Ryan White HIV/AIDS Treatment Extension Act of 2009

The Ryan White Program works with cities, states, and local community-based organization to provide HIV-related services to more than half a million people each year. The program is for those who do not have sufficient health care coverage or financial resources for coping with HIV disease. Ryan White fills gaps in care not covered by these other sources.

Ryan White is administered by the U.S. Department of Health and Human Services (HHS), Health Resources and Services Administration (HRSA), HIV/AIDS Bureau (HAB). Federal funds are awarded to agencies located around the country, which in turn deliver care to eligible individuals under funding categories called Parts, as outlined below. First authorized in 1990, the Ryan White HIV/AIDS Program is currently funded at $2.1 billion.

The majority of Ryan White funds support primary medical care and essential support services. A smaller but equally critical portion funds technical assistance, clinical training, and research on innovative models of care.

The Ryan White legislation created a number of programs, called Parts, to meet needs for different communities and populations affected by HIV/AIDS. Each is described below.

Part A	Part A provides grants Eligible Metropolitan Areas and Transitional Grant Areas.
Part B	Part B provides grants to States and Territories.
Part C	Part C provides grants directly to service providers. Part C also funds planning grants and capacity building grants.
Part D	Part D provides family-centered comprehensive care to children, youth, women, and their families.
Part F	The Special Projects of National Significance (SPNS) Program supports the demonstration and evaluation of innovative models of HIV/AIDS care delivery for hard-to-reach populations. SPNS also funds special programs to support the development of standard electronic client information data systems.
Part F	The AIDS Education and Training Centers (AETC) Program supports education and training of health care providers through a network of 11 regional and 4 national centers.
Part F	Dental Programs consists of two programs. 1) The Dental Reimbursement Program provides reimbursements to dental schools, hospitals with postdoctoral dental education programs, and community colleges with dental hygiene programs for uncompensated costs incurred in providing oral health treatment to patients with HIV disease. 2) The Community-based Dental Partnership Program provides support to increase access to oral health care services for HIV-positive individuals while providing education and clinical training for dental care providers, especially those located in community-based settings.
Part F	Minority AIDS Initiative grants provide funding to evaluate and address the disproportionate impact of HIV/AIDS on women and minorities.

Part A

Part A of the Ryan White HIV/AIDS Treatment Extension Act of 2009 provides emergency assistance to Eligible Metropolitan Areas (EMAs) and Transitional Grant Areas (TGAs) that are most severely affected by the HIV/AIDS epidemic.

ELIGIBILITY

To be an eligible EMA, an area must have reported at least 2,000 AIDS cases in the most recent 5 years and have a population of at least 50,000. In order to be eligible for a TGA, an area must have reported at least 1,000 - 1,999 new AIDS cases in the most recent five years. When the first Part A grants were awarded in FY 1991, there were 16 EMAs. Today, 24 EMAs and 31 TGAs receive funding.

FUNDING

In FY 2010, $652,551,753 was appropriated for Part A spending. Part A funding to EMAs/TGAs includes formula and supplemental components, as well as Minority AIDS Initiative funds targeted for services to minority populations.

- Formula grants are based on reported living HIV/AIDS cases as of December 31 for the most recent calendar year that data is available.
- Supplemental grants are awarded competitively based on demonstrated need and other criteria.
- Minority AIDS Initiative funding is formula-based targeting minority HIV non-AIDS and AIDS cases.

SERVICES

Part A funds may be used to provide a continuum of care for persons living with HIV disease with a requirement to provide 75 percent of the award for core medical services and 25 percent for support services. Core services are limited to: outpatient and ambulatory services; AIDS pharmaceutical assistance; oral health; early intervention services; health insurance premium and cost sharing assistance for low-income individuals; home health care; medical nutrition therapy; hospice services; home and community-based health services; mental health services; substance abuse outpatient care; and medical case management, including treatment adherence services.

Support services must be linked to medical outcomes and may include: outreach; medical transportation, linguistic services; respite care for person caring for individuals with HIV/AIDS; referrals for health care and other support services; case management; and substance abuse residential services.

GRANTEES

EMAs/TGAs range in size from one city/county to more than 26 different political entities, and some span more than one State. EMA/TGAs geographic boundaries are based on the U.S. Census. Grants are awarded to the chief elected official (CEO) of the city or county that provides health care services to the greatest number of people living with AIDS in the EMA.

Ryan White Program EMAs

Atlanta, Georgia
Baltimore, Maryland
Boston, Massachusetts
Chicago, Illinois
Dallas, Texas
Detroit, Michigan
Ft. Lauderdale, Florida
Houston, Texas

Ryan White Program TGAs

Baton Rouge, Louisiana
Bergen-Passaic, New Jersey
Caguas, Puerto Rico
Charlotte-Gastonia, North Carolina/South Carolina
Cleveland-Lorain-Elyria, Ohio
Denver, Colorado
Dutchess Co., New York

Los Angeles, California
Miami, Florida
Nassau-Suffolk, New York
New Haven, Connecticut
New Orleans, Louisiana
New York, New York
Newark, New Jersey
Orlando, Florida
Philadelphia, Pennsylvania
Phoenix, Arizona
San Diego, California
San Francisco, California
San Juan, Puerto Rico
Tampa-St. Petersburg, Florida
Washington, DC
West Palm Beach, Florida
Ft. Worth, Texas
Hartford, Connecticut
Indianapolis, Indiana
Jacksonville, Florida
Jersey City, New Jersey
Kansas City, Missouri
Las Vegas, Nevada
Memphis, Tennessee
Middlesex-Somerset-Hunterdon, New Jersey
Minneapolis-St. Paul, Minnesota
Nashville, Tennessee
Norfolk, Virginia
Oakland, California
Orange County, California
Ponce, Puerto Rico
Portland, Oregon
Riverside-San Bernardino, California
Sacramento, California
St. Louis, Missouri
San Antonio, Texas
San Jose, California
Santa Rosa-Petaluma, California
Seattle, Washington
Vineland-Millville-Bridgeton, New Jersey

PART A HIV HEALTH SERVICES PLANNING COUNCILS

Planning Council duties include setting priorities and allocating funds for services on the basis of the size and demographics of the HIV population and the needs of the population. Particular attention is given to those who know their HIV status but are not in care. Planning Councils are required to develop a comprehensive plan for the provision of services that includes strategies for identifying HIV-positive persons not in care and strategies for coordinating services to be funded with existing prevention and substance abuse treatment services.

Planning Council membership must reflect the local epidemic and include members who have specific expertise, such as health care planning, housing for the homeless, incarcerated populations, substance abuse and mental health treatment, or who represent other Ryan White CARE Act and Federal programs. At least 33 percent of the members must be people living with HIV who are consumers of CARE Act services. TGAs are required to use a community planning process, however Planning Councils are optional for the five new TGAs that were formed in 2007.

Part B

Part B of the Ryan White HIV/AIDS Treatment Extension Act of 2009 provides grants to all 50 States, the District of Columbia, Puerto Rico, Guam, the U.S. Virgin Islands, and five U.S. Pacific Territories or Associated Jurisdictions. Part B grants include a base grant, the AIDS Drug Assistance Program (ADAP) award, ADAP Supplemental grants and grants to States for Emerging Communities-those reporting between 500 and 999 cumulative reported AIDS cases over the most recent 5 years. All funding is distributed via formula and other criteria.

FUNDING

At least 75% of Part B funds must be used to fund core medical services which include: outpatient and ambulatory health services, ADAP, AIDS pharmaceutical assistance, oral health care, early intervention services, health insurance premium and cost sharing assistance, home health care, medical nutrition therapy, hospice care, community-based health services, substance abuse outpatient care, and medical case management services.

Up to 25% may be used to fund support services that are needed for individuals with HIV/AIDS to achieve their medical outcomes (such as respite care for persons caring for persons caring for individuals with HIV/AIDS, outreach services, medical transportation, linguistic services, and referrals for health care and support services.

In FY2010, $1,144,681,800 was appropriated for Part B programs, including the portion earmarked for ADAP.

- Base Part B grants are awarded to States and Territories using a formula based on living cases of HIV/AIDS reported. Also states with more than 1% of total AIDS cases reported in the United States during the previous 2 years must provide matching funds with their own resources using a formula outlined in the legislation.
- Additional Part B funds are "earmarked" for ADAP, which primarily provide medications. Fundable services also include treatment adherence and support as well as health insurance coverage with prescription drug benefits. 5% of the ADAP earmark is reserved for grants to States and Territories that have a severe need for medication assistance.
- Supplemental competitive programs are available to States and Territories based on demonstrated need criteria. This program has not been funded to date.
- Part B provides $5.0 million in supplemental grants to States for Emerging Communities-cities with between 500 and 999 reported AIDS cases in the most recent 5 years.
- Part B provides a competitive grant of $7 million for the Minority AIDS Initiative to provide education and outreach services to increase the number of eligible racial and ethnic minorities who have access to treatment through Part B.

PROVIDERS

Part B providers may include public or nonprofit entities. For-profit entities are eligible only if they are the sole available providers of quality HIV care in the area.

Most States provide some services directly, but others work through subcontracts with Part B HIV Care Consortia. A consortium is an association of public and nonprofit health care and support service providers and community-based organizations that plans, develops, and delivers services for people living with HIV disease. Services provided through a consortium are considered support services.

AIDS DRUG ASSISTANCE PROGRAM (ADAP)
The ADAP provides medications for the treatment of HIV disease. Program funds may also be used to purchase health insurance for eligible clients and for services that enhance access to, adherence to, and monitoring of drug treatments.

Funding

- Grants are awarded to all 50 States, the District of Columbia, Puerto Rico, Guam, the U.S. Virgin Islands, and the Pacific jurisdictions
- Congress "earmarks" funds that must be used for the ADAP, an important distinction because other Part B spending decisions are made locally. The ADAP earmark grew from $52 million in 1996 to $789,005 million in 2006 and $789,546 million in 2007. In FY08 the appropriation is $808,500 million. However, total ADAP spending is even higher, because State ADAPs also receive money from their respective States, from other Ryan White HIV/AIDS Program components, and through cost-saving strategies.
- A formula based on the most recent calendar year of living HIV/AIDS cases is used to award ADAP funds to States and Territories. However, 5% of the total earmark is reserved for supplemental grants to States and Territories with demonstrated severe need that prevents them from providing medications consistent with Public Health Service guidelines. In previous years, estimated living cases of AIDS was used in determining the formula and 3% was reserved for supplemental grants.

Implementation
The ADAP in each State and Territory is unique in that it decides which medications will be included in its formulary and how those medications will be distributed. New legislation requires that each State/Territory establish of a list of drug classes under which ADAPs must provide therapeutics.

- Many States and Territories provide medications through a pharmacy reimbursement model. Patients show enrollment cards at participating pharmacies to receive their medications, and the pharmacy invoices the ADAP for payment.
- Some ADAPs use pharmacies located within public health clinics to distribute drugs.
- A few ADAPs purchase drugs and mail them to clients directly.

Eligibility
Each State and Territory establishes its own eligibility criteria. However, all States/Territories are required to implement an ADAP recertification process every six months to ensure only eligible clients are served. All require that program participants document their HIV status.

Increasing Demand
Pressure on ADAP resources has increased substantially.

- Highly active antiretroviral therapy (HAART) is the standard of care for the majority of people living with HIV disease. Its cost may be $12,000 or more per year, in addition to the costs of addressing opportunistic infections, side effects, and other treatment issues.
- AIDS mortality has decreased dramatically in the United States since 1995, and HIV incidence remains constant at approximately 40,000 new infections annually. Therefore, the total number of people living with HIV disease continues to climb.

The epidemic is growing rapidly among minorities, who have historically experienced higher risk for poverty, lack of health insurance, comorbidity, and disenfranchisement from the health care system. The result is a growing number of people living with HIV disease who require public support.

Part C: Early Intervention Services

Part C Early Intervention Services of the Ryan White HIV/AIDS Treatment Modernization Act of 2006 funds comprehensive primary health care in an outpatient setting for people living with HIV disease.

ELIGIBILITY
The following organizations may receive Part C grants:

- Community Health Centers, Migrant Health Centers, and Health Care for the Homeless sites funded under Section 330 of the Public Health Service (PHS) Act
- Family planning grantees (other than States) funded under Section 1001 of the PHS Act
- Comprehensive Hemophilia Diagnostic and Treatment Centers
- Federally qualified health centers funded under Section 1905(1)(2)(b) of the Social Security Act
- Current public or private not-for-profit providers of comprehensive primary care for populations at risk for HIV
- Faith-based and community-based organizations

FUNDING
The FY 2009 appropriation was $201,877,000 million to more than 360 Part C funded EIS programs.

SERVICES
The Part C Program divides allowable costs among five Part C Cost Categories. These categories are Early Intervention Services Costs, Core Medical Services Costs, Support Services Costs, Quality Management Costs, and Administrative Costs.
Early Intervention Services Costs are those costs associated with the direct provision of medical care and make up at least 50 percent of a grantee budget. Services include:

- Primary care providers
- Lab, x-ray, and other diagnostic tests
- Medical/dental equipment and supplies
- Medical Case Management
- Electronic Medical Records
- Patient education, in conjunction with medical care
- Transportation for clinical care provider staff to provide care
- Other clinical and diagnostic services regarding HIV/AIDS and periodic medical evaluations of individuals with HIV/AIDS

Core Medical Services Costs include those listed above plus the following:

- HIV Counseling
- The following core medical services have historically been paid by Parts A or B, but not Part C; and should only be provided by Part C with justification.
- AIDS Drug Assistance Program
- Health Insurance Premium and cost sharing assistance for low income individuals
- Home health care
- Hospice Services
- Home and community-based health services as defined under Part B.

Clinical Quality Management Costs are those costs required to maintain a clinical quality management program. With a HAB expectation that no more than 5 percent of the grant be spent on Clinical Quality Management, examples include:

- Continuous Quality Improvement (CQI) activities
- Clinical Quality management coordination

- Data collection for clinical quality management purposes
- Consumer involvement to improve services
- Staff training/technical assistance (including travel and registration) to improve services- this includes the annual clinical update and the biennial All Grantee Meeting, as well as local travel to meetings not directly related to patient care.

Support Services Costs are those costs for services that are needed for individuals with HIV/AIDS to achieve their medical outcomes. Support Services Costs include:

- Patient transportation to medical appointments
- Staff travel to provide support services
- Outreach to identify people with HIV, or at-risk of contracting HIV, to educate them about the benefits of early intervention and link them into primary care
- Translation services, including interpretation services for deaf persons
- Patient education materials for general use
- Participation in Statewide Coordinated Statement of Need process
- Patient advocates to maintain access to care
- Respite Care (historically paid by Parts A or B, but not Part C; and should only be provided by Part C with justification).

Administrative Costs are those not directly associated with service provision. By law, no more than 10 percent of a Federal Part C EIS budget can be allocated to administrative costs. Examples of administrative costs include:

- Indirect costs, which are allowed only if the applicant has a negotiated indirect cost rate approved by a recognized Federal agency. Indirect costs are those costs incurred by the organization that are not readily identifiable with a particular project or program, but are considered necessary to the operation of the organization and performance of its programs. All indirect costs are considered administrative for the Part C EIS program and therefore are subject to the 10 percent limitation on administrative expense.
- Rent, utilities, and other facility support costs
- Personnel costs and fringe benefits of staff members responsible for the management of the project (such as the Project Director and program coordinator), non-CQI program evaluation, non-CQI data collection/reporting, supervision, and other administrative, fiscal, or clerical duties
- Telecommunications, including telephone, fax, pager and internet access
- Postage
- Liability insurance
- Office supplies
- Audits
- Payroll/Accounting services
- Computer hardware/software not directly related to patient care
- Program evaluation, including data collection for evaluation

Part C: Planning Grant Program

Part C Planning Grant Program of the Ryan White HIV/AIDS Treatment Extension Act of 2009 funds eligible entities in their efforts to plan for the provision of high-quality comprehensive HIV primary health care services in rural or urban underserved areas and communities of color. Planning grant funds are intended for a period of 1 year. Planning grants support the planning process and do not fund any service delivery or patient care.

ELIGIBILITY

Eligible applicants must be public or private nonprofit entities that are or intend to become a comprehensive HIV primary care provider. Current Ryan White Programs Part C EIS and Part D Program grant recipients are eligible only if they are proposing to open a new program. Faith-based and community-based organizations are eligible to apply for these funds.

FUNDABLE ACTIVITIES
Part C planning grants can include the following activities:

- Identifying key stakeholders and engaging and coordinating potential partners in the planning process
- Gathering a formal advisory group to plan for the establishment of services
- Conducting an in-depth review of the nature and extent of the need for HIV primary care services in the community (including a local epidemiological profile, an evaluation of the community's service provider capacity, and a profile of the target population)
- Defining the components of care and forming essential programmatic linkages with related providers in the community
- Researching funding sources and applying for operational grants.

Part C: Capacity Development Grant Program
Part C Capacity Development Grant Program of the Ryan White HIV/AIDS Treatment Extension Act of 2009 are designed to assist public and nonprofit entities in their efforts to strengthen their organizational infrastructure and to enhance their capacity to develop, enhance, or expand access to high quality HIV primary health care services for people living with HIV or who are at risk of infection in underserved or rural communities and communities of color.

Activities supported by this grant funding are not intended for long-term activities. Instead, the activities should be of a short-term nature and should be completed by the end of the one year project period.

For the purposes of this grant program, capacity development is defined as activities that promote organizational infrastructure development and that will lead to the delivery or improvement of HIV primary care services.

ELIGIBILITY
Eligible applicants must be public or private nonprofit entities that are or intend to become comprehensive HIV primary care providers. Current Ryan White Programs service providers are eligible to apply for funding. Faith-based and community-based organizations are eligible to apply for these funds.

FUNDABLE ACTIVITIES
Part C capacity development activities fall into five infrastructure development categories: Management Systems; Service Delivery Systems; Evaluation Systems; Cultural Competency; and Self Management.

Fundable activities under these categories include:

- Identifying, establishing and strengthening clinical, administrative, managerial, and management information system (MIS) structures.
- Developing a financial management unit of the organization that is capable of managing multiple sources of funding for HIV primary care services;
- Developing and implementing a clinical continuous quality improvement (CQI) program
- Gathering necessary documents and applying for Medicaid certification and if applicable, appropriate state clinic licensure.
- Increasing the capability of your organization to oversee its HIV service provision, including development of an organizational strategic plan for HIV care, education of Board members regarding the HIV program, and staff training and development regarding HIV care
- Purchasing clinical supplies and equipment for the purpose of developing, enhancing, or expanding HIV primary care services (i.e., purchase of dental chairs and equipment to

begin an HIV dental clinic; modification of a ventilation system to accommodate TB care, etc.);

- Developing an organizational strategic plan to address managed care changes or changes in the HIV epidemic in your community;
- Developing a cultural competency training program aimed at staff or other HIV provider partners.
- Increasing the capability of your organization to implement and/or manage consumer involvement.
- Developing a Patient Self Management support program that emphasizes the patient's role in the management of their health.

Part D

Part D of the Ryan White HIV/AIDS Treatment Modernization Act of 2006 provides family centered care involving outpatient or ambulatory care (directly or through contracts) for women, infants, children, and youth with HIV/AIDS.

Grantees are expected to provide care, treatment, and support services or create a network of medical and social service providers, who collaborate to supply services.
Part D funds the following services:

- Family-centered primary and specialty medical care
- Support services
- Logistical support and coordination.

In addition grantees are to educate clients about research and research opportunities and inform all clients about the benefits of participation, and how to enroll in research.

IMPLEMENTATION
The Title IV programs (now referred to as Part D) started in 1988 as the Pediatric AIDS Demonstration Projects. The projects originally served infected infants and children, infected pregnant women and their families. They provided supportive care to families to help infected children receive medical care. Beginning in 1994, Congress funded these projects under Title IV of the Ryan White Comprehensive AIDS Resource Emergency (CARE) Act. In 1999, in response to the alarming growth of HIV infected youth being identified, the HIV/AIDS Bureau (HAB) funded a Youth Initiative, which currently supports 17 youth specific programs across the nation. In 2006, Congress funded the Part D programs under Title XXVI of the Public Health Service Act as amended by the Ryan White HIV/AIDS Treatment Modernization Act of 2006. The Part D program has improved access to a comprehensive system of health and social services for populations least able to cope with HIV/AIDS.

FUNDING
The FY 2009 appropriation was $76,845,000. Since 1994, the Part D Program and Pediatric AIDS Demonstration Program has provided nearly $1 billion in funding to States and communities.

Part F: Special Projects of National Significance (SPNS)

The Special Projects of National Significance (SPNS) advance knowledge and skills in the delivery of health and support services to underserved populations diagnosed with HIV infection. SPNS grants fund innovative models of care and support the development of effective delivery systems for HIV care. The SPNS Program provides the mechanisms to:

- Quickly respond to emerging needs of individuals receiving assistance under this title,
- Fund special programs to develop a standard electronic client information data system to improve the ability of grantees under this title to report client-level data,
- To advance knowledge and skills in the delivery of health and support services to people with HIV who are underserved,
- Support and assess the effectiveness innovative program design of particular models of care,
- To fund innovative models of care and to support the development of effective delivery systems of HIV care and services, and
- Promote the dissemination and replication of effective models of care.

PRIORITIES

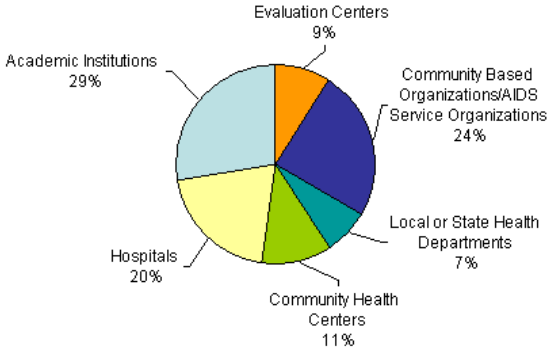
The original SPNS effort began in 1991 with some of the first Federal grants to target adolescents and women living with HIV. Each year, $25 million is set aside for the SPNS Program; and, today, a portfolio of 54 grants address emerging issues in the provision of HIV primary care and ancillary services.

The SPNS Program is an integral link to all Ryan White HIV/AIDS programs, providing opportunities to develop new services while assessing the effectiveness of models of care and promoting their replication. To meet program goals, funded organizations must contain a strong evaluation component and disseminate information necessary for effective replication. As grantees develop innovative services, the SPNS Program provides the funding and expertise for grantees to evaluate innovations and disseminate findings to the HIV community. Current priorities include the following activities:

- Evaluating innovative methods for integrating Buprenorphine opioid abuse treatment in HIV primary care
- Developing outreach, care, and prevention strategies to engage HIV-positive young men who have sex with men of color
- Developing innovative models to provide oral health care to HIV-positive, underserved populations
- The enhancement and evaluation of existing health information electronic network systems for people living with HIV/AIDS in underserved communities
- Enhancing linkages to HIV primary care in jail settings
- Capacity building to develop standard electronic client information data systems
- Engaging and retaining women of color in care

GRANTEES

Ryan White HIV/AIDS Program SPNS Sites by Organization (N=54)



SPNS INITIATIVES
Current SPNS Initiatives include:

- Prevention with HIV-infected persons seen in primary care settings
- Evaluation of innovative methods for integrating buprenorphine opioid abuse treatment in HIV primary care
- Development of outreach, care, and prevention strategies to engage HIV-positive young men who have sex with men of color
- Developing innovative models of care to provide oral health care to HIV-positive, underserved populations
- Enhancement and evaluation of existing health information electronic network systems for PLWHA in underserved communities
- Enhancement of linkages to HIV primary care in jail settings
- Capacity-building to develop standard electronic client information data systems

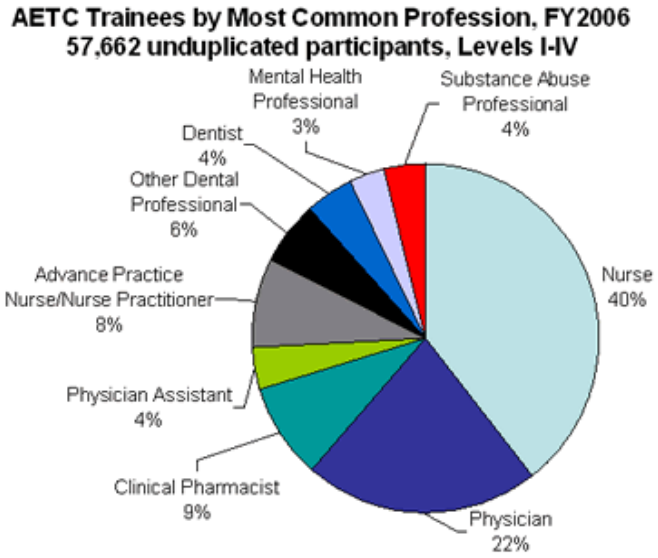
SPNS PUBLICATIONS
SPNS Publications can be downloaded from the TARGET Center Library (keyword SPNS).

If you know the name of the publication you are looking for, you can also order free hardcopies from the HRSA Information Center.

Part F: AIDS Education and Training Centers (AETCs)

The AIDS Education and Training Centers (AETCs) Program of the Ryan White Program is a network of regional and national centers that train health care providers to treat persons with HIV/AIDS. As the clinical training component of the Ryan White Program, AETCs seek to improve health outcomes of people living with HIV/AIDS through training on clinical management of HIV disease in such areas as use of antiretroviral therapies and prevention of HIV transmission. During the 2005-2006 grant year, more than 118,760 participants attended AETC training events. The program targets providers who treat minority, underserved, and vulnerable populations in communities most affected by the HIV epidemic.

Focus of Provider Training
Innovative training methods—skill-building workshops and clinical practice placements—augment traditional didactic education. AETCs also provide clinical consultation and decision support to clinicians regarding care and the use of antiretroviral therapies and technical assistance in improving service delivery at the organizational level.



- Training targets health care providers who serve minority populations, the homeless, rural communities, incarcerated persons, and Ryan White-funded sites.
- The AETCs focus on training a clinical core of physicians, physician assistants, nurses, nurse practitioners, dentists, pharmacists, as well as other paraprofessionals.
- Training activities are based upon assessed local needs.
- Emphasis is placed on interactive, hands-on training and clinical consultation to assist providers with complex issues related to the management of highly active antiretroviral therapy.
- The AETCs collaborate with Ryan White-funded organizations, area health education centers, community-based HIV/AIDS organizations, community and migrant health centers, and medical and health professional organizations.
- Clinicians trained by AETCs have been shown to be more competent with regard to HIV issues and more willing to treat persons living with HIV than other primary care providers.

AETC Training Network

AETC training is through a network of 11 regional centers (and over 130 local performance sites) serving the nation. Four national centers also support this network of provider training through sharing of resources and training strategies.

- The 11 Regional AETCs serve multi-state areas, covering all 50 States, the District of Columbia, the Virgin Islands, Puerto Rico, and the six U.S. Pacific Jurisdictions. Their focus is on rapid dissemination of state-of-the-art information on HIV clinical management by linking HIV expertise from academic and highly skilled community HIV clinicians and/or tertiary level medical institutions to front line HIV clinical care providers who serve minority and disproportionately affected populations.
- AETC National Resource Center (NRC) disseminates training resources and the latest HIV clinical information across the family of AETCs via such venues as the NRC website, which is a central repository of AETC training materials, best practices, and contact information.
- National HIV/AIDS Clinicians' Consultation Center (NCCC) provides health care providers with timely and appropriate responses to clinical questions related to treatment of persons with HIV infection. Components include the following:
    - National HIV Telephone Consultation Service (Warmline) (800-933-3413) offers physicians and other health care providers with answers to routine HIV management questions.
    - National Clinicians' Post-Exposure Prophylaxis Hotline (PEPline) (888-448-4911) offers treating clinicians around-the-clock advice on managing occupational exposures (e.g., needle sticks, splashes) to HIV, hepatitis, and other blood-borne pathogens.
    - National Perinatal HIV Consultation and Referral Service (Perinatal Hotline) (888-448-8765) provides 24-hour clinical consultation and advice on perinatal transmission, counseling and testing, prophylaxis, and perinatal patient management.
- National Minority AETC (NMAETC) builds capacity for HIV care and training among minority health care professionals and health care professionals serving communities of color.
- National AETC Evaluation Center is responsible for program evaluation activities, including assessing the effectiveness of AETCs grantees education, training, and consultation activities.

In addition to these AETC activities, HRSA 's HIV/AIDS Bureau supports international health care provider training through the International Training and Education Center on HIV (Not a U.S. Government Web site). I-TECH promotes activities that increase human capacity for providing HIV/AIDS care and support in countries and regions hardest hit by the AIDS epidemic.

Part F: Minority AIDS Initiative

The Ryan White HIV/AIDS Program recognizes that HIV/AIDS has had a devastating impact on racial/ethnic minorities in the U.S. African Americans accounted for 49 percent of all HIV/AIDS cases diagnosed in 2005.

The law codifies the Minority AIDS Initiative as part of the Ryan White HIV/AIDS Program in the Public Health Service Act under Title XXVI and provides funding for activities to evaluate and address the disproportionate impact of HIV/AIDS on racial and ethnic minorities.

Through Parts A and B, metropolitan areas and states receive formula-based awards to address disparities in access, treatment, care, and health outcomes. Parts C, D and F (AIDS Education and Training Center) programs also receive Minority AIDS Initiative funding as part of their other Ryan White funds.