

## **HIV/AIDS Resources for RHCs**

**Moderator: Bill Finerfrock**

**December 12, 2013, 3:00 pm ET**

**Coordinator:** And thank you for standing by. At this time all participants are in a listen only mode. During the question and answer session please press star 1 on your touchtone phone. Today's conference is being recorded if you have any objections you may disconnect at this time. Now I will turn the meeting over to Mr. Finerfrock, Sir you may begin.

**Bill Finerfrock:** Thank you operator. And thank you to everyone whose taken time to participate and listen in on this call today. My name is Bill Finerfrock, and I'm the Executive Director of the National Association of Rural Health Clinics, and I'll be the moderator for today's call.

Today's topic we're going to discuss, and our speakers are going to discuss, some of the HIV education and resources that are available to rural providers and rural health clinics to help provide care and education for the patients in your community, individuals in your community, who may be dealing with HIV/AIDS.

This series, the overall series, is sponsored by the Health Resources and Services Administrations Federal Office of Rural Health Policy, and is done in conjunction with the National Organization of State Offices of Rural Health, as well as the National Association of Rural Health Clinics.

The purpose of the series is to provide C-Staff with valuable technical assistance and information. Today's call is the 56th in a series which began in late 2004, during that time we've provided over 15,000 participants with information on a bi-monthly basis through this forum.

As you know there is no charge to participate in this series and we encourage you to refer others who might benefit from this information to sign up to receive announcements regarding dates, topics, speakers, et cetera.

There will be a Q&A period at the end of the presentation, during that time we ask you to identify yourself by name, city and state before you're asking. So we can get a sense of where folks are from geographically.

In the future if you have questions you'd like to submit, please send them ahead of time to info, I-N-F-O, @narhc.org, put RHCTA Question in the Subject line. That's also an email you can use to send us ideas for topics for future rural health clinic

calls. All questions and answers we will attempt to try and post through this - the transcript, or if possible, through our RHCTA listserv.

Again, I want to thank all of you for participating. Today we have several speakers who are going to talk about various aspects of this topic. We have Deborah Parham Hopson, a PhD from the Health Resources and Services Administration, Ronald Goldschmidt, MD with the National HIV/AIDS Clinicians Consultation, Jan Probst, PhD with South Carolina Rural Health Research Center and Jon Allen with HIV Heart, which is the AIDS Education Training Center.

Our first speaker is going to be Deborah Parham Hopson. In the slides that you received or you linked to, Deborah's are identified as Number 2. So she will be using Slide Packet Number 2. Our next speaker, Ronald, will be using Slide Packet Number 1, followed by Jan who will using Slide Packet Number 3 and then lastly, Jon who will be using Slide Packet Number 4 if you want to follow along.

So at this time I'd like to turn control of the presentation over to Deborah, the time is yours.

Dr. Deborah

Parham Hopson: Thank you so much and good afternoon everyone. I am pleased to be with you on this conference call this afternoon to talk to you about the Ryan White HIV/AIDS Program and how it is designed to provide care for people living with HIV.

Before I go into the specifics of the program however, I'd like to talk about the National HIV/AIDS Strategy. So please refer to Slide Number 2.

The National HIV/AIDS Strategy was released three years ago by President Obama on July 13, 2010. . You see the vision here on slide #2. "The United States will become a place where HIV infections are rare, and when they do occur, every person has access to high quality, life extending care free from stigma and discrimination."

That's a lofty vision, there are four main goals of the strategy:

1. Reducing new HIV infections;
2. increasing access to care and improving health outcomes for people living with HIV and AIDS;
3. reducing HIV related disparities and health inequities; and
4. achieving a more coordinated national response to the HIV epidemic.

Next slide.

As part of that strategy, the Ryan White HIV/AIDS Program is a federal program that has been around since 1990. We specifically address the second goal of the National

AIDS Strategy of increasing access to care and improving health outcomes for people living with HIV.

As I said, the purpose of the program is to increase access to care for people living with HIV. In 2011, the Ryan White Program served almost 554,000 people living with HIV, which is about half of all people living with HIV in the United States.

The Ryan White Program is the only disease specific discretionary grant program for care and treatment for people living with HIV. When you actually think about it, the Medicare and Medicaid spend more dollars on people living with HIV, but those programs care for people with a number of health diseases. The Ryan White Program is specifically for people living with HIV.

One of the tenets of the legislation that established the Ryan White program is that it must be payer of last resort. So like many other HRSA programs, it is a safety net program for uninsured and low-income people living with HIV.

The program does not provide services directly, but what the HRSA does is to provide funding to organizations that then pay for care for people living with HIV. We provide funding for primary health care services, including medications, provider training, support services, technical assistance and demonstration projects.

Next slide.

The Ryan White Program was authorized by legislation that was first passed in 1990 and most recently re-authorized in 2009. There are many different parts of the Ryan White Program. I think it's important that I explain the Program so that you will have an understanding of how the funding flows from here in Rockville out the various communities around the United States.

Under Part A, money goes to the 53 cities that have the most people with HIV and AIDS living within them. Now some of those cities, which are actually metropolitan areas, do include some rural counties. But mainly it is for people living in the 53 cities.

Part B is money that goes to each state and territory. I know we're talking to rural health clinics today and the Part B Program is a major source of funding for HIV care and services in the rural areas.

The AIDS Drug Assistance Program (ADAP) is part of the Ryan White Part B Program. ADAP is a program that pays for medications for people who are living

with HIV because, as many of you may know, those medications can be very expensive.

The Part C and the Part D Program are community based programs. Money goes directly from the federal government to health clinics to pay for the care of people living with HIV.

And we have other Ryan White programs funded under Part F including the Dental Reimbursement and Community-based Dental Education Program, the Minority AIDS Initiative Program, as well as the Special Projects of National Significance or SPNS, which is actually what we call our R&D Program. SPNS is a program that funds new models of care and once those models are developed and evaluated, those that are found to work we try to integrate into the other Ryan White programs.

So what services does the Ryan White Program pay for? Next slide.

Under Part A, B and C, ( money that goes to the cities, the states and community based organizations) there are 13 core medical services that each of those programs must pay for, and you see those medical services listed here.

The AIDS Drug Assistance Program, oral health care, mental health care, and hospice services are examples of required services that must be paid for.

As we transition into the Affordable Care Act, we do know that the ACA will start paying for some of these services. When that happens, it will free up Ryan White funding to be spent on other services.

If you turn to the next page, Slide Number 6, you see examples of support services that the Ryan White Program may also pay for including outreach, transportation, child care, respite services and so on. This is not an exhaustive list, it is just some examples of the support services that the Ryan White Program funding may be used to pay for.

As we move towards full implementation of the Affordable Care Act, the Ryan White Program will continue to fill gaps and also provides for care completion. We know that many people living with HIV require a full range of services in order to maintain their health. The Ryan White Program, combined with the resources available under the Affordable Care Act, does allow people living with HIV to have a fuller range of services available to them – i.e. services needed to “complete their care.” Next slide.

Support for the Ryan White HIV/AIDS Program remains strong. The program was re-authorized through September of this year but it does continue because Congress appropriated funding for the Program even though it has not been re-authorized.

Lack of authorization is not unique to the Ryan White Program. There are many federal programs with expired authorization; they continue to operate based on the appropriated funds from Congress.

The Administration does recognize the need to continue the Ryan White Program even as full implementation of the Affordable Care Act moves forward.

Next slide

I've given you a lot of information and I wanted to provide a list of some training and technical assistance tools that are available to you.

I started out my presentation talking about the National HIV/AIDS Strategy. I encourage you to go to the Web site that you see listed here and download a copy or just read the National HIV/AIDS Strategy. It's not very long; it's a fairly quick read so I encourage you to become very familiar with it.

There are lots of technical assistance tools that have been developed by the Ryan White programs over the years. These tools are collected and updated periodically at the Target Center; you see the Web site listed. It's a central source for technical assistance for Ryan White programs, as well as other programs that may not receive Ryan White funding but do provide services or want to provide services for people living with HIV.

The last Web site is integrating HIV innovative programs. I invite you there to read about some of the innovative programs that are available.

If you have additional questions, the last slide has my contact information. Again, thank you very much for participating today and I look forward to answering your questions at the end of this call. Thank you.

Finerfrock: Thanks Deborah. Next up is Ronald Goldschmidt, who's with the National HIV/AIDS Clinician's Consultation Center. And this was Slide Packet Number 1, there's only a single slide on this packet. Ronald.

Dr. Ronald Goldschmidt: Thank you very much, thanks for asking me to be on the call. It's a nice opportunity and I will describe the Warmline, the PEpline and Perinatal HIV Hotline, which I suspect many of the folks from the rural clinics listening have some experience with.

But I think it's probably important for me to just cover the basics of all those lines and what we do have to offer.

Let me say that we're based at the University of California - San Francisco, at San Francisco General Hospital. And our support comes from HRSA thanks to Dr. Parham Hopson's leadership and others. We've been going for the past 20 years or so and have been able to provide more than 200,000 consultations by telephone to clinicians around the country. About 20% of the clinicians who call us are from rural areas. And last year we had about 14,000-15,000 calls, so that's more than 1100 or 1200 calls per month. So we're quite busy.

We have a very dedicated and devoted group of rural clinician callers who call us quite consistently because we provide some additional consultation for them that they can't have access to quite so readily.

Our group includes about 20 clinicians: physicians who are generalist internists, generalist family physicians, infectious diseases physicians, nurses, nurse practitioners and clinical pharmacists and OB/GYN. Not everybody is full-time, of course, and we're basically here on the lines Monday through Friday, plus we have off-hours coverage as well. So we have a multi-disciplinary group which we find is very helpful in giving help to the our callers, who have a wide range of experience with HIV.

The Warmline is for HIV consultation, and this deals with things such as interpreting HIV test results, how to start patients on anti-retroviral drugs, consultation on when anti-retroviral drug resistance happens, consultation for co-infection such as hepatitis C. So this is basically a clinical consultation, clinical management service. The hours of operation for the Warmline are 9:00 am to 8:00 pm Eastern.

Everything we do, of course, is free. And we have lots of calls across the entire spectrum of HIV problems from clinicians who have the entire spectrum not only of professions, but experience and expertise with HIV.

We provide support to a lot of folks who we know are being quite heroic in their management of just a few cases in their area. There are countless clinicians who call us who are managing one patient who has come home and is living among family in a rural area, and we are really their source of clinical support. So we really appreciate how heroic they are in their work and it's great to be able to support them.

The PEPLine I think most of you will know about because it is the National Needle Stick Hotline. And we're very busy with calls from throughout the country, from emergency rooms to occupational health, primary care offices and elsewhere.

We give advice on how to assess the risk after a needle stick injury or splash or something along those lines, whether to give post-exposure prophylaxis, if so, what medications to give and how to follow up.

In addition, the PEpline takes care of non-occupational exposures as well, such as sexual assaults or sexual encounters that were unprotected, et cetera, because post-exposure prophylaxis is generally recommended for those exposures as well.

So that's our National PEpline, which is open from 9:00 am until 2:00 am Eastern Time. We take those calls from home, the rest of the calls are taken from our offices here at San Francisco General Hospital.

And finally, we have a Perinatal HIV hotline that provides advice for the care of HIV infected pregnant women, including labor and delivery and the various things that need to be done to ensure that transmission does not occur to the infant.

Since we have been providing antiretroviral interventions against HIV transmission in the perinatal world the number of transmissions has dropped absolutely precipitously. So all these techniques and interventions are very successful.

I should add that since the development of post-exposure prophylaxis for healthcare workers and the implementation of post-exposure prophylaxis, as well as all the safety measure that we are doing in practice, there have been no transmissions - to healthcare workers over the past 12 years now."

So all of these interventions are very important to the population, to healthcare workers and to folks with HIV.

So I think at that point I will stop and turn it over. So thank you.

Finerfrock: Thank you. Just real quickly, and I know you have to go, so I did want to ask. You - all these have toll free numbers, is there a way to communicate through email, or is that not something that you guys do?

Goldschmidt: Thank you, that's a really great question. Yes, we are about to launch email consultation, and I was hesitant to put into this slide because I was thinking then, people would start to try to access and become frustrated.

But I think in about three or four months we should be able to be doing that and we're having an entire new database and a new system put in place. I guess the way to find

it would be to just go to our Web site, which I should have put on the slide. I apologize. It is [www.nccc.ucsf.edu](http://www.nccc.ucsf.edu).

That Web site will open to a database and clinicians can enter directly into a database, they can enter their data and questions. We will have them identified and they can then start to sort through their questions through an algorithm that will help them define what their questions are.

And then we will consult with them either through the email, or we will do a combination of email and Warmline, PEPLINE, Perinatal Hotline call. Or they can choose to just call us from there. So this will be available, but I would say, "Check back in about three or four months on that."

Finerfrock: Okay. And if you remember, if you want to, once that's up and running, if you wanted to reach out to us, we would be happy to send that information out about how the Web site and the - how to email or communicate once it's up and running, and we will send that out to all of our listserv participants, which is about 2,500 people.

Goldschmidt: That's great.

Finerfrock: So feel free to share with us that information when it's available, and we'll pass it along to our community.

Goldschmidt: Very good. Thank you so much.

Finerfrock: Thank you for your - for those comments.

((Crosstalk))

Finerfrock: Next up is Jan Probst who's going to talk to us about HIV/AIDS in the rural U.S., prevalence and service availability. Jan is with the South Carolina Rural Health Research Center. Jan.

Dr. Jan Probst: Thank you. Apologies in advance if I do any coughing, I'm coming off antibiotics.

As I mentioned, if you look at the first slide you'll notice that there are several names listed in addition to mine. Pretty much everything we do at our center is a team effort, and we like to acknowledge everyone who has worked on the project. You'll notice we have a mixture of clinical and non-clinical researchers.

I probably don't need to say this for a clinical audience, but Slide 2 tries to sum up really, really quickly what HIV is, just in case we had listeners who are not familiar

with this disease. The human immunodeficiency virus (HIV) reduces the number of CD4 cells in the body. Your CD4 cells fight infections. If they fall below a certain level, you are prone to opportunistic infections. When opportunistic infections manifest, you are deemed to have acquired immune deficiency syndrome, which, as we remember from back in the 80's, was defined before the underlying virus was identified. In addition, the lower the CD4 count, the more contagious you are.

We know now that antiretroviral treatment will protect the CD4 cells and the immune system, but this treatment needs to be provided. In addition, people who have HIV need to be educated about the precautions that they need take. And they need to be educated on an ongoing basis, because, as all of us know, we don't always do the things our physicians tell us to the first time we hear them.

Our first speaker, Dr. Parham Hopson, mentioned that the Ryan White Act treats more than 500,000 persons. [Slide 3] That's approximately half of the 1.2 million persons living with HIV/AIDS. HIV is a disease that disproportionately affects minorities, women and persons living the South. And a theme of my presentation here, HIV could become a rural disease. Thus, I want to talk briefly about the relevance of HIV positivity in rural America, and service availability in rural America.

Knowing that I'm talking to a clinical audience, I will not subject you to the details on Slide 4, but let's just say that, "All of the information presented here is based on publicly available county level data."

"Publicly available" is important because HIV is a stigmatized disease. When I start showing maps you'll see that a lot of states, or a lot of counties, will be missing. That's because when the number of cases gets below a certain level, most states and the CDC will not report them at the county level.

An overview of the big picture that will be drawn by this presentation is offered in Slide 5. HIV is present in rural America, as the callers and listeners probably already know or they wouldn't have called in. HIV tracks very closely with poverty and with minority, race-ethnicity at a geographic level. And finally, the part that scares me, HIV rates in rural counties are rising.

Slide 6 presents data from a report our Center did for the Office of Rural Health Policy. It was limited to 2008 county-level HIV rates that we could get from individual state health department web sites. Because of this limitation, there are a number states grayed out, because they simply did not publish the data.

As you look at this map, think about your state, and look at where the map sort of lights up with that deep red color. The colors represent quartiles of HIV prevalence per 100,000 persons in U.S. counties. The deepest color is the highest prevalence rate, the upper quartile, of prevalence..

Some of the very low prevalence areas, with very low rates, are where one might expect to find them: in the relatively well-to-do counties of the upper Midwest. But when you look at the counties with a high concentration of minority and poor populations, the South throughout the Southwest, through the Native American enclaves in the upper Northwest, the county colors on the map lights up.

Those rural counties are where AIDS lives; it doesn't just live in cities. Those upper quartile counties represent large parts of the rural Mississippi Delta, the rural Old South.

Soon after our report was completed, the Robert Wood Johnson Program came out with its huge county rankings data set, which we used to create the map shown in Slide 7. This map contains a little bit more information, some of the states that were greyed out totally now have data in them. Because we had so much data we were able to characterize counties by whether they were urban counties or rural counties, and whether they were above or below the median prevalence of HIV. Please note that , "above the median" means not just above the median for rural, but above the median for the U.S.

If you look at the map in Slide 7, you may be able to identify counties in your own state. The rural South lights up even more clearly than it did in the preceding slide. If you look closely at the counties in the Southwest that light up, they're American Indian areas or high Hispanic areas. In the West Virginia Appalachia area, a cluster of rural counties are above the national median. And across the country, various rural counties display high HIV prevalence, for reasons that we can't explain at this time.

Slide 8 takes the data up to 2010. You'll see that the picture remains similar. If we have any listeners from New York, upstate New York is an area of high prevalence for rural HIV/AIDS, and I remind listeners that the State of New York does have intensely rural areas. There are counties with are high HIV prevalence all along the Atlantic Coast. The geographic picture of HIV presence at rates above the national median in both rural and urban counties does not change.

Slide 9 offers some digital magic. It compares counties in Kansas and Oklahoma for 2009 (data on the left), and 2010 (data on the right). In all of the rural counties that are marked with a red arrow, HIV prevalence has gotten higher. A county that once had so few cases that it was suppressed now has enough cases to be reported,

although in the lower half of prevalence. In some cases, a rural county that was in the lower prevalence ranking pops up to the dark red of above the national median.

I find the change somewhat alarming: of the rural counties in the two-state area that changed, only one went from being above the median to below. All the rest, seven rural counties, moved up a step. As noted, they went from non-reportable to reportable numbers of HIV patients, or from being below the median to above the median. Our Center hopes to do more work to see what is influencing the growth of HIV in rural counties, to see if there are factors that we can address.

The next slides present data from the maps in a numeric summary. Slide 10 compares rural prevalence rates to overall prevalence rates in 2008. Of the 28 states we examined, one, South Carolina, had a rural prevalence of HIV that was greater than its statewide prevalence. Further, in several other states, for example, New Hampshire, the differences between rural and overall prevalence aren't large. In New York, yes, where HIV was principally an urban problem. In some of the other states the disparities are less clear.

Slide 11 uses 2010 data. This analysis is limited to the states for which we had complete data on every county in the state, so it includes only 16 states. In 2010 the rural prevalence of HIV at the county level was greater than the urban prevalence in two states, Florida and South Carolina. This direction of change – rural HIV prevalence catching up to urban prevalence – parallels the suggestion in Slide 9, which showed rural counties individually moving toward higher HIV rates.

Slide 12 outlines some facts about HIV treatment probably well known to everyone here. HIV treatment is expensive; half of HIV+ patients receive care through the Ryan White Program.

Because the Ryan White Program is so important, we decided it could be used as a proxy for knowledgeable care availability. While the National Clinicians Consultation Center run by Dr. Goldschmidt is enormously helpful, HIV care remains complex and many rural physicians may not have enough patients to become familiar with care protocols. However, Ryan White provider should be familiar with how to care for the medical complications of an HIV patient.

Slide 13 shows counties in which Ryan White HIV providers are located. The dark color indicates that an HIV provider is present, the red indicates present in a rural county. A dark brown color indicates an urban county.

Looking at the slide, there is a fair distribution of Ryan White providers in the South, in the Northeast, and probably reasonably in the West. Texas seems to have a

reasonable distribution of Ryan White programs. But some of these states in the middle of the U.S., in the Midwest, have very few Ryan White providers.

We may be underestimating the availability of care for HIV+ persons when we look at the counties with no Ryan White provider. But here's why we worry: there is a concept known as "travel impedance." We do know anecdotally that people who are receiving HIV care in rural counties would prefer maybe not have everybody know about it. They might want to drive "a ways" from their own community. The question is, "How far is a ways?"

Please look at Slide 14, which shows the map of Kansas and Oklahoma. Norton, KS is an "above the national median HIV prevalence" rural county. From Norton Kansas to Wichita, which holds the nearest Ryan White provider, is 268 miles. Similarly, from Guymon, Oklahoma to Oklahoma City is 263 miles. That's a hike. Distances of that magnitude might be enough to deter people from seeking care, to encourage them to say, "I'm okay, I don't need to fill my prescription and I can let slip a month." That distance may be enough to create a barrier to appropriate care.

Leading to our conclusions (Slide 15). These conclusion will be somewhat obvious based on the information presented:

- Right now there are few Ryan White providers in rural counties.
- There is some concern, at least on our part as public health researchers, that the absence of Ryan White providers might affect the ability and the willingness of patients to adhere to their therapy regimens.

Finally, we acknowledge that additional research is needed. It may be that HIV+ patients are going to CHCs and other sources for their care. Alternatively, there may be resources available that we have not acknowledged that are helping patients receive medically appropriate care in the absence of Ryan White providers. Nonetheless, we find the low availability of providers in some areas, coupled with the evidence to increasing HIV prevalence in rural counties, to paint a disturbing picture.

Since this is a teleconference, at the end the informed discussants from the RHC community can help us academic types learn more about the rural picture. Thanks.

Finerfrock: Thank you for that, it was very helpful. Our last speaker before we move onto questions is Jon Allen, who's going to talk about AETC support for rural healthcare providers. Jon - and he should be Slide Packet Number 4, I believe.

Jon Allen: Thank you for the opportunity. I practice at the University of Arkansas for the Medical Sciences, I've done HIV care for 25 years. I started specializing in HIV care

in Los Angeles for the first seven years, but I've practiced in rural Arkansas since 1996.

Finerfrock: Not much of a difference though, right?

Allen: Huge. And I really appreciate a lot of the things that Dr. Probst had to say, and those are the issues that we live with every day. The old model of care was that if a patient was diagnosed with HIV you refer them to a specialist and they handle everything.

HRSA recently did a study which showed that showed that many HIV specialists and primary care providers are nearing retirement. Also fewer medical students are choosing to specialize in infectious diseases and therefore there will be fewer and fewer people to take care of HIV patients, especially in rural America.

So HRSA has an initiative to develop rural healthcare providers and have them get some experience and expertise in providing primary care for HIV patients, and certainly the focus there is not to expect you to hit the ground running and be able to take care of HIV patients, but just to recognize that the struggles that patients have when they live in rural areas in getting access to medicines and care. When patients start on HIV medications, staying on their medicines is just incredibly important, and rural health care providers play a very important role with that.

The other thing that Dr. Probst talked about and showed so clearly with her slides about prevalence in rural areas is that a lot of people live with HIV in those areas and when they don't have access to medicines and they have a high viral load, the potential is much higher for them to infect their sexual partners ,and in fact in communities where people are in care, on medicines and have an undetectable viral load the possibility of them giving HIV to someone else is very, very low.

So just let me get on my soapbox and say, "All of you should be doing universal testing on all of your patients and then getting them in care to prevent new HIV infections." So please go to the next slide.

This AETC regional map shows the 11 regional centers. The AETC reaches out to all areas of the country and to Puerto Rico and the Virgin Islands as well. Other than these 11 regional sites there are also 130 local performance sites that can arrange training for your clinics.

The goal of the AETC is to reduce new HIV infections by developing providers of HIV care and getting people educated about HIV prevention, care and testing, to increase access to care and thereby improving health outcomes for people living with HIV. By strengthening the current provider workforce to improve their quality of

HIV care, the program improves the health outcomes for their patients who live with HIV.

As I mentioned before, there is a shortage of available providers of HIV care, and one of the ways we're addressing that is with our telehealth programs. The AETC offers training on site at local clinics and also telehealth programs via the Web. The program also provides technical assistance for physicians, physician assistants, nurses, APNs, pharmacists, and dentists to take better care of their HIV patients.

Those training efforts have expanded over the years to also include medical case managers and social workers to help promote HIV testing and prevention to their clients. Next slide.

So here's the slide that shows the types of training offered. Level 1 trainings would be the traditional lecture for example, talking about the signs and symptoms of acute HIV infection.

An example of a Level 2 would be an interactive case based workshop on promoting universal HIV testing in rural health clinics or how to talk to patients about the need for HIV testing.

A Level 3 training would cover a more intensive training where a rural health provider might travel to an academic medical center and do a clinical residency to learn about how to care for HIV patients, how to interpret lab tests used in HIV care.

A Level 4 training would consist of either a telephone consult or contacting an HIV expert to get help in managing one of your patients. This might include referral to local HIV resources in your community or where to transfer a patient for inpatient HIV specialty care.

A Level 5 training would provide technical assistance. An example would be a community hospital that wanted to implement rapid HIV testing in labor and delivery, and be able to test women who had no prenatal care, identify whether or not they had HIV infection and immediately give the necessary medications to prevent HIV infection in the newborn. Next slide.

This slide shows the links on the national Web site for the AETC and the links to find your AETC regional training centers. And if you click on one of these training center sites you'll find the contact information of how to arrange a training for your clinic or how to get a hold of a clinician to help you with your patient.

Also on this Web site are the national resources that Dr. Goldschmidt mentioned, the Post exposure prophylaxis line and the Warmline, and those contact numbers are there as well. Next slide.

Also on the AETC Web site are comprehensive slide sets with an overview of different disease states, including HIV infection, prevention of vertical transmission or syphilis. If you needed a consult for one of your patients or you wanted to learn more about an opportunistic infection, you could find that information in detail on the site.

The AETC also offers telehealth training centers and there are ten of those nationally located in academic medical centers. As Dr. Probst showed in her slides, many people who live in rural areas have to travel a half a day to get to their HIV care provider.

And for those patients who live hand to mouth, can't afford the gas, can't afford the time away from their job and can't get childcare, it's really a great thing for them to be able to drive 15 or 20 minutes to see their local healthcare provider and be able to link up via telemedicine with the academic medical center and actually see an HIV expert.

The other benefit of this program is that when we do one of those consults and see patients in this manner we're also teaching the rural healthcare provider about HIV specialty care and aspects of primary care for an HIV patients as well. Next slide.

This shows the HIV telemedicine program here at University of Arkansas. We see patients in south Arkansas and the Fort Smith area, which is on the western side of the state. We're also starting to see patients in rural health clinics with the Health Department and perhaps soon, also with the state prisons.

Again, this program allows the patient to see an HIV specialist without traveling half a day, supports the rural health care providers in delivering high quality HIV care for their patients. Next slide.

Our clinic is staffed by UAMS Infectious Diseases faculty members. In addition we also see OB patients at remote hospitals, so we may also work with high risk OB specialists to manage a patient who's HIV positive and pregnant. And after the woman delivers, we make sure that the infant also gets into care with a pediatric infectious diseases specialist. We also provide HIV follow up for the mother, as well. Next slide.

So in summary, we're here to help support you in in the care of your HIV patients and to help you get experience and expertise and following your HIV patients at a greater comfort level when doing their primary care. And if your patients can't travel two or

three hours to see a HIV specialist, there are programs throughout the country that can help them link up with a specialist via telemedicine. Thank you.

Finerfrock: Thank you Jon, appreciate that presentation and to all of our speakers. At this point we'd like to open it up for any questions from folks in the audience. Operator if you would go over the instruction of how people can open up their phone lines so they can ask a question, we'd appreciate it.

Coordinator: Thank you. We will now begin the question and answer session. If you'd like to ask a question on the phone line please press star then 1. Please unmute your phone and record your name clearly when prompted. Once again, to ask a question please press star then 1. One moment please.

Finerfrock: We request that you also identify at least your first name and the city and state that you're calling from.

Coordinator: If you have a question please press star then 1.

Finerfrock: Go ahead caller. Caller, you're (unintelligible).

Coordinator: At this time we have no questions.

Finerfrock: They cancelled? Okay. Was there anything any of you, that a subsequent speaker perhaps touched on that any of our other speakers may have wanted to either expand on or had a question or needed some clarification? Sometimes one speaker may cite something that triggers a thought with another speaker, something that you didn't think to mention during your portion of the presentation.

Parham Hopson: This is Deborah Parham Hopson, and I'd just like to again thank all of the presenters for some really timely information. One of the things that I did want to respond to is the fact that there are not Ryan White programs in every community where there are people living with HIV.

That is true. One of the things that we're trying to do at HRSA is to figure out how we can expand the reach and expand the knowledge of the Ryan White programs as well as other providers of HIV care out into the more rural areas.

I was gratified to hear the presentation from the AETCs. Some of our efforts include the telemedicine clinics and the telehealth training centers. Under the Affordable Care Act, there has also been significant expansion of the community health centers.

In my role as the Senior Advisor for HIV/AIDS Policy here at HRSA, one of the things that I'm trying to do is to help those community health centers that are not Ryan White funded clinics, but centers where people living with HIV may choose to access care. How do we make sure that they're able to provide high quality care for people living with HIV because that's where the growth in healthcare providers has come under the Affordable Care Act. We're trying to tap into that resource (i.e. health centers) so that it is a resource that is viable for people living with HIV.

Finerfrock: Thank you. I had two things, one is, Jon could you expand a little bit more on the difference between the consult program that you are operating through AETC and the program that Dr. Goldschmidt referenced that is being done out of the University of San Francisco?

Allen: Sure. I've been practicing for 25 years and let me say what a great program that they have in San Francisco, and I use it as a consumer. There are times when I see a patient with a resistant virus and I contact them to get help in designing what medications to use. And some of these patients can get to be very, very complex.

I think that with the pep line, as Dr. Goldschmidt said, they're there nearly 24/7 to be able to immediately respond to the need to get a healthcare worker or somebody that been sexually assaulted on medications.

What we do is, that differs from them, is that what we want to do is be able to develop trainings in rural health clinics, and those of course, don't have to be immediate, but we want to train everybody on a site to take, you know, to implement HIV testing and prevention.

We would also be available to do a consult on a patient, especially if they needed to be linked to care here at the med center, whether it be by telemedicine, or to be admitted to the hospital.

The other difference would be that, say if I get a call from south Arkansas about an HIV patient, having worked here for 16 years, and to be able to do that consult that's set up through the AETC, I can tell them where to send their patient for HIV specialty care, how to get HIV medicines in Arkansas and how to access the Ryan White Programs.

So I think there are similar kind of consults, it's just that the people in San Francisco are doing the high level stuff, we're more boots on the ground and be able to link people to care in Arkansas.

Finerfrock: That's you have counterparts in other states. So just as you're able to be familiar with the resources available in Arkansas, there are others through this particular program in other states that have that same capability so that San Francisco, as you said, they're calling and getting one.

But if you want to know, "Gee, you know, what do I do in South Carolina, what I do in Florida," there are people just like you available in those states who can give them a better sense of what the boots on the ground resources are available in those states.

Allen: And so for instance I'm in the Delta Region and there's counterparts in Louisiana and Mississippi that do similar kind of work at academic medical centers that can link those people to care. Also patients in rural areas don't stay in the same place, they go from place to place, and we're able to make sure they have continuity of care another state. The AETC also has links to where clinicians can refer their patients for care, and that's all across the country.

Goldschmidt: This is Ron Goldschmidt from the warm line. Let me just add to that. I don't think that the consultants such as Jon are just - have their boots on the ground. I mean although we refer callers back to the regional AETCs and folks like Jon all the time for that kind of help, at many sites it's - that's the best consultation they can get. Because it's really personal, it's a direct connection as opposed to our being in California Connection.

And - but not every place can have a Jon or some other one like that. And so that's one of the reason that we do exist, is because we can fill some of those gaps.

Finerfrock: Right.

Goldschmidt: But the best thing is when we can all coordinate, which we all try to do. The AETCs refer people to us and vice versa, it really does seem to be an excellent comprehensive system.

Finerfrock: Great. Operator have we gotten any questions from the audience?

Coordinator: At this time we have no questions.

Finerfrock: Okay, the last thing before I'll let everybody go then, and I think you know, Jan, you were touching on some of those statistical information and the increasing prevalence, and I really think that is critical.

And partly why, you know, we were receptive to doing this particular program, because it is something. I think there's still a view in many rural communities and

perhaps some of our rural health clinics that, "We don't have patients like that," or you know, "That's not an issue for our community."

And I think part of the point that your data was trying to show is just because you haven't necessarily experienced patients with HIV/AIDS in the past don't presume that's it's not going to become an issue for you at some point. Is that kind of really a part, a critical part, of the message here?

Probst: Definitely. And I would emphasize, yes, it's everywhere, yes you need to test. You know, the CDC does recommend - I think they recommend universal testing for every ED visit, certainly for all your maternity patients.

Yes, there is no place in America that can say it is not touched by the epidemic, and if we don't acknowledge that it exists locally, and start looking for local solutions, we're not going to solve it.

Finerfrock: And perhaps lastly, I think the other is that the nature of the patient population that suffers from HIV/AIDS, or experiences HIV/AIDS, has continued to change. I mean you know, clearly early on it was - this was a disease that was at one time, felt exclusive to the gay community, and then it was expanded to gay and drug users.

But I think it's a disease where it cuts across all various gender, socio-economic, sexual preference, drug use, non-drug use, to where folks should not just presume that this is something isolated to certain particular communities, but is something that is a potentially an issue for just about anybody. Is that a fair statement?

Probst: Well spoken.

Finerfrock: Okay. Well again, operator, if we have no question from the audience, I want to thank all of our participants for taking the time out of, I'm sure, your busy schedules to help bring this information to the rural community, to those who are participating in the audience on today's call.

And also as I mentioned at the outset, this information will be up on the ORHP Web site, and folks who weren't able to participate to today can go and listen to the recording, read a transcript and look at the slides that each of you presented.

So if there are folks who, for whatever reason, their schedule didn't allow, we'll be able to get that out. And we will continue to refer people to that information to try and get the word out and make sure people not only what may be, you know, an issue for the community, but more importantly, where to go to get resources to help their patients who may dealing with HIV/AIDS.

So again, thank you to all of our participants, thank you to our audience, and thank you to the Federal Office of Rural Health Policy and the National Organization of State Offices of Rural Health for helping bring this program to the rural health clinics community.

I'm Bill Finerfrock, the Executive Director of the National Association of Rural Health Clinics, thank you all for participating and we'll get you information about our next call as soon as possible. Thanks everybody.

Woman: Thank you.

Man: Thank you.

Woman: Thank you.

Coordinator: Thank you and thank you for joining today's conference. You may disconnect at this time.

END