Fenway Institute comments on the National HIV/AIDS Strategy

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1) Reducing new HIV infections

Increase support for promising biobehavioral prevention approaches, including pre-exposure prophylaxis (PrEP) and microbicides. Support development of innovative PrEP modalities, including implants, injectables, and intermittent and pericoital PrEP. Support development of vaginal rings with microbicides to empower women to protect themselves against HIV infection. Train providers in how to prescribe PrEP and educate at-risk communities—including MSM, transgender women, people who inject drugs, and sex workers—about PrEP as an option.

CDC-supported STD prevention training centers should scale up the training of providers in evidence-based HIV and STD prevention.

State and local public health departments, the CDC, and schools and other institutions, especially those serving youth, should combat anti-gay prejudice as a public health threat. This should involve funding for social marketing campaigns and community fora challenging anti-gay prejudice and promoting family acceptance of LGBT youth, gay-straight alliances, school nondiscrimination and anti-bullying laws, and teacher and staff training.

All youth-serving agencies should be culturally competent to serve LGBT youth. The Massachusetts Commission on LGBTQ Youth produces annual recommendations for all state agencies serving youth that could serve as a model for other states. These recommendations address staff training to ensure cultural competency, nondiscrimination policies, and data collection to ensure equal access to services for LGBTQ youth.

HRSA and state and local health departments should support large-scale education of health care providers in LGBT health to create environments that are welcoming and inclusive for LGBT people and others at risk of HIV infection. The Mississippi Collaborative for Inclusive Care offers a model for state health departments to work with safety net providers across the state to increase LGBT cultural competency and access to care. Through such education, barriers to accessing prevention and care can be decreased and eliminated.

Repeal the ban on use of federal funds for syringe exchange and scale up this intervention, one of the most effective in preventing the spread of HIV.

Encourage new payment methods for health care to embrace key HIV prevention and treatment strategies. For example, require federally qualified

health centers (FQHCs) to report the number of their patients who have documented HIV tests, as well as the number of HIV patients with suppressed viral loads, and incentivize these metrics as quality measures. Document dissemination of PrEP information to those at risk; this could also be part of Accountable Care Organization (ACO) and other payer quality measures.

Defund abstinence-only-until-marriage programs and fund large scale comprehensive sex education that explicitly addresses same-sex behavior and sexual health for LGBT people.

HIV prevention programs that address the needs of gay and bisexual men and transgender women should be funded at levels proportionate with the epidemiology of the HIV/AIDS epidemic. Current incidence data indicate that more than two thirds of new HIV infections occur among these populations.

Culturally sensitive, HIV risk-reduction interventions for substance-using gay and bisexual men and transgender women must be developed, including interventions to prevent and stop crystal methamphetamine use. These interventions should be tailored to meet the needs of gay men of all races.

2) Increasing access to care and improving health outcomes for PLWH

Maintain the Ryan White HIV/AIDS Program and increase funding to support a growing caseload and critically important support services.

Increase the number of health care providers who reflect the communities most affected by HIV—in particular African Americans, gay and bisexual men of color, and transgender women. Address structural barriers to accessing education and job training required for these positions. AIDS service organizations and HIV care providers should value, invest in, and provide equitable pay for case managers and peer health workers.

HRSA and state and local health departments should support large-scale education of health care providers in LGBT health to create environments that are welcoming and inclusive for LGBT people and others at risk of HIV infection. Through such education, barriers to accessing prevention and care can be reduced and eliminated.

Prioritize care for the 600,000 Americans age 50 and older living with HIV, who experience comorbidities and require culturally competent health care and elder services to age in place.

The U.S. Administration on Aging could strengthen social support networks for LGBT elders by encouraging more states to use Older Americans Act Title III C1 funds to support congregate meal programs for LGBT older adults and their friends. Only 5 states currently use such funding for LGBT-specific congregate meals. Such programs help establish and strengthen social support networks, leading to improved mental health, reduced substance use, and improved antiretroviral treatment adherence.

The federal and state governments should consider creative approaches to providing Medicaid and marketplace insurance. These could include waivers into existing Medicaid or providing targeted subsidies to assist low-income individuals to purchase insurance in the marketplaces.

HRSA and other agencies should increase support for the development of the HIV provider workforce. With people living into older adulthood with HIV, patient caseloads high, and many first-generation HIV providers nearing retirement age, innovative solutions are needed. These could include targeted loan forgiveness through the National Health Service Corps for medical providers who work at Part C-funded sites, increased support for clinical training opportunities in HIV medicine, and increased Medicaid reimbursement rates for HIV care.

Expand the role of AETCs in training providers. Increase resources available to AETCs to ensure that they are able to train the next generation of HIV medical providers.

3) Reducing HIV-related disparities and health inequities

Address the impact that structural racism has had on the systems and structures (healthcare, housing, criminal justice, employment, education, etc.) that have created such dramatic HIV-related health disparities and inequities in our country.

Strengthen the Ryan White Program's focus on gay and bisexual men and other MSM, especially young Black gay and bisexual men. Strengthen the program's focus on Black women, most of whom are heterosexual.

Fund social marketing and community mobilization campaigns that challenge anti-gay stigma and HIV-related stigma. Train HIV testers and other health care providers to provide culturally competent care to Black gay and bisexual men and others disproportionately burdened by HIV.

Train health care providers in culturally competent care for LGBT patients, including discussing sexual orientation and gender identity (SO/GI) with patients, collecting SO/GI data in Electronic Health Records, and using the data to better understand LGBT health disparities in access to care, preventive screenings, risk behaviors, disease burden and health outcomes.

The Centers for Medicare and Medicaid Services should explicitly include sexual orientation and gender identity (SO/GI) in Meaningful Use Stage 3 to incentivize providers to collect and use SO/GI data in clinical settings.

As part of its proposed health information technology certification requirements, the Office of the National Coordinator of Health Information Technology should require that Electronic Health Record vendors include sexual orientation and

gender identity functionality (fields) as part of the Demographics criterion in the Base EHR definition and in the Common Clinical Data Set.
HHS should issue a regulation banning discrimination on the basis of sexual orientation and gender identity in the provision of health care in the U.S. While Section 1557 of the Affordable Care Act protects against discrimination on the basis of gender identity (due to a 2013 HHS ruling that interprets Title IX of the Education Amendments of 1972 as covering gender identity), most providers, clinical staff, and transgender patients are not aware of this protection. There is currently no federal protection against discrimination on the basis of sexual orientation.

Congress should pass a comprehensive nondiscrimination law banning discrimination on the basis of real or perceived sexual orientation and gender identity in employment, housing, and public accommodations. States should also pass such laws.

4) Achieving a more coordinated national response to the HIV epidemic

HRSA and CDC should collaborate to build education for consumers and primary care providers on HIV prevention and treatment. Treatment as prevention and PrEP can work together synergistically to reduce incidence and increase viral suppression rates. We need to put aside the artificial boundaries imposed by funding sources and the territory of federal agencies and develop a consolidated approach focused on health and ending HIV.

HRSA and the U.S. Administration on Aging should work closely to train elder care providers—including home care aides—in culturally competent care for older adults living with HIV and older LGBT people.

Congress should reauthorize the Older Americans Act and designate LGBT elders and older adults living with HIV as populations of "greatest social need." This would increase the use of OAA funds for research, training, and targeted services to these populations.

The U.S. Administration on Aging should designate LGBT elders and older adults living with HIV as populations of "greatest social need."

State administrations on aging should designate LGBT elders and older adults living with HIV as populations of "greatest social need," as Massachusetts did in 2012.

HRSA should work closely with the Substance Abuse and Mental Health Services Administration to train behavioral health providers in issues affecting older adults living with HIV and LGBT people, including LGBT elders.

Simplify grantee application and reporting procedures. Most AIDS service organizations must report data in several different systems to federal agencies alone, not to mention to state and local agencies. Government agencies should synchronize their data systems to reduce ASO and provider burden.

Thank you for considering these recommendations. For more information please contact Sean Cahill, Director of Health Policy Research, at scahill@fenwayhealth.org or 617-927-6016.