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—Linda Frank
Pittsburgh AETC



Program Origins

PART F SPNS, AETCs, Dental, and MAI

In 2008, more than 70 percent of Ryan White HIV/AIDS Program clients self-identified as racial or ethnic minorities. Through Part F, the Minority AIDS Initiative has played a major role in eliminating disparities in HIV/AIDS care for these populations.



In 1989, Anthony S. Fauci, M.D. (left), HHS director of the National Institute of Allergy and Infectious Diseases, and Louis Sullivan (right), Secretary of HHS, announce the promising results of AZT trials, leading to aggressive treatment and training programs directed at reducing mother-to-child transmission of HIV.

● Part F: A Diverse Portfolio for an Evolving Epidemic

When incorporated into the Ryan White Comprehensive AIDS Resources Emergency (CARE) Act in 1996, Part F included the AIDS Education and Training Center (AETCs), the Special Projects of National Significance (SPNS) program, and the Dental Reimbursement Program. The Minority AIDS Initiative was added during the 2006 reauthorization. Although Part F did not enter the legislation until 1996, 3 of its 4 programs were up and running long before that date: one in another section of the Act and two others at HRSA but not within the domain of the legislation.

Evolution of AIDS Education and Training Centers

AETCs, dedicated to training health care providers in HIV treatment and prevention, were the first component of Part F to launch. Inaugurated in 1987 as HRSA’s other HIV care initiatives were starting, the AETCs initially included four sites and were housed in the Bureau of Health Resources Development. The network of sites quickly expanded to 11 in 1988. At that time, given the lack of meaningful treatment options, their focus was primarily on support services and death and dying, according to Linda Frank, who has directed a Pennsylvania AETC since 1988.¹

As treatment options became available, AETCs evolved to provide relevant training. In the early days, that meant training on the prevention and treatment of opportunistic infections and, later, on the use of AZT monotherapy. “At that point, the assumption was that anyone could treat, and we were training providers to give people one pill,” says Frank.¹

When the AIDS Clinical Trials Group study 076 (ACTG 076) protocol showed dramatic results reducing perinatal transmission in 1994, the AETCs played a critical role by training a broad swath of providers, including many at Community and Migrant Health Centers, on how to prevent mother-to-child transmission. In 1996, with the advent of combination therapy and greater understanding of the importance of viral load, the AETCs began to focus more intently on clinical training and clinical management for providers treating larger volumes of patients. Included was the service of one-on-one consultations. As treatment became more complicated, the AETCs added trainings on important topics, such as viral resistance, complex comorbidities, and adherence.

TIMELINE OF AETCS²

- 1987: 4 sites
- 1988: 11 sites
- 1989: 13 sites
- 1990: 15 sites
- 1991: 17 sites
- 1995: 15 sites
- 1999: 14 sites + 4 national centers
- 2002: 12 sites + 4 national centers
- 2005: 11 sites + 4 national centers
- 2010: 11 sites + 5 national centers

The number of AETC sites has evolved over the years (see timeline this page), as has its home at HRSA. In 1991, the AETC Program moved to the Bureau of Health Professions.

National Centers Strengthen Training Efforts

AETCs became a part of the Ryan White HIV/AIDS Program following the 1996 reauthorization and were first funded through the program in FY 1997. The addition of four national training centers—the AETC National Resource Center, the AETC National Evaluation Center, the National HIV/AIDS Clinicians' Consultation Center, and the National Minority AETC—all strengthened the ability of the AETCs to respond to the evolving needs of on-the-ground providers.

Specialized AETC Trainings

Over its history, the AETCs have been called on to provide a variety of specialized training and support, often with resources provided by other Public Health Service agencies. In 2003, for example, the AETCs were funded to provide targeted trainings to American Indians/Alaska Natives and providers of care and support services along the U.S.-Mexico border. The Substance Abuse and Mental Health Services Administration (SAMHSA) provided funding in 2004 for targeted training on HIV to mental health agencies and providers. In 2007, the Centers for Disease Control and Prevention provided funding to AETCs for training, consultation, and technical assistance on its new recommendations for HIV testing in primary care settings.

Reflecting on the role of the AETCs in the Ryan White HIV/AIDS Program, Frank notes, "I've always said that

because we do training, we protect our investment. The dollars do no good if folks don't know how to use the medicine."¹



Beginning with the prevention and treatment of opportunistic infections in the early years of the epidemic, today's training programs have evolved and expanded, today covering a complex array of subject matter—from medical breakthroughs, to treatment regimens, to more culturally appropriate outreach strategies.

Innovative Models of Care Through the SPNS Program

Originally housed in Part B, the SPNS program has been a proving ground for innovative models of care that focus on the most vulnerable populations of people living with AIDS. Congress moved the program into Part F in 1996. SPNS projects consist of sets of initiatives designed to address a specific community or service delivery challenge.



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SPNS PROJECTS OVER THE YEARS – A SAMPLE

- Innovative Methods for Integrating Buprenorphine Opioid Abuse Treatment in HIV Primary Care
- Enhancing Linkages to HIV Primary Care and Services in Jail Settings
- Demonstration and Evaluation Models that Advance HIV Service Innovation Along the U.S.–Mexico Border
- Assessing Existing Efforts to Increase Adherence to Medications

The program began with some of the first Federal grants to target adolescents and women living with HIV, and over the years, initiatives have been developed to reflect the evolution of the epidemic and the health care arena. For example, as more treatment options for HIV became available, the program examined models for supporting people living with HIV/AIDS in adhering to their prescribed treatments. As the Nation was moving to electronic medical records, the project launched its second health information technology initiative to promote and evaluate network systems serving people living with HIV/AIDS in underserved communities. Many of the initiatives also have focused on specific populations or health care settings, including youth, correctional facilities, and American Indians/Alaska Natives.

The Power of Replication

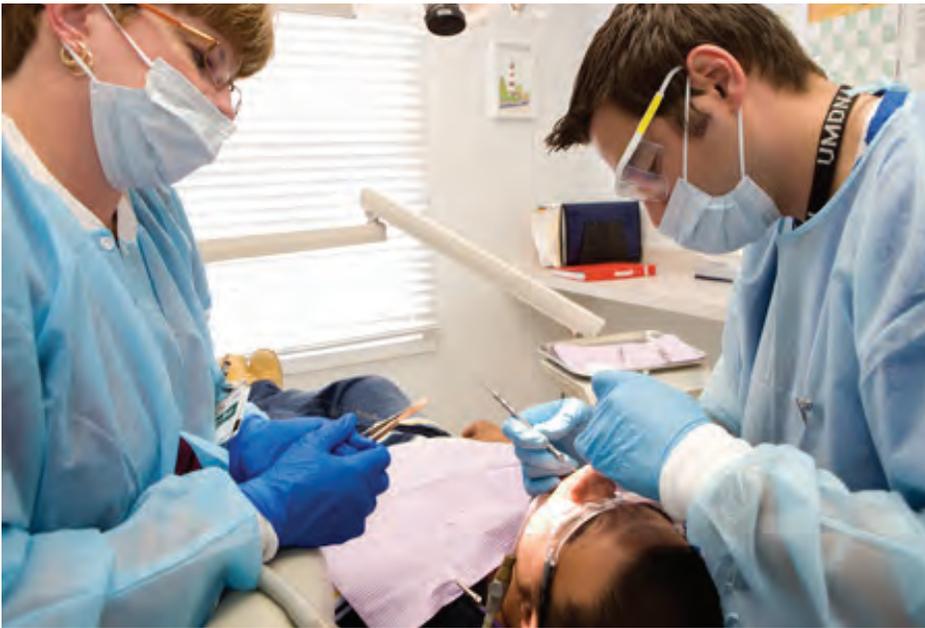
Underlying all the initiatives is a strong commitment to evaluation and dissemination of results. HRSA provided resources and expertise for grantees to evaluate their findings and to disseminate those findings to the HIV community, with the goal of replicating innovative initiatives at other sites. A 2005 study of 108 SPNS grants awarded from the beginning of the program in 1991 through 2002 found that large percentages of grantees had met the program’s mandate of developing innovative and integrated models of care targeting historically underserved groups and had effectively disseminated their results through a variety of tools.³

The legislation has always required that the potential for new SPNS models to be replicated be a factor in SPNS grant awards, and the first three versions of the legislation also included specific populations that might be served through the initiative. The 2006 reauthorization was far less prescriptive in terms of populations served, but it did include a new requirement that SPNS fund special programs to develop a standard electronic client information data system to improve the ability of Ryan White Program grantees to report client-level data. The goal is for Congress, HRSA, service providers, and planning bodies to have concrete data on how many people are being served along with important demographic information.

A Growing Role for Dental Care

[The Dental Reimbursement Program \(PDF – 94.9 KB\)](#) was first authorized in 1991, but it was not funded until 1994. It was then incorporated into the Ryan White Program in the 1996 reauthorization.

The idea for a Federal program to support dental care for people living with HIV/AIDS germinated in conversations between Henry Cherrick, dean of the UCLA School of Dentistry, and Jay Gershen, who was chair of the school’s Public Health Dentistry Department and active in the American Association of Dental Schools (AADS, now the American Dental Education Association).⁴ The school was providing a substantial amount of unreimbursed care for people living with HIV/AIDS. Cherrick also saw that many of the patients had soft-tissue lesions in their mouths and realized that dentists



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—Jay Gershen, Chair
UCLA Public Health Dentistry Department

could play a key role in AIDS diagnosis and treatment, if trained appropriately.

Recognizing that other dental schools also needed funding to support the uncompensated care they were providing, Gershen worked closely with Martha Liggett at AADS to build congressional support for a Federal funding stream to support dental care provided in academic settings for people living with HIV/AIDS. Key allies included Representatives Henry Waxman (D-CA), Barbara Boxer (D-CA), and Edward Roybal (D-CA), all Californians who had assignments on important congressional committees.

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—David Reznik, Director
Oral Health Center,
Grady Health System

Dental Partnerships Extend Care Into the Community

The Dental Reimbursement Program provides resources to cover some of the costs of uncompensated care for people living with HIV/AIDS provided by academic dental institutions (dental schools, hospitals with postdoctoral dental residency programs and, since the 2000 reauthorization, dental hygiene programs). In 2010, the program awarded funding to 57 grantees.

Congress added a second component to the program in the 2000 reauthorization. The Community-Based Dental Partnership Program, first funded in FY 2002, supports collaborations between dental education programs and community-based dentists and dental clinics. Designed to further expand the reach of services into communities that lack academic dental institutions, the program proved to be a valuable training tool through clinical rotations for students and residents in community-based settings.

“Students go out to [the] community health center, and they are not just treating a mouth, they are treating the whole person,” says David Reznik, director of the Oral Health Center at Grady Health System’s Infectious Disease Program in Atlanta and the founder of HIVdent. “They learn that as opposed to just treating a person with HIV, you have to treat other factors that influence their lives. You have to ask the right questions and listen.”⁶

According to Reznik, who started treating people living with HIV/AIDS in 1987, there was substantial unmet need for training in those early days to help dentists overcome

COMMUNITY-BASED DENTAL PARTNERSHIPS

- Twelve Dental Partnerships in 11 States have formed networks of community-based HIV dental care, comprising university-based dental schools and community agencies to extend access to oral health care.
- Dental care was provided to more than 5,300 people living with HIV in 2008.



Above: Members of the Congressional Black Caucus—including, left to right, Chairman Elijah E. Cummings, D-MD, Diane Watson, D-CA, speaking, Sheila Jackson-Lee, D-TX, Barbara Lee, D-CA, Danny Davis, D-IL, and Melvin Watt, D-NC—along with advocates from African-American and Latino communities were instrumental in providing \$22.3 million to improve HIV/AIDS care among minority populations as part of the 1999 Omnibus Appropriations Bill.



Rep. Maxine Waters, D-CA, was among the members of the Congressional Black Caucus who helped spearhead the MAI and later worked to increase MAI funding and demographic reach into other minority communities—including Asian-Americans, American Indians/Alaska Natives, Native Hawaiians, and Pacific Islanders.

ignorance and fear, and the training supported by these programs has been an incredible service. Gershen echoed that sentiment along with the program's role in fostering a more central role for the dental profession in HIV/AIDS care and treatment.

Origins of the Minority AIDS Initiative

The Minority AIDS Initiative (MAI) has been providing resources to the Ryan White Program since 1999, but it was not included in the legislation until the 2006 reauthorization. The MAI's roots can be traced to a March 1998 Centers for Disease Control and Prevention consultation with African-American community leaders and HIV prevention program grantees.

"We were presented with stark and depressing news about [the] continuing impact of HIV in communities of color, and much to our dismay, there was no offer of additional assistance or a strategy," says H. Alexander Robinson, who participated in the meeting and served on the Presidential Advisory Council on HIV/AIDS at the time. "We were confronted with a lack of creativity, and we saw that was driven by a paucity of resources."⁷

The participants developed a call to action with nine demands, among them the declaration by the President and the Surgeon General of a "state of emergency" in the African-American community. That demand was endorsed by the Presidential Advisory Council on HIV/AIDS and the Congressional Black Caucus (CBC), which also convened a forum on the issue.

Launch of the CBC Initiative

Advocates worked with CBC staff to draft language targeting funds to address HIV/AIDS in the African-American and Latino communities. The funding was ultimately included in the FY 1999 Omnibus Appropriations Bill. Those appropriations, which provided \$22.3 million to the Ryan White Program in that first year as well as significant resources for other HIV/AIDS programs, marked the launch of the CBC initiative. Together with members of Congress, President Clinton announced the creation of the CBC Initiative to be implemented within the Department of Health and Human Services, providing an additional \$36 million.^{8,9}

The following year, the Congressional Hispanic Caucus and the Congressional Asian Pacific Caucus joined forces with the CBC to advocate for increased resources. The initiative was expanded to include Asian-Americans, American Indians/Alaska Natives, Native Hawaiians, and Pacific Islanders in addition to the African-American and Latino communities and was renamed the Minority AIDS Initiative. In the ensuing years, MAI continued to fund Federal initiatives through the annual appropriations bill. The first 2 years of the MAI provided funds to Title I, Title III, Title IV, and Part F/AETCs of the CARE Act. The funding continued in subsequent years and added Title II in FY 2001. The Department of Health and Human Services allocated additional MAI funding each year to the HIV/AIDS Bureau to increase the skills and capacity of community-based organizations, support service providers, and consumers.^{8,9}

MAI Fosters Culturally Sound Service Delivery

Funding levels grew substantially in the early years of the initiative, and the guiding legislative language changed significantly. Notably, the language increasingly emphasized the intent of the U.S. Congress that the funds be used to strengthen the capacity of minority community-based organizations (MCBOs) to serve people of color affected by HIV/AIDS. According to a report from the National Minority AIDS Council, “MAI funding historically has been slated only for MCBOs, even though many non-minority-specific CBOs have demonstrated their ability to provide culturally sound HIV services in communities of color. This issue has been debated since the MAI initiative began, and [congressional] Report language has changed yearly to reflect the changing opinions of members of Congress and community leaders around the topic in an effort to benefit MCBOs and CBOs that serve minority-based communities.”¹¹

According to Robinson, one important impact of the MAI has been that AIDS service organizations, given the requirements placed on them for accessing the funds, have made an effort to diversify board and organizational leadership, resulting in the delivery of more culturally appropriate services.

The movement to include the MAI in the 2006 reauthorization grew from a concern about the initiative’s long-term survival and the desire to refocus on its original intent of capacity building, according to Ernest Hopkins, an HIV/AIDS advocate who has worked with CBC on the MAI since its inception.¹² MAI-related discussions and proposals during the reauthorization process were wide ranging, but the legislative language ultimately maintained the existing MAI services and required the program to be consistent with the language in the [FY 2002 appropriations. \(PDF – 20.1 KB\)](#) One significant change, however, was to make Part A and Part B MAI awards to States and

MAI PARTNERSHIPS¹⁰

The Minority HIV/AIDS Initiative (MAI) is part of the larger effort by the U.S. Department of Health and Human Services to eliminate racial and ethnic disparities in health status. The following agencies have been involved in working with the MAI toward this goal:

- Centers for Disease Control and Prevention
- Substance Abuse and Mental Health Services Administration
- National Institutes of Health
- Health Resources and Services Administration
- Office of Minority Health
- Indian Health Services

localities a competitive process. Those funds had previously been distributed on the basis of a jurisdiction’s proportion of the racial and ethnic minority AIDS case nationwide.

“The discussions about how to incorporate the MAI into the law were a moment to reflect on what has been done and should be done,” says Hopkins. Referring to possible future legislative efforts beyond the Ryan White Program, he notes that “many members of Congress were invigorated to do more and different things going forward.”¹²

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



The MAI’s guiding legislative language has increasingly emphasized the intent of the U.S. Congress to strengthen community-based organizations that provide culturally sound HIV services in communities of color.

Credits and Sources

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