Academy of Nutrition and Dietetics

Ryan White HIV/AIDS Program

Overview

The Ryan White HIV/AIDS Program, also known as the Ryan White Comprehensive AIDS Resources Emergency (CARE) Act, was first established in law in 1990. It is the largest federal program dedicated to providing treatment and care to people living with HIV. The Ryan White HIV/AIDS Program (RWHAP) was named in honor of a U.S. teenager who fought AIDS-related discrimination after contracting the disease through a contaminated blood transfusion in 1984, and is administered by the Department of Health and Human Services' (HHS) Health Resources and Services Administration (HRSA), HIV/AIDS Bureau (HAB). Since originally becoming law, this legislation has been reauthorized with bipartisan support four times.

As a "payer of last resort," the RWHAP is not health insurance but rather fills gaps in care not covered by Medicare or Medicaid or third party insurers. In FY2012, 33% of those served by RWHAP were uninsured, and an additional 56% were underinsured[1]. The program funds essential treatment when no other resources are available, and therefore comprises a key component of our nation's public health safety net. By increasing access to care for underserved populations, the program also decreases health care costs by decreasing mortality, reducing the need for costly emergency services and inpatient care, and improving quality of life for people living with HIV.

Key Takeaways

- Ryan White programs serve half a million Americans per year.
- Medical Nutrition Therapy improves health outcomes in patients with HIV infection, facilitates access to adequate dietary intake, and is essential to the adherence and effectiveness of HIV/AIDS medications.
- A patient can be provided with a diet specifically tailored to his or her unique combination of illnesses for only $20/day.
- The Academy of Nutrition and Dietetics supports robust funding for the provision of food and nutrition services in the Ryan White program.

The RWHAP works with states, cities, and community-based organizations to provide primary medical care and essential supportive services to more than half a million people every year. Nutrition services are provided by many Ryan White grantees, including education and counseling, home-delivered meals, groceries, food vouchers, liquid nutritional and other dietary supplements. When provided by a registered dietitian nutritionist (RDN), these medical nutrition therapy (MNT) services are considered allowable "core medical services"[2] under Ryan White, which must comprise at least 75% of the funds of many Ryan White grant programs (while "supportive services"[3] may only comprise up to 25% of the program funds).

Why Nutrition is an Essential Part of HIV/AIDS Care

Since 1981, more than 1.7 million people in the U.S. have been infected with HIV, with an estimated 1.1 million living with the disease today.[4] Many people living with HIV face economic insecurity, social isolation and stigmatization, substance use, and other comorbidities, and may as a result confront food and nutrition insecurity and barriers to food access.[5] Poor nutritional status can affect immune function independent of HIV infection[6], and nutritional status is strongly predictive of survival during the course of HIV infection. While death rates are higher among HIV-infected individuals with malnutrition[7] [8], well-nourished individuals living with HIV are more likely to be able to withstand the

[1] HRSA, *FY2012 Justification of Estimates for Appropriations Committees,* p. 245, http://www.hrsa.gov/about/budget/budgetjustification2012.pdf.
[2] Core Medical Services defined as outpatient and ambulatory medical services, pharmaceutical assistance, dental health, early intervention services, health insurance premium and cost-sharing assistance, home health care, hospice services, home and community-based health services, mental health services, substance abuse outpatient care, medical case management, and medical nutrition therapy.
[3] Supportive services defined as transportation, respite care, outreach, language services, and nutritional services not provided by an RDN.
[4] CDC. *HIV Surveillance Report*, Vol. 22; 2012.
[5] Position of the American Dietetic Association: Nutrition Intervention and Human Immunodeficiency Virus Infection (2010). *J Am Diet Assoc.* Vol 110(7):1105-1119.

[6] Hughes S, S, Kelly P. (2006). Interactions of malnutrition and immune impairment, with specific reference to immunity against parasites. *Parasite Immunol.* Vol 18:577-588.
[7] Mangili A., Murman D.H., Zampini A.M. (2006). Nutrition and HIV infection: Review of weight loss and wasting in the era of highly active antiretroviral therapy from the nutrition for healthy living cohort. *Clin Infec Dis.* Vol 42:836-842.
[8] Paton N.I., Sangeetha S., Bellamy R. (2006) the impact of malnutrition on survival and the CD4 count response in HIV-infected patients starting antiretroviral therapy. *HIV Med.* Vol 7:323-330.

effects of HIV infection and possibly delay the progression of the disease.[9] [10]

The benefits of MNT provided by a RDN for patients with HIV are numerous. In addition to improving health outcomes in HIV infection and facilitating access to adequate dietary intake, MNT is essential to the adherence and effectiveness of HIV medications. Lifelong pharmacotherapy presents challenges to and can negatively affect nutrition status by introducing potential interactions with food, changing body metabolism and causing adverse side effects. MNT has been found to improve the effectiveness and tolerance of medications[11], and it helps manage and alleviate adverse drug effects such as nausea, diarrhea, fatigue, and elevated blood glucose and lipid levels[12]. In doing so, MNT can prevent hospitalizations, emergency room visits, and invasive and costly medical procedures[13]. So critical is expertise in nutrition to the comprehensive treatment of HIV patients that HHS's Health Resources and Services Administration has stated that "ideally, all people living with HIV/AIDS should have access to the services of a RDN with expertise in HIV who can provide nutrition assessments, counseling, and education and help determine whether the client has adequate access to food."[14]

Cost-Effectiveness of Nutrition Support in the Ryan White Program

Research shows that a patient can be provided a diet specifically designed for his or her unique combination of illnesses for only $20 per day, while a hospital stay costs upwards of $4,000 per day. Investing in food and nutrition services, including medical nutrition therapy, translates into less spending in the future on care and treatment. According to a study conducted by the Metropolitan Area Neighborhood Nutrition Alliance (Philadelphia, PA), the average monthly health care costs for HIV/ AIDS clients in the six months following initiation of food and nutrition services went from an average of roughly $50,000 per month (prior to receiving these services) to approximately $17,000 per month after the initiation of food and nutrition services.[15] Additionally, people with HIV/AIDS who are food insecure report more missed appointments for primary care visits than those who do not have difficulties obtaining enough food[16], and thereby may not be adhering to medication therapy or preventing nutrition-related complications that could have lasting health and economic consequences. As a program that provides medical nutrition therapy to HIV/AIDS patients who might otherwise not have access to nutrition assistance and counseling, the Ryan White HIV/AIDS Program plays a fundamental role in ensuring that patients achieve food and nutrition security while managing nutrition-related complications of HIV infection.

Priorities of the Academy of Nutrition and Dietetics for the Ryan White Program

The Academy of Nutrition and Dietetics supports robust funding for the provision of food and nutrition services, including medical nutrition therapy, to patients receiving HIV/AIDS services through Ryan White programs.

[9] Fergusso P., Chinkhumba J., Grijalva-Eternod C., Banda T., Mkangama C., Tomkins A. (2009). Nutritional recovery in HIV-infected and HIV-uninfected children with severe acute malnutrition. *Arch Dis Child.* Vol 94: 512-516.
[10] Thomas A.M., Mkandawire S.C. (2006). The impact of nutrition on physiologic changes in persons who have HIV. *Nurs Clin North Am.* Vol 41:455-468.
[11] Spada C Treitinger A., Reis M., Masokawa I.Y., Verdi J.C., Luiz M.C., Silveira M.V., Oliveira O.V., Michelon C.M., Avial-Junior S., Gil D.O., Ostrowsky S. (2002). An evaluation of antiretroviral therapy associated with alphatocopherol supplementation in HIV-infected patients. Clin Chem Lab Med. 2002;40:456- 459.
[12] HHS Health Resources and Sciences Administration (2004). HRSA Care Action: Providing HIV/AIDS Care in a Changing Environment. August 2004.
[13] *Ibid*.
[14] *Ibid.*
[15] Coalition letter to Administrator Mary Wakefield, Administrator, HRSA (July 30, 2012). Re: Ryan White Food and Nutrition Programs.
[16] Aidala A., Yomogida M., and the HIV Food & Nutrition Study Team. (2011). *Community Health Advisory & Information Network Factsheet: HIV/AIDS, Food & Nutrition Service Needs*. Columbia University Mailman School of Public Health.