Federal Partners Mend the Safety Net

US Conference on AIDS • Washington, DC • September 11, 2015

HRSA
Health Resources & Services Administration

Agenda

- Learning objectives
- Presenters
- Directions and areas of emphasis at HRSA
- Collaborations across the safety net
- Recommendations and promising practices

HRSA
Health Resources & Services Administration

Learning Objectives

- Understand new directions and areas of emphasis by federal agencies
- Describe examples of ways HRSA grantees and partners are responding
- Understand recommendations and promising practices for moving forward

HRSA
Health Resources & Services Administration

Presenters

Deborah Willis-Fillinger, MD
Division of Community HIV/AIDS Programs
HAB, HRSA

Antigone Dempsey, MEd
Division of Policy and Data
HAB, HRSA

Rene Sterling, PhD, MHA
Office of Quality Improvement
BPHC, HRSA

M. Maximillian Wilson, PhD
HIV/AIDS Section
Florida State Department of Health

Alelia Munroe, MPH
Special Projects Coordinator
Healthcare Center for the Homeless – Orlando, FL

Howell Strauss
Ann Ferguson
AIDS Care Group

Mira Levinson
Stewart Landers
ACE TA Center - JSI

Directions and Areas of Emphasis at HRSA

HRSA
Health Resources & Services Administration

Health Resources and Services Administration

Improving health and health equity through
access to quality services,
a skilled health workforce and
innovative programs

HRSA
Health Resources & Services Administration

FY 2015 HRSA Budget: $10 Billion

Program	Dollars (in Millions)
Health Center Program	**$5,000,633**
HIV/AIDS	**$2,318,781**
Maternal and Child Health	$1,254,238
Health Workforce	$1,057,784
Rural Health	$147,471
Healthcare Systems	$110,693
Program Management	$154,000
Total	$10,043,600

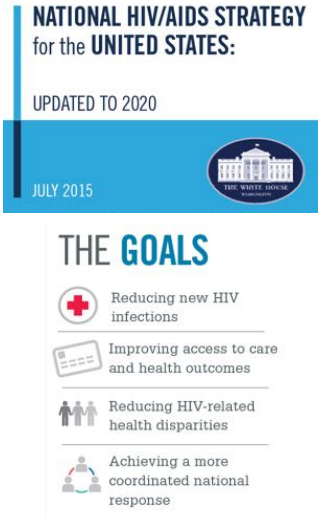
HRSA Health Resources & Services Administration

7

National HIV/AIDS Strategy 2020

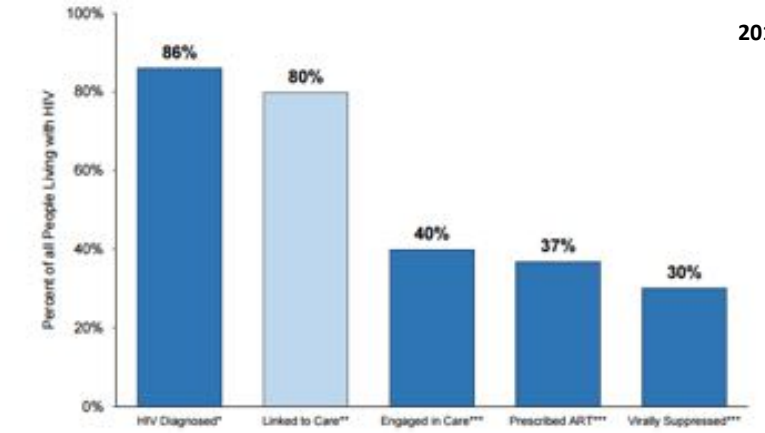
- National strategy with a vision for next 5 years
- 4 Goals, 11 Steps, 37 Actions
- Builds upon major advances and successes in response to HIV
- **HRSA working with federal agencies across government to establish Federal Action Plan**

Visit AIDS.gov to learn more



HRSA Health Resources & Services Administration

HIV Care Continuum



* Diagnosed is a calculated estimate based on data reported to the National HIV Surveillance System, the denominator is the estimated number of persons living with HIV (1.2 million).
** Linkage to care was calculated based on percentage of persons newly diagnosed in 2011 (n=15,499) that were linked to medical care (12,333) within 3 months after diagnosis.
*** Engaged in care, prescribed ART and virally suppressed data come from the Medical Monitoring Project (MMP) and are based on people who had at least one visit during 2011. The dominator is the estimated number of persons living with HIV (1.2 million).

HRSA Health Resources & Services Administration

Safety Net

- Need to engage all components of the safety net, including public health and primary care
- Each component has an important role in addressing HIV and bring unique expertise

Community Based Orgs	Ryan White HIV/AIDS Program Providers
AIDS Service Orgs	Primary Care Providers
Substance use treatment centers	Health Centers
Public Health Departments	

- Building partnerships is key to
  - Improving outcomes across the care continuum
  - Strengthening the safety net

HRSA Health Resources & Services Administration

Ryan White CARE Act 25th Anniversary

25 YEARS Ryan White HIV/AIDS Program

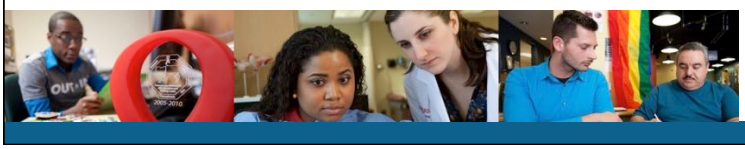
Moving Forward with CARE: *Building on 25 Years of Passion, Purpose, and Excellence*

HRSA Ryan White & Global HIV/AIDS Programs

25 YEARS Ryan White HIV/AIDS Program

Who We Serve

- The Ryan White HIV/AIDS Program **served half a million (524,675) people** in 2013
- Approximately **2 out 3 people** living with HIV (PLWH) who are engaged in medical care are served by the RWHAP
- 47% Black/African American and 23% are Hispanic (2013)
- **Close to 90%** are living at or below 200% of the Federal Poverty Level (2013)



25 YEARS Ryan White HIV/AIDS Program

Ryan White HIV/AIDS Program and Healthcare

- The RWHAP supports a **dynamic and complex system of care**; it is not an insurance program for discrete services
- The **need for an HIV care system for low-income PLWH remains** until the outcomes on the HIV care continuum are addressed and there is a cure

HRSA
Ryan White & Global HIV/AIDS Programs
25 Years
Ryan White
HIV/AIDS Program
Moving Forward with CARE: Building on 25 Years of Passion, Purpose, and Excellence

2015 Priorities Moving Forward

- **Focus on areas of greatest health disparities and HIV Care Continuum**
- **Advance data utilization to improve health outcomes**
- **Continue with the integration of the Ryan White HIV/ AIDS Program within the changing health care landscape**
  - Increase focus on community-based engagement
  - Evaluating RWHAP client health care needs in shifting health care landscape and filling gaps

HRSA Ryan White & Global HIV/AIDS Programs

25 Years Ryan White HIV/AIDS Program
Moving Forward with CARE: Building on 25 Years of Passion, Purpose, and Excellence

Health Center Program Anniversary

Serving America's Communities for 50 Years

HRSA Health Center Program

16

Bureau of Primary Health Care

*Improve the health of the Nation's **underserved communities and vulnerable populations** by assuring access to **comprehensive, culturally competent, quality primary health care services***

Visit us at bphc.hrsa.gov

HRSA Health Center Program

17

Who We Serve

One out of every 14 people living in the U.S. receive care at a health center

1,300 health centers
9,000 service delivery sites
170,000+ employees

In 2014, health centers served approximately 23 million people

- **50% members of racial/ ethnic minority groups**
- **28% uninsured**
- **31% are children**

HRSA Health Center Program

18

Why Integrate HIV Into Primary Care?

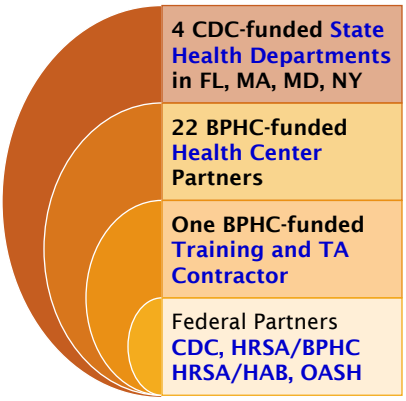
- Populations served by health centers **at risk for HIV**
- HIV is **manageable in primary care settings**
- **Growing need for primary care** among people living with and affected by HIV
- Significant **disparities in access to care and health outcomes**
- Closely tied to mission and values of Health Center Program – ***equity, justice, access, quality***

HRSA Health Center Program

19

Partnerships for Care (P4C)

- Three-year project funded by the Secretary's Minority AIDS Initiative Fund (SMAIF) and the Affordable Care Act for $41M total
- Goal to improve HIV outcomes across the HIV care continuum by
  - **Strengthening partnerships** between state health departments and health centers
  - Supporting **workforce and infrastructure development** within health centers
  - **Identifying promising practices** for improved HIV service delivery, care coordination, and use of data



Learn more at P4CHIVTAC.org

HRSA Health Resources & Services Administration

Questions and Answers

HRSA
Health Resources & Services Administration

Collaborations Across the Safety Net

Florida State Health Department

Healthcare Center for the Homeless, Orlando FL

AIDS Care Group

HRSA
Health Resources & Services Administration

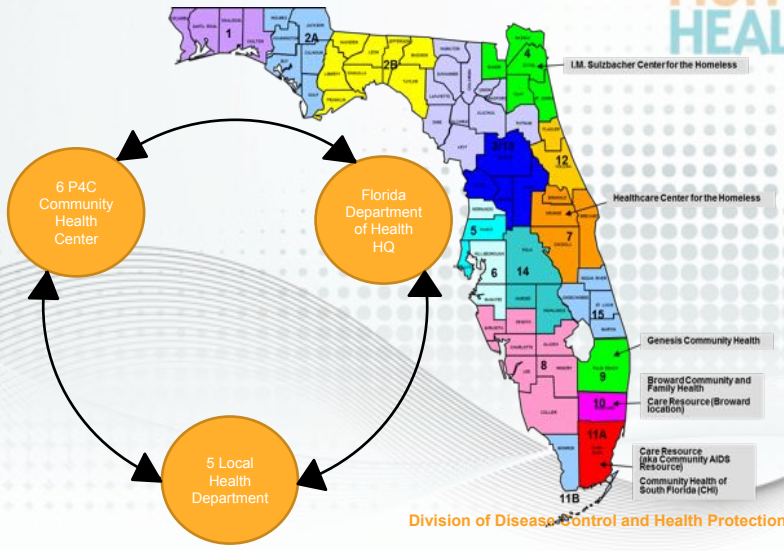
FLORIDA DEPARTMENT OF HEALTH PARTNERSHIP FOR CARE

United States Conference on AIDS
September 11, 2015

M. Maximillion Wilson, Ph.D.
Statewide Evaluation Consultant
HIV/AIDS Section
Florida Department of Health

Division of Disease Control and Health Protection

Florida's P4C Project



Division of Disease Control and Health Protection

State-level DOH Team

- Prevention Manager- Mara Michniewicz
- P4C Coordinator – Juan Vasquez
- Clinical Consultant – David Andress
- Statewide Eval. Consultant – M. Maximillion Wilson
- Evaluation Specialist – Rehman Khan
- Programmer – Karteek Kalidindi
- Many other staff helping with Training, Testing, Medical TA/Capacity Building, Data Integration, and budget.

Local CHD Team (Roles)

- HIV/AIDS Program Coordinators (HAPC)
- STD Program Managers/Directors
- Disease Intervention Specialists
- Evaluation Coordinators
- Early Intervention Consultants (Testing)
- Prevention Training Consultants

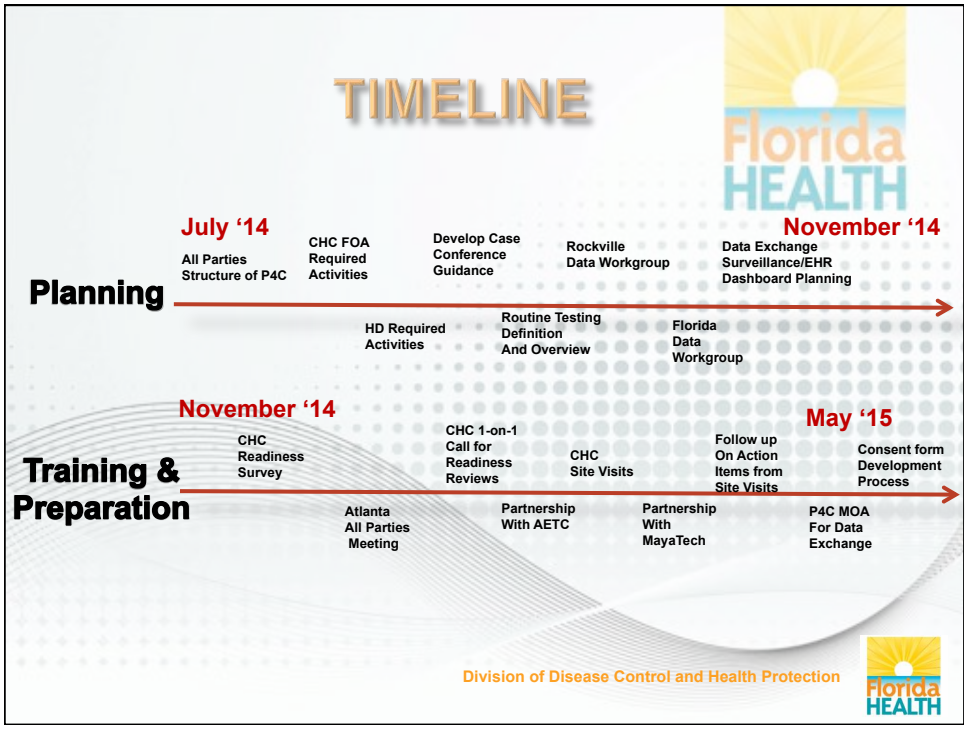
Collaborations with CHCs

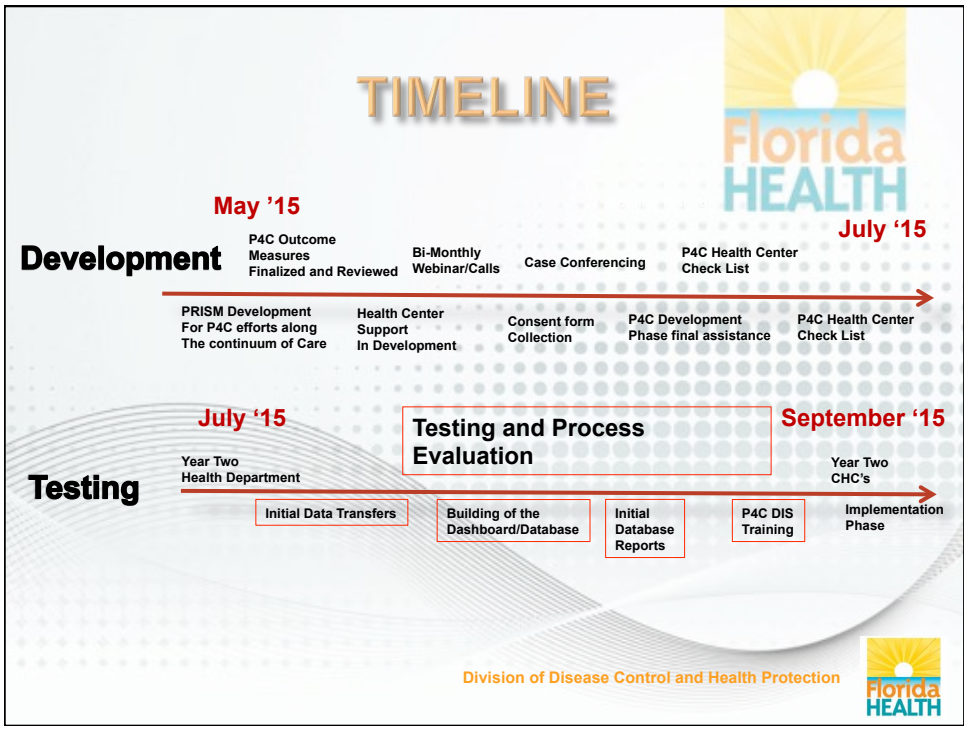
- State/Local DOH
  - Partner services, training and support for testing, linkage, staff trainings, coordination with Ryan White, STD, Data Integration, etc.
  - HCN electronic health records and data exchange
- Florida/Caribbean AETC
  - Clinic and provider trainings and support
- MayaTech – coordination of readiness reviews, now providing training
- Florida Statewide Training Coordinator
  - Prevention Interventions: CLEAR, ARTAS
    HIV 500/501
    Billing and Reimbursement

Health Department Activities

- Use of state HIV surveillance data and health center EHR data to improve health outcomes for PLWH
- Expand partner notification, linkage, retention, and re-engagement with care services for PLWH. Health departments will enhance their capabilities to offer linkage, retention, and re-engagement services for PLWH who may be served by participating health centers
- Support Training, TA and collaboration activities for health centers to expand HIV testing, care and services for PLWH

Develop sustainable partnerships with health centers


TIMELINE
Florida HEALTH
Planning
July '14
All Parties Structure of P4C
CHC FOA Required Activities
Develop Case Conference Guidance
Rockville Data Workgroup
November '14
Data Exchange Surveillance/EHR Dashboard Planning
HD Required Activities
Routine Testing Definition And Overview
Florida Data Workgroup
Training & Preparation
November '14
CHC Readiness Survey
CHC 1-on-1 Call for Readiness Reviews
CHC Site Visits
May '15
Follow up On Action Items from Site Visits
Consent form Development Process
Atlanta All Parties Meeting
Partnership With AETC
Partnership With MayaTech
P4C MOA For Data Exchange
Division of Disease Control and Health Protection
Florida HEALTH


TIMELINE
Florida HEALTH
Development
May '15
P4C Outcome Measures Finalized and Reviewed
Bi-Monthly Webinar/Calls
Case Conferencing
P4C Health Center Check List
July '15
PRISM Development For P4C efforts along The continuum of Care
Health Center Support In Development
Consent form Collection
P4C Development Phase final assistance
P4C Health Center Check List
Testing
July '15
Year Two Health Department
Testing and Process Evaluation
September '15
Year Two CHC's
Initial Data Transfers
Building of the Dashboard/Database
Initial Database Reports
P4C DIS Training
Implementation Phase
Division of Disease Control and Health Protection
Florida HEALTH

Implementation Planning and Support

Community Health Center Checklist

____ P4C MOA between Department of Health and Community Health Center

____ Implementation of Routine HIV Testing

____ Data Exchange – set up SFTP and participate on Data Workgroup

____ P4C Consent Development, Approval, and Implementation Plan

____ Case Conferencing

____ P4C MOA between Department of Health and Community Health Center

____ Implementation of Routine HIV Testing

____ Data Exchange – set up SFTP and participate on Data Workgroup

____ P4C Consent Development, Approval, and Implementation Plan

Health Department Checklist

____ Coordinate implementation of 4th Gen, routine HIV testing in the P4C Health Centers; provide support, training, and technical assistance.

____ Coordinate the development and implementation of Case Conferencing.

____ Resolve legal and confidentiality issues regarding conferencing and data exchange

____ Development of the P4C Dashboard, and capabilities of PRISM, for the use of surveillance data and EHR to improve health outcome of PLWHA

Capacity Building and Education

- Data systems enhancements (PRISM, EHR)
- Solutions for AETC issues
- MayaTech readiness review identified training needs
- Continued support for health centers as identified

Other State-level Innovation

- Initial data exchange with health centers, finalize development of database and reports
  - Information Broker "Dashboard"
  - PRISM buildout outlined

  Quarterly All Party Webinars
- P4C specific training for P4C DIS. Use of PRISM and P4C dashboard for P4C services. (linkage, re-engagement, partner services)
- Monthly Case Conferencing Reports are being developed
- Changes to PRISM for P4C DIS services planned for October

Local CHD Considerations

- Establish agreements and good working relationships between P4C CHCs and local (Ryan White funded) DOH HIV clinics.
  - To provide capacity to manage complex patients, and promote better integration of the new CHC program into the existing local, HIV Service Network.
- CHCs can become important members of local community planning (prevention, Ryan White Parts A & B).

Lessons Learned So Far

- Open and active communication is needed to help fully realize routine testing.
  - Some CHC partners participate in the Expanded Testing Initiative (PS12-1201, Category B).
- The level of data exchanged between DOH and CHCs requires special attention to patient consent.
- Though local CHDs and CHCs have been very cooperative, the model of case conferencing used is new for everyone, and requires flexibility and good timing.

For More Information . . .

Mara Michniewicz
Prevention Program Manager
850-245-4444, ext 2597
Mara.Michniewicz@flhealth.gov
or
Juan Vasquez
Interventions Team Lead/P4C Coordinator
850-245-4444, ext 2611
Juan.Vasquez@flhealth.gov

Partnerships for Care (P4C)
A Health Center's Perspective

United States Conference on AIDS
Washington, DC
September 11, 2015

Alelia E. Munroe, MPH
Special Projects Coordinator
Health Care Center for the Homeless, Inc.

ORANGE BLOSSOM FAMILY HEALTH

37

ORANGE BLOSSOM FAMILY HEALTH

OBFH Main Site

38

ORANGE BLOSSOM FAMILY HEALTH

Mission Statement

"To provide quality health care services that improve the lives of the homeless and medically indigent people in our community"

39

ORANGE BLOSSOM FAMILY HEALTH

History

- **1993 – HCCH founded by Dr. Rick Baxley**
- **1995 – Robert Wood Johnson Foundation grant**
- **1998 - HOPE (Homeless Outreach Partnership Effort) Team**
- **2002 – FQHC Status obtained; low-income housed uninsured population; Behavioral Health Services**
- **2006 – Opened clinic building in Orlando, Orange Blossom Family Health, converted to EHR**
- **2007 – HOPE Mobile Medical Unit launched**
- **2010 – Launched Mobile Dental Unit; Established as HIV testing site**
- **2013 – Opened first Satellite site ; NCQA Level 2 PCMH certification**
- **2014 – P4C Project site; opened Kissimmee and Sanford sites**

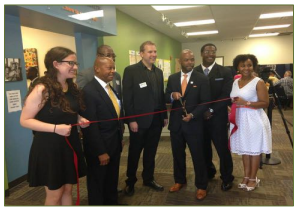
40

ORANGE BLOSSOM FAMILY HEALTH

Satellite Health Centers

@ Community Food and Outreach Center Orlando

@ Community Hope Center Kissimmee



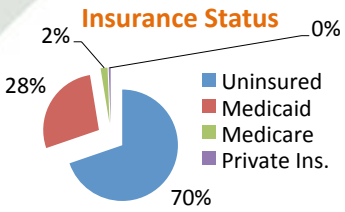
@ Harvest Time International Sanford

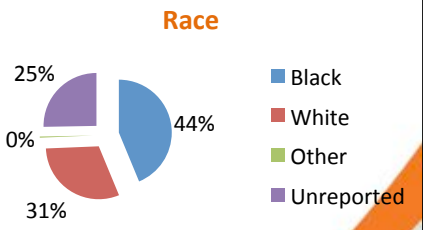
41

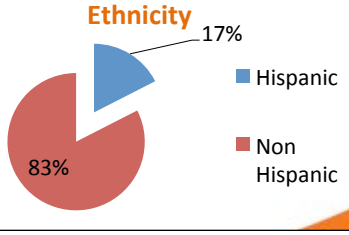
ORANGE BLOSSOM FAMILY HEALTH

Patients Served By HCCH In 2014

15,251 Unduplicated patients







42

ORANGE BLOSSOM FAMILY HEALTH

Patients Served By Site In 2014

Main
Total Patients: 11,433
Total Staff: 91 (10 Providers)

South Orlando
Total Patients: 518
Total Staff: 4 (1 provider)

Kissimmee
Total Patients: 2,744
Total Staff: 6 (1 provider)

Sanford
Total Patients: 556
Total Staff: 4 (1 provider)

43

ORANGE BLOSSOM FAMILY HEALTH

Types of Funding

- HRSA/BPHC Section 330
- Medicaid
- Medicare
- Commercial Insurance
- Self Pay/Discounted Fees
- HUD/Homeless Services Network
- HUD/Veterans Outreach
- Florida Dept. Of Health
- City of Orlando
- Ryan White Part A (Oral Health only)
- Orange County Government (indigent care)
- Orange County CRP
- Florida Hospital PC3
- CDBG (Behavioral Health)
- Central Florida Foundation
- State of Florida - LIP

44

Orange Blossom Family Health

Services Offered

- Primary Medical Care - at all 4 locations
- Behavioral Health – at 3 sites (not yet offered in Sanford)
- HOPE Team – main site
- Mobile Health Services
- TB Shelter
- Pharmacy – main site
- Vision Care – main site
- Special Programs – main site
  - Mammography Screening
  - Denture Sponsorship for Homeless
  - P4C including HIV Testing
- Oral Health Care – main site

45

Orange Blossom Family Health

HIV Services Vision

"To be the Center of Excellence in HIV care for uninsured and underinsured residents of Central Florida."

46

ORANGE BLOSSOM FAMILY HEALTH

Guiding Principles for Integration

- **Ensure universal access to HIV prevention, treatment, care and support in accordance with the goals of the NHAS;**
- **Use of a Public Health Approach**
- **Strengthening service provision through innovation & learning**
- **Increasing the effectiveness and efficiency of services**
- **Promoting human rights and health equity**
- **Cost-effective service delivery**

47

ORANGE BLOSSOM FAMILY HEALTH

Guiding Principles Cont'd

- **Increasing the effectiveness and efficiency of services**
  - Use of strategies to improve adherence and retention
  - Maintain partnerships to link patients requiring a higher level of care
- **Promoting human rights and health equity**
  - Implementation of services based on core human rights and ethical principles
  - Ensure environment minimizes stigma and discrimination
  - Service provision is culturally proficient
- **Cost-effective service delivery**

48

ORANGE BLOSSOM FAMILY HEALTH

Key Activities

- Workforce Development
- Infrastructure Development
- Service Delivery
- Partnership with Health Department
- Project Evaluation and Quality Improvement

49

ORANGE BLOSSOM FAMILY HEALTH

Workforce Development

- **Establish multi-disciplinary HIV Care Team**
  - Identified positions required
    - Clinical Team Lead
    - HIV Specialist
    - Nurse
    - Medical assistant
    - Pharmacist
    - Behavioral Health Specialist
    - Dentist
    - Medical Case Manager
    - Peer Mentor

50

ORANGE BLOSSOM FAMILY HEALTH

Workforce Development

- Strategically recruited for vacant positions
- Identified training needs
- Identified available training resources
  - DOH
  - AETC
  - MayaTech
- Provided Center wide Training
  - Clinical & non-clinical staff
  - Board Members

51

ORANGE BLOSSOM FAMILY HEALTH

Infrastructure Development

- **Designate HIV Program Lead**
- **Developed and revised policies and procedures for HIV care**
  - HIV Counseling & Testing
  - HIV clinical protocols
  - Administrative & fiscal
  - Change patient consent to allow for data sharing
  - Case Conferencing guidelines

52

ORANGE BLOSSOM FAMILY HEALTH

Infrastructure Development

- **Establish formal written agreements for referrals**
  - Identified needed referral resources
  - Developed formal Memorandum of Agreements
- **Implement system enhancements for EHR**
  - Working with HCN to:
    - incorporate HIV data elements in EHR
    - facilitate data sharing/exchange with DOH
    - ensure appropriate report formats

53

ORANGE BLOSSOM FAMILY HEALTH

Service Delivery

P4C provided the opportunity to integrate HIV services into the broad array of services offered to patients:

- Routine HIV testing
- Basic HIV Care & Treatment
- HIV Prevention Services
  - PrEP & nPEP
- Medical Case Management Services

54

ORANGE BLOSSOM FAMILY HEALTH

Service Delivery Cont'd

- Pre P4C
  - All HIV-infected patients referred out for HIV care
    - Established
    - Newly identified
  - Some continued with primary care others transferred care (Ryan White program)
  - Testing approximately 170 individuals/month
  - Approximately 32 infected patients (primary care)

55

ORANGE BLOSSOM FAMILY HEALTH

Service Delivery Cont'd

- Post P4C
  - As of 8/19/15 enrolled 37 current patients, 22 newly identified
  - New patients linked to HIV specialist (both primary & HIV care
  - Established patients who sero-convert remain with primary care provider but also see the HIV specialist for HIV care
  - No pregnant infected or HIV/HCV dually diagnosed
  - Testing approximately 250 individuals/month

56

ORANGE BLOSSOM FAMILY HEALTH

Partnership with Health Department

- Establish formal agreement with local HD:
  - Linkage to DIS
    - Partner notification
    - Location of clients lost to care
  - Case Conferencing
  - Clinical Consultation, Linkage for Pregnant Infected women & HCV/HIV infected
- Establish membership on community planning groups
  - Part A Planning Council
  - Part B Consortium (Prevention)

57

ORANGE BLOSSOM FAMILY HEALTH

Project Evaluation & Quality Improvement

- **Identify data required to evaluate the project**
  - Newly diagnosed vs previously diagnosed
  - # tests completed & results
  - # newly diagnosed linked to care & timeframe
  - # previously Dx. linked to care & timeframe
- **Develop data collection procedures**
  - Frequency & timing
  - Reports & frequency
- **Update Quality Management Plan to incorporate HIV specific indicators**
  - Medical visit frequency
  - Retention in Care
  - ARV prescription
  - Viral suppression

58

ORANGE BLOSSOM FAMILY HEALTH

Recommendations

- What percentage established patients currently being referred out?
- With implementation of routine HIV testing, will the percent increase?
- Identify service delivery model
  - Primary medical care integration vs. HIV specialty clinic
- What supportive services will be included, if any?
- Get buy-in from board and staff

59

ORANGE BLOSSOM FAMILY HEALTH

Recommendations Cont'd

- Ensure that you identify a dedicated administrative staff person
- Identify training needs of staff
- Identify training resources that are readily available to staff
- Identify additional resources (staff, space, etc.)
- Establish membership in HIV planning bodies
- Identify and establish MOAs with AIDS Service Providers (Ryan White & Private)

60

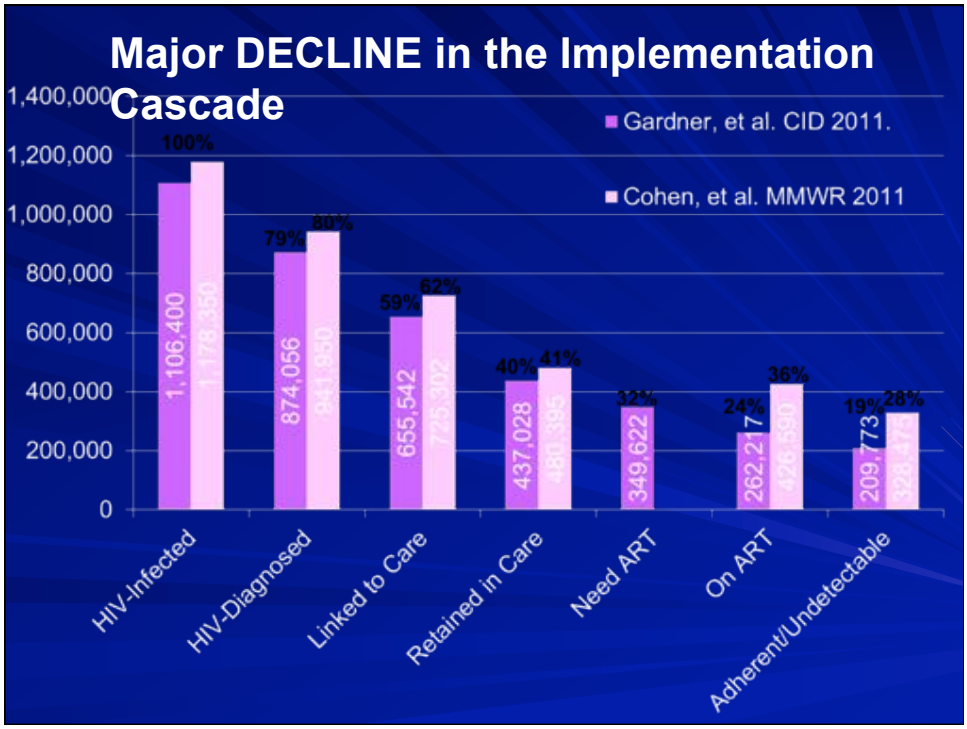
ALELIA E. MUNROE, MPH
SPECIAL PROJECTS COORDINATOR
HEALTH CARE CENTER FOR THE HOMELESS, INC.
232 N. ORANGE BLOSSOM TRAIL
ORLANDO, FL 32805-1612
407-428-5751 X 367
amunroe@hcnetwork.org

61

"Utilizing Local, State, and Federal Partnerships to Improve Access to and Retention in Care"

United States Conference on AIDS
Washington, DC
September 11, 2015

Howell I. Strauss, DMD
Ann Ferguson, MSN, RN
AIDS Care Group
Chester, PA



Gap # 1 – Need Expanded Testing

- AIDS Care Group teamed with:
  1. Delaware County to provide HIV testing in drug & alcohol treatment centers.
  2. Part B and Pennsylvania State 656 HIV Prevention funds.
  3. State of Pennsylvania to be a contracted HIV testing site.
  4. CDC for a five-year program for testing.
  5. University of Pennsylvania for MSM Testing Initiative (with CDC) – 10 Cities.
  6. With Hershey State Medical Center and State of Pennsylvania for Expanded Testing Initiative.

Gap # 2 – Linkages to Care

- Transportation
- AIDS Care Group was provided a van by the State of Pennsylvania due to its participation in the food distribution program.
- “Wheels for Wellness” was supported by Part A. Another van was acquired with program income.
- Part B provides transportation assistance funding.
- Our motto became, “We’ll come and get you.”

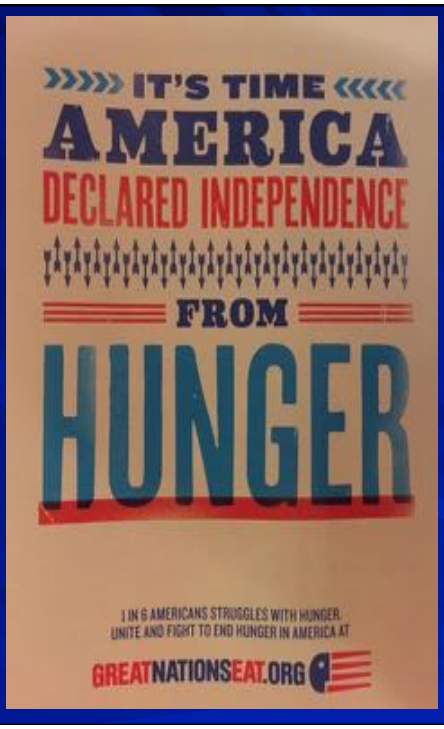
Gap # 3 – Addressing the Social Context of HIV/AIDS

- Dr. Jonathan Mann in addressing the HIV epidemic in developing nations asked, "Do we need more doctors, nurses, and clinics? Or, do we need to address other basic societal issues, such as human rights and issues surrounding poverty." (Johns Hopkins Clinical Care Conference, March 1997)

- **If,** the ultimate goals of working with persons living with HIV are timely linkage to health care and improved health outcomes in PLWHA;
- **Then,** any and all factors (including medical and non-medical or social issues) that are barriers to the achievement of goals should all get equal weight and attention.

Within the AIDS Care Group

- 33% of clients have an incarceration history.
- 35% have hepatitis C.
- 20% of the clients seen for medical care and services do not have clean, safe, or affordable housing.



The Hook is Food

- Poverty and hunger are pervasive in Chester's central business district.
- Without a poster advertising the opening of the Drop-in-Center, the knowledge of a morning breakfast center became instantly well-known. (Funded by Part A – Congressional Black Caucus. Now known as Minority AIDS Initiative).
- AIDS Care Group relies on funding from Part A, Part B, and Pennsylvania Department of Agriculture.

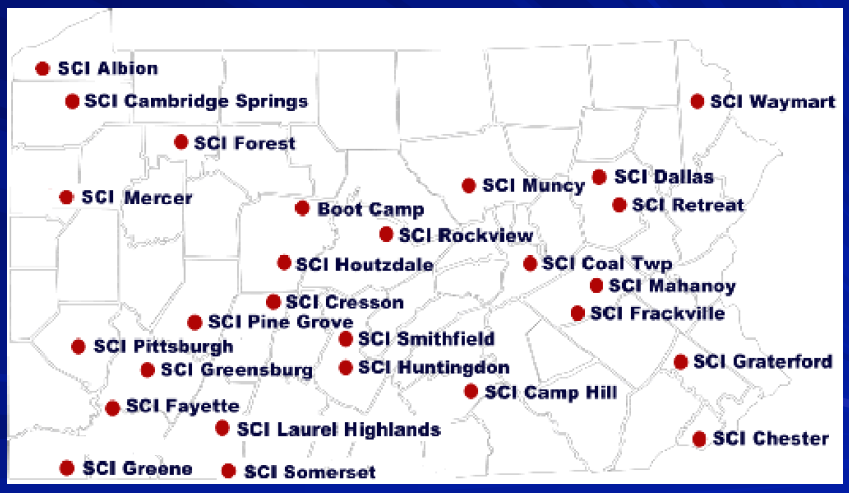
Health Care Providers and Housing

- Housing is the major missing element among services provided to AIDS patients.
- Housing is a key element to the quality of life and in adherence to medical treatment plans.
- AIDS Care Group found HOPWA funding from Delaware County; and a McKinney-Vento Grant from HUD.
- Even the ACA mentions housing

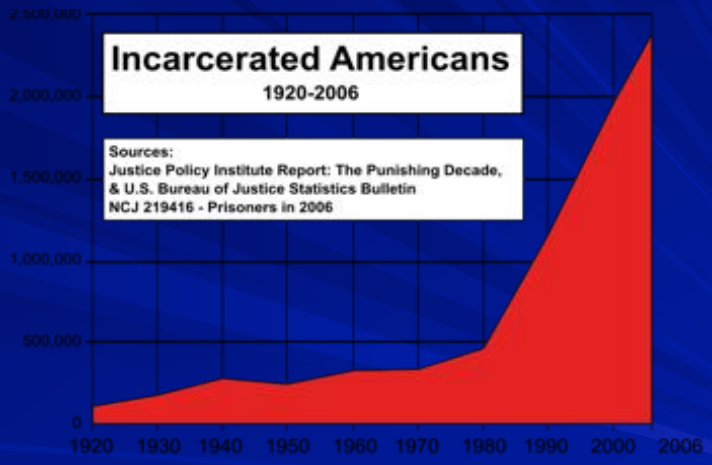
National HIV/AIDS Strategy of the United States-2010
2006 and 2007-Initiatives by the Special Projects of National Significance

- Social Determinants of Health
- Poverty
- Crime
- Housing, food, and employment insecurities
- Threats of substance abuse
- Structural, provider, and client inputs regarding access to health care and health

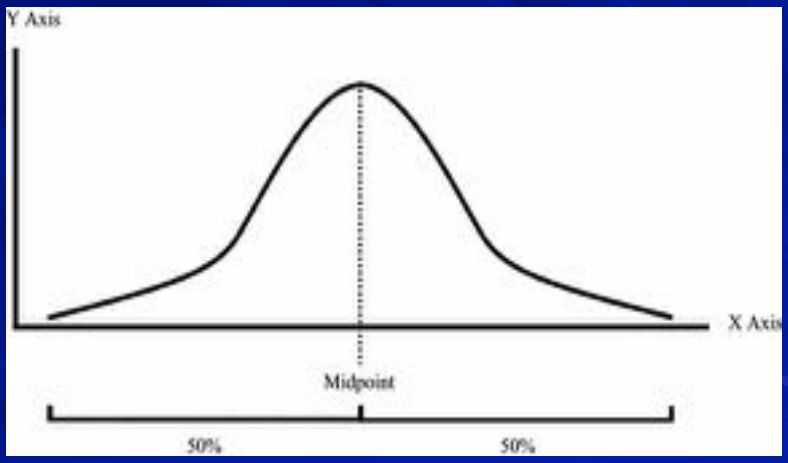
Counties in PA



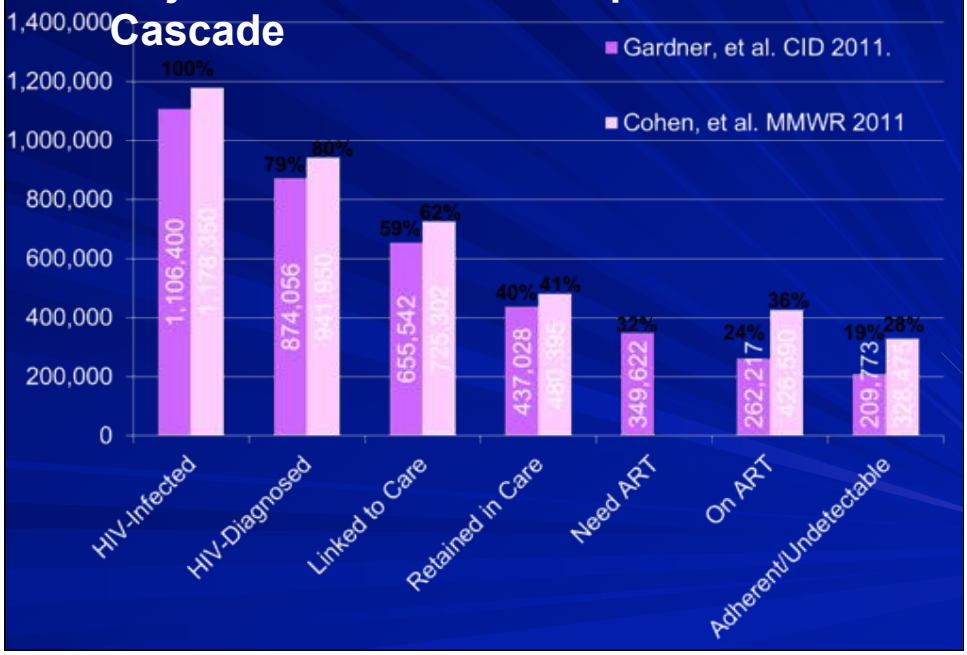
Context of the problem



The US general population increased by 2.8 times from 1920 to 2006. In the same time period the prison population increased 24 times.



Major DECLINE in the Implementation Cascade



"Discharge to the Streets: Re-integrating the HIV+ Prisoner"

- The State prison system has over 700 persons living with HIV/AIDS.
- The 67 county and municipal jails hold over 1,700 living with HIV/AIDS.
- 90% are discharged. For those who are uninsured, this is where we come in.
- AIDS Care Group repackaged the SPNS grant into a CDC initiative and continues to work with Delaware County.

George W. Hill Correctional Facility

Gaps #4 and #5 – Access to Anti-retroviral Therapy

- The clinical setting:
- The Ryan White HIV/AIDS Program, first authorized in 1990, is funded at $2.32 billion in fiscal year 2014. The Program is administered by the U.S. Department of Health and Human Services (HHS), Health Resources and Services Administration (HRSA), HIV/AIDS Bureau (HAB).

The Parts…

- The majority of Ryan White funds support primary medical care and essential support services. A smaller but equally critical portion funds technical assistance, clinical training, and research on innovative models of care.
- The Ryan White legislation created a number of programs, called Parts, to meet needs for different communities and populations affected by HIV/AIDS.

Part A

- Provides emergency assistance to Eligible Metropolitan Areas and Transitional Grant Areas that are most severely affected by the HIV/AIDS epidemic.
- AIDS Care Group receives Part A funds through the City of Philadelphia – AIDS Activities Coordinating Office for a continuum of services including medical, dental, substance abuse care and transportation services.

Part B

- Provides grants to all 50 States, the District of Columbia, Puerto Rico, Guam, the U.S. Virgin Islands, and 5 U.S. Pacific Territories or Associated Jurisdictions.
- AIDS Care Group receives Part B funds from the State of Pennsylvania through the Philadelphia Department of Health-AACO
- ACG receives PPA funding for HIV testing through the State and is a contracted STD provider with Penna.

Part C

- Provides comprehensive primary health care in an outpatient setting for people living with HIV disease. (Early Intervention Services)
- There are about 425 programs that are Part C
- AIDS Care Group receives Part C funding directly from Health Resources Services Administration (HRSA – the federal government)
- We have received Capacity Building funds to help expand women's health care, and one time Part C expansion funds in the past

Part D

- Provides family-centered care involving outpatient or ambulatory care for women, infants, children, and youth with HIV/AIDS.
- The AIDS Care Group receives Part D funds directly from HRSA
- There are 133 programs in the country that are concurrently funded by Part C and Part D

Additional Partners

- MTI grant through the University of Penna (part of the 12 cities initiative)
- CDC funding for HIV testing and outreach, education and jails outreach and discharge planning
- Northwestern Human Services
- Widener University (federal grant)

Gap #6 – Attaining Suppressed Viral Loads

- Looking at the entire spectrum of patient, provider, and setting.
- Mental illness and substance abuse
- Housing
- Triggers to recidivism
- Other behaviors and medical conditions

Integrative approach to medicine

- AIDS Care Group teamed with local mental illness and substance abuse center that is dedicated to Medicaid populations.
- Primary care is provided by AIDS Care Group.
- Suboxone treatment center utilizing an Integrative Model of Care was established by AIDS Care Group to support services at the local agency.

Special Projects

The AIDS Care Group was awarded a Special Projects of National Significance grant for "Oral Health Care – Outreach Project"

A new clinic was established in Coatesville in October, 2006

Clinical Care

- The AIDS Care Group was meant to be a clinically-based organization.
- It is now a clinical and social-services based organization where the clinical care division is busy due to efforts through outreach to keep clients linked to their providers.

- Develop relationships that keep clients linked into social services
- Meet people on their turf, drive them to appointments of all types (medical, SSI, court appearances)
- Address acute needs with great intensity and then transition clients into a more chronic model when it's appropriate
- Be creative and persevere

Thank you!

Need more information?

Howell Ira Strauss, DMD
AIDS Care Group
www.admin@aidscaregroup.org

Questions and Answers

HRSA
Health Resources & Services Administration

Recommendations and promising practices

Affordable Care Enrollment (ACE) TA Center

HRSA
Health Resources & Services Administration

How the ACA and the RWHAP Support the HIV Care Continuum

United States Conference on AIDS
September 11, 2015 4:30 p.m. – 6:00 p.m.

The ACE TA Center

The **ACE TA Center** helps Ryan White HIV/AIDS Program grantees and providers enroll diverse clients, especially people of color, in health insurance.

Objectives:

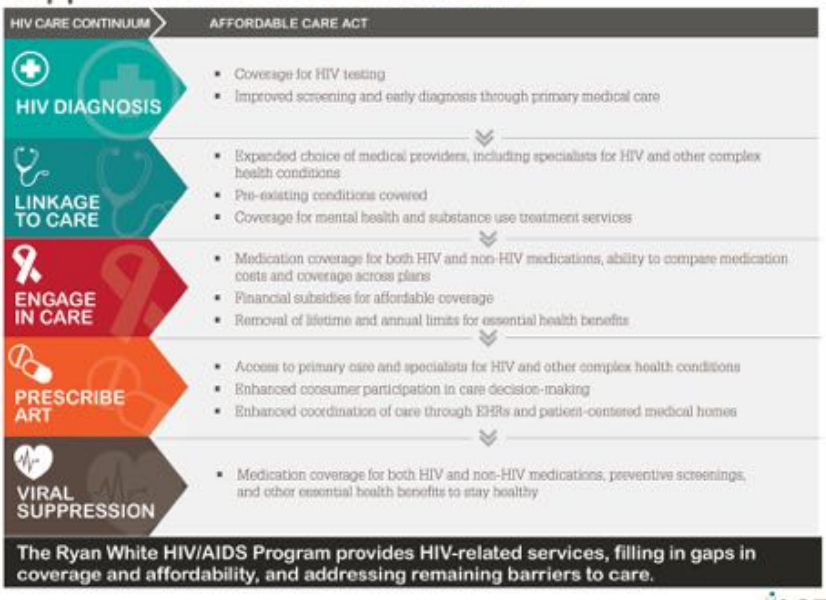
- Develop and share tools and resources to help providers enroll clients of color, always considering cultural and historical barriers to enrollment
- Provide TA and training to use these tools and resources
- Identify and promote best and promising enrollment practices for organizations

Presentation overview

- Review the relationship between the ACA, RWHAP and the HIV Care Continuum
- Introduce new tools to help organizations improve completeness of coverage for clients
- Briefly review ACE TA Center resources
- Show participants how to access the ACE TA Center and stay up-to-date about new tools and upcoming events

ACE TA CENTER

How the ACA and RWHAP Support the HIV Care Continuum



What is "coverage completion"?

Broadly defined, **coverage completion** is the process of *examining the array of services covered by other payment sources* (e.g., Marketplace, Medicaid) and coordinating the use of these resources with RWHAP funds to fill in gaps in affordability and address remaining barriers to care.

Affordability and coverage completion

- Advanced premium **tax credits** (APTCs) and **cost sharing** reductions (CSRs) make marketplace insurance more affordable
- **RWHAP funds can help** with premium payments, co-pays, and deductibles
- RWHAP ensures HIV **coverage completion** for insured clients and a safety net for the uninsured (including ineligible clients)

New self-assessment and data toolkit for RWHAP service providers

ACE TA CENTER

Organizational self-assessment

- Web-based module asks questions about current practices
- Generates a customized summary based on your responses
  - Areas for improvement
  - Helpful resources to help you get started
- Includes an interactive **best practices** guide

ACE TA CENTER

Example Best Practices

1. **Prepare** your organization to best meet the enrollment needs of clients.
   - Ensure your organization is part of provider networks for QHPs and Medicaid
   - Train staff on how the RWHAP can support ineligible clients

2. **Engage** clients to enroll in health coverage, use their coverage, and stay enrolled.

3. **Document** and **monitor** your organization's engagement and enrollment efforts.

Example Best Practices

1. **Prepare** your organization to best meet the enrollment needs of clients.

2. **Engage** clients to enroll in health coverage, use their coverage, and stay enrolled.
   - Assess your workflow to routinely screen clients for eligibility and plan renewals
   - Tailor messaging appropriately to your client population
   - Provide one-on-one assistance for most clients

3. **Document** and **monitor** your organization's engagement and enrollment efforts.

Example Best Practices

1. **Prepare** your organization to best meet the enrollment needs of clients.

2. **Engage** clients to enroll in health coverage, use their coverage, and stay enrolled.

3. Document and **monitor** your organization's engagement and enrollment efforts.

- Document your efforts to identify, engage, and educate clients who may be eligible for coverage
- Use data to monitor, target, and improve enrollment

ACE TA CENTER

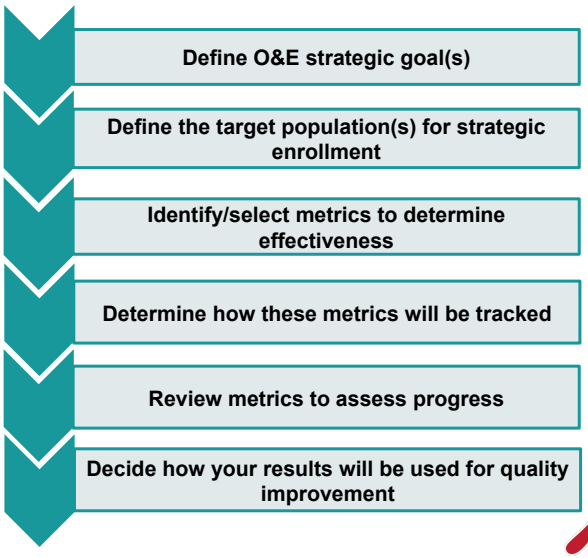
Data Toolkit

- **Helps organizations use data for health insurance outreach and enrollment**

- **Toolkit includes…**
  - Framework for collecting and using outreach and enrollment (O&E) data
  - List of O&E metrics
  - Data inventory template

ACE TA CENTER

The O&E Metrics Framework



ACE TA CENTER

Sample O&E metrics include…

- Assessment of eligibility
- Clients receiving assistance with the application process
- Percent of submitted applications that are approved/ enrolled
- Timely application approval and enrollment
- Clients receiving financial help
- Retention in coverage and churn (e.g., clients that changed coverage, re-enrolled, or remained uncovered)
- Medicaid and Marketplace renewals

ACE TA CENTER

ACE Webinars!

OCT. 8 — **Organizational best practices** ***(launch of self-assessment and O&E metrics guide)***

OCT. 22 — **Preparing for Open Enrollment**

Fall/Winter 2015 (dates TBD):

- Enrollment strategies in diverse communities
- Enrollment strategies for immigrants living with HIV

ACE TA CENTER

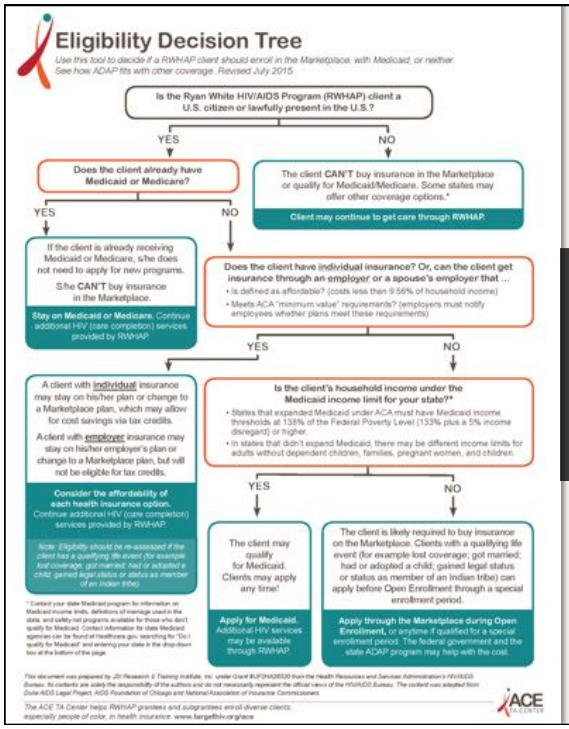
What else is available from the ACE TA Center?

ACE TA CENTER

Tools and job aids for case managers

Enrollment Steps

ACE TA CENTER



Eligibility Decision Tree

Use this tool to decide if a RWHAP client should enroll in the Marketplace, with Medicaid, or neither. See how ADAP fits with other coverage. Revised July 2015.

Is the Ryan White HIV/AIDS Program (RWHAP) client a U.S. citizen or lawfully present in the U.S.?

YES

Does the client already have Medicaid or Medicare?

YES

If the client is already receiving Medicaid or Medicare, s/he does not need to apply for new programs.

S/he **CAN'T** buy insurance in the Marketplace.

Stay on Medicaid or Medicare. Continue additional HIV (care completion) services provided by RWHAP.

NO

Does the client have individual insurance? Or, can the client get insurance through an employer or a spouse's employer that ...

- Is defined as affordable? (costs less than 9.56% of household income)
- Meets ACA "minimum value" requirements? (employers must notify employees whether plans meet these requirements)

YES

A client with individual insurance may stay on his/her plan or change to a Marketplace plan, which may allow for cost savings via tax credits.

A client with employer insurance may stay on his/her employer's plan or change to a Marketplace plan, but will not be eligible for tax credits.

Consider the affordability of each health insurance option. Continue additional HIV (care completion) services provided by RWHAP.

Note: Eligibility should be re-assessed if the client has a qualifying life event (for example lost coverage; got married; had or adopted a child; gained legal status or status as member of an Indian tribe).

NO

Is the client's household income under the Medicaid income limit for your state?*

- States that expanded Medicaid under ACA must have Medicaid income thresholds at 138% of the Federal Poverty Level (133% plus a 5% income disregard) or higher.
- In states that didn't expand Medicaid, there may be different income limits for adults without dependent children, families, pregnant women, and children.

YES

The client may qualify for Medicaid. Clients may apply any time!

Apply for Medicaid. Additional HIV services may be available through RWHAP.

NO

The client is likely required to buy insurance on the Marketplace. Clients with a qualifying life event (for example lost coverage; got married; had or adopted a child; gained legal status or status as member of an Indian tribe) can apply before Open Enrollment through a special enrollment period.

Apply through the Marketplace during Open Enrollment, or anytime if qualified for a special enrollment period. The federal government and the state ADAP program may help with the cost.

* Contact your state Medicaid program for information on Medicaid income limits, definitions of marriage used in the state, and safety-net programs available for those who don't qualify for Medicaid. Contact information for state Medicaid agencies can be found at Healthcare.gov, searching for "Do I qualify for Medicaid" and entering your state in the drop-down box at the bottom of the page.

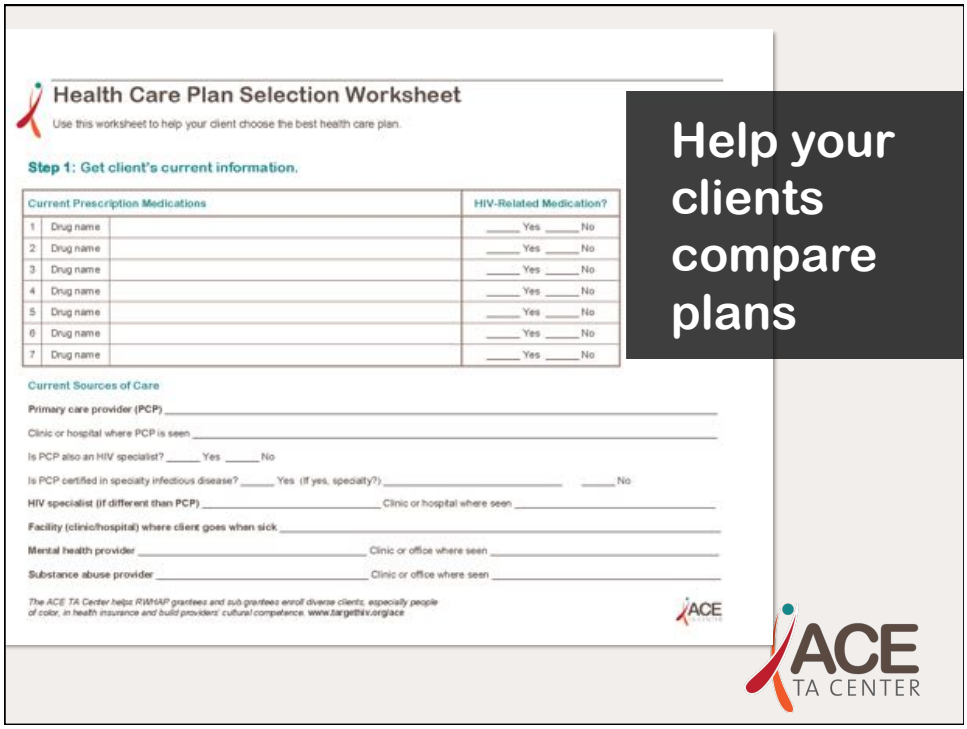
This document was prepared by JSI Research & Training Institute, Inc. under Grant #U2PHA26530 from the Health Resources and Services Administration's HIV/AIDS Bureau. Its contents are solely the responsibility of the authors and do not necessarily represent the official views of the HIV/AIDS Bureau. The content was adapted from Duke AIDS Legal Project, AIDS Foundation of Chicago and National Association of Insurance Commissioners.

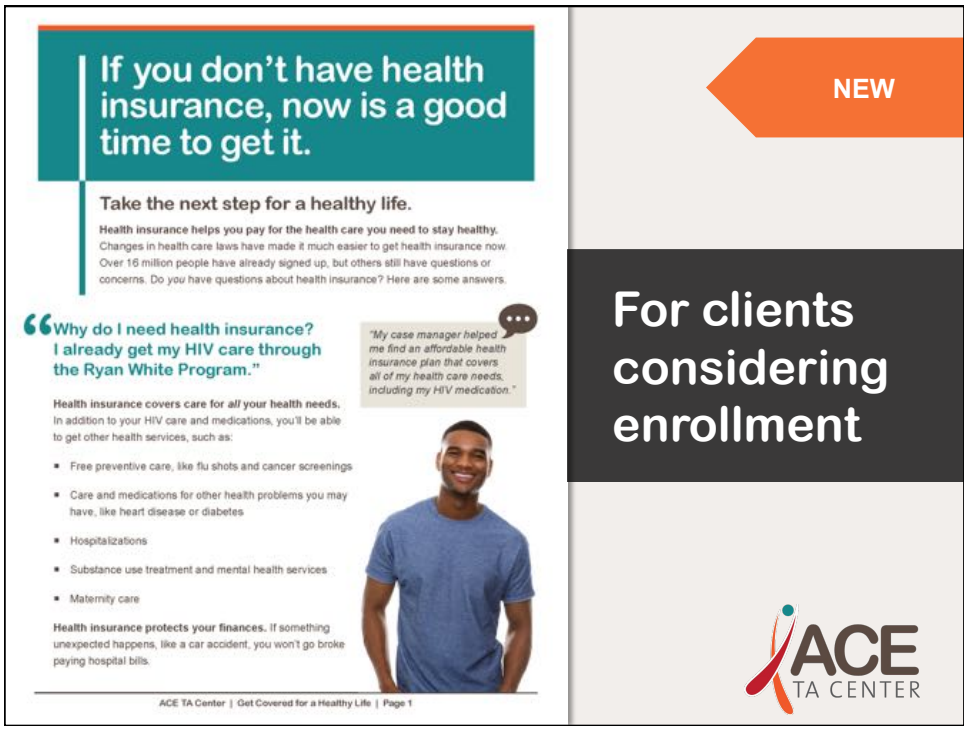
The ACE TA Center helps RWHAP grantees and subgrantees enroll diverse clients, especially people of color, in health insurance. www.targethiv.org/ace

ACE TA CENTER

Medicaid, Marketplace or neither?

ACE TA CENTER


Health Care Plan Selection Worksheet
Use this worksheet to help your client choose the best health care plan.
Step 1: Get client's current information.
Current Prescription Medications
HIV-Related Medication?
1 Drug name
2 Drug name
3 Drug name
4 Drug name
5 Drug name
6 Drug name
7 Drug name
Yes No
Current Sources of Care
Primary care provider (PCP)
Clinic or hospital where PCP is seen
Is PCP also an HIV specialist? Yes No
Is PCP certified in specialty infectious disease? Yes (If yes, specialty?) No
HIV specialist (if different than PCP)
Clinic or hospital where seen
Facility (clinic/hospital) where client goes when sick
Mental health provider
Clinic or office where seen
Substance abuse provider
Clinic or office where seen
The ACE TA Center helps RWHAP grantees and sub-grantees enroll diverse clients, especially people of color, in health insurance and build providers' cultural competence. www.targethiv.org/ace
Help your clients compare plans
ACE TA CENTER


If you don't have health insurance, now is a good time to get it.
Take the next step for a healthy life.
Health insurance helps you pay for the health care you need to stay healthy. Changes in health care laws have made it much easier to get health insurance now. Over 16 million people have already signed up, but others still have questions or concerns. Do you have questions about health insurance? Here are some answers.
"Why do I need health insurance? I already get my HIV care through the Ryan White Program."
"My case manager helped me find an affordable health insurance plan that covers all of my health care needs, including my HIV medication."
Health insurance covers care for all your health needs. In addition to your HIV care and medications, you'll be able to get other health services, such as:
Free preventive care, like flu shots and cancer screenings
Care and medications for other health problems you may have, like heart disease or diabetes
Hospitalizations
Substance use treatment and mental health services
Maternity care
Health insurance protects your finances. If something unexpected happens, like a car accident, you won't go broke paying hospital bills.
ACE TA Center | Get Covered for a Healthy Life | Page 1
NEW
For clients considering enrollment
ACE TA CENTER


Making the Most of Your Coverage
Now that you've enrolled in health insurance, use this guide to learn how to start using your benefits.
ACE TA CENTER
NEW
Help clients use their new coverage
ACE TA CENTER

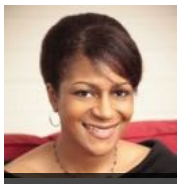

And lots more…
Posters for client enrollment
Links to past webinars
Coming soon: podcasts for clinicians
ACE TA CENTER

Thank you for joining us!

acetacenter@jsi.com

targethiv.org/ace
Sign up for our mailing list, download tools and resources, and more

Visit us at Booth #720!


BISOLA


STEWART


MIRA


TAJAN

ACE TA CENTER

Questions and Answers

HRSA Health Resources & Services Administration

Thank you

Antigone Dempsey, MEd
Director
Division of Policy & Data
HIV/AIDS Bureau
Health Resources and Services Administration
5600 Fishers Lane
Room 7C-26
Rockville, MD 20857
P: 301-443-0360
adempsey@hrsa.gov

Rene Sterling, PhD, MHA
Senior Advisor
Office of Quality Improvement
Bureau of Primary Health Care
Health Resources and Services Administration
5600 Fishers Lane
Room 16W49B
Rockville, MD 20857
P: 301-443-9017
rsterling@hrsa.gov

HRSA
Health Resources & Services Administration