

After a local hospital defunded what had been the only HIV clinic in the community, the Ursuline Sisters HIV/AIDS Ministry in Youngstown, OH, stepped into the breach to offer primary care for people living with HIV/AIDS.



Program Origins

PART C Early Intervention Services

Direct grants to primary care providers have been funded from the time Ryan White CARE Act legislation first passed. The number of sites has grown significantly, from 114 in 1991 to 350 in 2010.

● Part C: HIV Care Rooted in the Community

From the beginning of the Ryan White Program, Part C, Early Intervention Services (formerly Title III), has been squarely focused on primary care services. Although its core mandate has remained intact over the years, Part C has experienced important changes as the services that Part C–funded agencies provide have evolved along with the epidemic.

Origins of Part C

Representative Henry Waxman (D-CA) was a key player in drafting the original version of the Ryan White Comprehensive AIDS Resources Emergency (CARE) Act. The inclusion of Title III reflected his desire to create a funding stream to get more people tested for HIV and to help those in all stages of the disease access early intervention and medical care in hopes of slowing disease progression.¹

Waxman originally hoped to accomplish this goal by giving States the option to expand Medicaid to include coverage for people with HIV and by providing funds to the Centers for Disease Control and Prevention to provide State grants for HIV counseling, testing, and treatment. Before final passage of the Ryan White CARE Act, however, the provisions changed quite a bit.

As ultimately established, Title III contained two major components aimed at providing testing and early intervention services: formula grants directly to States and categorical grants to public and nonprofit entities that provide primary medical care. The State component was never funded and was later repealed, but direct grants to primary care providers have been funded from the beginning. The number of sites has grown from 114 in 1991 to 350 in 2010.

ABCs of Early Intervention Services

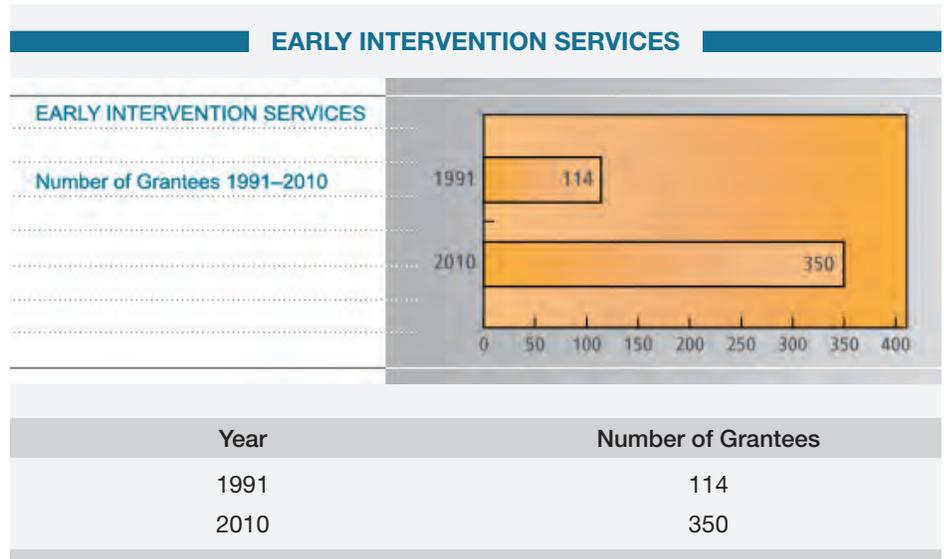
Part C grants are made directly to the funded entities, which include a wide range of primary care sites. Many of these primary care sites receive other Federal funds as Community and Migrant Health Centers, Federally Qualified Health Centers, hemophilia



Many Ryan White HIV/AIDS Program grantees, like this clinic in Yakima, WA, receive other Federal funds as Community and Migrant Health Centers, Federally Qualified Health Centers, hemophilia diagnosis and treatment centers, clinics for the homeless, and family planning providers.

diagnosis and treatment centers, clinics for the homeless, and family planning providers. Early intervention services include

- HIV counseling and testing;
- monitoring of disease progression;
- treatment of HIV;
- diagnosis and treatment of related infections; and
- case management and assistance accessing other Federal, State, and local programs that could provide needed health and support services to people living with HIV/AIDS.



See also *PART C - Early Intervention Services*

Part C Grapples with Sensitive Issues

The focus on testing and concerns about the ramifications of HIV status in areas such as employment and health insurance coverage led to provisions in the Title III section of the Ryan White CARE Act related to confidentiality and anonymous testing. Title III dealt with other sensitive public health and political issues as well, such as informed consent for HIV testing, the content of counseling for HIV testing, and prohibitions on HIV testing as a requirement for other health services.

Filling in the Gaps in Care

From the beginning, the Title III/Part C program sought to fill gaps in primary care by giving preference to sites in areas that lacked those services and sites located far from communities with an adequate level of HIV care. The program's original home within HRSA's Bureau of Primary Health Care reflects its central focus, which Congress strengthened in the 1996 reauthorization by including a mandate that 50 percent of funds be used for primary care services.

ORGANIZATIONS ELIGIBLE FOR PART C

- Federally Qualified Health Centers as described in Title XIX, Section 1905, of the Social Security Act
- Family planning agencies, other than States, under Section 1001 of the PHS Act
- Comprehensive Hemophilia Diagnosis and Treatment Centers
- Rural health clinics
- Health facilities operated by or under contract with the Indian Health Service
- Community-based organizations, clinics, hospitals, and other health facilities that provide early intervention services to people infected with HIV/AIDS through intravenous drug use
- Nonprofit private entities that currently provide comprehensive primary care services to populations at risk of HIV/AIDS, including faith-based and community-based organizations

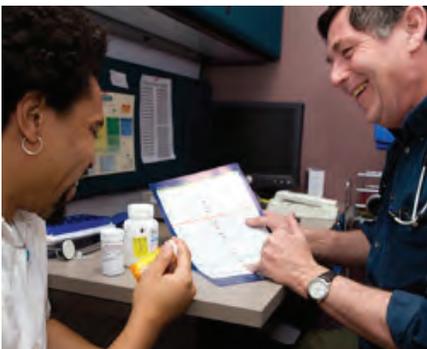


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Reauthorizations Reflect Changing Needs

In the first reauthorization of the Ryan White CARE Act, Congress added a provision for small planning grants to help sites develop services and qualify for funding and gave preference to sites in rural or under-served communities.

In 2000, the planning grants were expanded to include larger capacity-development grants but continued to target those same communities. In the first year of the program, HRSA awarded 48 grants to 20 States as well as the District of Columbia and Puerto Rico.² Recognizing the vital role that Title III providers played in rural and under-served communities, Congress also included language in 2000 giving funding preference for service dollars to agencies in those communities.



Part C clinics are rooted in their communities and thus are well equipped to offer culturally competent primary care. “We’ve been able to provide unfettered access to care for patients . . . without regard to gender, cultural differences, or ethnicity,” notes physician Bruce Williams, shown here with a patient at the Truman Street Health Clinic in Albuquerque, NM.

Power to Reach Isolated Populations

The power of Part C to increase access in more isolated locations is illustrated by a network of sites funded through the Fletcher Allen Health Care/University of Vermont College of Medicine. In addition to the central site at the university, the program has sites at three small hospitals around the State using the hospital’s infrastructures for billing and appointment scheduling. The clinics have on-site nurse practitioners and social workers, and doctors travel to the sites on a regular schedule.

By integrating the HIV/AIDS clinics into the hospital’s larger clinics at two of the three sites, the program addressed concerns about stigma while ensuring access to specialized providers. Originally funded through the Ryan White Program Special Projects of National Significance (SPNS), the project also illustrates the successful transition of the SPNS program to a sustainable funding stream, a key priority in the establishment of that program. “The SPNS and Title III funding in Vermont have been a godsend,” says Christopher Grace, who runs the program. “Without those funding streams, these clinics wouldn’t exist, particularly the three rural clinics, and I don’t know what those people would be doing or what their level of care would be.”³

Addressing Issues of Quality in HIV/AIDS Care

Program changes have been driven not only by the desire to increase access to services but also to improve the quality of those services. As treatment became more available and complex, a requirement was added to ensure that patients at funded sites received care consistent with federal treatment guidelines. “The treatment guidelines are an important component of maintaining a standard of care across the program,” says Henia Handler of Fenway Community Health in Boston. “Because Part C clinics are rooted in the communities they serve, they provide that care with the cultural competence necessary to best meet the needs of their patients.”⁴

BUILDING INFRASTRUCTURE FOR HIGH-QUALITY CARE

The Part C Planning and Capacity Development Grants Programs provide time-limited resources to help public and private nonprofit agencies lay the groundwork for high-quality HIV care. Planning grants were added in 1996 and capacity development grants in 2000 to increase the pool of HIV care providers in communities with limited or no access to care. Both programs focus on agencies in rural or urban underserved areas and in communities of color.

The 1-year planning grants help agencies conduct research and lay the groundwork for new programs. Activities may include

- conducting needs assessments,
- convening planning bodies of stakeholders and partners,
- researching and applying for grants, and
- negotiating linkages with other agencies.

Capacity development grants strengthen the infrastructure of agencies that are already providing HIV care or are planning to do so. Also limited to 1 year, the grants help agencies create management, financial, and quality improvement systems and support in the following areas:

- Strategic planning
- Cultural competency training
- Consumer involvement
- Purchase of clinical supplies and equipment.

Changes in Spending

Beginning with the 2006 reauthorization, Title III became Part C. As required in Parts A and B, Part C grantees had to spend 75 percent of their funds on core medical services. This change built on an earlier requirement, instituted in 1996, that at least half of Part C funds received by a grantee be directed toward HIV testing, diagnosis, and medical treatment. This requirement was maintained in the 2009 reauthorization.

[See Part C funding information by State.](#)

[Read more about Part C.](#)

Credits and Sources

Sources

1. Interview with Timothy Westmoreland, Counsel to the Subcommittee on Health and Environment, Committee on Energy and Commerce, U.S. House of Representatives, during this period. Interview conducted October 2007.
2. HIV/AIDS Bureau, Health Resources and Services Administration. Implementing the CARE Act amendments of 2000. HRSA Care Action. January 2002.
3. Personal communication with C. Grace, April 2008.
4. Personal communication with H. Handler, April 2008.

Photography

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Ohio Teen and Doctor Photograph © [See Change](#).

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