



***National HIV/AIDS Strategy***  
***Improving HIV/AIDS Care in the Health Center Community***  
Summary of a HRSA/BPHC Grantee TA Call - Held January 31, 2011

This document summarizes the HRSA/BPHC National HIV/AIDS Strategy Grantee TA Call, convened January 31, 2011. The call explored how Health Centers can respond to the Strategy's call to expand their involvement in HIV/AIDS care in order to better serve the people hit hardest by the epidemic—the people served every day in Health Center clinics.

**Introduction and Overview**

Angela Powell, HRSA/BPHC

The Year 2010 saw several groundbreaking events in health care, which represent important context for expansion of Health Center involvement in HIV/AIDS. In early 2010, the Affordable Care Act was passed. The legislation includes reforms in health insurance and expands access for the underserved, in part through Health Centers.

In July of 2010, the National HIV/AIDS Strategy (NHAS) was released. The NHAS is the first-ever comprehensive plan to improve the nation's response to HIV/AIDS. The Strategy outlines action steps for HHS agencies and the programs they fund. Many provisions specify an expanded role for Health Centers. The need for greater involvement is evident:

- In the U.S., approximately 1 million people are living with HIV/AIDS (PLWHA)—more than at any time since the epidemic emerged over 30 years ago.
- It is estimated that 20 percent of infected persons do not know their HIV status. These individuals are not getting care and may also be unknowingly infecting others.
- Each year, approximately 56,000 new cases are identified.

This Bureau of Primary Care (BPHC) TA Call was developed to examine ways Health Centers can enhance their HIV/AIDS activities under the framework of three questions:

- What do the National HIV/AIDS Strategy and Affordable Care Act require Health Centers to do?
- How can Health Centers expand and enhance their HIV/AIDS activities?
- What are Health Centers already doing in HIV/AIDS work and what can we learn from them?

**Improving HIV/AIDS Services: Strategy and Implementation Plans**

**The National HIV/AIDS Strategy (NHAS)**

Jim Macrae, HRSA/BPHC

**The Strategy and Implementation Plans**

The NHAS has three primary goals: 1) reduce new infections, 2) increase access to care and improving health outcomes for PLWHA, and 3) reduce HIV-related disparities and health inequities. One of the recommendations of the Strategy is a call for more Health Center work in HIV/AIDS care.

There is a framework for such change. Many Health Centers are already providing primary medical care and support services to PLWHA. They can do more by building on existing capacity and integrating HIV/AIDS care within the context of their regular primary care services. According to 2009 UDS data, Health Centers provided care to almost 95,000 PLWHA.

Health Centers need to expand their HIV/AIDS work as more people are in need than ever before.

The charge—for Federal agencies and funded programs—is to turn this Strategy into action. A number of steps are outlined in the NHAS Federal Implementation Plan, which includes specific activities for the Health Center Program, such as: expanding HIV testing; caring for HIV positive persons according to Federal treatment guidelines; implementing models of care for co-case management and multidisciplinary teams of practitioners.

At the Federal level, implementation will involve improved collaboration and coordination among various stakeholders. BPHC is working closely with the HIV/AIDS Bureau (HAB), other HRSA Bureaus, and other Federal agencies across HHS in various work teams to identify strategies for improving agency coordination. Many agencies have created detailed operational plans for implementing the Strategy.

Access to the NHAS, the Federal Implementation Plan, and Operational Plans, is at <http://aids.gov/>.

### **Implementation is Already Underway**

Health Centers, and Ryan White HIV/AIDS Program grantees, are already taking steps that implement Strategy recommendations.

- Many Ryan White grantees are pursuing FQHC status. Currently, one-third of Ryan White Part C community based grantees are already FQHCs.
- Health Centers are building their HIV/AIDS capacity. One venue is a new Ryan White technical assistance center that is offering assistance to Health Centers to build their capacity to deliver HIV/AIDS care (see “National Initiatives and Resources” section below for additional information).
- Health Centers are expanding routine HIV testing.

BPHC’s goal is to help Health Centers integrate HIV/AIDS care into their work and not treat it as something separate.

### **FYI: HHS Survey Underway on Health Center HIV Testing**

In January 2011, the HHS Office of Inspector General (OIG) initiated a survey of 500 Health Centers to assess the level of HIV testing in sites and identify barriers to testing. This survey is not an investigation or audit but is rather a study to determine ways in which HHS and Health Centers can most effectively expand HIV testing activities. Health Centers are strongly encouraged to participate in the survey in order to generate a wealth of sound data on HIV testing issues.

## **HRSA/BPHC NHAS Implementation Plans**

Seiji Hayashi, HRSA/BPHC

### **Framework for Change: Building Upon Existing Initiatives**

BPHC’s framework for tackling HIV/AIDS is within a larger goal: improving community and population health. BPHC tackles that goal under the framework of Triple Aim, which seeks to: improve the health of the population, improve the patient’s care experience, and reduce costs. To get there, BPHC focuses on increasing access and improving quality. And how are BPHC and Health Centers working together to get there?

- Creating access points—putting Health Centers in the right places.
- Providing high quality comprehensive care under the medical home model.
- Integrating Health Center care within the local health care system.

The guide for Health Centers in addressing HIV/AIDS can be found in the HRSA/BPHC implementation plan, which is centered on the Strategy goal to integrate HIV/AIDS care into primary care. BPHC’s implementation plan builds

upon three existing BPHC initiatives: 1) Adoption of Meaningful Use of Health Information Technology; 2) Patient Centered Medical Homes; and 3) Development of the Health Center Workforce. Each is summarized below.

### **Health Information Technology (HIT)/Meaningful Use**

HIT implementation costs can be high, but Health Centers are actively working to put systems in place. HIT technical assistance (TA) is available nationally from the Office of the National Coordinator for Health Information Technology to support Health Centers on HIT adoption and implementation.

As part of HIT transformation, BPHC is also exploring ways to do more HIV/AIDS data reporting under the Uniform Data System (UDS), including working with the Health Center Controlled Network to carry out HIV/AIDS data collection, sampling, analysis, and aggregation to support increased reporting.

Attention to HIT is necessary to address the medical home model, which requires better data and enhanced medical records to deliver care more effectively and to respond to HIT reform activities including Meaningful Use requirements, which provide incentivized reimbursement for use of Electronic Medical Records in a manner that will make a positive difference in the quality of care that is delivered.

### **Medical Homes**

Health Centers are already moving toward becoming patient-centered medical homes, a model that puts the patient at the center of the health care system through more coordinated care. Part of the medical home model depends on the right staff, the right mix of staff, and the correct delivery of care so clinics know they are doing the right thing for patients. HIV/AIDS care as provided by Ryan White programs reflects the medical home model and can prove instructive to Health Centers.

BPHC has issued one Program Assistance Letter to date to support expanded HIV/AIDS work among Health Centers (<http://bphc.hrsa.gov/policy/pal1013/pal1013.pdf>). This PAL discusses implementation of Federal guidelines on routine HIV testing. BPHC's goal here is to further expand and make HIV testing a routine part of primary medical care. (An additional PAL will be released early 2011 addressing HIV/AIDS Care and Treatment.)

### **Development of the Health Center Workforce**

A key recommendation of the Strategy is to increase the number and diversity of available providers of clinical care and related services for PLWHA. BPHC is working with the HRSA HIV/AIDS Bureau to build Health Center workforce HIV/AIDS capacity through the AETC provider training network. Finally, additional and varied activities to improve Health Center capacity to deliver HIV/AIDS care are underway. They include: Performance Improvement Activities, Primary Care Association (PCA) and other cooperative agreement initiatives, and sharing of models of HIV/AIDS care by high performing Health Centers.

## **National Initiatives and Resources**

### **ECHPP/12 Cities Project: Enhanced Prevention Planning/Health Center Roles**

David Purcell, CDC

#### **ECHPP Goals**

The goal of the Enhanced Comprehensive HIV Prevention Plans (ECHPP) project is to create improved HIV/AIDS prevention plans for the 12 Metropolitan Statistical Areas (MSAs) most affected by the HIV/AIDS epidemic. These plans are the foundation for activities to further reduce HIV risk and incidence. Intensified HIV prevention efforts are needed to address a mix of challenges (e.g., substance abuse, mental illness, homelessness) that compound risks of acquiring and transmitting HIV/AIDS.

## **Funded Jurisdictions**

The 12 ECHPP jurisdictions funded in the first year are: Atlanta, Baltimore, Chicago, Dallas, Houston, Los Angeles, Miami, New York City, Philadelphia, San Francisco, San Juan, and Washington, DC.

## **Implementation**

Staff from HRSA/BPHC and HRSA/HAB are involved in an implementation working group to help foster cross-agency support for ECHPP. HRSA's involvement is but one of our responses to the National Strategy's call for better cross-agency coordination to figure out that optimal combination of care and prevention services that's going to make a difference in reducing new infections and getting people in care.

ECHPP is being supported by HHS leadership under an initiative titled the "12 Cities Project" led by Dr. Ron Valdiserri. This project is composed of leaders from HRSA and other HHS agencies and is organized to try to bring departmental resources and visibility to bear in supporting the ECHPP goals.

## **HIV/AIDS Care Issues, Guidelines/Protocols, Resources**

Margarita Figueroa-Gonzalez, HRSA/HAB

HRSA's health programs have taken a leading role in HIV primary care for over 20 years. In fact, some of HRSA's first HIV/AIDS programs came out of BPHC and were later folded into Ryan White Program at HRSA/HAB. Today, Health Centers make up at least a third of all Ryan White clinics funded under Ryan White's Part C community-based program.

There may be a perspective among some agencies that HIV/AIDS is a complex disease and is perhaps best left to the specialists. Thus, are Health Centers equipped to take on HIV/AIDS care? Yes. Clinics can either have a specialist on the team or connect to an HIV/AIDS specialist while delivering regular primary care. Clinics also need to know how to treat the many co-morbid conditions that PLWHA often present with. Where should Health Centers and their clinicians turn when looking to deliver HIV care?

- Federal HIV/AIDS guidelines cover topics ranging from how to administer antiretroviral therapies to how to conduct HIV testing (see <http://aidsinfo.nih.gov>).
- HRSA's clinical protocols give instructions on how to deliver HIV/AIDS care (see <http://hab.hrsa.gov>).

HRSA/HAB can help Health Centers build their HIV/AIDS capacity. Many TA resources are available and can be accessed from the TARGET Center Web site at <http://careacttarget.org>. They include:

- Regional and national network of HIV clinical training from the AIDS Education and Training Centers (AETCs). For example, within this network is the National Clinicians Consultation Center, which includes a Warmline service for clinicians that need special consultations on HIV/AIDS care.
- A new project added to the AETC network in 2010, which is just for Health Centers. It's called the AETC National Center for Expansion of HIV CARE in Minority Communities. This resource is working to strengthen the organizational capacity of Health Centers to deliver HIV care and treatment to racial and ethnic minorities. The focus is on Health Centers not funded by Ryan White. In early 2011, the Center embarked upon a search for 30 sites to work with, with selections based upon needs and gaps in HIV/AIDS and readiness of Health Center leadership to take on more HIV/AIDS work.
- AETC training to build the capacity of medical care facilities to conduct HIV testing and counseling. This project has been in place for multiple years and is a HRSA/CDC partnership.

Health Centers can also apply for Ryan White Part C capacity building funds in order to build their expertise. This may position them to become competitive for Ryan White funding as sub-grantees to their State and local jurisdictions receiving Ryan White funding under Parts A and B.

## Health Centers Integrating HIV/AIDS Services

A panel of Health Center representatives shared an assortment of ways in which their programs have incorporated HIV/AIDS care services into clinic practices—from development of performance measures to expanded HIV/AIDS testing. Below are summaries from the four panelists.

### **Performance Measures and Networking Enhance HIV/AIDS Care Work**

#### **Delaware Valley Community Health, Philadelphia, PA**

Scott McNeal, Chief Medical Officer

Delaware Valley serves 43,000 patients annually, predominantly people of color. The agency made HIV/AIDS care an integral part of its Health Center plan in the mid-1990s. Their HIV/AIDS initiatives include:

- Establishment of a performance measure goal to increase HIV screening of men who have sex with men (MSM). As a result, screening increased from 60 percent in 2008 to 82 percent in 2010.
- Networking with other health centers. Delaware Valley is part of CareLink, a regional HIV/AIDS care network comprised of 15 federally qualified community Health Center sites. The model develops an infrastructure to provide integrated HIV/AIDS services in low-income communities whose residents would otherwise face barriers to obtaining accessible, culturally sensitive and gender specific care.

### **Performance Measures Track Improvements in HIV/AIDS Care**

#### **Mendocino Community Health Clinic, Ukiah, CA**

Catherine Rada, Grants Administrator and Ann McAfee, Director of Nursing and Quality

Mendocino is funded by BPHC and Ryan White (Part C and the Special Projects of National Significance, SPNS). The agency serves 26,000 patients in its primary care clinic and 200 patients in its HIV clinic. Among their HIV/AIDS activities are the following:

- A performance measure goal was established to annually see over 85 percent of patients with HIV/AIDS with two or more medical visits at least three months apart. In 2010, the clinic hit 96 percent.
- A clinical outcome measure was also established to assure that over 85 percent of patients with CD4 cell counts greater than 200 are taking HIV medications. In 2010, 91 percent were on medications.

Mendocino's HIV/AIDS program (along with its nurse case management work) has provided the clinic with demonstrable experience in improving other aspects of primary medical care, including establishment of electronic medical records and accreditation by the Joint Commission as a patient-centered medical home.

### **Expanding HIV/AIDS Testing—Including Rapid Testing**

#### **Chase Brexton Health Services, Baltimore, MD**

Kerry Avant, Director of Nursing

Chase Brexton was founded in 1978 as a gay health clinic and has evolved into a multi-faceted Health Center offering a continuum of care to a diverse and medically underserved community. The agency is a recipient of Ryan White funding, including Parts A, B, C, D and SPNS. Chase serves 17,000 patients through its primary care clinics, and close to 4,000 patients with HIV/AIDS. Among their HIV/AIDS initiatives is expansion of HIV testing as part of routine primary care visits—including the use of rapid HIV tests. The goal is to provide clients with the opportunity to be tested at least once in their lifetimes.

Providers were initially concerned about the impact of routine HIV testing on primary care clinic patient flow. However, the process has been successfully integrated into patient visits during initial intake. To date, routine testing has enabled the clinic to identify a small number of HIV-positive clients and transition them into HIV/AIDS care and case management.

### **Transitioning HIV/AIDS Care Into a Health Center**

#### **Santa Rosa Community Health Centers, Sonoma County, CA**

Brian Griffiths, Program Manager

In 2010, PLWHA faced a potentially major problem in Sonoma County, CA when the county's largest HIV provider—the health department's HIV/AIDS clinic—was going to close for budget reasons. However, a solution was found when the county HIV/AIDS services were transitioned, along with its funded grant programs, to two networked community Health Centers: Santa Rosa Community Health Centers and West County Health Center. Overall, the transition of services to the health center network was a win-win for all parties.

Patients and the former county HIV care program benefited in several ways:

- Medicaid reimbursement rates are better with the health center than the previous county rate.
- Patients have access to broader primary care services through the health center.
- The health center uses electronic health records—something that was not in place under the county system.

The health center, in turn, benefited from absorbing the new HIV/AIDS care program, gaining insights into the patient-centered medical home concept in managing chronic conditions for all patients.

## Follow Up to Questions and Answers

Below are responses to participant questions in the form of requests for links to resources related to HIV/AIDS care and prevention services.

### HIV Services for Women

Ryan White HIV/AIDS Program Part D grants provide family-centered primary care, specialty medical care, and support services for women, infants, children, and youth with HIV/AIDS. For more information about the program, including program priorities and grant cycles, go to: <http://hab.hrsa.gov/treatmentmodernization/partd.htm>.

### Ryan White Special Projects of National Significance (SPNS)

Ryan White SPNS funds innovative models of care and supports the development of effective delivery systems for HIV/AIDS care. See <http://hab.hrsa.gov/treatmentmodernization/spns.htm>.

### Building Health Center HIV/AIDS Capacity

Although health center planning grants are not available for current section 330 health centers, there are additional resources available to assist health centers with developing their HIV/AIDS capacity.

- The AETC National Center for Expansion of HIV CARE in Minority Communities seeks to strengthen the organizational capacity of Health Centers to deliver HIV care and treatment to racial and ethnic minorities. The focus is on Health Centers not funded by Ryan White. See <http://careacttarget.org> (Topics: Clinical Care).
- The Ryan White Part C Capacity Development Grant program is designed to assist public and nonprofit entities in their efforts to strengthen their organizational infrastructure and to enhance their capacity to develop, enhance, or expand access to high-quality HIV primary health care services for people living with HIV or who are at risk of infection in underserved or rural communities. Planning grant funds are intended for a period of 1 year. See <http://hab.hrsa.gov/treatmentmodernization/partc.htm>.

### Pre-Exposure Prophylaxis (PrEP)

PrEP is short for PreExposure Prophylaxis and is a form of HIV/AIDS prevention whereby HIV negative people who are at high risk take antiretroviral medications daily to try to lower their chances of becoming infected if they are exposed. To date, PrEP has been shown to be effective in MSM and transgender women who have sex with men. Studies are underway to evaluate whether it is safe and effective in reducing HIV infection among heterosexual men and women as well as injection drug users, but those results are not yet available. See CDC resources on PrEP, including fact sheets and interim guidance, at <http://www.cdc.gov/hiv/prep/>.

Ryan White HIV/AIDS Program funds cannot pay for PrEP as the person using PrEP is not HIV infected and therefore not eligible for Ryan White-funded medications. HRSA/HAB released a program letter to grantees about PrEP. See <http://hab.hrsa.gov/law/ltr1012.pdf>.

### **Access to HIV/AIDS Medications**

Beginning January 1, 2011 AIDS Drug Assistance Program (ADAP) copayments, premium assistance, deductibles, and co-insurance paid by ADAP count towards True Out-of-Pocket (TrOOP) expenses for ADAP-eligible/Medicare Part D-eligible clients. HRSA/HAB released a program letter to grantees about this policy change. See <http://hab.hrsa.gov/law/ltr1011.pdf>.