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August 3, 2020

Jeffrey M. Zirger
Information Collection Review Office
Centers for Disease Control and Prevention
1600 Clifton Road NE
MS-D74
Atlanta, Georgia 30329

Reference: Medical Monitoring Project Facility Survey

Dear Mr. Zirger,

The Academy of Nutrition and Dietetics (the "Academy") appreciates the opportunity to submit these comments to the United States Preventive Services Task Force relative to its June 2, 2020 request for comment on the information collection*: Medical Monitoring Project Facility Survey*. Representing more than 107,000 registered dietitian nutritionists (RDNs),[1] nutrition and dietetics practitioners, registered, and advanced-degree nutritionists, the Academy is the largest association of food and nutrition professionals in the world and is committed to a vision of the world where all people thrive through the transformative power of food and nutrition and related support systems. Every day our members provide medical nutrition therapy for patients with many diagnoses, including HIV and AIDS.

The Academy supports this survey of the characteristics of HIV care facilities in order to assess the nation's existing HIV care infrastructure and the capacity to implement the strategies of the Ending the HIV Epidemic Federal Initiative. We offer the below comments and suggestions to enhance the utility of the planned survey and improve sensitivity to health disparities.

I. Section I: General Characteristics

In the list of options for the respondent to describe the facility, notably missing are Indian Health Service Health Centers, Tribal Health Centers, and Urban Indian Health Centers. According to prior MMP surveillance reports, American Indians/Alaskan Natives (AI/AN) have the fourth highest HIV infection diagnosis rates among all racial and ethnic groups, yet little has been published about the impact of HIV in this population.[2] AI/AN people living with HIV experience high levels of poverty, depression, HIV-related stigma[3] and have lower viral suppression rates

[1] The Academy approved the optional use of the credential "registered dietitian nutritionist (RDN)" by "registered dietitians (RDs)" to more accurately convey who they are and what they do as the nation's food and nutrition experts. The RD and RDN credentials have identical meanings and legal trademark definitions.

[2] Baugher AR, Beer L, Bradley HM, Evans ME, Luo Q, Shouse RL. Behavioral and clinical characteristics of American Indian/Alaska Native Adults in HIV Care – Medical Monitoring Project, United States, 2011-2015. MMWR Morb Mortal Wkly Rep. 2016;67:1405-1409. DOI: http://dx.doi.org/10.15585/mmwr.mm675152a1.

[3] Ibid.

compared to the overall U.S. population living with HIV.[4] IHS-operated, Tribal, and Urban Indian Health Programs may receive Ryan White Program funds to provide HIV-related services to the AI/AN population.[5]

In the survey question regarding cultural competency training, rather than merely offering a fill-in-the blank option, it may be advantageous to request more details specifically related to the National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care in order to obtain more quantifiable data,[6] specifically people with disabilities, low health literacy, racial and ethnic minorities, sexual and gender minorities, and limited English proficiency.[7]

II. Section II: Clinical and Supportive Services

In the survey question seeking to define availability of nutrition counseling, we suggest confirming the type of provider supplying nutrition counseling. Nutrition counseling and medical nutrition therapy provided by RDNs play an important role in maintaining the health status of people living with HIV. Studies show both the health benefits of access to MNT and nutrition counseling for people with HIV infections[8] and the resulting decreases in their healthcare costs.

In addition to inquiring about food bank or meal delivery services, it may be worthwhile to inquire about assistance with applying for Supplemental Nutrition Assistance Program (SNAP) benefits, given that HIV prevalence disproportionately affects low-income populations in the U.S.[9] and the documented associations between food insecurity and HIV viral suppression.[10]

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[4] Centers for Disease Control and Prevention. HIV and American Indians and Alaska Natives. https://www.cdc.gov/hiv/group/racialethnic/aian/index.html. Update May 18, 2020. Accessed June 30, 2020.

[5] Indian Health Service. Ryan White Program and IHS. https://www.ihs.gov/hivaids/ryanwhiteprogram/. Accessed June 30, 2020.

[6] U.S. Department of Health and Human Services Office of Minority Health. The National CLAS Standards: https://minorityhealth.hhs.gov/omh/browse.aspx?lvl=2&lvlid=53#:~:text=The%20National%20Standards%20for%20Culturally,the%20nation's%20increasingly%20diverse%20communities. Updated October 2, 2018. Accessed June 30, 2020.

[7] National Committee for Quality Assurance. Building an Organizational Response to Health Disparities: A Practical Guide to Implementing the National CLAS Standards: For Racial, Ethnic and Linguistic Minorities, People with Disabilities and Sexual and Gender Minorities. Washington, DC: National Committee for Quality Assurance; 2016. https://www.cms.gov/About-CMS/Agency-Information/OMH/Downloads/CLAS-Toolkit-12-7-16.pdf. Accessed June 30, 2020.

[8] Academy of Nutrition and Dietetics. HIV/AIDS Nutrition Evidence Analysis Project. http://www.adaevidencelibrary.com/conclusion.cfm?conclusion_statement_id=250707. Accessed August 2, 2020.

[9]Aibibula W, Cox J, Hamelin A et al. Association between food insecurity and HIV viral suppression: a systematic review and meta-analysis. AIDS Behav. 2017;21:754–765. https://doi.org/10.1007/s10461-016-1605-5

[10] Pellowski JA, Kalichman SC, Matthews KA, Adler N. A pandemic of the poor: social disadvantage and the U.S. HIV epidemic. Am Psychol. 2013;68(4):197-209.

III. Section III: Enrollment and Initiation of Antiretroviral Therapy

In addition to assessing availability of various clinical and supportive services, including nutrition counseling and food bank or meal delivery services, we also suggest that Section III verify

- the approximate proportion of patients utilizing such services, and the frequency of such usage, as eligibility requirements may determine, and
- whether staffing of each type of health care provider is adequate to meet demand. Assessing capacity to implement the strategies of the Initiative can best be accomplished by determining facility capacity to meet the current demand for each clinical and supportive service. While Section III does ask about overall provider capacity, being as specific as practical will likely enhance utility of the survey to assess capacity to meet the Initiative's strategies.

The Academy appreciates your consideration of our comment for the *Medical Monitoring Project Facility Survey* docket. Please contact either Jeanne Blankenship at 312-899-1730 or by email at jblankenship@eatright.org or Mark Rifkin at 202-775-8277 ext. 6011 or by email at mrifkin@eatright.org with any questions or requests for additional information.

Sincerely,

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