physician Assistant Studies from the University of Nebraska, Omaha in 1999, and a Doctorate of Health Services at Walden University in Minneapolis in 2006. He currently serves as a Clinical Faculty for the Physician Assistant Department and as a Senior Emergency Room Physician Assistant at the Georgia Health Sciences University in Augusta.

He also practices at the Peach Tree Family Medical Clinic in Edgefield, South Carolina, and as a Senior Physician Assistant with Doctors Care of Aiken, South Carolina. Certified by the National

Commission on Certification of Physician Assistants in the Georgia and South Carolina State Composite Boards and Medical Examiners, Dr. Taylor holds positions of promise with several organizations. He is the Vice President of the Association of Family Practice PAs, and also serves as a member of the AFPPA Conference Committee, and Chairs the Public Education Committee for the AFPPA and the Georgia Association of Physician Assistants. And with that, I will turn it over to Captain Mofidi.

**Mahyar Mofidi:**

Thank you so much Governor Colyer, and good afternoon everyone. Thank you for inviting the HRSA's HIV/AIDS Bureau to be part of this important meeting and present briefly on the Ryan White HIV/AIDS Program in rural areas. I've been with HRSA for almost 14 years, and it's a great organization with a great mission. It is the premier organization for maintaining and increasing the safety net for vulnerable and underserved populations, and so much of the work we do inside and outside of HRSA is through partnership, and the HIV/AIDS Bureau has had a strong partnership over the years with the Federal Office of Rural Health Policy to promote the wellbeing and health of people with HIV in rural areas.

This has been an exciting year for us. It is the 30th anniversary of the Ryan White Program, which was passed into law in August of 1990. The HIV/AIDS Bureau administers the Ryan White Program. This has been the guiding vision and mission of our Bureau for a while now. We strongly believe in the vision of optimal HIV/AIDS care and treatment for all. A few words about the Ryan White HIV/AIDS Program since 1991, the program has been providing a comprehensive HIV care for people with HIV that includes primary medical care and essential support services. The program works with cities, states and community based organizations to provide HIV services to more than half of people with diagnosed HIV in the United States. Working within the parameters of the Ryan White legislation, recipients and not the federal government determine service delivery and funding priorities that are based on local needs and planning process.

And finally, the Ryan White Program has a payer of last resort legislative provision to assure that there are no duplication of effort for those available state and federal dollars. Those of you who are familiar with the Ryan White Program know that it's divided into five parts. Part A provides grant funding to population centers that are the most severely affected by the HIV/AIDS epidemic. Part B provides grant funding to states and territories. Part C provides grant funding to community based organizations. Part D provides grant funding also to community based organizations, but specifically for women, infants, children and youth with HIV. And finally Part F provides grant funding that supports several research, technical assistance and access to the care programs, including two specific dental programs. And through all of our collective and combined efforts in partnership with our recipients, more than 87% of Ryan White patients achieved viral suppression in 2018, exceeding the national average of 62.7%. And this is a number that we are very proud of, but know we can do better.

So the Ryan White Program was funded at \$2.4 billion in fiscal year 2020. This slide shows the amount of funds appropriated for the five parts of the Ryan White plus new money, \$70 million for ending the HIV epidemic initiative. So who are the clients served by the Ryan White HIV/AIDS Program? This is an infographic that presents demographic information on the clients that Ryan White Program serves. In 2018, The Ryan White Program served over 533,000 clients, the majority of whom were living with HIV. Ryan White Program serves predominantly racial/ethnic minorities and individuals with low income. Nearly three quarters of Ryan White clients are from racial/ethnic minority populations that approximately 61% are living at or below the federal poverty level. And these numbers are reflective of the national averages of African-Americans and Hispanics with HIV and suggests that the Ryan White Program is on target in terms of reaching and linking these populations to care. In addition, 46% of clients in 2018 were aged 50

and over. This is mostly because people are living much longer with HIV, thanks to effective antiretroviral therapy.

So let's spend a minute on HIV clinical outcomes based on individual level data that we collect. We use data to address gaps and disparities. As you know, because there is no cure for HIV at this time, treatment is a lifelong process and the end goal of the HIV care continuum is achieving and maintaining viral load suppression so people can be healthy and less likely to transmit the virus. We are excited to share that the Ryan White viral suppression data for 2018 show a continued upward trend in viral suppression, with, as I mentioned before, 87.1% of our clients achieving viral suppression representing a 17.6 percentage point increase since 2010. And as I mentioned a minute ago, these improvements are encouraging and promising, but we also know that improving viral suppression for the 13% who are not yet there, the very hard to reach populations will be difficult as are individuals who experience many life challenges.

State level viral suppression in 2010 compared against 2018 where darker red color represents lower viral suppression. Overall, as you can see, all states have seen increases in viral suppression. However, some states particularly in the Southern US continue to have room for improvement. This is a busy slide that shows viral suppression among key populations served by the Ryan White Program. It shows a side-by-side comparison of viral suppression for each sub population in 2010 indicated by dark green bar, and in 2018 indicated by light green bar. And for comparison, viral suppression for all Ryan White clients in 2010 was 69.5% indicated by the dark green line, and was 87.1%. Again, in 2018, as indicated by the light green line, you can see an upward trend in viral suppression occurring across all the key populations that are outlined here.

However, it is important to note that challenges persist in achieving viral suppression for certain populations. And most notably, as you can see in 2018 clients with viral suppression lower than the overall percentage of 87.1%, were transgender youth ages 13 to 24, and clients who are unstably housed. Now in terms of the Ryan White Program in rural communities, nationally 6.2% of Ryan White providers are located in rural areas. Rural areas are defined according to the Federal Office of Rural Health Policy's method for determining role of designated areas for grant eligibility. Please note that when I refer to Ryan White providers, I'm referring to an organization funded by Ryan White Program to deliver specific services to Ryan White clients.

In Ryan White Program terminology, a provider is not an individual person, but an organization. So over half of the states had a Ryan White provider that was in a rural area. Among states with Ryan White rural providers, the proportion of rural providers within the state ranged from a low of 0.8% in Florida to a high of 92% in New Hampshire. Five states had more than one quarter of the Ryan White providers located in rural areas, Kentucky at 33.3, Montana 70%, South Dakota 75%, Maine and New Hampshire at 92%. Approximately 90% of Ryan White rural providers also received Public Health Service Act 330 funding, which is the umbrella under which the HRSA funded health centers reside.

Nearly half of our providers provided services to anywhere between one to 99 clients, and over 50% of our providers serve over 100 Ryan White clients. As you can see from the first two bars on the graph, Ryan White providers located in rural areas were funded to deliver a greater number of service categories per site than non-rural providers, 44% versus 34% compared to non-rural providers. A greater proportion of Ryan White rural providers were funded for such services as outpatient ambulatory health services, emergency financial assistance, medical case management, medical transportation, and oral health care. In contrast, 10.6% of rural providers were funded for outpatient substance use services, while 13.8% of non-rural providers were funded for that same service.

The demographic characteristics of the Ryan White Program clients who visited only rural Ryan White providers were similar to the overall demographic profile of Americans in rural areas compared with Ryan White clients who visited only non-rural providers. Rural clients were older, less likely to be a member of a racial or ethnic minority, and more likely to be living below the federal poverty level and being uninsured. The identification of these sociodemographic differences may inform initiatives designed for certain key populations, such as initiatives to meet the needs of older people with HIV who access care in rural areas.

Although studies have shown that rural people with HIV experienced a multitude of barriers to accessing and remaining engaged in HIV care, only some studies have actually found a significant association between rurality and HIV clinical outcomes. But within the Ryan White Program, these barriers do not appear to negatively impact the HIV clinical outcomes of Ryan White clients that is rates of retention in HIV care and viral suppression among Ryan White clients visiting rural providers were comparable to the 97% of clients who visited only non-rural providers. As you can see, for example, 85.5% of clients who visited only rural providers were virally suppressed, closely matching the 85.9% of clients who visited only non-rural providers.

As you well know, many social, environmental and economic factors convert to cause a host of barriers and challenges that complicate HIV/AIDS treatment and prevention in rural areas. You're very familiar with these barriers. They include stigma, lack of services, specialized service providers, transportation to services, which is one of the most frequently cited challenges in rural areas, behavioral substance use conditions, staffing, lack of HIV education and awareness, limited syringe service programs and non-Medicaid expansion contributing to lack of availability of public health insurance.

Addressing the needs of people with HIV in rural communities means developing innovative approaches to retain clients in care and reach viral suppression, including transportation, for example, Ryan White providers partnering with community action agencies to address transportation challenges in their rural service areas, or Ryan White Clinics that use alternative medical visits, for example, through telemedicine or our engaging pharmacist, community pharmacist as an alternative case management model, and utilizing Community Health Workers, peer workers, as those trusted members of the community to provide HIV education and awareness.

The next two slides highlight two federal resources created to address HIV related stigma. Specifically CDC has created Let's Stop HIV Together campaign that highlight the role that each person plays in stopping HIV stigma, and gives voice to people with HIV. There are many small things that we can do every day that will make a big difference. The words we use matter. We can talk openly about HIV and stigma in a way that can help empower those with HIV. We can do our part to stop HIV stigma by being intentional and thoughtful when choosing our words and choosing to use supportive rather than stigmatizing language when talking about HIV. For example, instead of saying HIV patient or HIV client, the preferred term is person with HIV. Again, avoid defining people by the disease.

Similarly, the Southeast AIDS Education and Training Center, one of the training arms of the Ryan White Program has developed a cultural humility and reducing stigma and discrimination curriculum specifically for providers. It is a guide for healthcare providers to learn cultural competency and address stigma. As with the CDC resource a minute ago, this particular guy suggests using people first language, which describes, again, a way of speaking that puts the person before the diagnosis, calling attention to what the person has rather than what they are. I would like to conclude by saying that the Ryan White Program providers are a crucial component of HIV care delivery in rural United States, especially given that healthcare options for people with HIV in rural areas may be limited.

Despite evidence of significant barriers to engagement in care for rural people with HIV, Ryan White clients who visited rural providers were just as likely to be retained in care and virally suppressed as their counterparts who visited non rural providers. The Ryan White Program, especially in partnership with Rural Health Clinics and their HRSA funded Community Health Center Program has the infrastructure and expertise to work towards ending the HIV epidemic in rural America. I want to thank everyone who joined today's webinar for your commitment and dedication to providing high quality HIV care treatment and support services for people with HIV, and working in tandem, in partnership together to end the HIV epidemic, especially in rural areas. With that, I'm going to turn over the webinar to Mr. Michael Murphree.

**Michael Murphree:** Thank you Dr. Mofidi. I really appreciate the opportunity to be able to present information that we're doing here in Alabama in our rural centered care program. We are a nonprofit 501(c)(3) program which started in 1987 and have grown dramatically through these years. We now have 115 employees working hard to serve the people of our communities. We are a Ryan White Part C grantee, and we also are a Part B provider and a Part D provider for grantees. We've been very fortunate in the past few years to look at other funding streams to supplement us, so we did initiate a pharmacy program, a dental clinic program, we have a behavioral health rapidly growing project. And then we have an internal telehealth resource center that's really helped us a lot. That'll be a big part of what I'll be talking and sharing with you all today, is about our telehealth programming.

It's just one of those moments I want to just share and just say how proud I am of a nonprofit being able to do this, and all of these folks who are working in our dental clinic and in our pharmacy to help in our service delivery. We look at a concept of putting everything under one roof as much as possible. So we have a four quad zone. We do medical care, social work, we do education, both community and professional, and then we also do behavioral health. And we're expanding our medical care program to go even deeper beyond just the HIV specialty, but to go into other healthcare issues, particularly because we serve so many rural communities and that's the crux of our program and the needs there are so much greater, and that's what we're finding, so we're expanding that out.

If I were looking at demographics, one thing to make a note of is the consumers and recipients we serve predominantly identify as Black or African-American, about 76%, with the next largest communities that we're seeing are people who identify as White or Caucasian. I also want to make a note under the gender identity, cisgender women of makeup 33% of the folks that we're serving. And that's been rarely a growing group that we're noting, particularly from our rural counties, and I think it's been a trend nationwide that we see a lot of cisgender women who are contracting HIV and oftentimes in these rural communities. And so we're very cognizant of that fact, and trying to make sure our outreach work is definitely reaching that community.

So our area covers a large portion of the southern part of the state. And this was a reason, part of it, why we really moved to TeleMed, one of several. First and foremost, we are covering 18,675 square miles, mainly of small town and very densely rural communities. And so with that, we had to come up with some different ways to how to address this. And one of the ways we're doing it, we have three hub sites that we've dispersed throughout our region in the different corners. Those then reach out to our satellites, and these satellites are actually at partnering organizations. So it's like the best way in the world to talk about collaboration because they're allowing us the space and we are doing their specialty care and bringing TeleMed into their system. So that's been a great relationship and we've really appreciated that.

So if you looked at HIV in the state of Alabama, in these very dark counties throughout the state, but particularly in the south, those are those with the highest rates. And if you remember that our coverage area is in the very heart of that group. And so we're seeing HIV in rural Alabama as

very significant. In fact, if you took the individuals who are living with HIV, where they're located, they're actually not in the major urban centers, they're throughout the state in small town, in rural areas. And I think Mississippi is also seeing that a lot. And one thing to always note, I'm looking at HIV right now, but if you work in rural care, you know that the rural disease burden is never just one disease. It goes broader. And we've seen that certainly in this kind of a situation. I leave you two options or concepts there.

We've got on the left our cardiovascular disease mortality rate. And on the right, you're seeing our stroke mortality rate. So I'll make a point of seeing the numbers in the southern part of the state, which are really significant. These are the areas where oftentimes people who are dealing with these particular health issues are dying. And we certainly say that in the mountain communities too, in the north, but in the southern part of the state, we seem to have a strong pattern. And I preface or I say this rather, for those who serve people living in rural America and beyond, the reality is that in most diseases you're going to see the mortality is always going to be greater in rural areas and small towns. And it's due primarily for resource acquisition, but there's also a variety of reasons. But if I'm looking at us in Alabama and in the southern part, we also see that there's a kind of a historic factor that kind of led to this, and I'll reference the plantation culture of 1860s.

And so if you notice this particular picture, the areas that had these large blue globes, where the blue part is brighter, those are areas where you've had more individuals who were identified as slaves. Those were also some of the largest plantations in the state of Alabama back in the 1860s. So what you see is when that system failed, that you had just a very few very wealthy and a massive numbers of very poor, no middle class to really stabilize that system. And so you flash-forward to us today, we're still dealing with that. We saw those healthcare outcomes in those same areas that were significantly impacted. Well, poverty rates are still significantly impacted. Again, remembering that particular view, looking at it today, it's still impacting us in 2020. And so we're the sixth poorest state in the union. We have 67 counties and 64 of those have poverty rates that are higher than the national average.

And again, you see it in the mountain communities of the north, but you also see it heavily in these old areas in the Southern part of the state. And then you add on to that the issue of health professional landscape, the shortage areas. We have 63 of our 67 counties are either partially or entirely health professional shortage areas. And that's not just specialty care, that's all care. And that's something that we are dealing with in a very significant manner by TeleMed again with some of the things that we started looking at. And then just real quickly noting, and Captain Mofidi made reference to it too. We've had issues in our zones. We've had hospital closings in our rural communities, specifically linked unfortunately to the fact that we chose not to expand Medicaid, and that is impacting our health care landscape. Getting our state and local leaders to buy in to the healthcare equity is a part of what we try to do, we try to educate them. And then we had those high rates of uninsured people in rural communities. And more often than not, if you look at the areas where people are uninsured, especially in non-Medicaid expansion states, they are in rural and small towns.

Dr. Mofidi also mentioned about the stigma factor and very much so. Beyond just the HIV stigma, it's that whole idea about healthcare. There is still a barrier of folks in rural communities worldwide of really taking a part of healthcare, preventative healthcare. They tend to want to go toward home care remedies and not engage into the community. So that's a health literacy issue that I think we all must be involved with. So our traditional rural HIV care models have been taking a van out with a doctor, nurses, social workers, and driving multiple hours to one clinic and driving back. The problem with that is you've got long drives of two or three hours one way, two or three hours back, and then no patients being seen during that time. And most assuredly, just from a fiscal standpoint, no billable services.

So we looked at direct practice TeleMed option back in 2008. And we're able to actually start seeing it come about through the Alabama e-Health program in 2012. So in that original model, we partnered with our sister organizations in Huntsville at Thrive Alabama and Whatley Health Services in Tuscaloosa. And again, the model was satellite clinics would be linked to these hubs where you had these nurse practitioners and doctors being able to provide the care to more isolated communities. And so what telemedicine at MAO means, it's a video chat environment that has your doctor or nurse practitioner and a patient or recipient with a nurse on the other end. Again, it's not an echo model, it's direct practice. So the nurses, they're working with our recipient, making sure everything is flowing. They're using high-def cameras, they're using Bluetooth peripherals that I will show in a second. And then for many people who've questioned about security, our encryption system is actually along the lines of the US Department of Defense.

So how we look currently is, we have these providers working with our recipients, with the nurse there with them. They're connected to our electronic health record system through the laptops. They're talking back and forth, doing a complete direct exam as if they would be in an exam room. And we're using these kinds of options. We have these roll-out carts that can be moved anywhere at our satellites, Bluetooth stethoscopes that are linked or mated to the partnering one. So the doc or NP has his or hers, and the nurse has his or hers and using with our recipient. They're talking back and forth, they can amplify, they can hear, they are able to use the dermatoscopes and otoscopes for the others.

And we're doing a variety of things at this point, not just the medical care, but we're doing prep utilizing it. We're doing tele-behavioral health, which has come in very handy, and we're doing social service monitoring and client support. And we're also training providers through it, but also doing community education just through this whole Telehealth system. And then we use it for agency-wide communication. And one piece that I'll make a note of just in light of COVID-19 limitations is, that really with third party payers and with people allowing more use, we've been able to use Telehealth to far greater opportunities than we ever thought. So if I look just at 2019, we had 279 of our 2038 recipients that were served by Telehealth. And following the model Dr. Mofidi was mentioning, we had actually 90.2% of our folks with viral load suppression, which is keeping that virus at below detectable or very low levels.

And that was even greater than our 88.4 in the clinic. And then our retention rate was actually higher at the 85, which is a little bit more than actually our retention rate in the clinic. So our zip code concept, which is useful, we save financially over \$361,000 in a five-year study in just driving expenses. And then we also had a savings in driving miles of 662,000 plus miles by our patients. And you look at that along with the number of hours saved, with 11,042 in that five years by our patients alone, it really made the Telehealth, TeleMed worth it. And so lastly, I'll just mentioned to you, we will continue to do our traditional face-to-face. We're going to still do our satellite clinics and do as close to our recipients as possible, but if we can see the continuation of Telehealth options, where people can access through their smart phones and through locals, or they can do telephone option, particularly for maintenance, that's going to be a game changer. I think for the future of HIV specific care in rural America.

And then our suitcase units are the designs where we would actually have a unit to go out with our nurse, into the community, to see our patients in their home, along with our mobile medical units. And all of that is particularly because we want to see more options available to recipients or patients, because when we give them those options, we have a better chance they're going to find the one that actually fits them the best and therefore we're going to be able to retain them in care. So I thank you all very much for letting me share. I'm very happy now to be able to pass on to Dr. Ben Taylor, where he can do his part on today's presentation.



**Ben Taylor:**

Thank you, Michael. I was a chair of a committee that went out to Hobson City, Alabama. It's located in the Eastern region of Alabama and it has a population of roughly 761 residents. They are a medically underserved community and also designated as a primary care health professional shortage area. Additionally, they have a high need for geographic mental health, high health professional shortage areas also. So this clinic, the Health Services Center, has operated since 1990. They're a 501(c)(3) registered nonprofit or a community based organization. They are responsible for the HIV/AIDS medical care, education and support up to 14 county area of East Alabama, and they provide free HIV testing and counseling, medical care, medical assistance, housing assistance, mental health and transportation.

So we talked to several local state groups that serve as stakeholders, and I want to say that these people are very passionate about taking care of HIV patients. One lady, they were doing barbecues and doing free HIV screenings, and they were paying for it out of their pockets themselves, which is very admirable. The site visit themes and perspectives. The main thing was funding. They talked about expansion and modernization of the Ryan White Care Act to include the prep and other preventative services. They want to make the program more consistent with the work being done for the precedence ending the HIV epidemic initiative. They want us to have the Ryan White provide prefaces for rurality, and then the health concerns about rural health groups at the grassroots level, not getting funds directly.

They felt like the money was going through too many hands per se. However, they also wanted to ensure that the money was not being taken away from the federally qualified health centers or the FQHCs. So we talked about ensuring that community-based organizations and other organizations working on the ground, they know what's available. They want to be able to know what's available. They felt like they didn't know what grants were available to them, and it took us so much research to find what was available to them. They also wanted to simplify the process of applying to and receiving grants. They felt there was too much paperwork and too many hurdles when applying for these grants. And so they wanted also revisit grant funding which populates specific stipulations to ensure that work on the ground is not disrupted. But we felt like this may be happening at the state level, and not at federal level.

The stigma that my two esteemed colleagues have all both discussed previously, was something that we discussed also. We discussed a broad, comprehensive education is needed to combat community provider and systemic stigma surrounding HIV. There's a need for increasing public awareness about HIV criminalization laws and their impacts, increasing the availability of harm reduction programs and education communities about the benefits, increasing the telehealth program that worked in all medical facilities, integrating sexually transmitted infection testing, and HIV care to include the behavioral health system with primary care and ED services.

I had an offshoot conversation with another gentleman there, and I told him how hard this was to be in since I do emergency medicine, how hard this would be to perform in the Emergency Department since most insurance company would not consider that to be an emergency and wouldn't pay for it. It was also a great interest in pilot programs, and one of the thoughts they had was to use some of the local abandoned storefronts in the rural communities and to access it with computers, to do telehealth related to HIV. And it felt like this was one way to increase the CDC rural health HIV pilots.

So our policy recommendations to the HHS Director. The Committee recommends the Secretary in modernizing the Ryan White Treatment Extension Act of 2009, focus on enhancing the ability of the program to meet the needs of rural communities. And we felt like this should include increased rural target funding to support pilot programs and capacity building. And when issuing notices of funding opportunities, consider the rule of demographics as the funding factor. We kept going back and forth with this, and it came back to they should always consider it as a

funding factor. Giving rural applicants and designated health professional shortage areas additional consideration through the use of preferences, and expansion of the use of telehealth and telemedicine to increase access to services and reduce stigma in rural population, it seems like Michael down in the south has been doing this already. So that's a good thing.

We also recommended Secretary in maximizing the scientific advances made in HIV prevention, increase the access to prep for rural residents through the existing statutory authority in Section 330 and 330(a) of the Public Health Service Act, and Captain Mofidi alluded to this earlier. We also want as a Committee to... The Committee wants to recommend to the Secretary that support streamlined grant application process for resource strapped rural providers, as well as more virtual grant writing technical assistance for rural communities to enhance their ability to successfully apply for Health and Human Services funding. We kept coming back to this also in our discussions with the stakeholders, that they just felt like it was just such a hard thing that a lot of times they just gave up trying to apply for the grants because it was just so hard for them to do this and they kept getting denied.

So there are further policy considerations. The Committee believes that HSS would benefit from a more targeted focus on harm reduction which can further reduce the likelihood of outbreaks and significantly reduce their scope. Recent outbreaks of HIV and hepatitis C driven by the opioid epidemic in rural areas such as Indiana and West Virginia, show that a lack of harm reduction efforts, for example needle exchange, can lead to a significant burden in rural areas.

Consideration 2: the Committee heard from several speakers who expressed concerns about the implications of criminalization of those with HIV. And that research indicates that such laws are more likely to be enforced in rural communities. So they felt like HIV transmission should not be criminalized, except in instances of intentional transmission or intentionally reckless disregard, that went on to say under any other condition, they felt like the right to health and mitigating factors preclude treating HIV transmission as a criminal offense. Consideration 3: the Committee urges CMS to provide guidance to states regarding Medicaid telehealth coverage policies that can better serve rural residents with HIV.

Consideration 4: while HRSA supports a range of efforts to provide rural training experiences for health professional students in rural areas, it is not clear that those clinical opportunities include chance to treat people with HIV. So the Committee, we encourage HRSA to expand the number of rural HIV training experiences, so that future health care professionals will have the experience in caring for this medical population. And this includes all healthcare population from nurse practitioner, doctors, PAs, Community Health Workers, everyone that deals with anyone who had anything to do with HIV should be able to go to rural areas and experience the propensity to deal with HIV patients.

Consideration 5: We want to address the stigma, especially as it pertains to the LGBTQ people and meet with those who inject drugs in relation to provider attitudes, biases, cultural competency issues that serve as barriers to people with HIV being linked to and retained at HIV care. One of the individuals there also stated that she had to have a conversation with one of the providers at a local facility who had this cultural bias about treating HIV patients. And so she says she finally won him over, and then he had no problems with it after that, which is a good thing. The Committee knows that HHS consider whether existing efforts on stigma reduction are as effective in rural communities, and if not, what additional educational campaigns could be used to address this issue.

HHS should play a key role in better understanding how to help Community Health Workers' initiatives achieve sustainability. So for those of you not familiar with the Community Health Workers, their responsibilities include helping individuals, families, groups and communities

develop their capacity and access to resources, including health insurance, food, housing, quality care, and health information, and obtaining pharmaceuticals. So in essence, they advocate for local health care needs.

Consideration 7: the Committee acknowledges that Medicaid is the primary coverage insurance for many people with HIV, especially in the Southeast. So given the important role Medicaid plays in supporting this population, the Committee believes HHS should provide states with maximum flexibility to support innovative approaches that enhance care options for rural and Medicaid patients with HIV. And our last consideration was we heard from speakers and stakeholders that one of the most challenging issues they face in providing HIV services is a lack of transportation. And I want to say that I've been on this Committee for four years, and every time we have gone out to any area in rural America, that barrier came up over and over and over again, it was the lack of transportation. While we know this issue is beyond the HHS jurisdiction in their purview, the Committee believes that they should work more closely with the federal partners to address these concerns.

I had another conversation with some of the people and they were actually using their own cars to transport patients to get care, which is optimal in the rural areas. It wouldn't be so optimal in the urban areas. That was a good thing also. If you want more information about the Committee, you can visit our website. This is the office, and that's your point of contact down there. And I'm going to turn it back over to Kristine at this time.

**Kristine Sande:**

Thank you so much. And now we will open up the webinar for questions. We have just a few minutes left. If anybody has a question please do enter those in the Q&A box at the... there's an icon at the bottom of your screen that you can click on and it'll bring up a spot to enter your questions. And while we wait for that, I'll just mention that you can find information about HIV and AIDS on the RHHub website. We have a toolkit on that topic, as well as several models and innovations in our Models and Innovation section. And also additional information about HIV and AIDS can be found on the Chronic Disease topic guide. And I'd also, at this point, just like to thank our speakers today, as well as Governor Colyer and the National Advisory Committee on Rural Health and Human Services for being with us today and for the National Advisory Committee for co-sponsoring this webinar. We'll wait just another few seconds, I guess, to see if anybody has any questions.

All right, it looks like we do have one. Given the high proportion of low income individuals, do you know if many are accessing the ready set prep program that provides prep at no cost to those without insurance? Do any of our speakers want to answer that question?

**Mahyar Mofidi:**

This is Captain Mofidi. I don't have the answer to this. I think this is a program that is being coordinated and managed by Department of Health and HHS. So I think that they will be the best point of contact to address this type of question.

**Kristine Sande:**

All right.

**Michael Murphree:**

This is Michael Murphree. One of the things we do, we have a project with Alabama Department of Public Health, we're rolling out in a greater level. Unfortunately got caught a little bit by COVID-19, but now we've been able to re-initiate it. And that is specifically for communities, uninsured particularly. We've actually had some success. We've been doing prep for a while, and actually the majority of the folks that we're serving right now in our prep program have no insurance and we've been able to use some resources for that. So I don't know for sure. I'm interested to see after our relationship with Department of Public Health grows with it at how many more we're going to see. But we actually initiated the project on our own through just

some revenue programs we had finally been able to get, because so many of our folks of greatest need had no insurance and we wanted to make sure they had access to prep.

**Kristine Sande:** Great. Thank you. Another question I believe for you, Michael. I think you talked about the increases in women infected with HIV. Are there targeted outreach strategies for testing that you have found successful with that population?

**Michael Murphree:** We have. I'm very fortunate my education outreach program has a department head that's just very much an innovation, but she's also very focused on women's issues. And so we've been working a lot with our collaborating partners on accessing the places where women gather, particularly in rural areas. Church, of course, in the rural south is a big piece to that. So initiating that project. But also just those individuals in the communities that we traditionally in the arena call gatekeepers. But then they're just like the... the folks that are like the grandmothers to the community are the first ladies of the church, people that folks respect. We access them to be able to get to the other folks in need. And sometimes we even just go into the community and start advertising what we're doing, and we get somebody said, "Oh, you need to go talk to miss so-and-so."

So I think for our women, particularly cisgender women that is a resource of using community links. And that's why you want local folks involved with any program or project you do. You've got to get those local people because they can tell you where to go.

**Kristine Sande:** Right. Looks like there are a couple of questions related to technology, and the kind of the technology divide, technology literacy, internet access. Can you speak to those issues in terms of how it affects access and use of telehealth services?

**Michael Murphree:** Yeah, I will. So in talking about it from our satellite clinic piece, it's very much, we ran into some issues on broadband, even at some health places. Some of our FQHCs were in very rural areas, their broadband couldn't handle our equipment. So we actually helped them to build that infrastructure to get the broadband available. We even had some towns, truly the town doesn't have the broadband capacity to be able to handle the type of equipment we were using. But we were able to go through some other resources to do it. Sometimes that could be a satellite plane, but for the most part now we're seeing in many states, a push toward broadband expansion, that's become an important rally for rural education and rural health care. So our satellites are pretty good, but the question that came up after COVID-19 was, so how do we engage our recipients who are now not able to come into the clinic as frequently, mainly because of their concern about just being around a lot of people?

What we found was that the large majority actually had the capacity to do telehealth, which is the basic check-in using their cell phones and others. We expected that they wouldn't have capacity, but they surprised us. But a lot of that's because sometimes in our good hearts, as providers of care in our country, we think that the people we're serving, aren't able to get access to some things. But many times they do, they're a lot more resourceful. But then what we are obligated to do as providers is that if they then in turn can't get access to it, our social service department and our IT division or telehealth resource center, they became engaged to make sure they had the equipment that they were going to need.

And that's a part, I think, of community-based organizations need to make that a plan, that if they have someone, even someone "homeless" or underserved in their housing, we can figure a way to get them something to where at least they maintain contact through a telehealth visit. And that's going to be, I think, on organizations. And I think certainly, nationally, funding providers need to look at that for our future, especially as telehealth expands to greater levels. I hope that answered the question.

**Kristine Sande:** Yes, I think it did. Thank you. And the here's a question, I think probably for Captain Mofidi. How can free clinics access funding for HIV testing? Are there any grant suggestions you might have for this specifically?

**Mahyar Mofidi:** Yeah, that's a great question. So one way will be to visit [hrsa.gov](https://www.hrsa.gov) and there are a number of grant programs, for example, through the Community Health Centers, Rural Health Clinics, Ryan White Clinics. You can always become a sub recipient or a contractor to receive funds and then to provide the HIV testing in the division that I work at, the Division of Community HIV/AIDS Programs. Every year we provide capacity development grant for one year or supplemental funding, and most often they include an HIV testing component. And so awarded applicants have up to \$150,000 to target those funds across a number of activities, including HIV testing. So again, it's going to take a little work, and I would start by visiting [hrsa.gov](https://www.hrsa.gov), looking at the various announcement opportunities, programs specifically with the Rural Health Clinics, Community Health Centers and Ryan White Clinics and see what are the eligibility requirements. You have my contact information, feel free to also send me an email.

**Kristine Sande:** All right. And it looks like there's another comment in the questions box saying that the CDC notice of funding opportunity for HIV prevention services by community-based organizations is out. So folks might want to check that out. And I think that's all of the questions that I see. So I think we will bring the webinar to a close. Once again, thank you to our presenters for the great information that you've shared today. And thanks so much to all of our participants for being with us. A survey will automatically open at the end of the webinar, and we do encourage you to complete that survey to give us some feedback that we can use for future webinars. The slides used in today's webinar are currently available at [www.ruralhealthinfo.org/webinars](https://www.ruralhealthinfo.org/webinars). In addition, a recording and a transcript of the webinar will be made available on the RHIfhub website, and also sent to you by email in the near future so that you can listen again or share the presentation. Thank you again for joining us and have a great day.