

**Public Comment of Patricia Bass, RN, MA  
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**Presented to the CDC/HRSA Advisory Committee on HIV and STD Prevention and Treatment, Ryan White CARE Act Reauthorization Workgroup**

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I would like to thank the Ryan White CARE Act Reauthorization Workgroup of the CDC/HRSA Advisory Committee on HIV and STD Prevention and Treatment for the opportunity to provide public comment on priority issues in the upcoming CARE Act reauthorization.

My name is Patricia Bass. I am the Chair of the CAEAR Coalition and a consultant for the Philadelphia Department of Public Health and today I am presenting public comment in my capacity as chair of the CAEAR Coalition. The CAEAR Coalition represents more than 300 grantees under Title I and Title III of the CARE Act, including the 51 major metropolitan areas most adversely affected by the HIV/AIDS epidemic. The CAEAR Coalition is a leading voice in Washington for HIV/AIDS care and treatment and for over a decade has led the successful annual federal appropriation advocacy effort for CARE Act Title I and Title III.

The Ryan White CARE Act has provided emergency relief to regions across the country hardest hit by the HIV/AIDS. The CARE Act works by utilizing an innovative model of public/private partnerships to address the emerging needs of communities and people living with HIV/AIDS. By maximizing the local public and private resources to provide

people living with HIV/AIDS with high quality care and supportive services, the CARE Act has been able to minimize the potentially devastating impact of the HIV/AIDS epidemic on the already overburdened public health care system.

### **The Roles Title I, Title III and Part F**

Title I supports comprehensive HIV health care and treatment for increasing numbers of uninsured and underinsured persons living with HIV/AIDS. It is the major safety net for thousands of low-income persons living with HIV/AIDS who are ineligible for entitlement programs and would not otherwise receive HIV/AIDS treatment and care. Over 75% of people living with AIDS in the U.S. reside in Title I areas. Nearly two-thirds of Title I clients are people of color and 30% are women. Many people of color living with HIV/AIDS are burdened by poverty, homelessness, substance abuse, mental illness, and/or other sexually transmitted diseases. Title I provides comprehensive care and support services so that these factors are effectively addressed in order to provide access and retention in primary care.

Title III provides support to health centers for HIV-related early intervention and primary care services. Annually, over one-quarter of all persons served by Title III providers are new patients. Most new Title III patients are classified as moderately to severely ill, therefore requiring extensive and costly medical services. Additionally, Title III is the primary means for providing HIV care to rural areas. In fact, about half of all Title III providers serve rural areas and they frequently are the only means by which many persons living in rural areas receive HIV testing and care.

Part F contains resources for both the AIDS Education and Training Centers (AETC) and Dental Reimbursement program. The AETCs support training for health care providers. The AETCs have trained over 1 million HIV/AIDS care providers through 12 university-based programs with a network of 70 training sites serving all 50 states, the District of Columbia, Puerto Rico, and the U.S. territories. The Dental Reimbursement Program supports non-reimbursed dental care. In 2001, there were 74 grantees that provided dental care for over 29,000 people with HIV.

### **The CARE Act Works**

The Ryan White CARE Act is an innovative program that brings together the skills, resources, and commitment of the country's public and private providers to increase access to high quality HIV care and supportive services. The CARE Act reduces the burden of the HIV epidemic on local communities by instituting local control, maximizing limited resources, coordinating care delivery systems, and rapidly responding to the changing epidemic.

### **Local Control**

The CARE Act is designed to ensure that all impacted public and private parties are able to develop an integrated and coordinated response to their local HIV epidemic. Through the establishment of local and state planning bodies, the CARE Act requires funded agencies to develop systems of care that are tailored to each community's unique needs. The critical leadership role of people living with HIV/AIDS in these planning bodies ensures that the service delivery systems are responsive to the needs of other people

living with the virus in their local communities. These planning bodies have proved to be a powerful and effective tool in ensuring fiscal and programmatic accountability. No other publicly funded health care system demands nor achieves such high levels of public accountability.

### **Coordinated Care and Integrated Support Services Reduce Burden on Public Health Infrastructure and Improve Consumer Health Status**

Through the development of integrated support services into the care delivery system, the CARE Act has been able to bring people into care, maintain their access to care over time, and provide appropriate levels of care. A study by HRSA-funded researchers at Columbia University found that CARE Act services have a significant impact on the health outcomes of people with HIV/AIDS. Examining the impact of services funded through all CARE Act titles in New York City, the researchers found that among people with HIV/AIDS in the study:

- those receiving primary medical care from a CARE Act-funded provider were 60-70 percent more likely to report appropriate medical care and 40-50 percent more likely to report being on HAART than those who received their primary medical care from a non-CARE-Act-funded provider;
- those receiving case management and/or client advocacy from a CARE Act-funded provider were 80-90 percent more likely to report appropriate medical care and 70 percent more likely to be on antiretroviral therapy than those who received case management and/or client advocacy from a non-CARE-Act-funded provider; and

- those who received primary medical care from a non-CARE Act-funded provider were half as likely as clients of CARE Act providers to report care that met minimum HIV practice guidelines.

By providing stabilizing support services such as case management, substance abuse treatment, mental health, housing, food, and other services, the CARE Act helps people living with HIV/AIDS to maintain their connection with their medical provider, which improves their health status, and, over time, gradually reduces utilization of services.

These innovative components of the CARE Act have resulted in substantial improvement in health status of people living with HIV/AIDS and a concomitant reduction of cost to already overburdened state and local public health systems. The CARE Act is essential in assisting local public health systems to manage health service needs and costs.

### **Rapid Response to Changing Epidemic**

The CARE Act, in no small part due to local control, has remained flexible and able to quickly respond to changes in the local epidemic and system of care. This flexibility ensures that local communities will rapidly address emerging trends through thoughtful refinements to the local systems of care.

## **Quality Improvement**

CARE Act funding is used to ensure that people living with HIV/AIDS have access to quality health care. The direct medical providers are funded to deliver services that adhere to established best practice guidelines and the Public Health Standards. Strategies have been developed to ensure quality medical care includes vital health-related support services. The CARE Act model can be used to encourage further public health planning by fully bringing to the table all public and private health service providers to develop efficient, integrated, and coordinated systems of care for those most in need. This could include the development of methods for annualized data sharing, more fully coordinated health services planning with national, state, and local partners such as the Veterans Administration, Medicaid, and Medicare.

Additionally, implementing the principles of continuous quality improvement should allow for reporting, both locally and nationally, to be directly related to the improvement of care systems and services for those in need.

## **The CARE Act Works: Continued Support**

During a time of diminishing resources it is critical for the Administration to support programs and systems with a proven record of success, which improve the health status of those in need, and have consistently been deemed fiscally and programmatically efficient. The CARE Act is just such a program.

Evidence has shown that that CARE Act works:

- The Ryan White CARE Act is an innovative program that brings together the skills, resources, and commitment of the countries public and private providers to increase access to high quality HIV care and supportive services.
- The CARE Act reduces the burden of the HIV epidemic on local communities by instituting:
  - Local control,
  - Maximizing limited resources,
  - Coordinated Care and Integrated Support Services Reduce Burden on Public Health Infrastructure and Improve Consumer Health Status, and
  - Providing a rapid response to the changing epidemic.
  - Ensuring the leadership role of PLWH throughout the reauthorization process

The CAEAR Coalition respectfully encourages the CDC/HRSA Advisory Committee on HIV and STD Prevention and Treatment to strongly support the Ryan White CARE Act. Additionally, the Coalition strongly encourages the body to maintain the central role of people living with HIV/AIDS in the reauthorization process.