AETC Program Rural Health Committee
January 10, 2014 12 p.m. – 1 p.m. EST

Present: Anna Kinder (**MT-PLAINS**), Donna Sweet (MT-PLAINS), Charlotte Ledonne (MT-PLAINS), Susan Tusher (MT-PLAINS), Chris Davis (MT-PLAINS), Char Lowman (MT-PLAINS), Tami Hogie-Lorenzen (MT-PLAINS), Beth Amdalh (MT-PLAINS), Dennis Fleming (**Pacific**), Alyssa Bittenbender (Pacific), Jennifer Janelle (**FL/Carribean**), Sean McIntosh (FL/Carribean), Harold Katner (**SEATEC**),
Natalia Martinez-Paz (**NW**), Deborah Kutzko (**NE**), John Nelson (**NRC**).

Absent: Lindsay O'Connell (MT-PLAINS), Adrena Harrison (SEATEC), Jeanne Harris (SEATEC)

1. **Introductions**
   - A. multidisciplinary team identified through introductions: health educators, physicians, nurses/nurse practitioners, health educators, physician assistant, program coordinators/administrators, occupational therapist
   - B. U.S. regions represented: Hawaii, California, Nevada, Arizona, Utah, Wyoming, Washington, Colorado, Kansas, Georgia, Florida, New York/New Jersey, Vermont, South Dakota
2. **Committee role, expectations, and function within the AETC Program**
   - A. Anna Kinder led the discussion by explaining why she proposed this committee being formed initially: issues affecting the education of rural health care providers as well as addressing barriers of engagement and linkage of PLWHA in rural settings
   - B. Committee understood to be a group of experts regarding the AETC Program as well as issues related to providing quality, evidence-based HIV care to PLWHA in rural communities
   - C. Committee to address (through methods identified by committee members) issues related to rural U.S. communities and the provision of quality HIV care; committee will discuss, brainstorm, collaborate, and support the advocacy of rural HIV health care needs in the U.S. (? Position statements, reports, guideline development, resource collection or development; discussion generation among national AETC Program members regarding rural HIV care issues/challenges/model programs)
   - D. What is being done currently in the U.S. to address the rural health care needs of HIV-infected, affected and at-risk persons?
     1. Other programs have "rural health" committees or groups including: Association of Nurses in AIDS Care (ANAC); Rural Center for AIDS/STD Prevention; National Rural Health Association/Rural HIV/AIDS Resource Center
     2. Telehealth Programs
     3. Graduate Medical Education program specifically addressing rural health HIV primary care
     4. Multiple preceptorship/mentorship programs offered throughout the AETC

Program for health care providers (some specifically catering to educating providers about PLWHA in rural areas – Georgia, Arizona, Idaho)

5. Use of mobile vans to provide care in rural settings
6. Consultation services for primary care providers by HIV care specialists
7. Innovative computer based consultation/educational services for health care providers to use regarding HIV care information
8. AETC Program sites linkages/affiliations with health profession schools to use rural HIV care sites as clinical learning sites; loan-repayment (but ?? remain about whether or not these experiences lead to long-term work with these populations)

E. Issues of concern/needing to be addressed/raised:

1. With ACA unrolling, more individuals in rural settings will have insurance coverage, but limited number of providers to see them (for HIV/Hepatitis/STD testing as well as HIV/Hepatitis/STD prevention and treatment); with federal funding cuts, some rural clinical programs are closing with concern expressed of more of this happening over time
2. Reports of rural health center providers not having adequate training on HIV care, providing inappropriate care (i.e. poor or non-recommended ARV regimens); concern of this increasing with more primary care providers seeing HIV-infected persons without ongoing consultation and recommendations of ID/HIV care specialists
3. Concerns expressed regarding disinterest or non-adoption of HIV counseling and testing recommendations by rural clinical care providers and facilities ("too many other health care issues take priority")
4. Inconsistent state policies and recommendations regarding health insurance coverage (Medicaid Expanding and non-Expanding states for example) and HIV testing (NY State DOH mandates documentation of annual HIV testing or opt-out discussion with patients in any setting: inpatient, emergency/urgent care, outpatient for all persons 13-64 y.o. whereas other states have no such mandate; state reporting and data surveillance varies . . .)
5. Limitations and barriers for PLWHA in rural areas: transportation and time needed to get to HIV specialist since many rural providers are not experienced or want to take on the on-going HIV care of infected persons; ?? increased stigma for rural PLWHA (more isolated)
6. Concern was expressed about funding being cut for the provision of CEUs for AETC trainings; the CEUs are a bridge to the population of providers needing this education but with little time to get it outside of mandated CEUs so free CEUs for trainings is essential; John reported that at the last HRSA-AETC Program Directors call, it was announced that Ryan White Funding, as with clinical care,

can only be used as funding of last resort for CEU credentialing by AETC trainings.

3. **Next Steps**
   A. Group agreed to meet once/month to keep the discussion fresh and on-going
   B. Group agreed on second Friday of each month at 12 pm – 1 pm EST for meeting time
   C. Group agreed to have committee meetings recorded for those not able to attend along with meeting minutes being kept and sent out after each meeting by John and Anna; all agreed to have email addresses available to other group members.
   D. Next meeting scheduled for Friday, February 14, 2014 at 12 pm EST