INTRODUCTION

Strengthening collaborations with community health centers (CHCs) is an increasingly important issue for health department HIV/AIDS and viral hepatitis programs. With implementation of the Patient Protection and Affordable Care Act (ACA), federal investment in CHCs has increased. Strengthened collaboration between health departments and CHCs is also essential to facilitating and promoting access to HIV/AIDS and viral hepatitis prevention and care services; improving coordination and continuity of care; and enhancing the quality and effectiveness of both clinical and public health services, ultimately leading to improved health outcomes.

THE AFFORDABLE CARE ACT: NEW OPPORTUNITIES FOR PUBLIC HEALTH

Implementation of the ACA has brought about an important time of innovation in the health system. The ACA has significant implications for individuals living with and/or at risk for HIV/AIDS and/or viral hepatitis infection. Many individuals who previously have not had health insurance or who were inadequately insured will now have access to coverage. Benefits will be more robust, particularly with respect to health promotion and disease prevention, mental health, substance use, and management of complex chronic conditions – services crucial to meeting the needs of individuals and communities impacted by HIV/AIDS and viral hepatitis.

At present, there are over 1,200 CHCs in the U.S. represented by 8,000 practice sites. Collectively, CHCs provide medical, preventive and support services to nearly 20 million people. In preparation for the ACA’s public and private insurance expansions, the ACA provides a significant amount of federal funding to expand the capacity of CHCs to provide primary and preventive health care services to underserved populations, including people living with and/or at risk for HIV/AIDS and viral hepatitis. To date, CHCs have received ACA funding for:

- Establishment of new access points for health services.
- Capacity building and capital improvements to support construction projects to increase health center capacity to provide health services.
- Outreach and enrollment assistance activities to facilitate enrollment of eligible health center patients and service area residents into new ACA coverage options.
- The adoption and meaningful use of electronic health records (EHRs), and the use of other health information technology to improve quality in health centers.

In addition to ramping up CHC capacity, the ACA invests in a range of public health infrastructure and services, including disease surveillance, health

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education/health promotion and community-based programming. New benefits requirements mean that preventive services, including routine HIV screening and HCV screening for certain populations, will be covered by public and private insurance. For individuals living with and/or at risk for HIV/AIDS and viral hepatitis this means that HIV, HCV and sexually transmitted disease screening will become more accessible as will other preventive services, such as vaccinations and risk reduction counseling that can support behavior change. In this ACA environment, CHCs will play an increased role in HIV and HCV screening, linkage to care, and, in some cases, provision of HIV/AIDS and viral hepatitis care and treatment.

As the ACA is implemented, states are preparing for massive changes to the health care system simultaneously while state and federal funding to support health departments in the planning, delivery and evaluation of HIV/AIDS and viral hepatitis prevention, care and treatment services is diminishing. At the same time, state and federal policy makers are increasingly emphasizing shifting costs to third-party payers, services that are currently funded through grants and similar funding mechanisms. Coupled with changes in the health delivery system, especially with respect to the expanded role that CHCs will assume, significant changes in how individuals with and at-risk for HIV/AIDS and/or viral hepatitis infection receive services can be expected. As a result, health departments must urgently examine their future roles and responsibilities in supporting prevention, treatment and care for HIV/AIDS and viral hepatitis and identify strategies that will strengthen and expand collaborations with CHCs.

**STRENGTHENING COLLABORATION: AREAS OF FOCUS**

There are three key areas on which health department and CHCs can focus their collaborative efforts: (1) facilitating and promoting access to HIV/AIDS and viral hepatitis prevention and care services; (2) improving coordination and continuity of care; and (3) enhancing the quality and effectiveness of both clinical and public health services.

**Access to Prevention and Care Services:**

Through the ACA, many individuals living with or at risk for HIV/AIDS and/or viral hepatitis infection will gain access to coverage and services that are responsive to their needs. People living with HIV/AIDS (PLWHA) and viral hepatitis will have increased access to medical care, including access to prescription drugs. In addition, individuals living with or at risk for HIV/AIDS and/or viral hepatitis will have improved access to and coverage of preventive services (e.g., HIV and HCV testing, vaccinations), substance abuse services and mental health treatment.

Under ACA, CHCs are leading and have received funding to support outreach and enrollment assistance activities to facilitate enrollment of eligible health center patients and service area residents into new ACA coverage options. This is an important area of collaboration for health departments and CHCs. Health departments should work with CHCs to ensure that outreach and enrollment activities include information about HIV/AIDS and viral hepatitis programs.

As health insurance coverage expands under ACA and HIV prevention and care becomes increasingly integrated into primary care, some individuals currently served by health department-supported HIV/AIDS and viral hepatitis prevention and care programs will receive these services from CHCs. Health departments and CHCs need to collaborate to ensure that providers are aware of new coverage requirements and to prepare for a smooth transition for clients as new forms of coverage go into effect and new resources for prevention and care services become available. It will also be important for health departments and CHCs to identify gaps in services and identify strategies to address these gaps.

**Coordination and Continuity of Care:**

The ACA calls for expanded investments in chronic disease management. Individuals living with and/or at risk for HIV/AIDS and viral hepatitis infection often have complex needs requiring multiple clinical, preventive and support services. To be optimally effective, service provision must be well managed and coordinated. The ACA also calls for new investments to improve chronic disease management and recognizes the value of patient-centered medical homes (PCMH) in strengthening and ensuring the quality and comprehensiveness of care for individuals with complex, chronic conditions such as HIV/AIDS and/or hepatitis C (HCV) infection.

Individuals living with HIV/AIDS and currently receiving care coordination, health navigation, and
other support services through health department and/or Ryan White-supported programs may gain access to those services by virtue of new or expanded health care coverage. Other individuals, such as those living with HCV infection or individuals at increased risk for HIV and/or HCV due to co-occurring mental illness, substance use or other chronic conditions may also gain access to care and support services not previously available to them. Health departments and CHCs need to collaborate to ensure a smooth transition for clients as new forms of coverage go into effect and new resources for care coordination and support become available. Health departments and CHCs should also collaborate to implement best practices learned from Ryan White programs to promote and facilitate coordination and continuity of care responsive to the needs of PLWHA and to adapt care coordination and navigation models to meet the needs of individuals living with HCV infection and/or at risk for HIV/AIDS and viral hepatitis infection.

**Quality and Effectiveness of Services:**

Contemporary HIV assays have dramatically reduced the window period for detecting HIV infection and new testing algorithms enable diagnosis of acute infection, thereby facilitating engagement with treatment early in the course of infection. New diagnostic technologies, coupled with emerging treatment options, impact treatment guidelines. Treatment options for HCV are also expanding and emerging medications will continue to increase the potential for a cure.

Health departments and CHCs should collaborate to ensure high-quality evidence-based services are available in a community. Health departments can support CHCs in implementing screening and strengthening compliance with prevention and treatment guidelines by building awareness of emerging technologies and treatments, and providing education and training to community health center staff.

Health departments and CHCs should also collaborate, along with other stakeholders, in monitoring and evaluating the quality of HIV/AIDS and viral hepatitis services. Data from disease surveillance and health assessment activities conducted by health departments, coupled with service data compiled by CHCs and other providers of health services, can inform and improve practice management. Health departments compile data on and related to a variety of reportable health conditions. Health departments also compile a wide variety of data related to publicly funded health and preventive services, including HIV and HCV testing, hepatitis immunizations and HIV and viral hepatitis care services, including medication utilization (via drug assistance programs). CHCs, of course, maintain extensive data on clinical services provided to their patients. Taken together, these data can assist health departments and CHCs in assessing the extent to which providers, individually or across a community, are providing services that are responsive to community needs and priorities as well as responsive to treatment guidelines. Evaluating these multiple sources of data can also help to identify emerging health issues and concerns and health departments and CHCs can work together to identify appropriate strategies to address emerging issues.

**CURRENT STATUS OF COLLABORATION: RESULTS OF SURVEY ON COLLABORATION**

In May 2013, NASTAD requested that health departments participate in an on-line survey about collaboration between health departments and CHCs and primary care associations (PCAs). In total, 41 health departments completed the survey including 40 (80%) of 50 state health departments.

Health departments reported a relatively high level of collaboration with CHCs, with 57% of health departments reporting that they conduct collaborative events with CHCs or provide funding or other support to CHCs for HIV/AIDS and viral hepatitis services. However, health departments are collaborating with relatively few CHCs. With over 1,200 CHCs in the U.S., health department HIV/AIDS and viral hepatitis programs report collaboration, through funding and/or other forms of support, with 281 CHCs (23%) (Table 1).
Table 1: CHCs Receiving Funding or Other Support from HDs, by Service (N=32)

<table>
<thead>
<tr>
<th>Service</th>
<th>Total # of CHCs</th>
<th>Median # of CHCs</th>
<th>Mean # of CHCs</th>
<th>Range of CHCs</th>
</tr>
</thead>
<tbody>
<tr>
<td>HIV care and treatment</td>
<td>161</td>
<td>3</td>
<td>5.6</td>
<td>0-30</td>
</tr>
<tr>
<td>HIV prevention</td>
<td>85</td>
<td>3</td>
<td>4.5</td>
<td>0-20</td>
</tr>
<tr>
<td>HIV testing</td>
<td>153</td>
<td>5</td>
<td>6.7</td>
<td>0-23</td>
</tr>
<tr>
<td>Viral hepatitis care and treatment</td>
<td>8</td>
<td>0</td>
<td>0.5</td>
<td>0-3</td>
</tr>
<tr>
<td>Viral hepatitis prevention</td>
<td>5</td>
<td>0</td>
<td>0.3</td>
<td>0-3</td>
</tr>
<tr>
<td>Viral hepatitis testing</td>
<td>39</td>
<td>1</td>
<td>2.0</td>
<td>0-13</td>
</tr>
<tr>
<td>Other</td>
<td>2</td>
<td>0</td>
<td>0.3</td>
<td>0-2</td>
</tr>
</tbody>
</table>

Only 23% of health departments collaborate with primary care associations (PCAs) by conducting collaborative events or other programming (e.g., awareness campaigns) or providing funding or other support.

Twenty-six health departments provide funding to 161 CHCs to support HIV care and treatment services. A total of 71 CHCs in 19 jurisdictions are funded for HIV care and treatment services both by health departments and under Ryan White Part C. This represents 24% of all of the CHCs supported by health departments for HIV care and treatment, with an average of three dually-funded CHCs per jurisdiction.

Nine health departments currently collaborate with CHCs or PCAs to implement medical home models for HIV care (Figure 1).

Of the 30 health departments not currently collaborating with PCAs or CHCs, only six (20%) report plans to work on implementation of a medical home model during the coming year.

Ninety percent of health departments provide training or professional education to CHC staff. Topical areas generally align with the services funded by health departments (Table 2).
Table 2: Topical Areas of Training and Professional Education (N=36)  Number (%)  

<table>
<thead>
<tr>
<th>Topic</th>
<th>Number (%)</th>
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<tbody>
<tr>
<td>HIV testing</td>
<td>31 (86%)</td>
</tr>
<tr>
<td>Data collection and reporting</td>
<td>26 (72%)</td>
</tr>
<tr>
<td>HIV basics</td>
<td>24 (67%)</td>
</tr>
<tr>
<td>HIV prevention behavioral interventions</td>
<td>24 (67%)</td>
</tr>
<tr>
<td>HIV epidemiologic overview</td>
<td>23 (64%)</td>
</tr>
<tr>
<td>Partner services</td>
<td>22 (61%)</td>
</tr>
</tbody>
</table>

Fifty-three percent (21) of health departments report that they share data electronically with CHCs. Of 21 health departments that electronically share data, 18(86%) reported electronically sharing data at the client-level - primarily service data (e.g., Ryan White funded services, HIV testing). Lack of interoperability of data systems and lack of needed information technology (IT) infrastructure were cited as barriers to data sharing by 38% and 31% of health departments, respectively.

A majority of health departments have evaluated CHC responsiveness to preventive services guidelines for HIV (Figure 2) while very few (six) report assessing CHC responsiveness to HCV screening guidelines.

![Figure 2: Percent of Health Department Reporting Evaluating CHCs’ Responsiveness to Preventive Services and Treatment Guidelines (N=40)](figure2.png)

Health departments were asked to rank the factors that hinder collaboration with CHCs. The factor which received the rank of 1 was the “most important.”

Table 3: Top Ranked Factors that Hinder Health Department and CHC Collaboration (N=40)  Ranking  

<table>
<thead>
<tr>
<th>Factor</th>
<th>Ranking</th>
</tr>
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<tbody>
<tr>
<td>Lack of funding to support collaboration</td>
<td>1</td>
</tr>
<tr>
<td>Health department lacks capacity to support CHCs in implementation</td>
<td>2</td>
</tr>
<tr>
<td>CHCs lack capacity to implement HIV/AIDS or viral hepatitis services</td>
<td>3</td>
</tr>
<tr>
<td>Data reporting requirements</td>
<td>4</td>
</tr>
<tr>
<td>CHCs lack capacity to expand services</td>
<td>5</td>
</tr>
</tbody>
</table>

In addition, 51% of health departments report having experienced resistance from CHCs in implementing HIV/AIDS and/or viral hepatitis services.
More in-depth discussion of current health department efforts to collaborate with CHCs and PCAs is contained in a full report of the survey. Survey findings will inform NASTAD’s technical assistance and advocacy efforts in this area.

**CHALLENGES AND STRATEGIES: DISCUSSION GROUP ON HEALTH DEPARTMENT – COMMUNITY HEALTH CENTER COLLABORATION**

A discussion group, ”Working with Community Health Centers” was held at NASTAD’s Annual Meeting in May 2013. Through facilitated discussion, representatives from 11 health departments discussed current collaborative activities and challenges associated with health department and CHC collaborations. Challenges noted include:

1. **Workforce:**

   Workforce issues were identified as an important challenge to health department and CHC collaborations. According to health department participants, CHCs report to them that there are not enough clinicians to provide the current range of needed HIV and HCV services. Adding HIV/AIDS or viral hepatitis services is often not seen as feasible. The perceived complexity of care for HIV/AIDS and HCV infection is a related concern articulated to health departments by CHCs.

2. **Federal Policy:**

   Federal policy was cited as a challenge to collaborations. Health departments indicate that CHCs need to be “pushed” by the Health Resources and Services Administration (HRSA) to “accept their responsibility” to integrate HIV/AIDS and viral hepatitis into their scope of services. The medical home model was also cited as a particular concern to health departments with respect to the extent to which this model can provide comprehensive coordinated care, to the same degree as Ryan White-funded services. There is significant variation across states in how the medical home model is implemented. HRSA requires only that CHC medical homes make referrals for services. Medical homes are not required to themselves provide referral services. Monitoring of and accountability for the appropriateness, quality, and completion of referral services must be addressed.

3. **State Policy:**

   Health departments also cited policy challenges at the state level as a barrier to collaborations. In some states, HIV/AIDS and viral hepatitis programs have been discouraged or barred by health department administrations from working directly with CHCs or PCAs on integration of HIV/AIDS and viral hepatitis services or developing HIV/AIDS medical home models. In these health departments, collaboration with CHCs is managed centrally, often as part of strategic efforts to implement the ACA. Other health departments report that they are not involved in efforts to strengthen collaborations centrally managed within their health departments, and several indicated that they are not even aware of these efforts, if any, within their institutions.

4. **Resistance of CHCs to Integration of HIV/AIDS and Viral Hepatitis:**

   Lack of interest and/or resistance on the part of CHCs in integrating HIV/AIDS and viral hepatitis services was cited by health departments as a challenge to collaboration. The perceived complexity of HIV/AIDS and HCV treatment; low financial incentives; lack of perceived priority of HIV/AIDS or viral hepatitis (by boards of directors, administrators, clinical managers); data reporting requirements; and stigma were all cited by health departments as barriers to expanded collaboration.

   Health departments also identified and discussed some strategies for addressing challenges to strengthened collaboration. These include:

   - Invest in telemedicine to address clinician knowledge and skills to evaluate and manage HIV/AIDS and viral hepatitis.
   - Collaborate with AIDS Education and Training Centers (AETC) or state PCAs to build awareness about HIV/AIDS and viral hepatitis, and to address professional education and skills building needs.
   - Work with AIDS service organizations (ASOs) or other community-based organizations to expand their capacity for services, especially clinical services. One health department indicated that an ASO accomplished expansion through co-location of services with a CHC. Another health department reported that an existing ASO was “converting” to a CHC.
Next Steps
NASTAD will continue to monitor health department and CHC collaborations and challenges associated with strengthened collaboration. NASTAD will also continue to assess areas of opportunity for enhanced collaboration between health departments and community health centers and identify strategies to assist health departments in taking advantage of such opportunities.

STRENGTHENING COLLABORATION: ACTION STEPS FOR HEALTH DEPARTMENTS
In working to expand and strengthen collaboration with CHCs, health departments should consider the following action steps:

Get involved in your health department’s efforts to implement the ACA.
Identify the organizational unit within your health department where these efforts occur and get a seat at the table or consult with designated representatives to raise levels of awareness about the issues and concerns of HIV/AIDS and viral hepatitis programs. This will help to facilitate visibility for HIV/AIDS and viral hepatitis program issues in your state’s efforts to implement the ACA.

Advocate for an HIV/AIDS and/or HCV medical home.
Many states are working to implement medical home models for chronic care, including HIV/AIDS. The model of HIV/AIDS care and treatment supported by Ryan White may be easily translatable. More information about Medicaid Health Homes, including technical assistance resources, is available at the Health Home Information Resource Center. As of July 2013, 15 states have health home State Plan Amendments approved by the Centers for Medicare and Medicaid Services (CMS). Three states – New York, Oregon and Wisconsin - have included HIV/AIDS among the chronic conditions covered in their health home plans. Oregon’s also includes hepatitis C. More information about the features of these health home plans is available in CMS’s State-by-State Health Home State Plan Amendment Matrix.

Work with the health department sister programs that already “have a foot in the door.”
Leveraging relationships with family planning, tuberculosis, sexually transmitted disease, or substance abuse programs may facilitate enhanced collaboration between health department HIV/AIDS and viral hepatitis programs and CHCs. These programs may have existing, successful relationships with CHCs; HIV/AIDS and viral hepatitis services may be appropriately integrated into such services.

Raise awareness and correct misperceptions.
Work with AIDS Education and Training Centers (AETCs), PCAs and Prevention Training Centers (PTCs) to identify strategies that will raise awareness among CHCs about the impact of HIV/AIDS and viral hepatitis; the role that CHCs and health departments should play in delivery of prevention and care services; and the opportunities and resources for professional education and skills enhancement. Consider segmenting efforts and activities to address clinicians, administrators and CHC boards of directors.

Make use of data.
Data can be used to raise awareness about the impact of HIV/AIDS and viral hepatitis in a community. It can also help CHCs understand the extent to which their services are responsive to community needs and where practice could be improved. Develop CHC-specific or community continuum of care cascades to stimulate evaluation of the adequacy of services and identify areas for practice improvement. Consider working with the PCA to develop strategies to evaluate responsiveness to preventive service and treatment guidelines. Disease surveillance data combined with CHC service data (often available from PCAs) can be valuable in this regard. Evaluation of CHC service data may also help the health department identify emerging health issues such as trends in depression or substance use.