

**EXPLORING HIV/AIDS AND VIRAL HEPATITIS
HEALTH DEPARTMENT AND COMMUNITY HEALTH CENTER
COLLABORATIONS:
CONSULTATION SUMMARY AND ASSESSMENT REPORT**

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Prepared by:

National Alliance of State & Territorial AIDS Directors (NASTAD)
Christopher Cannon
Natalie Cramer
Ann Lefert
Murray Penner



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Executive Summary

In 2011, the National Alliance of State and Territorial AIDS Directors (NASTAD) examined the level of collaboration between state health department (HD) HIV/AIDS and viral hepatitis programs and community health centers (CHC) through a one-day consultation and a survey of all state and territorial health departments. This examination was supported by an independent educational grant from Janssen Therapeutics. The National Association of Community Health Centers (NACHC) provided technical expertise to NASTAD in the development of the consultation agenda and survey. The consultation was an opportunity for HDs, CHCs and federal partners to come together and identify “models of excellence,” opportunities to collaborate, the factors driving the need for greater collaboration and barriers and challenges to collaboration. The subsequent survey of HD HIV/AIDS and viral hepatitis programs was designed to substantiate the themes discussed during the consultation.

The summary of the consultation and survey will contribute to the development and prioritization of future technical assistance (TA) activities.

“Models of Excellence”

The existence of collaborations between HDs and CHCs was reported by 84 percent of survey respondents. Out of the 1200 CHCs across the country, approximately 130 Ryan White Part C funded CHCs and 151 non-Ryan White Part C funded CHCs are currently involved in collaborations with state HDs. Contractual agreements, providing TA, referring patients to clinical services and data sharing were identified as the most common collaborative relationships.

The consultation highlighted several collaborative “models of excellence.” Project ECHO is a telemedicine model being utilized in New Mexico, Washington and elsewhere. The Sixteenth Street Community Health Center and Chase Brexton Health Center have participated in creative partnerships with state and local HDs to pilot several new initiatives. The Massachusetts Department of Health demonstrated success through internal program integration with their HIV/AIDS and viral hepatitis programs in order to support mono-infected hepatitis patients, incorporating those programs into four Ryan White funded CHC programs at six sites. Together for Tots, a project designed to increase infant immunization rates, was a CDC and NACHC led initiative that increased dialogue among federal partners, CHCs and HDs to identify and agree upon necessary and effective performance measures.

Opportunities and Strategies

Service delivery is one area where HDs and CHCs can collaborate. An example of this is using shared personnel to increase capacity for both HDs and CHCs, thereby stretching limited

resources. This has been done successfully by the Los Angeles Gay and Lesbian Center and the New York State and Massachusetts HDs. The survey demonstrated that 31 percent of HIV/AIDS programs and three percent of viral hepatitis programs currently provide funds for staff positions in CHCs.

The Patient Protection and Affordable Care Act (ACA) mandates the expansion of CHCs and expansion of the Patient Center Medical Home (PCMH) model of care delivery into existing CHCs. This mandated expansion is an opportunity for HDs to be involved in planning and decision making processes by providing necessary community surveillance data and technical assistance to CHCs. Sixty-three (63) percent of HDs are providing surveillance data to CHCs in their jurisdictions. HDs can also provide lessons learned from the implementation of Ryan White Program care services, such as medical case management/care coordination.

Provider education is central to the future success of CHCs' expansion and integration of prevention and care services. Much of this education can be provided through TA programs provided by HDs. Eighty percent of HDs currently provide TA directly to CHCs.

Factors Driving Collaborations

The Ryan White Program, the National HIV/AIDS Strategy (NHAS) and the ACA are major drivers for greater collaboration between CHCs and HDs, according to consultation participants. Seventy-two (72) percent of respondents to the survey indicated the Ryan White Program drove collaboration 64 percent responded that the NHAS encouraged collaboration and 50 percent identified the ACA as a driver of collaboration.

Biomedical and technology advances were also identified as significant factors for collaboration at the consultation. State HIV/AIDS prevention programs (61 percent), care and treatment programs (58 percent) and viral hepatitis programs (39 percent) also identified biomedical and technology advances as significant factors driving collaboration.

Barriers and Challenges

The consultation participants identified eight challenges to achieving greater collaborations: "HIV/AIDS exceptionalism," stigma, chronic illness/co-morbidities, workforce capacity, definition of care coordination, clinical and data systems, financial sustainability/resource constraints and reimbursement. Survey results further demonstrate obstacles to collaboration as: CHC or provider apprehension to provide HIV/AIDS and viral hepatitis services, stigma of HIV and sexual behaviors and insufficient third party reimbursement for services. Financial resources contributing to collaborations consist of three main sources: Ryan White Part B funding (64 percent), Center for Disease Control and Prevention (CDC) resources (53 percent) and state funds (42 percent).

Introduction

Community Health Centers (CHCs) provide primary health care to more than 20 million patients in nearly 1,200 CHCs with over 8,000 locations, both urban and rural, across the United States and territories.¹ CHCs play a major role in the health care system by serving millions of uninsured or underinsured individuals. CHCs also generate nearly \$24 billion dollars in savings to the health care system by preventing unnecessary emergency rooms visits and hospitalizations.²

Currently, it is estimated that there are nearly 1.2 million individuals in the U.S. living with HIV infection with nearly half living with an AIDS diagnosis. Approximately 50,000 individuals are newly infected each year, with 42,959 individuals diagnosed with HIV in 2009.³ It is also estimated that there are between 3.5-5.3 million individuals living with viral hepatitis, and nearly 65-75 percent of those individuals are not aware of their infection.⁴ A sizeable percentage of individuals are living with both of diseases. There is an obvious overlap between populations served by CHCs and those most highly impacted by HIV/AIDS and viral hepatitis.

Interest in enhanced collaborations between CHCs and programs traditionally serving individuals living with HIV/AIDS and viral hepatitis has recently increased due to several factors, including the passage of the ACA, the release of the [NHAS](#), the continued stagnation of federal resources for Ryan White and other HIV programs and recently approved hepatitis C (HCV) diagnostics and treatments that greatly increase the possibility of a cure. Meanwhile, CHCs have experienced an increase in resources that may or may not translate into the provision of additional services. The impending changes to our nation's health system, due to health reform through the ACA, are likely to have a huge impact on how individuals living with HIV/AIDS and viral hepatitis receive care. Increased collaboration between health department (HD) HIV/AIDS and viral hepatitis programs and CHCs is one element in an ever-changing landscape of ensuring that people living with, and at risk for, HIV/AIDS and viral hepatitis receive the services they need.

The ACA, NHAS and the [Viral Hepatitis Action Plan](#) call for increased expansion of services in CHCs. The ACA specifically includes \$9.5 billion dedicated to fund new CHCs and expand

¹National Association of Community Health Centers. America's Health Centers, August 2011, available at: <http://www.nachc.com/client//America's%20Health%20Centers%20Fact%20Sheet%20August%202011.pdf>

²National Association of Community Health Centers. About Our Health Centers, available at: <http://nachc.org/about-our-health-centers.cfm>

³ CDC. Basic Statistics, August 11, 2011, available at: <http://www.cdc.gov/hiv/topics/surveillance/basic.htm#hivest>

⁴Department of Health & Human Services. Combating the Silent Epidemic of Viral Hepatitis 2011, available at http://www.hhs.gov/ash/initiatives/hepatitis/actionplan_viralhepatitis2011.pdf

capacity of existing CHCs to be able to care for an additional 20 million patients. This will be compounded when insurance coverage and Medicaid expansion begin for millions of individuals in 2014 who will seek medical services from CHCs. The NHAS sets goals to increase identification of individuals with HIV from 79 percent to 90 percent and reduce new infections by 25 percent, as well as link individuals to medical care within three months from 65 percent to 85 percent. The federal viral hepatitis plan has goals to increase the identification of hepatitis B virus (HBV) infections from 33 percent to 66 percent, increase identification of hepatitis C virus (HCV) infections from 45 percent to 66 percent and reduce new HCV infection by 25 percent.

The National Alliance of State and Territorial AIDS Directors (NASTAD), through an independent educational grant from [Janssen Therapeutics](#), engaged in a national assessment of the level of collaboration between state HD HIV/AIDS and viral hepatitis programs and CHCs. The assessment was two-fold. First, a one day consultation was organized to bring together representatives from HDs, CHCs and federal agencies. Second, a national assessment of state HD HIV/AIDS and viral hepatitis programs was conducted to gather baseline data on relationships and collaborations with CHCs and Primary Care Associations (PCAs). NASTAD received additional collaborative support from the [National Association of Community Health Centers \(NACHC\)](#) in the design of the assessment.

The overall purpose of the consultation and assessment was to identify best practice models of collaboration between HDs and CHCs, explore new opportunities for collaboration and examine existing obstacles to effective collaborations. NASTAD will disseminate the information from this report to HDs to stimulate their collaborative work with CHCs and to determine next steps in providing technical assistance (TA) and guidance to states in strengthening CHC and HD HIV/AIDS and viral hepatitis program relationships and collaborations.

Consultation Meeting Summary Report

On May 6, 2011, NASTAD hosted a one-day consultation designed to foster dialogue between representatives from state HDs, CHCs and federal agency partners on collaborations between state HD HIV/AIDS and viral hepatitis programs and CHCs (see Appendix A for consultation agenda). Through facilitated discussion, the consultation sought to:

- Identify successful examples of collaborative relationships;
- Identify specific obstacles to creating relationships;
- Identify the factors that affect the development and success of collaborations; and
- Identify strategies and opportunities to initiate collaborations.

The meeting also served as a springboard for the assessment of state HD HIV/AIDS and viral hepatitis programs that NASTAD conducted to gather baseline data on collaborations between HD HIV/AIDS and viral hepatitis programs and CHCs and PCAs.

Participants included HD representatives from Maryland, Massachusetts, New York, Texas, and Washington; CHCs from California, Maryland, New York, and Wisconsin; representatives from the Centers for Disease Control and Prevention (CDC), Health Resources and Services Administration's (HRSA) Bureau of Primary Health Care (BPHC) and HIV/AIDS Bureau (HAB), Health and Human Services Deputy Assistant Secretary for Health, Infectious Diseases, and collaborative partners from NACHC and HealthHIV (see Appendix B for a list of consultation participants).

This report is a synthesis of discussions held during the meeting. It provides examples of existing collaborations and challenges to establishing closer relationships between HDs and CHCs and provides a context for the environment in which collaborations exist.

Successful Examples of Collaborations

In planning the day-long meeting, NASTAD worked closely with NACHC to identify a geographically diverse mix of CHCs and HD HIV and viral hepatitis program staff. NASTAD identified both participants with active collaborations in place as well as others, particularly in high prevalence areas, where there was great potential for meaningful collaboration between CHC staff and HD HIV and/or viral hepatitis programs. Collaboration was defined as any partnerships between CHCs and HDs and during the meeting, participants examined a continuum of collaborations that included a simple contract of services relationship to fully integrated programs that share staff and/or resources. From the onset of the dialogue between meeting participants, there was a clear desire to identify CHCs and HDs that have highly integrated HIV/AIDS or viral hepatitis services as "models of excellence." Participants shared examples of innovation in creation of programs, models of care delivery and

collaboration. It was clearly expressed throughout the consultation that many of the examples involved collaborations between HDs and Ryan White Part C funded clinics located in CHCs.

By the end of the meeting, participants agreed that identification of “models of excellence” is crucial, but that additional examination of paths to enhanced HD and CHC collaboration is equally valuable to the success of future collaboration building (e.g., there are important lessons to be learned regarding the process, as well as from successful outcomes). In particular, greater work is needed on the future of primary care expansion in CHCs into HIV/AIDS and viral hepatitis services and the development of the Patient Center Medical Home (PCMH) care delivery. Both areas of focus are opportunities for future collaborations between HDs and CHCs. Insight can also be gleaned from Ryan White Program services provided within CHCs and programs that could be highly effective in promoting and creating new expansion projects and services.

Examples of best practice collaborations between HDs and CHCs are provided below:

Project ECHO

One the most innovative examples of collaboration between a HD and CHC is Project ECHO (Extension for Community Health Care Outcomes). Project Echo is a telemedicine initiative originally created by the University of New Mexico Health Sciences Center in New Mexico, partially funded by [Robert Wood Johnson Foundation](#), for the treatment of hepatitis among rural patients. This telemedicine program has recently proven to be as effective as standard clinical care for treating HCV⁵ and is an example of an effective private/public partnership. Similar programs have been developed and used in other treatment realms as well, including HIV/AIDS, diabetes, cardiac care and pediatrics.

The Washington State Department of Health has successfully adapted Project ECHO for use in Washington. Project ECHO in the state is designed to be a provider-to-provider support model in rural and Indian health centers across the state of Washington. The Washington State Department of Health has worked with the University of Washington and CHCs located in rural areas to facilitate enhanced care for individuals infected with viral hepatitis. The program allows primary care physicians to teleconference with viral hepatitis specialists located in Seattle and allows the primary care physicians direct hands-on experience and support to treat their own patients independently without making additional costly and burdensome outside referrals.

⁵ Arora, S., Thornton, K., Murata, G. et. al. *Outcomes of treatment for hepatitis C virus infection by primary care providers*. New England Journal of Medicine. June 1, 2011. Available at <http://www.ncbi.nlm.nih.gov/pubmed/21631316>.

Additional Project ECHO models are being created around the country. [Community Health Center, Inc.](#) (Connecticut) has also adapted this model in order to connect with experts in New Mexico, but also to connect their own clinics with their own specialists, allowing for more treatment services to be integrated into primary care throughout all their locations.

Sixteenth Street Community Health Center

One example of a highly integrated CHC is the Sixteenth Street Community Health Center in Milwaukee, Wisconsin. The Sixteenth Street Community Health Center has had a long standing collaborative relationship with both the local and state HDs. This collaborative relationship helped Sixteenth Street CHC increase its innovation and willingness to implement new projects and programs. The clinic, which began as a free clinic four decades ago, has successfully integrated a transgender care program into their more traditional services. The program provides medical care to this underserved and often stigmatized population and also hosts community events to support the population, such as a transgender pageant. The Sixteenth Street CHC has also created a syringe exchange program operating from one of their clinical sites and has agreed to be a pilot site for rapid HCV testing. Taking on new approaches and services requires cultural competency training of staff to better understand and provide care to the local community. Some of these programs were initiated within the CHC and some were initiated by the HD. But all have grown successfully through coordinated support and dialogue.

Chase Brexton Health Center

Another highly integrated CHC is Chase Brexton Health Center in Baltimore, Maryland. Chase Brexton was the first Lesbian, Gay, Bisexual and Transgender (LGBT) health center to gain Federal Qualified Health Center (FQHC) recognition in the U.S. One of Chase Brexton's more successful collaborations came during an expansion to a new site in Howard County, Maryland. This collaboration involved both the local county and state HD to establish its new location in an underserved area. Taking a lead in collaborating on a county-based insurance program called Healthy Howard, Chase Brexton became the primary site for the uninsured population in the county. Chase Brexton was involved from the beginning, allowing design of a program that works for the structure within the community. Another example of an effective collaboration between Chase Brexton and the state HD was during the recent swine flu epidemic of 2009. Together, the clinic and the HD, along with other health facilities, were able to strategize and implement a successful statewide vaccination program.

Massachusetts Program Integration

The Adult Viral Hepatitis Coordinator from the Massachusetts Department of Health shared how CHCs, working with Ryan White Programs, have integrated viral hepatitis services into existing programs. The collaboration is two-fold. First, the viral hepatitis program in Massachusetts is fully integrated into the HIV/AIDS program within the state HD making it easier for coordination of both programs and sharing of valuable, yet limited, services and resources. Second, the HD implemented its mono-infected HCV program alongside existing Ryan White HIV/AIDS programs. The existing Ryan White Program's care coordination system was the entry point for integrating the mono-infected HCV program into four Ryan White Part C funded CHC programs at six sites, with expansion into more centers planned for this year. This program utilized the existing medical case management model to provide valuable services for individuals to navigate the health care system to insure that mono-infected HCV individuals are accessing necessary care and treatment services.

New York State Health Department

In 2008, New York State established specific state funding for comprehensive hepatitis C care and treatment services to facilitate integration of these services into primary care settings, including Federally Qualified Health Centers (FQHCs). Thirteen sites have been funded with eight sites also receiving Ryan White funds to support co-infected individuals. Services provided include mental health, care coordination, adherence support, nutritional support and substance abuse treatment. The first year for the five year program just closed and initial data shows positive results with identification of 490 new HCV mono-infected individuals, with 27 percent of identified individuals initiating treatment.

Together for Tots

Collaboration between HDs and CHCs is not limited to treatment issues, and can also be found on larger system issues such as the use of performance measurements. These levels of collaboration often require the participation of federal agencies. One example of this type of collaboration, led by NACHC and CDC, is the Together for Tots project in the 1990s that was focused on increasing immunization rates of infants. The key to this successful model was the support of the CDC to bring everyone from state HDs and local CHCs together to educate them on the new clinical measures. PCAs were also integral to the success of this relationship as they encouraged CHCs to participate directly in conversations about performance measures. Having a joint collaborative discussion allowed for partners to share exactly what they do, how they do it, and why they do it, but it also allowed them to create a common language and agree upon essential data requirements. As a result of the collaboration,

immunization rates increased from 54 percent to 84 percent between 1996 and 2000 across ten states using quality improvement to improve immunization rates in CHCs.⁶

Additional Examples of Collaboration

The collection and use of data is both a challenge and an area where examples of best practices are available. Some great collaborative work on issues of data has been taking shape with Health Center Controlled Networks (HCCN), as detailed by BPHC. These HCCNs are networks of CHCs within a regional area that join forces and work to integrate an electronic medical record system. Two of the largest HCCNs currently are the Oregon Community Health Information Network, which has 43 organizations with 200 different sites, and Health Choice Network in Miami, Florida, which has nearly 50 health center organizations covering almost one million patients. HCCNs allow for enhanced collaboration between CHCs and specialty providers by tapping into a wider network of clinics and service providers. This in turn, has allowed for the streamlining of data collection and referrals of patients. These new HCCNs are demonstrating strong collaborations between CHCs, but are currently limited in their relationships with HDs. BPHC stated that HCCNs are a potential opportunity for collaboration between CHCs and HDs.

Another example of collaboration is a recent [Minnesota Community Health Center-Ryan White Care Act Summit](#) held in Minneapolis, Minnesota in September 2011. HRSA's Office of Regional Operations, Minnesota Department of Health (MDH), and the Minnesota Association of Community Health Centers (MACHC) collaborated to plan a meeting to bring together all Ryan White Program grantees and CHCs in the state to focus on implementing the National HIV/AIDS Strategy in Minnesota. The meeting's objective was to bring all the CHCs and Ryan White Program grantees together with the state HD to network and collaborate on common issues. The meeting allowed for dialogue and relationship building in order to begin to address shared issues and challenges, as well as highlight and promote successful programs.

Opportunities and Strategies to Initiate Greater Collaboration

A number of opportunities to begin the process of building collaborations between CHCs and HDs emerged as themes from the consultation. Three major themes were service delivery, ACA resources and provider education.

⁶Centers for Disease Control and Prevention. *Principles of vaccination*. 2004. Available at <http://www2a.cdc.gov/nip/isd/immtoolkit/content/products/pinkbook.pdf>

Service Delivery

Service delivery may have the greatest impact on an individual's health and requires reexamination of the role of HD and CHCs staff. For example, the Los Angeles Gay and Lesbian Center identified areas where the inclusion of HD disease intervention specialists/partner services (DIS/PS) staff were integrated into the clinic in order to have a greater impact on promoting testing and treatment for HIV and viral hepatitis. In some jurisdictions, these integrated DIS/PS employees are responsible for conducting the public health investigations and partner notification services for the HD, but are full-time employees of the CHC. This model has been effective in the Los Angeles Gay and Lesbian Center as it recently secured funding for three additional DIS/PS staff. The New York and Massachusetts viral hepatitis programs were able to fund other staff positions, such as care coordinators within CHCs, in order to build capacity and increase access to care, creating variations of PCMH models.

Private and public partnerships, such as between HDs and private foundations and universities, may increase funding and structural support opportunities for programs in an era of limited or declining governmental funding. These partnerships may also encourage innovation and creativity in capacity building and technical assistance projects. Project ECHO is an example of a program that was developed with private funding, with collaborative support of a state university. Private/public partnerships may provide funding as well as opportunities for research and development that is often not traditionally utilized by HDs and CHCs.

Technology is a great opportunity for collaboration in service delivery. Telemedicine, such as Project ECHO, can be used in a variety of settings and capacities to provide care to individuals who are traditionally underserved. Use of technology can also support greater learning opportunities through teleconferencing and telelearning among providers, program staff, researchers and HD experts from around the country.

Affordable Care Act (ACA) Resources

The ACA will provide financial support to encourage new opportunities of collaboration. The ACA calls for the expansion of CHCs and the development of PCMH within these centers. Federal guidelines for funding of CHCs requires community involvement on CHC boards. CHCs should invite HD representatives to the table, while HDs should insist on participating as community experts. HD participation can ensure greater use of data focused on community needs assessments and ensuring that HIV/AIDS and viral hepatitis services are a part of important conversations to increase these needed services. And as preparation continues for full ACA implementation in January 2014, HDs have a unique opportunity to help ensure that

CHCs are ready for the increased HIV/ AIDS and viral hepatitis service delivery that will result from more individuals with insurance coverage (either public or private) seeking access to regular healthcare. HDs can provide increased TA and provider education to better adapt and improve services, as well as begin to focus on data collection and utilization improvements to limit the burden already placed on HDs and CHCs. HDs participating in HCCNs, for instance, would have greater access to data that is more timely and accurate, which will assist in greater assessment of dynamic community needs.

Provider Education

Through collaborations with CHCs, HDs can also present lessons learned to non-Ryan White CHCs about creating and maintaining care coordination using the Ryan White service model of medical case management. Provider education will help support meeting the goals of the NHAS and the Viral Hepatitis Action Plan. In order for primary care services to expand to include HIV and hepatitis services, many providers need to be educated and trained efficiently and effectively. With limited numbers of ID specialists, more PCPs will be needed to provide the long term care and treatment to achieve the NHAS goal of increasing access to care and improving health outcomes. Improved access to care will have a collateral effect of reducing new HIV infections by providing treatment to more HIV infected individuals⁷ as well as minimizing health disparities among high-risk populations. HDs can provide education to CHCs on HIV/ AIDS and viral hepatitis prevention, testing, treatment guidelines and cultural competency, including comprehensive sexual health for all individuals, particularly gay, lesbian, bisexual and transgender individuals.

Provider education collaboration could also include establishment of training programs for nurses and doctors to perform clinical rotations in CHCs. This can be an opportunity for greater partnerships with local colleges and universities, which could increase staffing capacity and lead to greater opportunities for providers to learn and practice primary care over specialty care, as well as receive cultural competency training.

Factors Driving Increased Collaboration

Throughout the consultation, participants discussed a variety of legislative and federal laws, policies and initiatives, new technologies, biomedical advances and funding opportunities that are factors driving the need for collaboration building between public health and CHCs.

⁷ Cohen, M., Chen, Y., McCauley, M., et al. *Prevention of HIV-1 Infection with Early Antiretroviral Therapy*. August 11, 2011. Available online at New England Journal of Medicine <http://www.nejm.org/doi/full/10.1056/NEJMoa1105243>.

Federal Initiatives

The ACA is the biggest change to our nation's health system in recent years. In 2014, more individuals will be insured than ever before. The increase in insurance coverage will provide greater opportunities for CHCs to seek reimbursement for services. The ACA also includes an expansion of CHCs through the building of new CHCs in underserved areas and by expanding operational capacity at existing clinics to enhance medical, behavioral or oral health services.

The NHAS [HHS Operational Plan](#) clearly addresses the role of CHCs in meeting the goals of the Strategy. The plan states that there will be examination of 12 jurisdictions through the CDC's "Enhanced Comprehensive HIV Prevention Planning and Implementation for Metropolitan Statistical Areas Most Affected by HIV/AIDS" (ECHPP) which requires participation of CHCs within those jurisdictions to undertake planning to identify needs and close gaps in programming for high-risk populations. HRSA will also assess the level of HIV testing in CHCs and develop and deliver TA to expand HIV testing, care and treatment capacity. HRSA and CDC also plan to identify and provide strategies for developing "co-location" of HIV testing and care services in CHCs.

Over the past 20 years, the Ryan White Program has successfully built a comprehensive medical and support system for uninsured and underinsured individuals living with HIV/AIDS. However, in many areas, this system has remained separate from other health care services in their communities. When many aspects of health reform are implemented in 2014, the Ryan White Program will need to appropriately address gaps in services that will exist. Many individuals receiving their care solely through Ryan White Programs will receive services through the Medicaid expansion and insurance purchased through the health exchanges. While there is currently agreement among HIV/AIDS community advocates of the need for Ryan White services beyond 2014, there is also agreement that the composition of necessary services may change. This is an opportunity for CHC and HDs to collaborate on lessons learned by establishing care coordination through the PCMH delivery model and CHC accreditation as FQHCs. Additionally, Part C of the Ryan White Program allocates money directly to clinics. Some of these clinics are CHCs, but many others are beginning to examine the need to partner with an existing CHC or pursue FQHC status for future sustainability. Establishing partnerships between clinics and HDs is a great opportunity to examine community need, strengthen and support existing programs and create new programs.

Biomedical and Technology Advancements

Biomedical and technology enhancements are sparking examination for collaborations as well. In recent months, the introduction of Pre-Exposure Prophylaxis (PrEP) to prevent HIV

infection, a new rapid HCV test and new HCV medication options are all contributing to greater expansion of services in primary care settings. As result of these advancements, new guidelines are also often released to ensure proper implementation of the interventions. For example, CDC recently released [interim guidelines for PrEP](#) and will soon release updated guidelines for increased HCV testing as part of routine standard of care for individuals born between 1945 and 1965.⁸ These new scientific advancements and implementation guidelines are opportunities for HDs to educate CHCs and other providers about HIV/AIDS, viral hepatitis and cultural competency issues. These advancements are also an opportunity for better prevention efforts to occur through early interventions.

Barriers and Challenges to Effective Collaborations

As with opportunities for building strong collaborative relationships between CHCs and HDs, there exist numerous challenges that must be addressed. The challenges range from the philosophical to the tangible. The following highlights represent current barriers to collaboration that emerged from the consultation, but these challenges may also represent unique opportunities for collaboration itself, through further discussion, examination and problem solving.

HIV/AIDS Exceptionalism

Participants expressed concern about “HIV/AIDS exceptionalism” being a major hindrance to successful collaborations. The standard of care for HIV/AIDS has traditionally been provided by an infectious disease (ID) specialist. These specialists often become the primary care physician (PCP) for patients’ other medical needs as well, which has perpetuated the idea that HIV infected individuals have more medical demands and need more specialty care. This then creates a circle of providers not wishing to treat outside of their scope and patients that are distrustful of providers that are not infectious disease specialists. However, because of the chronic nature of both HIV/AIDS and viral hepatitis infections, patients may not always need to be treated by ID specialists. HIV and viral hepatitis can increasingly be treated through effective medication regimens that are easier and less toxic. Follow-up care with a PCP versus an ID specialist for regular monitoring and maintenance may be more pragmatic for some or many individuals. With a variety of capacity constraints and limited resources, most CHCs have few, if any, ID specialists on staff and are staffed primarily with PCPs (the exception to this is Ryan White funded Part C clinics). With appropriate provider education, many CHCs, therefore, may be able to effectively provide primary care services to people living with

⁸ Family Practice New Digital Network. *CDC Poised to Advise Screening of Baby Boomers for HCV*. 2011. Available at <http://www.familypracticenews.com/news/more-top-news/single-view/cdc-poised-to-advise-screening-baby-boomers-for-hcv/f41b1fd64a.html>.

HIV/AIDS and viral hepatitis. The CHCs may still need to establish outside referrals for specialty HIV and viral hepatitis services, which may create barriers to care for clients (e.g., clients often have limited ability to travel to and from medical appointments.) unless innovative programs such as telemedicine are incorporated to minimize access challenges.

There is no one necessary or correct model of treatment, but integration of the primary and specialty care may improve the quality of care being provided in many communities. This integration will require greater collaboration between existing Ryan White HIV/AIDS programs (often funded by the HD) and CHCs (providing primary care).

Stigma

Many participants identified stigma as a barrier to the establishment of collaborations. HDs reflected that some CHCs are not open to providing care to HIV or viral hepatitis infected individuals or the populations most at risk of becoming infected with HIV and viral hepatitis. CHCs reflected that the specialized nature of HIV care and the specific requirements and/or protocols of the Ryan White Program were disincentives for providing HIV care.

Several participants expressed concerns related to provider education, particularly in the areas of cultural competency and sensitivity. Many providers have not been trained in how to discuss issues related to sexual behavior, drug use and gender identity. In order to achieve many of the goals of the NHAS, in particular reducing HIV-related health disparities, providers must learn to speak openly and in a culturally competent manner about issues of sexual orientation and behaviors, substance use and gender identity. This will address the negative effects of ongoing stigma and discrimination which is a barrier for many high-risk communities (e.g., men who have sex with men, Blacks and Latinos) from engaging in long-term care. Having frank and clear discussion in safer environments will provide opportunities to discuss behavior changes and provide more effective medical care, thus helping to meet other goals of the NHAS. More individuals engaged in care and receiving treatment will also provide greater opportunities to decrease the incidence of HIV infection, recently demonstrated in the HIV Prevention Trials Network study (HPTN 052).

Chronic Illness/Co-morbidities

Nearly all the CHC participants discussed HIV/AIDS and viral hepatitis as being complex and chronic illnesses or mentioned issues of co-morbidities as being a barrier to collaborations with HDs on these issues. With very effective antiretroviral therapies for HIV and new therapies recently approved and many more in the pipeline for HCV, many people with HIV and/or viral hepatitis are living longer. However, longer lifespans bring additional illnesses and age-related medical conditions. The expertise or training required for medical providers to

address these issues will be critical for HDs to investigate in order to present additional opportunities for PCPs located in CHCs to “buy-in” to providing HIV and/or viral hepatitis services.

Workforce Issues

The capacity of the existing healthcare workforce presents a major challenge for integrating HIV and viral hepatitis services at CHCs. This includes capacity of available providers and professional staff, but also the level of education providers receive about HIV and viral hepatitis.

The diminishing number of available health care professionals at all levels from primary care doctors to nurses to support staff has been widely reported.⁹ Both CHCs and HDs have experienced the effects of the decreased workforce.¹⁰ Primary care capacity is diminishing as physicians are increasingly electing to practice in specialty care fields versus primary care. This is often attributed to the level of income provided from billable services. Additionally, there are not enough mid-level providers such as nurses and medical assistants coming out of medical training programs to fill the necessary demands. HD representatives also asserted that the decreasing capacity within their programs, due to state budget cuts, was affecting their ability to create connections with CHCs as meaningful engagement takes dedicated staff time and resources.

Meeting participants contend that limited knowledge among providers about cultural competency is due to the lack of direct experiential opportunities. Opportunities could be afforded to providers with more clinical training in CHCs that work with specific populations including gay men and lesbians, active substance users, transgender individuals, the homeless, and immigrants. Some HDs have collaborated with CHCs to assist with cultural competency trainings, but limited staff and resources have resulted in challenges to maintain these collaborations.

What Is Care Coordination?

Participants also discussed challenges with the definition and role of care coordination within the PCMH model. The model requires that care coordination is provided by a PCP or nurse. This can be limiting and meeting participants discussed the need to expand the types of providers that fill this role. Some participants identified questions that need to be addressed

⁹Kaiser EDU.org. Primary Care Shortage, April 2011. Available at: <http://www.kaiseredu.org/Issue-Modules/Primary-Care-Shortage/Background-Brief.aspx>.

¹⁰American Public Health Association. The Public Health Workforce Shortage: Left Unchecked, Will We Be Protected? September 2006, available at: <http://www.apha.org/NR/rdonlyres/8B9EBDF5-8BE8-482D-A779-7F637456A7C3/0/workforcebrief.pdf>.

to allow for greater expansion of care coordination: Can this role be outsourced to other individuals? What is the necessary educational level required for this role? Can this activity be paid for under current payment mechanisms, or can the current mechanisms be changed to allow for adequate payment of services?

Clinical and Data Systems

CHC participants voiced concern that many of the federal policies and action plans will create further burden on already over-stretched CHCs that have higher than average patient-provider ratios than most private clinics and have high rates of burn-out among their personnel. Several participants expressed trepidation that more coverage or expansion of services (e.g., screening, care, and/or referral) will not automatically translate to quality care, unless expansion is properly examined and carefully implemented.

Another challenge is the difference in data systems and reporting requirements used by CHCs and state HD HIV/AIDS and viral hepatitis programs. Many HD participants expressed their frustration with the onerous grant reporting requirements of various federal HIV and viral hepatitis funding streams. The data that state HIV/AIDS programs are required to report to their funders can make it difficult to contract with CHCs to provide these services because their systems are not always constructed to provide and share data in a consistent manner. Both HD and CHC participants stated that there must be a focus within federal agencies to streamline federal reporting requirements.

Related to the performance measures discussed earlier are the inconsistent and incompatible data collection systems required by multiple funding sources. CHC and HDs that are Ryan White funded are required to report through CAREWare or other locally developed systems such as ARIES (AIDS Regional Information and Evaluation System), while many CDC funded projects are required to use the National HIV Monitoring and Evaluation (NHM&E). Currently, neither data system is able to share data and is further complicated if the CHC has an electronic medical records (EMR) system, which may or may not be compatible with any of these data collection systems and/or with other EMR systems. This data burden is even greater if the CHC or HD is not able to electronically collect the necessary data and must audit paper files for completion of required reports.

Financial Sustainability/Resource Constraints

Frustration was expressed by many participants about financial sustainability of existing collaborations and programs. Due to the current economic situation, federal and state funds for public HDs and CHCs are often times insufficient to meet demand for services. This undermines the ability of organizations to grow and implement new programs or even

maintain existing programs. Staffing is often one of the first resources targeted for cuts in the face of limited funding.

Many new funding opportunities require greater collaboration. One example of this collaboration is within the Sixteenth Street CHC. The Sixteenth Street CHC has worked with the local HD to become a collection center for urine based STD screening when the HD was challenged with maintaining an underutilized facility due to budget constraints. This type of collaboration meets community needs and also stretches limited resources by using existing health clinics to conduct necessary services.

The financial costs of expanding HIV services are often a major obstacle for many CHCs. CHCs that are providing HIV services openly discussed that they are performing these services through Ryan White Program Part C funding and without such funding they would not be able to continue these services. The future of the Ryan White Program and the uncharted territory of the ACA have created a number of additional questions about the financial sustainability of CHCs and access to HIV services.

Reimbursements

Adequate reimbursement for services provided at CHCs is another obstacle raised by meeting participants. CHCs are struggling under the current fee-for-service structure where many of the services lack adequate reimbursement under existing insurance programs. Many related non-medical or preventative services (e.g., HIV education, case management, etc.) are often not reimbursable under current payment mechanisms. The challenge comes as many of these wrap around services will increase as PCMH demonstration projects begin to expand. A comprehensive review of the current reimbursement system available to CHCs for HIV and viral hepatitis-related services could be useful to ensure adequate payment and coverage of services.

Conclusion

The consultation's objective was to identify possible "models of excellence," factors for the creation of and barriers to collaboration and strategize opportunities to establish new collaborations. The meeting was successful in meeting these objectives. Using the above information gleaned from this consultation, NASTAD identified areas of focus to be included in a survey of HDs, conducted in July 2011, that further examined the level of collaboration between HDs, CHCs and PCAs. The results of this survey are presented in the next section of this report.

CHC Collaboration Assessment Report

Introduction

According to NACHC, over 20 million people seek medical care at CHCs across the country. Currently, there are millions of individuals in the U.S. who are uninsured or underinsured and utilize CHCs because they often have sliding scales for payment of services, with many individuals often qualifying for free care. Some of these individuals seeking treatment are individuals living with HIV/AIDS and viral hepatitis.

NASTAD conducted an assessment of state HDs in July 2011 in order to identify best practice models of collaboration, new opportunities for collaboration and existing obstacles to collaboration. This assessment report will help guide NASTAD in providing TA for HDs and CHCs as they work together on implementation of the NHAS and the ACA. NASTAD will also work closely with NACHC and HealthHIV on next steps.

Assessment Methodology

With input from the previously described consultation and from NACHC on the survey design, NASTAD collected information electronically from state HDs through the use of a *Survey Monkey* online questionnaire (see Appendix C). The survey had a total of 42 questions which were either Yes/No format, multiple choice or open-ended.

The survey was transmitted electronically to 54 state and territorial HDs on June 28, 2011. A reminder notification was sent to all HDs prior to the survey closing date of July 15, 2011. Following that, individual email requests were sent to 10 individual jurisdictions that had not responded to the survey requesting that the survey be completed. A final total of 43 responses (80 percent of those receiving the survey) were collected and reviewed. Regional distribution of respondents to this survey was balanced with 23 eastern states, 19 western states, the District of Columbia and U.S. Virgin Islands completing the survey.

Analysis of Data

NASTAD exported the completed survey from *Survey Monkey* in an Excel spreadsheet. The data was analyzed and an aggregate summary of the 43 responses is presented below.

Assessment Findings

Collaborations

Collaborations between HDs and CHCs do exist, but as the data presented below demonstrate, much of this collaboration is limited in scope. Most of the collaborations that currently exist

are associated with the requirements of the Ryan White Care Program, and many of those are limited to service contract agreements and TA supported by HDs.

Of the 43 states completing the survey, 36 HDs (84 percent) reported that they do collaborate with CHCs, while seven (16 percent) stated they do not collaborate directly with CHCs. When asked about collaboration with PCAs, the local professional membership organizations of PCPs and CHCs, 27 HDs (64 percent) reported that they work together, while 15 (36 percent) responded that no relationship exists. Those states without collaborations with CHCs reported they were not able to do so because CHCs are not responsive to collaboration, that Ryan White HIV services are being handled at specialty clinics and not within CHCs or that collaborations are through PCAs only.

Thirty-six HDs reported having collaborative relationships between HDs and CHCs. These collaborations are varied and numerous, as illustrated in Table 1.

Table 1

Which of the following describes your programs' collaboration(s) with CHCs? (please select all that apply)	Response Percent (%)	Response Count (n=36)
Provides support for CHC services through a contractual or grant agreement.	69%	25
Technical assistance or educational services are provided by the HD to the CHC or PCA.	67%	24
The state HD refers patients to the CHC for outpatient, primary care services.	61%	22
The CHC refers patients for services directly provided by the state HD.	56%	20
Share information/data with the CHC for community needs assessments.	42%	15
Provides programmatic monitoring for state HD funded services.	36%	13
Other (please specify)	22%	8

HD relationships with PCAs are similar to collaborations with CHCs. Ten HDs stated that they are participating in regular meetings or serve on committees with local PCAs, six reported providing TA to PCAs and its members and five responded that they are working together to implement expanded HIV testing or HIV medical services. Four HDs also reported planning and creating data sharing systems, three are participating in the state's PCA annual meeting or conference and one reported designing plans for implementing medical home models of care delivery.

In order to understand the collaborative relationships that exist, identifying the factors impacting these relationships is important, especially as many of these factors could facilitate more collaborative relationships. These factors are indicated in Table 2.

Table 2

What factors or issues are informing or impacting your program’s current collaborations with CHCs? (please select all that apply)	Response Percent (%)	Response Count (n=36)
Ryan White	72%	26
National HIV/ AIDS Strategy	64%	23
State HIV/ AIDS Prevention Plans	61%	22
State HIV/ AIDS Care Plans	58%	21
Affordable Care Act	50%	18
State Viral Hepatitis Plans	39%	14
Other (please specify)	31%	11
National Prevention Strategy	28%	10
Healthy People 2020	22%	8
National Quality Strategy	8%	3
Legislative directive	6%	2

Other individual factors reported by some HDs that drive their collaborative relationships were related to CDC guidance and funding (n=5), IOM Hepatitis Report (n=1), Project ECHO¹¹ (n=1), state budget limitations (n=1) and existing CHC collaborative models (n=1).

Leadership and participation is equally important to the overall success of a strong collaborative relationship between CHCs and HD programs. The types of leadership that HDs reported exist in collaborative relationships with CHCs are described in Table 3.

Table 3

¹¹ Project ECHO. A force multiplier: Spreading access to specialty health care. Feb. 15, 2011. Available at: <http://www.rwjf.org/pioneer/product.jsp?id=71905>

Which of the following organizations and individuals participate in your program's current CHC collaboration? (please select all that apply)	Response Percent (%)	Response Count (n=36)
HIV/ AIDS program director	89%	32
CHC provider staff	78%	28
CHC administrative leadership (i.e., CEO, CFO, Medical Director)	64%	23
HD leadership (i.e., Director, Medical Officer, etc.)	56%	20
Hepatitis program director	56%	20
Primary Care Associations	50%	18
Other (please specify)	25%	9
HRSA/BPHC	14%	5

Other partners that HDs reported were involved in collaborative relationships include HRSA/BPHC (n=5), local HDs (n=3), Ryan White Program subgrantees (n=2) and HRSA Regional Offices (n=1).

Strong collaborations between HDs and CHCs may be based on the service program for which the collaboration exists. State HDs reported that they are collaborating on a variety of programs with CHCs (Table 4).

Table 4

In which of the following areas do your programs partner? (please select all that apply)	Response Percent (%)	Response Count (n=36)
HIV prevention and testing	84%	30
HIV care and/or treatment	81%	29
STD testing, care and/or treatment	72%	26
Viral hepatitis prevention and testing	56%	20
Oral health	33%	12
Behavioral health (i.e., mental health and/or substance abuse treatment)	31%	11
Other (please specify)	28%	10
Viral hepatitis care and treatment	25%	9
Emergency preparedness	3%	1

Additional unique programs that states reported collaborations with CHCs include infection control (n=3), education and TA programs (n=2), case management (n=2), quality management and planning (n=2) and emergency preparedness (n=1).

Table 5 shows the types of CHCs that exist and how these relationships are being funded.

Table 5

What is the source of this funding being provided to CHCs as part of the collaboration?(please select all that apply)	Response Percent (%)	Response Count (n=36)
Ryan White Part B	64%	23
Centers for Disease Control HIV or hepatitis funds	53%	19
State funds	42%	15
Other (please specify)	22%	8
None of the above applies; we do not provide funding to CHCs	17%	6
Ryan White Part D	6%	2
Ryan White Part F	3%	1

HIV/AIDS Testing, Prevention, and Treatment

Collaborations between HDs and CHCs are primarily focused on HIV/AIDS testing, prevention and treatment services versus hepatitis services. This is likely a result of the amount of funding provided for HIV/AIDS versus viral hepatitis services. The source of funding for HIV testing relationships in 27 HDs (84 percent) is from CDC core prevention grant funds, in 16 (50 percent) it is from state funds and in 12 (38 percent) it is from CDC PS10-10138 Expanded Testing Program grants. Table 6 illustrates how HDs collaborate with CHCs in providing HIV testing services, with the greatest focus being on training and TA for staff and providing test kits to CHCs. Table 7 demonstrates HIV prevention focus areas, with partner notification and HIV counseling being the top services supported. Table 8 details the HIV treatment focus areas, with laboratory testing, treatment in primary care and medical case management being the top three services supported.

Table 6

How does your program directly support the CHCs in their HIV testing programs? (please select all that apply)	Response Percent (%)	Response Count (n=36)
Training to build skills and/or certify staff	81%	29
Provide test kits	78%	28
Provide laboratory testing services	64%	23
Educate and promote awareness	64%	23
Provide direct funds	44%	16
Fund staff position(s)	31%	11
Other (please specify)	19%	7
Not applicable	11%	4

Table 7

With which other HIV prevention services does your program currently collaborate with CHCs (please select all that apply)?	Response Percent (%)	Response Count (n=36)
Partner notification services	56%	20
HIV counseling	56%	20
Condom distribution	47%	17
Evidence based interventions including DEBIs	33%	12
Prevention for positives	33%	12
Not applicable (we don't collaborate on prevention services)	22%	8
Post-exposure prophylaxis (PEP)	8%	3
Other (please specify)	6%	2
Syringe exchange	3%	1
Pre-exposure prophylaxis (PrEP)	3%	1

Table 8

With what HIV care and treatment related areas are your programs collaborating with CHCs?(please select all that apply)	Response Percent (%)	Response Count (n=34)
Laboratory testing (i.e., viral loads, CD4 counts, genotyping, resistance testing)	68%	23
HIV treatment in primary care	65%	22
Medical case management	62%	21
Medication adherence	53%	18
Oral health	41%	14
Behavioral health (i.e., substance abuse treatment and/or mental health treatment)	35%	12
Not applicable (we don't collaborate on care and treatment areas)	21%	7

Viral Hepatitis Testing, Prevention, and Treatment

Viral hepatitis testing, prevention and treatment are areas where collaboration exists on a lesser level compared to HIV/ AIDS services, as demonstrated below. Of the hepatitis related questions on the assessment, "not applicable" was among the top five responses to each question. Respondents indicated this was due to lack of funding, demonstrating deep limitations of collaborations currently in place that may otherwise focus on hepatitis services. HD support (i.e., financial and/or material) is highlighted in Table 9. Specific program support (i.e., funding or vaccine) for hepatitis A and B was nearly equal among the 36 HDs reporting with 17 (47 percent) responding affirmatively to providing such support and 19 (53 percent) not currently providing this support. How HDs are planning to expand (or initiate)

hepatitis C testing is exhibited in Table 10 while those planning to expand (or initiate) care and treatment for hepatitis C is demonstrated in Table 11.

Table 9

How does your program directly support CHCs in their viral hepatitis testing programs? (please select all that apply)	Response Percent (%)	Response Count (n=36)
Not applicable (we don't support viral hepatitis testing in CHCs at this time).	44%	16
Educate and promote awareness	44%	16
Provide laboratory testing services	31%	11
Training to build skills and/or certify staff	25%	9
Provide testing supplies/kits	17%	6
Other (please specify)	14%	5
Provide direct monetary support	6%	2
Fund staff position(s)	3%	1

Table 10

What is your program planning to do in the future to further expand (or initiate) HCV testing? (please select all that apply)	Response Percent (%)	Response Count (n=35)
Provider education campaign implementation	49%	17
Not applicable, we currently do not have plans	34%	12
Development of guidelines for testing	29%	10
Provider training and certification	23%	8
Other (please specify)	14%	5
Purchase of laboratory services	14%	5

State HDs also stated that HCV testing would be expanded through establishing rapid testing guidelines and providing HCV test kits (n=3) as well as greater integration with HIV testing services (n=3).

Table 11

What is your program planning to do in the future to further expand (or initiate) HCV care and treatment? (please select all that apply)	Response Percent (%)	Response Count (n=34)
Provider education campaign implementation	56%	19
Provider training and certification	32%	11
Development of guidelines for testing	29%	10
Not applicable, we currently do not have plans	27%	9
Other (please specify)	18%	6
Purchase of laboratory services	6%	2

“Other” responses included five HDs noted they plan to work on creating or expanding the telemedicine/ECHO project into their programs and one that reported working to integrate hepatitis C services into its existing HIV/AIDS program.

Technical Assistance and Education

HD HIV/AIDS and viral hepatitis programs also collaborate with CHCs and PCAs by providing education and TA. This represents the greatest area of collaboration currently in existence between HDs, CHCs and PCAs. The assessment, however, did not examine the effectiveness of these collaborations. Of the 41 respondents to this question (two states did not answer the question), 33 HDs (80 percent) provide TA to CDCs utilizing HD staff, eight (20 percent) provide funds for other individuals or organizations to provide TA and one (two percent) provides financial support to the PCA directly to meet TA needs. The modalities used to provide the TA are shown in Table 12 and TA topics provided in Table 13.

Table 12

What modalities does your program use to provide training to the CHCs or PCAs in your state (please check all that apply)?	Response Percent (%)	Response Count (n=35)
On-site trainings	77%	27
Off-site trainings	74%	26
Webinars or interactive classrooms	46%	16
Step-by-step guides/manuals	37%	13
Online tutorials	17%	6
Other (please specify)	11%	4

Other modalities identified by state HDs included conference calls, epidemiology bulletins, PCA newsletters/website and contracted trainers from other organizations.

Table 13

What subject areas does your program provide TA or training to CHC staff?(please select all that apply)	Response Percent (%)	Response Count (n=35)
HIV testing guidelines	77%	27
Data reporting requirements	69%	24
Medical case management	57%	20
HIV prevention practices	43%	15
HIV treatment guidelines	37%	13
Viral hepatitis prevention practices	37%	13
Viral hepatitis testing guidelines	31%	11
Provider certification or continuing education	31%	11
Cultural competency/sensitivity training	29%	10
Other (please specify)	17%	6
Viral hepatitis treatment guidelines	14%	5

Some programs also reported providing TA on sexually transmitted diseases other than HIV/AIDS and viral hepatitis (n=3), reimbursement guidance (n=1), funding sources and roles of AIDS Education Training Centers (n=1) and disease investigation activities (n=1).

Data Sharing

As previously described, differing data requirements and systems present a challenge for collaborations between HDs and CHCs. Currently, only 11 HDs (27 percent) have data sharing agreements in place with CHCs. Of the 11 HDs with data sharing agreements, all but one is using an electronic data sharing system. Even though there may not be a direct data sharing agreement in place, 26 HDs (63 percent) are providing surveillance data to CHCs to assist them with their service planning and overall needs assessments. HDs were specifically asked if they were aware of HCCNs. Thirty-eight HDs (88 percent) reported they are unaware of these networks, while only four (12 percent) are aware of them. Three HDs stated that they have plans to participate in an HCCN.

Patient Center Medical Home (PCMH)

The Affordable Care Act currently mandates that CHCs create PCMH models for care delivery within their plans for expansion or as new CHCs are created. Out of 42 states, four HDs (10 percent) affirmed that they have plans in place to assist CHCs in developing PCMHs within their existing systems while 38 (91 percent) do not. When asked about success with implementing PCMH models, very few states cited examples. Fourteen HDs responded that this question was not applicable while 21 skipped the question completely. Some successes reported by HDs are inclusion of PCMH models within requests for assistance (RFAs), providing limited TA on PCMHs, establishing wrap-around services that are not third party reimbursable and initiating early consultations.

The biggest challenge reported in working with CHCs in developing PCMH models is the lack of resources and capacity in CHCs (n=7). CHC or provider apprehension to provide HIV/AIDS and viral hepatitis care services, HIV and sexuality stigma exhibited by the CHC, insufficient third party reimbursement for wrap-around services and lack of overall interest from CHC leadership were also mentioned as obstacles to PCMH development by HDs.

Discussion

This assessment demonstrates that many state HD HIV/AIDS and viral hepatitis programs are working with CHCs in their jurisdictions. However, there are numerous opportunities to increase the level of collaboration and to incorporate HIV and viral hepatitis services. Although 84 percent of HDs are collaborating with CHCs, the overall number of CHCs that HDs are collaborating with is quite low. According to the results of this survey, there are approximately 130 Ryan White Part C funded CHCs and 151 non-Ryan White Part C funded CHCs (1,200 CHCs exist nationally) currently engaged in a collaborative relationship with HD HIV/AIDS and viral hepatitis programs. It is important to note that this survey was limited in

its scope to state HIV/AIDS and viral hepatitis programs and more collaborations with local HDs and CHCs in providing HIV and viral hepatitis services may exist.

The results of this survey also indicate that further outreach on the part of HDs to CHCs is necessary, particularly in the 16 percent of states that reported no relationship with CHCs. Additionally, greater communication and relationship building could enhance and expand collaborations between the HDs and the PCAs. Further analyzing how PCAs and HD HIV/AIDS and viral hepatitis programs can best utilize these associations to achieve greater integration of services in their jurisdictions is also an important consideration.

Further examination of current contractual and grant agreements between HD HIV/AIDS programs and CHCs could demonstrate a path to collaboration for other HDs. The current economic situation faced by all partners presents an opportunity to find cost-effective solutions to providing services to those in need. Collaborations could lead, for instance, to joint grant applications between HDs and CHCs and/or PCAs to apply for funding opportunities.

There are many drivers or factors that are contributing to the expansion of collaborations. The Ryan White Program, NHAS, state HIV/AIDS prevention and care plans and the ACA all provide opportunities for collaboration between CHCs and HDs. One of the greatest opportunities for collaboration is through implementation of the ACA as CHCs expand. Greater collaborations could occur through HD involvement with the formation of new CHCs or expansion of services. Seizing the opportunity to work with CHCs on new expansion plans may be the key to initiating discussions about creating innovative programs and systems to achieve the goals of the NHAS and individual state plans. There is also potential for using lessons learned from the Ryan White Program in order to support and encourage the formation of PCMH models.

Two other major areas for potential collaboration are TA/educational training programs and data sharing. TA opportunities allow for HDs to design trainings that are relevant to the needs of the state or municipality. These trainings can also be designed with the assistance or guidance from the CHC. These training opportunities can range from disease treatment guidelines to cultural competency. They can also include certification systems that ensure that providers are reaching thresholds of success in terms of knowledge and skill. This ability to train providers will allow for better and more immediate treatment for thousands of patients. Data sharing through involvement with HCCNs will give both CHCs and HDs the ability to capture and track data more accurately. As previously state, there are only three states that have plans to participate in HCCNs in the near future. This may be a particular issue that is beyond the direct scope of the HIV/AIDS or viral hepatitis programs and may need to be the focus of the HD at higher levels.

Obstacles are present that may hinder efforts to build collaborative relationships. Capacity and resources of both HDs and CHCs are central to the success or failure of most relationships. Effective leadership and the ability to take risks are valuable principles for achieving effective collaborations.

Next Steps

There are many models of existing collaborations between HD HIV/ AIDS and/or viral hepatitis programs and CHCs to build upon. Using the results of this project as a foundation, NASTAD will continue to explore best practices and existing barriers in order to assist with the development of new and innovative collaborations.

NASTAD will design new TA opportunities to aid HDs in building opportunities to partner with CHCs and PCAs. NASTAD's initial plans for future TA include:

- Collaborate with NACHC to provide a series of TA webinars focused on the following:
 - CHC 101 for HDs;
 - Collaboration profiles (e.g., Project ECHO, Sixteenth Street Health Center);
 - Population specific services (e.g., LGBT, women, migrant, homeless, substance users);
 - Addressing specific obstacles (e.g., reimbursement, establishing care coordination, data sharing); and
 - Potential opportunities (e.g., Health Center Controlled Networks, sharing staff).
- Produce series of fact sheets and briefs on best practices.
- Conduct site visits and provide TA support upon request.
- Create a peer based TA system between state HDs and CHCs, with the support of NACHC.
- Support the organization of statewide or regional consultation meetings between HDs and CHCs.
- Conduct an assessment (e.g., survey, interviews and focus groups) in the future to monitor the progress of collaboration and to identify further areas of need.

NASTAD is cognizant that HDs and CHCs are each unique and that not one model will work for every situation. NASTAD will continue to examine these unique relationships and the obstacles that exist that may hinder relationship development and collaborations. NASTAD will also continue to work closely with NACHC to ensure that TA provided is useful and takes into account current CHC developments.

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Julie M. Scofield, Executive Director

Amna Osman (Michigan), Chair

January 2012

Appendix A: Consultation Meeting Agenda

Exploring HIV/AIDS and Viral Hepatitis Health Department and Community Health Center Collaborations

Friday, May 6, 2011

Agenda

- 9:00 am Welcome and introductions
- 9:30 am Session One:
Objective: Establish a common language and understanding about collaborations between state HDs and community health centers (CHCs)
- Overview of role of CHCs and primary care associations (PCAs)
 - Patient Centered Medical Home Model: Quality Measure Indicators or the Public Health Matrix
- 10:30 am Break
- 10:45 am Session Two:
Objective: Identify the current drivers for change at the national and state levels
- Health Care Reform
 - Prevention and Public Health Fund
 - National HIV/AIDS Strategy
 - Ryan White
- 12:00 pm Working Lunch (provided)
- 12:15 pm Session Three:
Objective: How to make it work at the state and local levels: opportunities and barriers to partnerships
- Structural/systems opportunities and obstacles
 - Workforce issues
 - Capacity building issues
 - Cultural competency issues: racial/ethnic and GLBT
- 1:15 pm Break
- 1:30 pm Session Four
Objective: Identify the specific obstacles and successes as they relate to expansion of HIV/AIDS and viral hepatitis services.
- Prevention and testing of HIV and viral hepatitis
 - Moving into expansion of treatment services
- 2:30 pm Conclusion: Strategies to move forward?

Appendix B: Consultation Meeting Participants

Chris Aldridge
Director of Prevention Programs
HealthHIV
chris@healthhiv.org

Gustavo Aquino
Associate Director for Program Integration
CDC/ National Center for HIV/ AIDS,
Viral Hepatitis, STD, and TB Prevention
(NCHHSTP)
gaa1@cdc.gov

Stuart Berman
Senior Advisor to the Director
CDC/Division of HIV/ AIDS Prevention
smb1@cdc.gov

Anne Brenner
Adult Viral Hepatitis Coordinator
Washington State Department of Health
anne.brenner@doh.wa.gov

Dan Church
Epidemiologist/Viral Hepatitis
Coordinator
Massachusetts Dept. of Public Health
Daniel.Church@state.ma.us

Kathy Donovan
Director of Health Education and
Community Programs
16th Street Community Health Center
kathleen.donovan@sschc.org

Colleen Flannigan
Director Viral Hepatitis Section
New York State Dept. of Health
caf03@health.state.ny.us

Shawn Frick
Director, State Growth Services
National Association of Community Health
Centers
sfrick@nachc.com

David Haltiwanger
Director of Public Policy and Advocacy
Chase Braxton Health Services
dhaltiwanger@chasebrexton.org

Heather Hauck
Director
Maryland Health
Departmenthauck@dhhm.state.md.us

Seiji Hayashi
Chief Medical Officer
HRSA/Bureau of Primary Health
CareSHayashi@hrsa.gov

Kathy McNamara
Assistant Director
National Association of Community Health
Center
kmcnamara@nachc.com

Greg Millett
Senior Policy Advisor
CDC/Office of National AIDS Policy
ghm3@cdc.gov

Quentin O'Brien
Director, Health and Mental Health
Services
L.A. Gay & Lesbian Center
qobrien@lagaycenter.org

Liisa Randall
Consultant/Facilitator
NASTAD
reddoglr@earthlink.net

Ann Robbins
Manager
Texas Department of Health
ann.robbs@dshs.state.tx.us

Ronald Valdiserri
Deputy Assistant Secretary for Health,
Dept. of Health & Human Services
Infectious Diseases
ron.valdiserri@hhs.gov

Su Wang
Assistant Director of Medical Affairs
Charles B. Wang Community Health Center
swang1@cbwchc.org

Brad Ward
Senior Director of Programs
HealthHIV
javier@healthhiv.org

Lynn Wegman
Deputy Director
Division of Training & Technical
Assistance/
HIV/AIDS Bureau
lwegman@hrsa.gov

Appendix C: Health Department and Community Health Center Collaboration Assessment

Through an educational grant from Janssen Therapeutics, NASTAD is conducting an assessment to explore the existing or potential collaborations between state health department (HD) HIV/AIDS and viral hepatitis programs and Community Health Centers (CHC)/Primary Care Associations (PCA). The information collected through this survey will be used to identify best practices; describe challenges and barriers; assess technical assistance (TA) needs and inform future TA activities. The responses provided by states will be reported in aggregate. Thank you in advance for completing the survey. If you have questions, please contact [Christopher Cannon](#).

Please read the following instructions. The assessment includes electronic formatting to assist you in completing this evaluation via computer. The main formatting includes check boxes () and text boxes (____). These two electronic formats only appear within the document as it is viewed by computer. If necessary to print the survey for completion, these inclusions will not appear as they do electronically.

All respondents will simply need to maneuver through the evaluation by using the "tab" key or by double clicking with your mouse. The evaluation is "locked" and data may only be entered in designated cells. You can return to any question at any point to change or review your entry (ies). Once the evaluation is completed, **PLEASE SAVE THE DOCUMENT** as: "your state name" CHC RFI.doc (e.g., "America CHC RFI.doc").

Thank you for your valuable input and time!

Background:

1. Person completing this survey:
Name of state or territory:

Name of person completing this survey:

Title of person completing this survey:

Phone number of person completing this survey:

E-mail address of person completing this survey:

For the purpose of this assessment, **collaboration** is defined as the act of working with another or others on a joint project(s) either through consultation, training, or financial support (i.e., grant funding, material provision, or services).

Collaborations:

2. Do the HIV/AIDS and viral hepatitis programs within your HD have collaborations with CHCs for any program(s)?

Yes (skip to question #4)

No (skip to question #3)

3. If your HD does not currently have collaborations with CHCs please describe below what the challenges have been in establishing

collaborations? (Please skip to Question 28)

4. If yes to Question 2, which of the following describes your programs' collaboration(s) with CHCs? (please select all that apply)

- Provides support for CHC services through a contractual or grant agreement.
- The CHC refers patients for services directly provided by the state HD.
- The state HD refers patients to the CHC for outpatient, primary care services.
- Provides programmatic monitoring for state HD funded services.
- Share information/ data with the CHC for community needs assessments.
- Technical assistance or educational services are provided by the HD to the CHC or Primary Care Association.
- Other (please describe):

5. What factors or issues are informing or impacting your program's current collaborations with CHCs? (please select all that apply)

- The Affordable Care Act
- National HIV/ AIDS Strategy
- National Quality Strategy
- National Prevention Strategy

- Healthy People 2020
- Legislative directive
- State HIV/ AIDS Prevention Plans
- State HIV/ AIDS Care Plans
- State Viral Hepatitis Plans
- Ryan White
- Other (please describe):

- Not applicable (we have no collaborations)

6. Which of the following organizations and individuals participate in your program's current CHC collaboration? (please select all that apply)

- HD leadership (i.e., Director, Medical Officer, etc.)
- HIV/ AIDS program director
- Hepatitis program director
- CHC administrative leadership (i.e., CEO, CFO, Medical Director)
- CHC provider staff
- Primary Care Associations
- HRSA/ BPHC
- Other (please describe):

- Not applicable (we have no collaborations)

7. In which of the following areas do your programs partner? (please select all that apply)
- Emergency preparedness
 - HIV prevention and testing
 - HIV care and/or treatment
 - STD testing, care and/or treatment
 - Viral hepatitis prevention and testing
 - Viral hepatitis care and treatment
 - Oral health
 - Behavioral health (i.e., mental health and/or substance abuse treatment)
 - Other, please describe:
 - Don't know
8. If funding is provided to the CHC(s), how are your program's collaborations currently funded?(please select all that apply)
- State funds
 - Ryan White Part B
 - Ryan White Part D
 - Ryan White Part F
 - Centers for Disease Control HIV or hepatitis funds
 - Other (please describe):
 - None of the above applies; we do not provide funding to CHCs.

9. Was the collaboration stimulated as a result of the HIV/AIDS and/or viral hepatitis program's initiative?
- Yes
 - No (skip to question 11)
10. If yes, briefly describe one example of how collaboration was initiated by the HIV/AIDS and/or viral hepatitis program:

Ryan White Care Act Collaborations

11. Does your program currently have collaborations with Ryan White Part C-funded CHCs?
- Yes
 - No (skip to question 13)
12. If yes, with how many Ryan White Part C-funded CHCs does your program currently collaborate?
13. How many Ryan White Part C-funded CHCs in your state are also funded by Ryan White Part B?
14. Does your program currently collaborate with CHCs that are not funded by Ryan White Part C?
- Yes
 - No (skip to question 16)
15. If yes, with how many CHCs that are not funded by Ryan White Part C does your program currently collaborate?

HIV Testing, Care and Treatment

16. How does your program directly support the CHCs in their HIV testing programs? (please select all that apply)

- Provide direct funds
- Provide test kits
- Provide laboratory testing services
- Fund staff position(s)
- Educate and promote awareness
- Training to build skills and/or certify staff
- Other (please describe):
- Not applicable

17. What is/are the funding sources for the HIV testing supported in CHCs (please select all that apply)?

- PS10-10138 (Expanded Testing Program)
- CDC core prevention grant
- State funds
- Other (please describe):

18. How many CHCs does your program support to provide HIV testing?

19. With which other HIV prevention services does your program currently collaborate with CHCs (please select all that apply)?

- Evidence based interventions including DEBIs
- Partner notification services
- Prevention with positives
- HIV counseling
- Syringe exchange
- Condom distribution
- Pre-exposure prophylaxis (PrEP)
- Post-exposure prophylaxis (PEP)
- Other (please describe):
- Not applicable (we don't collaborate on prevention services)

20. With what HIV care and treatment related areas are your programs collaborating with CHCs?(please select all that apply)

- HIV treatment in primary care
- Medication adherence
- Treatment adherence (face-to-face provider follow-up)
- Laboratory testing (i.e., viral loads, CD4 counts, genotyping, resistance testing)
- Behavioral health (i.e., substance abuse treatment and/or mental health treatment)
- Oral health
- Medical case management
- Other, please describe:

Not applicable (we don't collaborate on care and treatment areas)

No

Viral Hepatitis

21. How does your program directly support CHCs in their viral hepatitis testing programs? (please select all that apply)

- Provide direct monetary support
- Provide testing supplies/kits
- Provide laboratory testing services
- Fund staff position(s)
- Educate and promote awareness
- Training to build skills and/or certify staff
- Other (please describe):
- Not applicable (we don't support viral hepatitis testing in CHCs at this time) (Skip to question 23)

22. How many CHCs does your program support to provide viral hepatitis testing?

23. Does your program provide support to CHCs (i.e., funding or vaccine) for hepatitis A and B?

Yes

24. What is your program planning to do in the future to further expand (or initiate) HCV testing? (please select all that apply)

- Provider education campaign implementation
- Provider training and certification
- Purchase of laboratory services
- Development of guidelines for testing
- Other, please describe:
- Not applicable, we currently do not have plans

25. What is your program planning to do in the future to further expand (or initiate) HCV treatment and care? (Please select all that apply)

- Provider education campaign implementation
- Provider training and certification
- Purchase of laboratory services
- Development of guidelines for testing
- Other, please describe:
- Not applicable, we currently do not have plans

Primary Care Associations

26. Does your program currently work with your state's Primary Care Association(s)?
- Yes
 No (skip to question 29)
27. If yes, with how many Primary Care Associations in your state is your program collaborating?
28. How has your program worked with your state's Primary Care Association(s)? (Please describe in detail):

- Viral hepatitis prevention practices
 Viral hepatitis testing guidelines
 Viral hepatitis treatment guidelines
 Data reporting requirements
 Cultural competency/sensitivity training
 Medical case management
 Provider certification or continuing education
 Other (please describe):

Training and Technical Assistance

29. Does your program provide technical assistance (TA) or educational training to CHC staff and providers?
- Yes, provided by HD staff
 Yes, HD funds PCA to provide
 Yes, HD funds other to provide
 No (skip to question 32)
30. If yes, what subject areas does your program provide TA or training to CHC staff? (please select all that apply)
- HIV prevention practices
 HIV testing guidelines
 HIV treatment guidelines

31. What modalities does your program use to provide training to the CHCs or PCAs in your state (please check all that apply)?
- Webinars or interactive classrooms
 Off-site trainings
 On-site trainings
 Step-by-step guides/manuals
 Online tutorials
 Other, please describe:

Data Sharing

32. Does your program have a data sharing plan in place between your program and CHCs?
- Yes
 No

33. Does your program have electronic data sharing capabilities with CHCs?

Yes

No

34. Does your program provide surveillance data to CHCs to help with their planning for services?

Yes

No

35. For what other purposes has surveillance data been shared or might it be shared with CHCs? (please describe):

36. Is your program aware of the [Health Center Controlled Network \(HCCN\)](#)? (click hyperlink for more information)

Yes

No (skip to question 39)

37. If yes, does your HD participate within this network(s)?

Yes (skip to question 39)

No

38. Do you have plans to participate or interest in learning how to participate with a HCCN?

Yes

No

Patient Centered Medical Home Engagement

39. Does your program have a plan in place to support the development of a medical home model of care delivery within CHCs related to HIV/ AIDS and/or viral hepatitis?

Yes

No

40. What successes has your program demonstrated in working with CHCs to support the development of a medical home model of care delivery related to HIV/ AIDS and/or viral hepatitis? (Please describe):

41. What challenges has your program encountered in working with CHCs to support the development of a medical home model of care delivery related to HIV/ AIDS and/or viral hepatitis? (Please describe):

Technical Assistance Needs

42. Describe any technical assistance needs as they relate to CHC/Primary Care Association collaborations that your program would like NASTAD to provide: