HIV PREVENTION AND TREATMENT CHALLENGES IN RURAL AMERICA

POLICY BRIEF AND RECOMMENDATIONS TO THE SECRETARY

MAY 2020

NACRHHS

National Advisory Committee on Rural Health and Human Services

EDITORIAL NOTE

During its 87th meeting in Atlanta, Georgia, the Committee examined rural HIV prevention and treatment and sought to understand the continuum of HIV care—including prevention, diagnosis, and treatment—among rural populations. To this end, the Committee heard from subject matter experts on HIV prevention and treatment challenges in rural communities at both the national and state level. The rural HIV subcommittee traveled to Anniston, Alabama to visit Health Services Center, Inc., which is a Ryan White funded community based organization providing HIV medical care, education and support across 14 counties in East Alabama (see **Appendix A**). While there, Committee members heard from providers and staff as well as other local HIV service organizations about the challenges and opportunities related to improving HIV care in the surrounding communities and the role of the U.S. Department of Health and Human Services in providing assistance.

ACKNOWLEDGEMENTS

The Committee would like to acknowledge all those whose participation helped make the March 2020 convening in Atlanta and this policy brief on rural HIV possible.

The Committee expresses its gratitude to each of the presenters for their contributions to the meeting and for their subject matter expertise. These individuals are: Dr. Ken Dominguez, MD, MPH, CAPT USPHS (Centers for Disease Control and Prevention); Dr. Mahyar Mofidi, DMD, PhD, CAPT USPHS (HIV/AIDS Bureau, Health Resources and Services Administration); Dr. Fayth Parks, PhD, MS (Georgia Southern University, Department of Leadership, Technology, and Human Development); Michael Murphree, LCSW (Medical Advocacy and Outreach); Eric Paulk, JD (Georgia Equality, Inc.); Gregory Felzien, MD, AAHIVS (Georgia Department of Public Health, Division of Health Protection).

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Special thanks goes to the Committee host and the Rural HIV Prevention and Treatment subcommittee chair, Ben Taylor. Additionally, special thanks goes to members who served on this subcommittee: Steve Barnett, Bob Blancato, Kari Bruffett, Wayne Deschambeau, Pat Schou, James Werth, and Loretta Wilson.

Finally, the Committee extends its gratitude to Lamar Greene for coordinating the activities of this meeting, summarizing the Committee's findings, and preparing this policy brief.

Policy Recommendations

Recommendation 1: The Committee recommends the Secretary, in modernizing the Ryan White HIV/AIDS Treatment Extension Act of 2009, focus on enhancing the ability of the program to meet the needs of rural communities. This includes:

- Increased rural-targeted funding to support pilot programs and capacity building and, when issuing Notices of Funding Opportunities, consider having rural as a funding factor and giving rural applicants in a designated Health Professional Shortage Area additional consideration through the use of Preferences.
- Expansion of the use of telehealth and telemedicine to increase access to services and reduce stigma in rural populations.

Recommendation 2: The Committee recommends the Secretary, in maximizing the scientific advances made in HIV prevention, to increase access to Pre-Exposure Prophylaxis (PrEP) for rural residents through the existing statutory authority in Sections 330 and 330A of the Public Health Service Act (HRSA's Community Health Centers Program and the Rural Health Care Services Outreach Program, respectively).

Recommendation 3: The Committee recommends the Secretary support a 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.

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INTRODUCTION

The United States has been grappling with the HIV epidemic since the early 1980s. Today, there are roughly 1.2 million Americans with HIV, and about 14 percent of them (1 in 7) are not aware they are infected.[1] The Centers for Disease Control and Prevention (CDC) estimated that 36,000 people became newly infected with HIV in 2018.[2] Furthermore, the CDC noted that in 2018 men accounted for 81 percent and women accounted for 19 percent of new HIV diagnoses.[3] Although there is limited data on HIV among transgender people, the CDC found that from 2014 to 2018, 3,009 transgender people received an HIV diagnosis.[3]

After five years of significant declines, the number of new annual HIV infections began to level off in 2013 to approximately 39,000 new infections per year.[2] The decrease in new HIV infections has plateaued because effective HIV treatment and prevention services are not adequately reaching the populations most disproportionately affected such as people who inject drugs, LGBTQ+ people, Black people, LatinX people, and members of Tribal communities. In addition, research shows that HIV cases have been increasing among rural communities and that barriers to HIV-related health care need to be addressed.[4]

In early 2019, the president announced the "Ending the HIV Epidemic: A Plan for America" initiative, which aims to reduce new HIV infections by 75 percent in the next 5 years and by 90 percent in the next 10 years. The plan points out that, "most infections are now highly concentrated in certain geographic hotspots … and certain rural areas carry a disproportionately high burden of HIV, especially in the South." The plan is structured around providing the geographic locations most affected by HIV (including rural areas) with the additional expertise, technology, and resources required to address the epidemic in their communities. The initiative will focus on four key strategies while working to end the HIV epidemic: Diagnose, Treat, Prevent, and Respond. More detailed information about the Ending the HIV Epidemic initiative can be found in the "Federal Programs" section of this policy brief.

BACKGROUND

Rural HIV

There are regional and geographic differences regarding the prevalence of HIV and access to HIV treatment and prevention services. Historic factors have contributed to HIV disparities based on geography. The HIV epidemic was first widely centralized in major cities, which meant that resources and research attention were heavily concentrated in urban areas despite rural areas potentially also being impacted.[5] In addition, incidence of HIV in rural communities may appear to be low because data are collected from where patients receive care, not where they live.[6] Stigma also plays a role in increasing the possibility of rural residents getting treated in urban areas or providing a false address to testing facilities out of fear that others in their community might learn about their HIV status.[6]

Some of these factors account for the limited amount of data on HIV in rural America. In 2010, the two counties with the highest HIV prevalence rates were rural counties, and 16 percent of the 50 counties with the highest HIV prevalence rates were rural.[6] Racial disparities were also apparent. In seven of eight high-prevalence rural counties, the proportion of Black American, LatinX, Tribal, and other minority populations exceeded the national average.[7,8] In 2015, the American Psychological Association reported that rural communities have HIV prevalence rates approaching those of urban areas.[9] Most recently, rural communities have been experiencing notable increases in recognized new HIV cases, at least in part because of the opioid epidemic, and especially in the southern regions of the country. It is reasonable to

assume that more research on rural HIV will be published in the future. The recent increases of HIV cases in rural areas led the National Advisory Committee on Rural Health and Human Services (NACRHHS) to focus on the issue during its March 2020 convening in Atlanta.

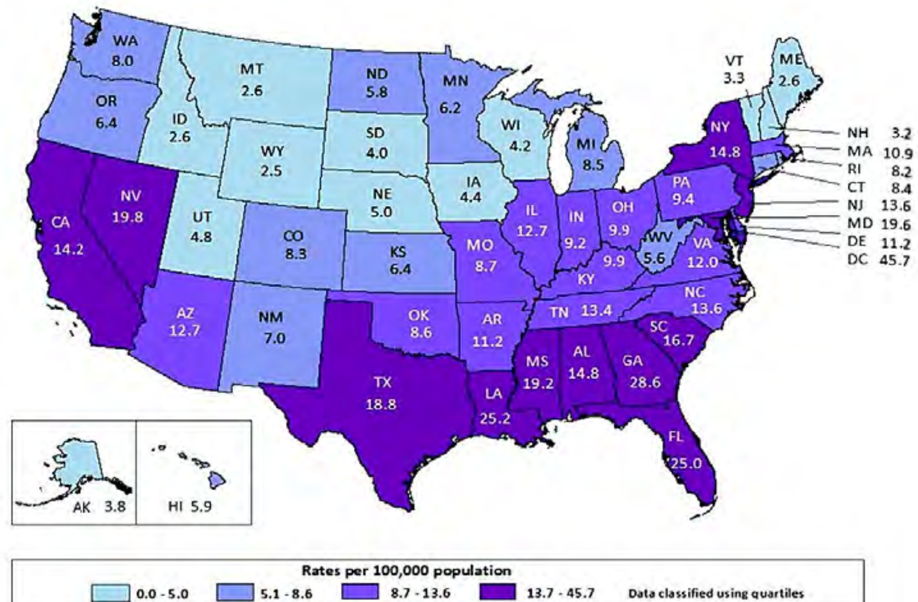

Figure 1: *Rates of Diagnoses of HIV Infection among Adults and Adolescents, 2018*. Source: CDC. Diagnoses of HIV infection in the United States and dependent areas, 2017. HIV

Among all regions of the country, the South has the greatest number of new HIV infections (see **Figure 1**), with Southern states accounting for 52 percent of new HIV diagnoses in 2018.[3] HIV rates for suburban and rural areas are higher in the South and Midwest compared to the Northeast and West. In the South, 23 percent of new HIV diagnoses occurred in suburban and rural areas, whereas in the Midwest, 21 percent were suburban and rural.[3] Gaps in access to HIV treatment and prevention services are especially problematic in rural areas for LGBTQ+ people and people who inject drugs.[10]

Barriers to Accessing Health Care

Social factors, HIV criminalization laws, and the lack of public health infrastructure investment lead to barriers and challenges complicating access to HIV prevention and treatment efforts in rural communities. In addition, compared to their urban counterparts, rural residents have higher rates of poverty, less access to health care and transportation, and are less likely to have health insurance.[4] The lack of available services is another barrier for health care access in rural areas. In fact, most rural counties have been deemed "Health Professional Shortage Areas" (HPSA) by the Department of Health and Human Services (HHS) because they have insufficient providers for primary, dental, and/or mental health care.[4] In addition, most rural communities will lack health care providers who specialize in providing care to persons with HIV disease.[6]

Further, many rural communities lack drug rehabilitation and syringe services programs (SSPs). Increasing rates of injection drug use in rural communities[i], driven by the opioid epidemic, has led to an increase in rates of HIV, Hepatitis C, and other infectious diseases in rural areas.[11] SSPs have been proven to decrease the spread of infectious diseases amongst people who inject drugs; however, these programs are uncommon, especially in rural areas.[12] Those SSPs that do exist are underfunded, partially because federal funding cannot be used for clean syringes. As of 2017, furthermore, a number of states had deemed SSPs illegal, with 15 states requiring legislative action to permit the operation of SSPs (see **Figure 2**).

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[i] Click here to learn more about increasing rates of injection drug use in rural areas

Because of the lack of availability of services, rural residents often must travel long distances to find a provider, which can be problematic because many rural communities have poor transportation infrastructure or lack public transportation systems.[12]

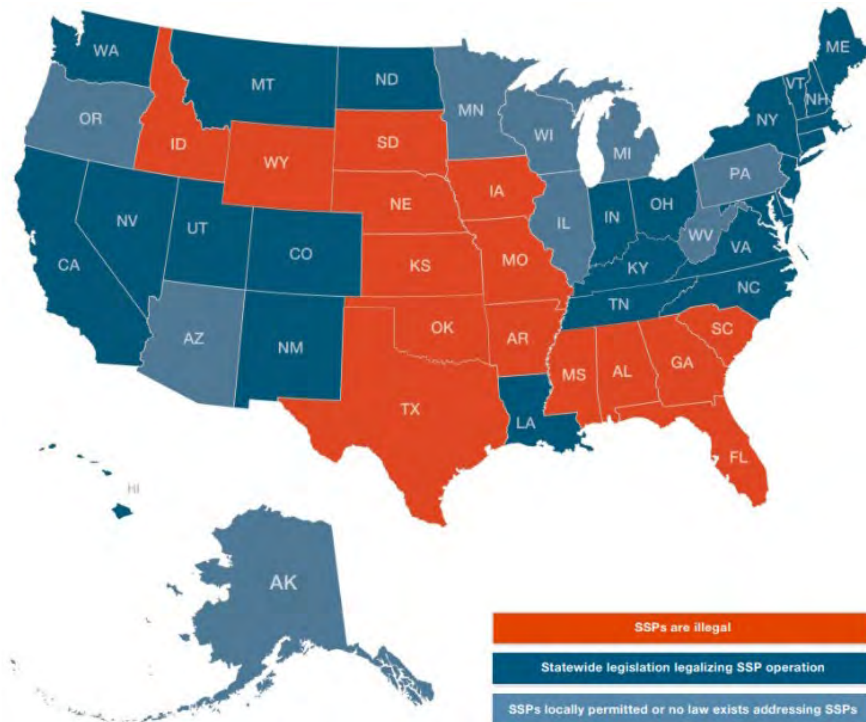

Figure 2: *Syringe Services Programs and the Opioid Epidemic, 2017.* Source: https://www.amfar.org/ssp-opioid-epidemic/

A systematic review of HIV care for people in rural areas noted that, nine of the 11 studies examined found transportation to be a significant, and perhaps the most problematic, barrier to people keeping their medical appointments and receiving HIV-related care.[12]

Lack of local health care providers and lack of transportation services to larger communities can make it difficult for rural residents to find out they are HIV positive, maintain pre-exposure prophylaxis (PrEP)[ii] regimens, engage in regular HIV care, and adhere to antiretroviral therapies (ART)[iii] as part of a comprehensive approach to HIV treatment.[12] Telemedicine offers promise for addressing the lack of providers and transportation issues in rural areas. Telemedicine can connect rural clinics to HIV specialty physicians in urban areas to rural clinics without the patient having to travel a great distance. The Committee has heard that clinics are beginning to use this HIV care delivery model and programs aimed at addressing provider and patient acceptance. On the other hand, billing for telemedicine presents some restrictions for site locations, and lack of high-speed internet is a significant obstacle to the use of telemedicine in some rural areas.

Another barrier to accessing HIV-related health care services in rural areas is the cost of care. Because residents of rural communities frequently struggle with persistent poverty, rural individuals may require financial assistance for treatment and medications, particularly if they are uninsured or do not qualify for Medicaid.[12] A study of rural women with HIV, for example, found that 17 percent of participants viewed affordability as "sometimes" or "always" a barrier to care and 15 percent reported that lack of insurance was "sometimes" or "always" a barrier to care.[13]

[ii] HHS defines PrEP as an HIV prevention method in which people who do not have HIV take medicine daily to reduce their risk of contracting the virus if they are exposed. When used correctly, PrEP is more than 90 percent effective. Patients must meet with their provider every 3 months for repeat STI testing, prescription refills, and follow up.

[iii] According to NIH, ART is the use of daily HIV medicines to treat HIV infection. ART cannot cure HIV, but HIV medicines help people with HIV live longer, healthier lives. ART also reduces the risk of HIV transmission.

Furthermore, because rural areas have a lower population density, and consequently a lower density of HIV-positive individuals, HIV programs in rural areas have a higher operating cost per person compared to programs in urban areas.[12] The higher operating cost per person feeds into the lack of availability of HIV-related health services and affordability concerns for both rural providers and residents. For people with HIV who lack insurance and needed financial resources, the Ryan White HIV/AIDS Program (RWHAP)[iv] serves as a safety net to help manage their HIV treatment. Most program funds for critical medical and support services are targeted toward eligible areas reporting 500 to 999 cumulative HIV cases in the most recent 5 years. However, because of the lower population density, rural counties often do not reach this threshold even with high case rates.[4] Research has found that 31 percent of urban counties had at least one RWHAP provider compared with 5 percent of rural counties, even after controlling for HIV prevalence rates.[14]

HIV-related stigma, negative beliefs, feelings, and attitudes towards people living with HIV, groups associated with people living with HIV, and other key populations at higher risk of HIV infection, is another obstacle that inhibits people in rural areas from accessing HIV-related health services and contributes to the social isolation of people with HIV in rural communities.[11,15] Rural communities are often made up of small, close-knit social networks, which can make it difficult for individuals to privately seek HIV-related care. People may be concerned that their neighbors or co-workers may see them accessing HIV-related services.[6] Stigma may make people less willing to engage in HIV testing, PrEP, and HIV treatment.[6] Stigma can be especially problematic for vulnerable populations in rural areas that are disproportionately affected by HIV, particularly LGBTQ+ people, and people who inject drugs.[6]

During the Committee's site visit to Health Services Center, Inc. in Alabama (see **Appendix A**), leaders of HIV services organizations across the state identified stigma as a significant problem. Most of the organizations represented had removed "*HIV*" or "*AIDS*" from their organization's or program names in order to reduce the impact of stigma and increase utilization of their services. One organization even noted how they worked with a local Critical Access hospital to create a destigmatized HIV treatment program, but no patients attended out of fear.

HIV stigma is also present in the health care system. People with HIV have experienced health care provider-related stigma and discrimination, which pose significant barriers to medical care. One study focused in the rural Southeast found that 11 percent of the sample had been turned away from a physician in the previous year, which not only leads to patients not being accepted into care but also increases the possibility that these individuals will not be inclined to return to care.[16] Other research has shown that patients were hesitant to talk openly with medical providers because of perceptions that the providers were uncomfortable with their sexual orientation and sexual behaviors.[17] This lack of trust in the patient-provider relationship can negatively affect patient engagement and retention in care.

In addition to having negative biases toward people with HIV, medical staff may not be equipped to address HIV prevention and treatment needs. According to the CDC, as of 2015 one in three primary care physicians and nurses across the country have not heard of PrEP, which may have been stifling HIV prevention efforts.[18] Beyond PrEP, research demonstrates that rural medical staff often are inadequately trained in providing comprehensive HIV care, especially in the context of a patient having multiple chronic conditions. Further, clinicians may defer starting antiretroviral therapies for people with HIV who also inject drugs. The widespread substance use disorder crisis has made treating HIV among people who also

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[iv] See the Federal Programs section for more information about the Ryan White Program

use drugs even more complicated. Providers also may be less confident in identifying and treating depression, substance use disorder, and chronic non-malignant pain in HIV patients.[4] Exacerbating these difficulties, rural medical staff often lack knowledge about federal and state resources available to assist people with HIV.[19,20]

HIV-related stigma extends to the policy and legal environments as well. In 1990, the Ryan White Comprehensive AIDS Resources and Emergency Act, which provided funding to assist vulnerable communities in accessing HIV treatment services, required states to certify that they had adequate criminal laws in place to prosecute individuals who knowingly exposed another person to HIV.[21] This requirement was excluded from the Act's reauthorization of 2000. Despite the removal, more than half of the states[v] currently have one or more HIV-specific criminal laws and the remaining states have, historically, used other laws to criminalize HIV and meet the requirements set forth by the Ryan White Act.[21] Most HIV-specific criminal laws require people with HIV to disclose their status before engaging in sexual penetration, sharing injection drug paraphernalia, and/or donating blood.[22] A majority of these HIV-specific laws criminalize non-disclosure, regardless of intent to transmit HIV or whether HIV is transmitted or not, and some states such as Georgia[vi] punish people with HIV for behaviors that are virtually impossible for transmitting the virus such as spitting or biting.[22]

A number of research studies that have shown HIV criminalization laws to be ineffective and have found no associations between these laws and safer sex practices such as abstinence, decreased number of sexual partners, condom use, or HIV status disclosure.[23, 24, 25, 26, 27] Legal and public health researchers generally oppose HIV criminalization laws because they may increase HIV-related stigma and discrimination, and because the laws do not take into account the development of transmission reducing treatments such as PrEP, sexual partner PrEP usage, and antiretroviral therapies.[22] More rural-specific research is needed in the area of HIV criminalization.

FEDERAL PROGRAMS

The U.S. Department of Health and Human Services (HHS) administers programs that support and enhance HIV prevention and treatment efforts in rural areas. Several agencies work to address the HIV epidemic through grant distribution, service delivery, capacity building, and program evaluation. While there may be other agencies and programs within HHS that address HIV prevention and treatment, this brief will cover the ones that the Committee identified as key: the National Institutes of Health (NIH), the Health Resources and Services Administration (HRSA), the Substance Abuse and Mental Health Services Administration (SAMHSA), the Centers for Disease Control and Prevention (CDC), the Centers for Medicare and Medicaid Services (CMS), and the Indian Health Service (IHS).

HHS – Ending the HIV Epidemic: A Plan for America[vii]

The Department of Health and Human Services began a 10-year initiative in FY 2020 with the goal of reducing new HIV infections to less than 3,000 per year by 2030. According to the National Plan to End HIV, reducing new infections to this level would essentially mean that HIV transmissions would be rare and meet the definition of ending the epidemic. The initiative[viii] will focus efforts in 48 counties,

[v] Click this link to see which states have criminal laws for HIV
[vi] Visit this link to learn more about HIV-specific criminal laws in Georgia
[vii] Click here to learn more about the goals and strategies for the Ending the HIV Epidemic Initiative
[viii] Click here to view the list of counties, territories, and states that will have an added focus during the initiative

Washington, DC, San Juan (PR), where >50 percent of HIV diagnoses occurred in 2016 and 2017, and an additional seven states (Alabama, Arkansas, Kentucky, Mississippi, Missouri, Oklahoma, and South Carolina) with a substantial number of HIV diagnoses in rural areas (see **Figure 3**). There are four key strategies in the initiative to end the HIV epidemic in the United States:

1. ***Diagnose** all people with HIV as early as possible after transmission.*
   Approximately 161,800 Americans are with HIV but do not know they have it.[2] Early detection is critical and can lead to quicker results in treatment and prevent transmission to others. Using the latest diagnostics and advanced automation systems, we will make HIV testing simple, accessible, and routine we will connect people with HIV immediately to care.

2. ***Treat** HIV rapidly and effectively to achieve sustained viral suppression.*
   People with HIV who take medication as prescribed and stay virally suppressed can live long, healthy lives and have effectively no risk of sexually transmitting HIV to a partner. Eighty percent of annual new infections are transmitted by those with HIV who are not receiving HIV care and treatment. We will establish and expand programs to follow up with people with HIV no longer receiving care—and provide the resources needed to re-engage them in effective HIV care and treatment. The Ryan White HIV/AIDS Program has achieved a viral suppression rate of nearly 86 percent. We aim to leverage the program's comprehensive system of care and treatment to increase viral suppression around the country to 90 percent.

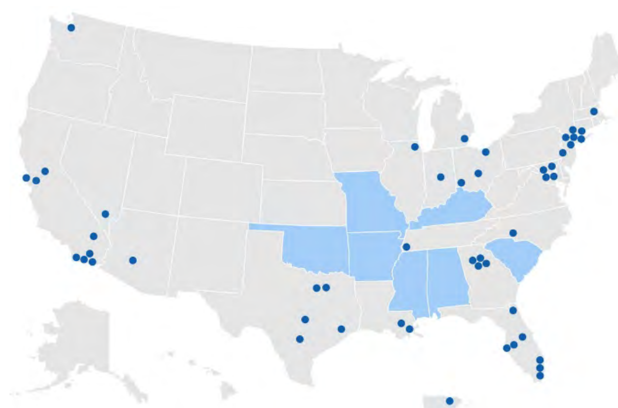

Figure 2: Geographic Hotspots - The 48 counties, plus Washington, DC, and San Juan, PR, where >50 percent of HIV diagnoses occurred in 2016 and 2017, and an additional seven states with a substantial number of HIV diagnoses in rural areas. Source: https://www.hiv.gov/

3. ***Prevent** HIV transmission among people at highest risk with Pre-Exposure Prophylaxis (PrEP) and prevention education.*
   Of the estimated 1 million Americans at substantial risk for HIV, and who could benefit from PrEP, less than 1 in 4 are actually using this medication. In May 2019, HHS and Gilead Sciences announced that the pharmaceutical company has agreed to donate PrEP medication for up to 200,000 individuals each year for up to 11 years. In December 2019, HHS launched Ready, Set, PrEP, a nationwide program that provides PrEP medications at no cost to thousands of individuals who qualify. In addition, SSPs are an effective component of a comprehensive, integrated approach to HIV prevention among people who inject drugs. Nearly 30 years of research has shown that comprehensive SSPs are safe, effective, cost-saving, do not increase illegal drug use or crime, and play an important role in reducing the transmission of viral hepatitis, HIV, and other infections.

4. ***Respond** rapidly to detect and respond to HIV clusters and prevent new HIV infections.*
   New laboratory methods and epidemiological techniques allow us to see where HIV may be spreading most rapidly, thereby allowing CDC and other partners to quickly develop and

implement strategies to stop ongoing transmission. We will work with impacted communities to ensure they have the technology, personnel, and prevention resources to follow up on all HIV cases and to intervene to stop chains of transmission, and to get those impacted into appropriate care and treatment.

Centers for Disease Control and Prevention[ix]

CDC provides clinicians with tools and guidelines, continuing education resources, and patient materials on HIV screening, prevention, treatment and care. CDC's largest single investment in HIV surveillance and prevention efforts are led by health departments in states, territories, and select cities. Health departments use this funding to implement high-impact HIV prevention activities that take full advantage of recent advances in surveillance data collection and HIV prevention and maximize the impact of every federal dollar. For its role in the national Ending the HIV Epidemic Initiative, the CDC will work with communities and other agencies to:

- Use the latest systems and technology to make HIV testing simple, accessible, and truly routine in healthcare and non-healthcare settings.
- Carry out focused approaches that encourage more people who are at substantial risk for HIV to be tested for HIV at least annually.
- Further collaboration to identify and implement innovative technologies and programs, such as self-testing, to make testing more accessible.
- Help partners expand local programs that identify and follow up with people who have stopped receiving HIV care and treatment. Data-to-Care tools and approaches will encourage them to get back in HIV care and treatment.
- Continue updating clinical guidelines for prescribing PrEP, and add more public and private providers who offer PrEP to its PrEP Locator.
- Continue providing education campaigns for both the public and healthcare providers to combat stigma associated with PrEP use, as well as the stigma associated with HIV.
- Assess and address gaps in staffing, expertise, and data management systems that prevent states and local areas from being able to fully investigate and respond to increases in HIV transmission and outbreaks.

HRSA's HIV/AIDS Bureau (HAB) – Ryan White HIV/AIDS Program[x]

The program provides a comprehensive system of HIV primary medical care (includes HIV medical services; also mental health, substance abuse, nutrition and oral health, medical case management, etc.), essential support services, and medications for low-income people with HIV who are uninsured and underserved. The Program funds grants to states, cities/counties, and local community-based organizations to provide care and treatment services to people with HIV to improve health outcomes and reduce HIV transmission among hard-to-reach populations.

- **Part A:** funds medical and support services to Eligible Metropolitan Areas (EMAs) and Transitional Grant Areas (TGAs). EMAs and TGAs are counties/cities that are the most severely affected by the HIV epidemic.

[ix] Visit this link to learn more about the CDC's HIV programs

[x] Visit this link to learn more about the Ryan White HIV/AIDS Program

- **Part B:** administers funds for states and territories to improve the quality, availability, and organization of HIV health care and support services. In addition, Part B also includes grants for the AIDS Drug Assistance Program (ADAP).
- **Part C:** administers funds for local community-based organizations to provide comprehensive primary health care and support services in an outpatient setting for people with HIV through Early Intervention Services program grants. Part C also funds Capacity Development grants to strengthen organizational infrastructure and increase access to high quality HIV primary health care services.
- **Part D:** administers funds for local, community-based organizations to provide outpatient, ambulatory, family-centered primary and specialty medical care for women, infants, children and youth with HIV. Part D funding may also be used to provide support services to people with HIV and their affected family members.
- **Part F:** funds support clinician training, technical assistance, and the development of innovative models of care to improve health outcomes and reduce HIV transmission. These programs include the Special Projects of National Significance Program, the AIDS Education and Training Centers Program, the Dental Programs, and the Minority AIDS Initiative.

HRSA's Bureau of Primary Health Care (BPHC) – Primary Care HIV Prevention (PCHP)[xi]

Fiscal year (FY) 2020 Ending the HIV Epidemic—Primary Care HIV Prevention (PCHP) funding will supplement identified health centers' current Health Center Program operational grant (H80) award. Health centers will use PCHP funding to expand HIV prevention services that decrease the risk of HIV transmission in geographic locations (PDF - 76 KB) identified by Ending the HIV Epidemic: A Plan for America, focusing on supporting access to and use of pre-exposure prophylaxis (PrEP). HRSA identified eligible health centers based on service delivery site location, and either existing Ryan White HIV/AIDS Program (RWHAP) funding or proximity to a RWHAP-funded organization. The objectives of the funding program is to increase outreach, HIV testing, partnerships, and personnel. Nearly 10 percent of the grant recipients are primary care providers in rural areas; however, with other awardees likely having service sites in rural areas, the rural footprint it presumably larger than just the direct awardees.

HRSA's Federal Office of Rural Health Policy (FORHP) – Rural Health Network Development Program[xii]

The purpose of this program is to support integrated rural health care networks that have combined the functions of the entities participating in the network, including skilled and experienced staff and a high functioning network board, in order to address the health care needs of the targeted rural community. Recipients will combine the functions of the entities participating in the network to address the following legislative aims: (i) achieve efficiencies; (ii) expand access, coordinate, and improve the quality of essential health care services; and (iii) strengthen the rural health care system as a whole. The RHND Program encourages innovative solutions to local health care needs identified by local communities and supports rural communities in preparing for changes within the health care environment. Furthermore, the program creates an opportunity for rural health networks to collaboratively address the key priorities of HHS: mental health, substance use disorder, and value-based care.

[xi] Click here to learn more about the Primary Healthcare Prevention Funding

[xii] Click here to learn more about the Rural Health Network Development Program

HRSA's National Health Service Corps (NHSC)[xiii]

Since 1972, the National Health Service Corps has been in place to strengthen and develop the primary care workforce. NHSC awards scholarships and loan repayment to primary care providers in eligible disciplines. Since the NHSC began, more than 50,000 primary care medical, dental, and mental and behavioral health professionals have served. By addressing the primary care shortage, the NHSC ensures access to healthcare for everyone (regardless of their ability to pay), prevents disease and illness, and cares for the most vulnerable people who may otherwise go without it.

NIH – Research for the National Plan to End HIV[xiv]

The NIH will make awards of up to $500,000 for research on effective approaches to screen and treat substance use or mental health disorders in the Health Resources and Services Administration's Ryan White HIV/AIDS Program. Research sites should be located within the National Ending the HIV Epidemic Plan, including the top 48 counties; Washington, DC; San Juan, Puerto Rico; and the 7 states with a disproportionate occurrence of HIV in rural areas.

SAMHSA – Substance Abuse & HIV Prevention Navigator Program for Racial/Ethnic Minorities[xv]

SAMHSA will make 82 awards from a total investment of $16.5 million for a five-year program providing services to racial/ethnic minorities at highest risk for HIV and substance use disorders. SAMHSA will also conduct outreach to vulnerable populations so they know what PrEP is and how to access it. Eligible applicants are community-based domestic public and private nonprofit entities, federally recognized American Indian/Alaska Native Tribes, and other Tribal organizations.

Division for At-Risk Individuals, Behavioral Health, and Community Resilience (ABC)[xvi]

The Division for At-Risk Individuals, Behavioral Health & Community Resilience (ABC) provides policy leadership, subject matter expertise, and coordination to internal and external partners to ensure that the access and functional needs of at-risk individuals, behavioral health, and community resilience are integrated in the public health and medical emergency preparedness, response, and recovery activities of the nation.

IHS – National HIV/AIDS Program[xvii]

The program coordinates and promotes HIV/AIDS prevention and treatment activities specific to Indians as part of a comprehensive public health approach. In addition to providing medical care to eligible beneficiaries, the IHS also serves as a public health system. The goals of the HIV/AIDS Program are to prevent further spread of HIV and improve health outcomes for those already with HIV and AIDS. Some of the manners in which these goals are supported include developing HIV prevention and care standards and performance measures, increasing routine HIV testing, increasing access to care, improving health outcomes for people with HIV/AIDS, and providing technical assistance to Native Tribes.

[xiii] Visit the link to learn more about the National Health Service Corps
[xiv] Click here to learn more about research awards the NIH has coordinated as part of the National Plan to End HIV
[xv] Visit this link to learn more about SAMHSA grants for the Prevention Navigator Program
[xvi] Visit this link to learn more about the ABC Division
[xvii] Visit this link to learn more about IHS' National HIV/AIDS Program

POLICY RECOMMENDATIONS & CONSIDERATIONS

There are a broad range of challenges in the provision of HIV services in rural communities as well as in prevention and screening. Some of these challenges include stigma, transportation issues, costs, and workforce shortages. Rural providers have noted that they simply do not have enough time to manage grant applications and management responsibilities in addition to providing clinical care. The Committee acknowledges that comprehensive social, behavioral, and biomedical approaches are necessary to address these intersecting barriers that limit rural patients from accessing and engaging in the full continuum of HIV care, including prevention and treatment. In an attempt to address these barriers and to ultimately reduce rural HIV disparities and end the epidemic, the Committee presents its recommendations. The focus of the recommendations is on enhancing federal funding to increase and improve capacity building for rural HIV services (including telehealth and PrEP) in addition to providing more technical assistance for community-based organizations around grant writing.

These recommendations were informed by subject matter experts and stakeholders during the Committee's March 2020 meeting in Atlanta and the subcommittee's site visit to Health Services Center in Anniston, Alabama (see **Appendix A**). During those presentations, the subcommittee heard stakeholders speak to a need for better infrastructure for HIV prevention services, additional attention to the importance of social and behavioral services, and common barriers that come up in their work. The subcommittee also heard about successful efforts regarding HIV prevention and treatment in rural areas.

Recommendation 1: The Committee recommends the Secretary, in modernizing the Ryan White HIV/AIDS Treatment Extension Act of 2009, focus on enhancing the ability of the program to meet the needs of rural communities. This includes:

- Increased rural-targeted funding to support pilot programs and capacity building and, when issuing Notices of Funding Opportunities, consider having rural as a funding factor and giving rural applicants in a designated Health Professional Shortage Area additional consideration using Preferences.
- Expansion of the use of telehealth and telemedicine to increase access to services and reduce stigma in rural populations.

Recommendation 2: The Committee recommends the Secretary, in maximizing the scientific advances made in HIV prevention, to increase access to Pre-Exposure Prophylaxis (PrEP) for rural residents through the existing statutory authority in Sections 330 and 330A of the Public Health Service Act (HRSA's Community Health Centers Program and the Rural Health Care Services Outreach Program, respectively).

Recommendation 3: The Committee recommends the Secretary support a 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.

In addition to the policy recommendations listed above, the Committee also sets forth a number of policy considerations to address rural HIV disparities and improve rural HIV prevention and treatment efforts. Policy considerations consist of actions the committee thinks should be taken that may involve

work across multiple departments or be outside of the jurisdiction for HHS. The considerations are also informed by the subject matter experts and site visit stakeholders that the committee heard from.

Consideration 1: The Committee believes HHS 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 lack of harm reduction efforts (e.g., 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 such laws are more likely to be enforced in rural communities.

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 profession students in rural areas, it is not clear that those clinical opportunities include the chance to treat people with HIV. The Committee encourages HRSA to expand the number of rural HIV training experiences so that future doctors, nurses, dentists and behavioral health providers will have been exposed to caring for this population. That familiarity could lead to increased numbers of these students choosing to practice in rural areas and in providing clinical services to those with HIV. The AIDS Education and Training Center Program's (AETC) National HIV Curriculum can play a role in educating future rural providers.

Consideration 5: Address stigma, especially as it pertains to LGBTQ people and people who inject drugs, in relation to provider attitudes/bias/cultural competency issues that serve as barriers to people with HIV being linked to and retained in HIV care. The Committee notes that HHS should 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.

Consideration 6: HHS could play a key role in better understanding how to help CHW initiatives achieve sustainability. The Committee is aware of calls to develop broader credentialing and uniform training of CHWs.

Consideration 7: The Committee notes that Medicaid is a primary coverage mechanism for many people with HIV, particularly in the Southeast. 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 Medicaid patients with HIV.

Consideration 8: The Committee also heard from speakers and stakeholders that one of the most challenging issues they face in providing HIV services is the lack of transportation. While this issue is beyond HHS' jurisdiction, the Committee believes HHS should work more closely with its Federal partners to address these concerns.

CONCLUSION

The United States has grappled with the HIV epidemic for several decades, and HIV-related programs and health care costs the country billions of dollars every year.[xviii] There have been notable increases in new HIV infections in rural communities, with the opioid crisis being one of many drivers behind this. According to HHS, 1 in 10 new HIV infections occur among people who inject drugs. In addition to people who inject drugs, other communities disproportionately affected by HIV in rural areas include racial minorities, members of Tribal communities, and LGBTQ+ people. Barriers such as transportation challenges, lack of broadband, persistent poverty, workforce shortages, and stigma have made HIV prevention and treatment work in rural areas more difficult. Given the scale and scope of this issue, through its policy recommendations and considerations, the Committee emphasizes the importance of focusing on comprehensive, multifaceted solutions to address rural HIV disparities, continue reducing the disease burden nationally, and ultimately end the epidemic.

[xviii] Overview of costs for U.S. government investment in domestic HIV response, noting an increase to more than $28 billion per year.

APPENDIX A – SITE VISIT PROFILE

Established in December 1990, Health Services Center (HSC) Inc. is a 501 c3 registered non-profit, Community Based Organization (CBO), and medical clinic providing HIV medical care, education and support to a 14 county area of East Alabama. The organization is a recipient of funding from the HIV/AIDS Bureau's "Ryan White Program." HSC's mission is the provision of quality, comprehensive HIV services to all HIV infected and affected persons in their service area. HSC provides comprehensive HIV health care across East Alabama with services including free HIV testing and counseling; HIV-specific medical care; HIV medication assistance; housing assistance for persons with HIV; mental health care for PLWH; substance abuse treatment for HIV positive and negative individuals; case management services; education, outreach and prevention programs; and convenient medical transportation services.

HIV Disparities in Rural Alabama

Compared to their urban counterparts, rural communities in Alabama have been disproportionately affected by the burden of new HIV cases affecting the state. Alabama is one of the 7 states identified by the "Ending the HIV Epidemic" initiative with a substantial number of HIV diagnoses in rural areas. At the end of last year, the Alabama Department of Public Health (ADPH) released HIV reports for the period of January 1 through September 30, 2019, noting that there were 390 confirmed new HIV diagnoses across the state. Assessments of the ADPH data revealed that 48 isolated counties in Alabama needed additional focus for containing HIV infection. Some of the most pressing challenges contributing to the high rates of HIV in Alabama include severe poverty and health provider shortages. According to Medical Advocacy and Outreach, 46 of Alabama's 67 counties have poverty rates higher than the national average. Sixty-two of Alabama's 67 counties are either partially or whole Health Professional Shortage Areas.

One of the ways that HSC engages in HIV prevention and educations among the rural communities that it serves is through their drop in center, which has recently been moved to the main office. The goal of the drop in center is to provide no cost testing and education prevention services to the residents of Northeast Alabama, especially people of color. There is an additional focus on young adult women of color (19 to 24 years) and their partners, who may be at higher risk for substance abuse and HIV infection.

Furthermore, HSC provides high quality specialized HIV health care services throughout their 14-county service area, regardless of ability to pay. Services are provided by three board certified infectious disease physicians and two experienced nurse practitioners across their primary site and four satellite locations. A contract psychiatrist and one or more mental health counselors attend each clinic to provide comprehensive mental health services. An annual oral health examination and referral to a local dental provider is made for all patients. Medication access, nutritional support services, and substance abuse treatment services are available as needed. Support is also provided for patients requiring housing assistance.

Given the increased rate of new HIV infections in rural areas, organizations providing comprehensive HIV health care services to rural communities is needed now more than ever. The Committee commends the work of HSC and all the health departments and HIV services organizations that they heard from during the site visit. Their insight was crucial for the development of policy recommendations and considerations.

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