NATIONAL ASSOCIATION OF
Community Health Centers®

Ending the HIV Epidemic by 2030: What Will It Take?

Thursday, March 9 | 8:00 – 9:15am

Georgetown University, Marriot Marquis

Washington, DC

THE NACHC MISSION

America's Voice for Community Health Care

The National Association of Community Health Centers (NACHC) was founded in 1971 to promote efficient, high quality, comprehensive health care that is accessible, culturally and linguistically competent, community directed, and patient centered for all.

NATIONAL ASSOCIATION OF
Community Health Centers®

NACHC's STRATEGIC PILLARS

1

Equity and Social Justice

Center everything we do in a renewed commitment to equity and social justice

2

Empowered Infrastructure

Strengthen and reinforce the infrastructure for leading and coordinating the Community Health Center movement, notably consumer boards and NACHC itself

3

Skilled and Mission-driven Workforce

Develop a highly skilled, adaptive, and mission-driven workforce reflecting the communities served

4

Reliable and Sustainable Funding

Secure reliable and sustainable funding to meet increasing demands for Community Health Center services

5

Improved Care Models

Update and improve care models to meet the evolving needs of the communities served

6

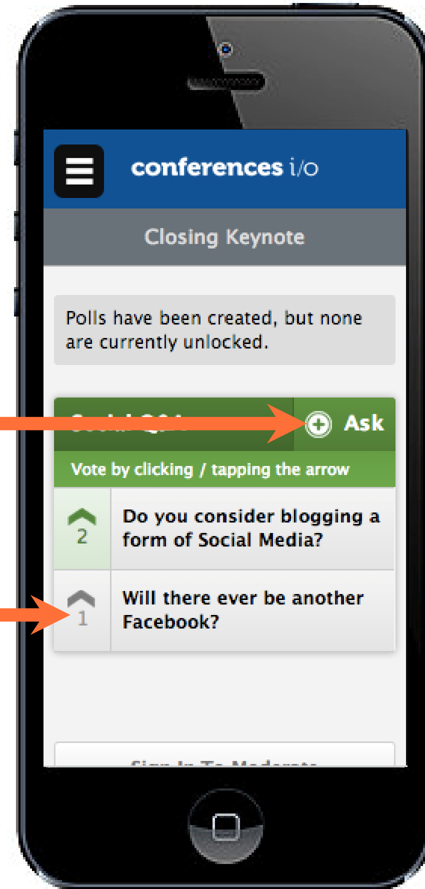
Supportive Partnerships

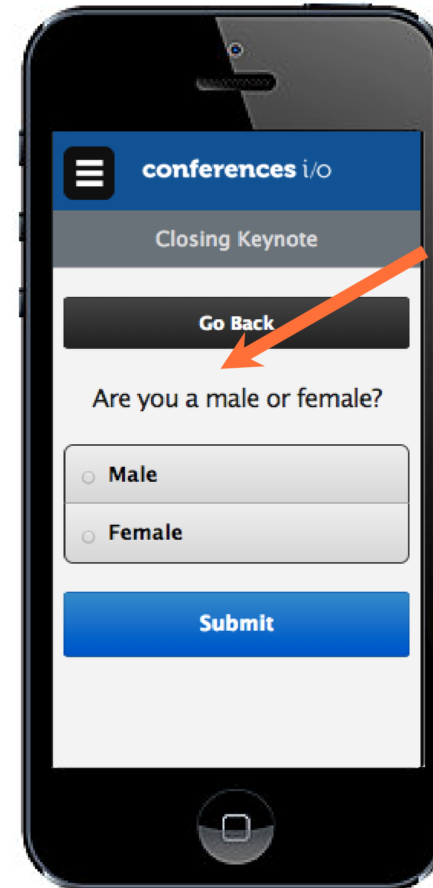
Cultivate new and strengthen existing mutually beneficial partnerships to advance the shared mission of improving community health

Vote / Give Feedback/ Respond to Polls

Give us Feedback

Up-Vote a Comment

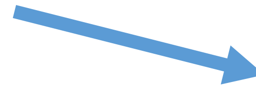




Click on question and then Respond to Polls when they appear

Audience Participation

Chat
(use to talk with peers)



Polling/Q&A
(participate in polls, ask questions to faculty)

P&I 2023

PThB2 - Policy, Oversight, and Strategy: Exploring Health Center Board Roles

Info Panel
Chat
Resources
Questions

Social Q&A Ask
There are no questions right now. Why not ask one?

NATIONAL ASSOCIATION OF Community Health Centers

Policy, Oversight, and Strategy: Exploring Health Center Board Roles

Notes

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9:22 AM EST
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AGENDA

1
Community Health Centers Critical Role in Ending the HIV Epidemic in the U.S.
Presented by Harold Phillips, MRP

2
Ending the HIV Epidemic by 2030: What Will It Take?
Presented by Ernia Hughes, MBA

3
Unity Health Care - HIV Care: Testing, Treatment, Prevention
Presented by Gebeyehu Teferi, MD

4
Q&A
Facilitated by Pedro Carneiro, MPH

5
Closing

Harold Phillips, MRP

Director of the Office of National AIDS Policy

White House

Community Health Centers Critical Role in Ending the HIV Epidemic in the U.S.

March 9, 2023

Harold J. Phillips, MRP
Director
White House Office of National AIDS Policy

Overview

- Implementation of the National HIV/AIDS Strategy (NHAS)
- Ending the HIV Epidemic in the U.S. Initiative
- Opportunities for Health Centers

NHAS Implementation

National HIV/AIDS Strategy (2022-2025)

Reflects President Biden’s commitment to re-energize and strengthen a whole-of-society response to the epidemic while supporting people with HIV and reducing HIV-associated morbidity and mortality.

Elements of the National HIV/AIDS Strategy

- 1 vision
- 4 goals
  - 21 objectives
    - 78 strategies
- 8 priority populations
- Indicators of progress
  - 9 core indicators
  - 8 disparity indicators
  - **1 developmental indicator**

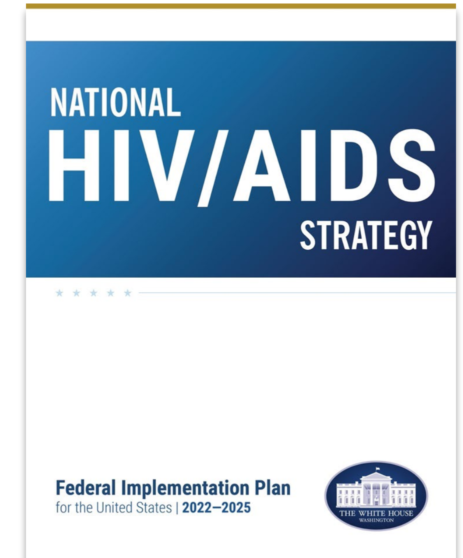
NATIONAL
HIV/AIDS
STRATEGY

for the United States
2022–2025

NHAS FEDERAL IMPLEMENTATION PLAN

Overview

- Details actions to be taken by **10 federal departments** to implement the NHAS between 2022-2025
  - Department of Agriculture
  - Department of Defense
  - Department of Education
  - Department of Health and Human Services
  - Department of Housing and Urban Development
  - Department of the Interior
  - Department of Justice
  - Department of Labor
  - Department of Veterans Affairs
  - Equal Employment Opportunity Commission



- **>380 action items** span programs, policies, research, and other activities
- Many involve collaborative items across multiple agencies

NEW QUALITY OF LIFE INDICATORS

5 New Quality of Life Indicators

Indicator 9: Increase the proportion of people with diagnosed HIV who report **good or better health** to 95% from a 2018 baseline of 71.5%.

Indicator 10: Decrease by 50% the proportion of people with diagnosed HIV who report an unmet need for services from a **mental health** professional from a 2017 baseline of 24.2%.

Indicator 11: Decrease by 50% the proportion of people with diagnosed HIV who report ever **being hungry** and not eating because there wasn't enough money for food from a 2017 baseline of 21.1%.

Indicator 12: Decrease by 50% the proportion of people with diagnosed HIV who report being **out of work** from a 2017 baseline of 14.9%.

Indicator 13: Decrease by 50% the proportion of people with diagnosed HIV who report being **unstably housed or homeless** from a 2018 baseline of 21.0%.

Ending the HIV Epidemic in the U.S. Initiative

Ending the HIV Epidemic

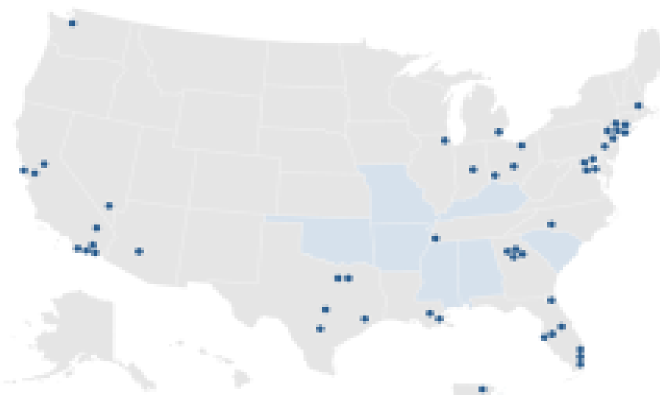
GOAL:

75%
reduction in new HIV infections in 5 years

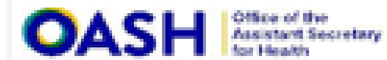
and at least
90%
reduction in 10 years.

FOCUSED EFFORT

- 48 counties, DC, and San Juan account for 50% of new HIV diagnoses in 2016.
- 7 states with the most substantial HIV diagnoses in rural areas.



Led by HHS



Ending the HIV Epidemic in the U.S. Initiative

Diagnose all people with HIV as early as possible.

Treat people with HIV rapidly and effectively to reach sustained viral suppression.

Prevent new HIV transmissions by using proven interventions, including pre-exposure prophylaxis (PrEP) and syringe services programs (SSPs).

Respond quickly to potential HIV outbreaks to get needed prevention and treatment services to people who need them.

Opportunities for Health Centers

1.2 Million People in the U.S. have HIV and Health Disparities Persist

Snapshot of Disparities

Higher HIV Incidence:

-Gay and Bisexual Men
-Black/African American Persons
-Hispanic/Latino Persons

Larger Gaps in PrEP Coverage:

-Black/African American Persons
-Hispanic/Latino Persons

Lower Rates of Viral Suppression:

-American Indian/Alaskan Native Persons
-Black/African American Persons

Higher HIV Prevalence:

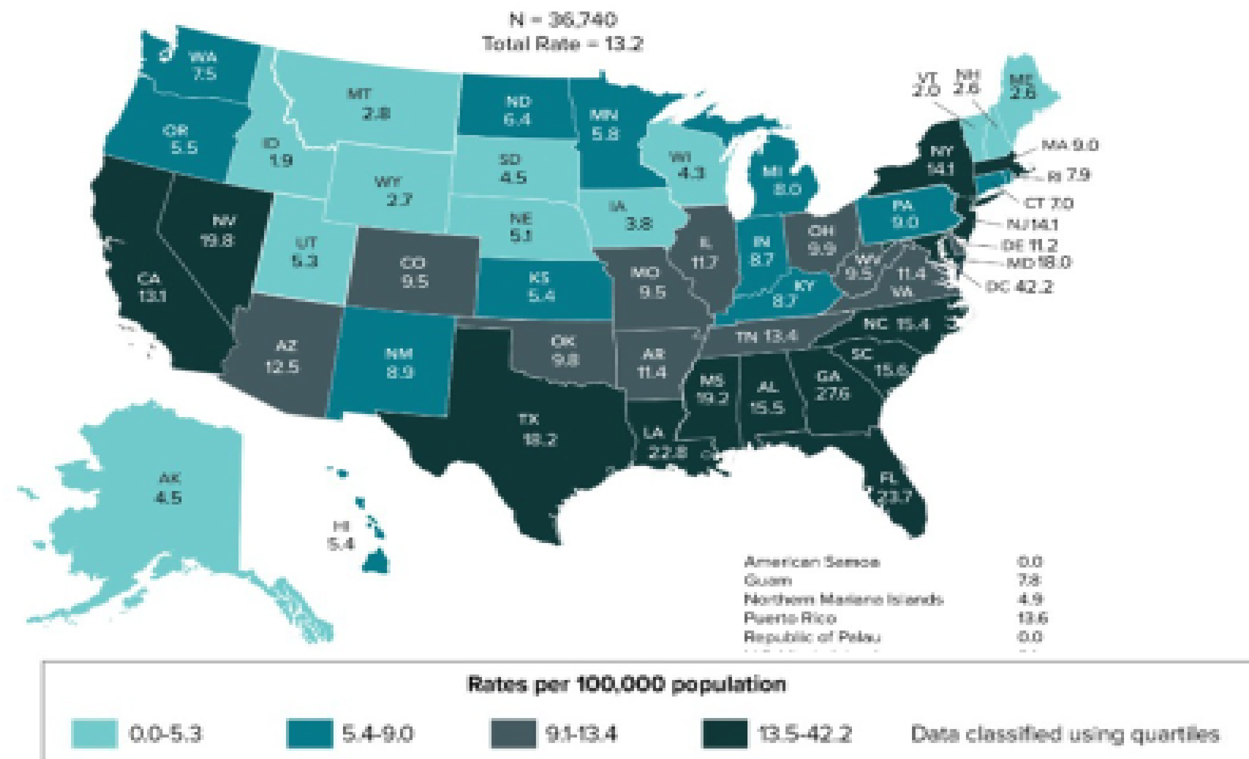
-MSM
-Transgender Women

More HIV Outbreaks

-People Who Inject Drugs

Rates of Diagnoses of HIV Infection are Highest in the South

(More than 50% of all new HIV diagnoses in 2019)



Credit: Division of HIV Prevention, Centers for Disease Control and Prevention

Opportunities for Health Centers – Dismantling Stigma

- ONAP is working with key partners to accelerate efforts to address HIV disparities. Health Centers are critical in these efforts.
- Specifically in several key areas:
  - Dismantling stigma and discrimination that affect HIV diagnoses and outcomes.
  - Ensuring key messages regarding knowing your HIV status, viral suppression (U=U), and PrEP availability are reaching those that need it from trusted messengers.

Opportunities for Health Centers – Reducing Disparities

- Conduct analyses with HIV, STI and other related data to ensure optimal service offerings and individual health outcomes
  - Examine data by race, age, sexual orientation to determine any additional interventions necessary
  - Identify missed opportunities for HIV testing
- Increase education and access to PrEP
  - Only **3 Black and 6 Hispanic/Latinx PrEP users for each new HIV diagnosis** within those racial/ethnic groups, **compared to 26 white PrEP users** for each new HIV diagnosis among white people.
  - In the **South, there were 7 PrEP users for each new HIV diagnosis in the region, compared to 15 PrEP users for each new HIV diagnosis in the Northeast.**

Opportunities for Health Centers – Increase Access & Outcomes

- Missed opportunities for HIV diagnosis
- Ensure co-location of services including HIV and hepatitis testing and linkages with behavioral health and substance use disorder treatment
- Over half of people living with HIV in the U.S. are over age 50.
  - Older adults are more likely than younger people to be diagnosed with late-stage HIV & are less likely to discuss sex & drug use with providers.
  - Older people living with HIV also have an increased risk of dementia, diabetes, osteoporosis, frailty, and some cancers.

THE WHITE HOUSE

WASHINGTON

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Ernia Hughes, MBA

Director of the Office of Health Center Investment Oversight

HRSA Bureau of Primary Health Care

HRSA
Health Resources & Services Administration

NACHC Policy & Issues Forum

Ending the HIV Epidemic by 2030: What Will It take?

March 9, 2023

Ernia Hughes, MBA
Health Resources & Services Administration (HRSA)/Bureau of Primary Health Care (BPHC)

Vision: Healthy Communities, Healthy People

Ending the HIV Epidemic in the U.S. (EHE) Primary Care HIV Prevention (PCHP) Funding

Purpose & Award History

To expand prevention services that decrease the risk of HIV transmission - including use of PrEP, testing, outreach, and care coordination – to health centers in the 57 EHE geographic jurisdictions.

FY 2020*: **$54 million** to support **195 health centers**

FY 2021: **$38 million** to support **107 health centers**

FY 2022: $20 million to support **64 health centers**

FY 2023: $35 million to support **≈100 health centers**

Funding Objectives

Increase the number of patients counseled and tested for HIV.

Increase the number of patients prescribed PrEP.

Increase the percentage of patients newly diagnosed with HIV who are linked to care and treatment within 30 days of diagnosis.

**A subset of FY20 PCHP awardees requested/received additional $10M to advance their projects, for total of $64M.*
**366 PCHP-funded health centers to date*

HRSA Health Center Program

Health Centers and HIV Prevention

HRSA's Health Center Program's Primary Focus in the EHE-PCHP Initiative includes:

Expanding HIV prevention services, including outreach, care coordination and;

Access to Pre-Exposure Prophylaxis (PrEP)-related services to people at high risk for HIV transmission through selected health centers in the identified jurisdictions.

- Conducted over **1.7 million** HIV tests
- Provided PrEP to **52,477** patients through more than **123,000** clinic visits
- Linked **86%** of newly diagnosed patients to care within **30** days

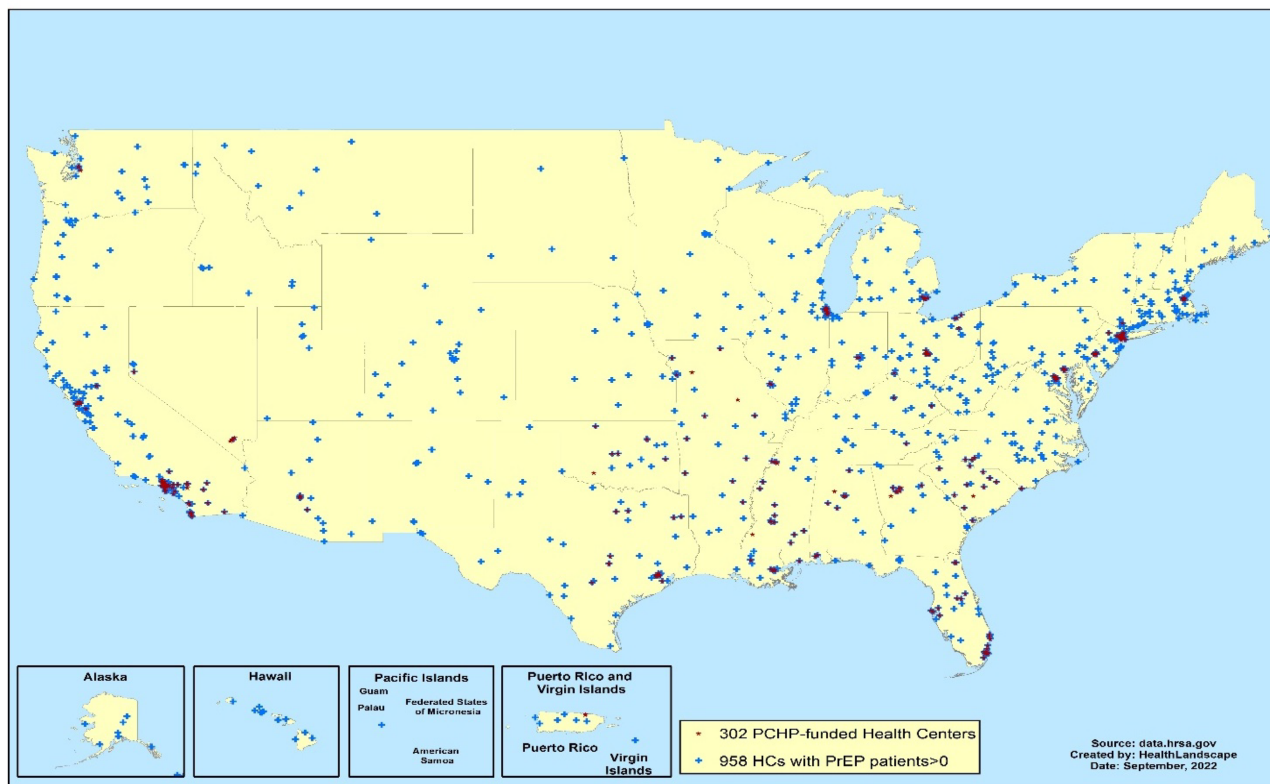
Source: 2021 Uniformed Data System (UDS)

Source: 2021 Uniform Data System (UDS).

HRSA Ryan White HIV/AIDS Program

Ending the HIV Epidemic – Health Center Progress

Health centers deliver critical primary care and HIV prevention services. In 2021, 958 of the overall health centers provided PrEP, including 302 that were PCHP-funded.*



The overall 958 Health Centers

- Served over **25 million** total patients
- **65%** racial or ethnic minorities
- Conducted nearly **3 million** HIV tests
- Provided PrEP to **79,163** patients
- Linked **83%** of newly diagnosed patients to care within **30** days

302 PCHP-Funded Health Centers**

- Served nearly **9 million** patients
- **79%** racial or ethnic minorities
- Conducted over **1.7 million** HIV tests
- Provided PrEP to **52,477** patients
- Linked **86%** of newly diagnosed patients to care within **30** days

Source: 2021 Uniform Data System (UDS).

*Pre-exposure prophylaxis (PrEP), Ending the HIV Epidemic - Primary Care HIV-Prevention (PCHP) funding.

**FY 2020-21 PCHP-funded Health Centers (HCs) only (FY 2020 = 195 HCs, FY 2021 = 107 HCs). An additional 64 HCs received PCHP funding in FY 2022.

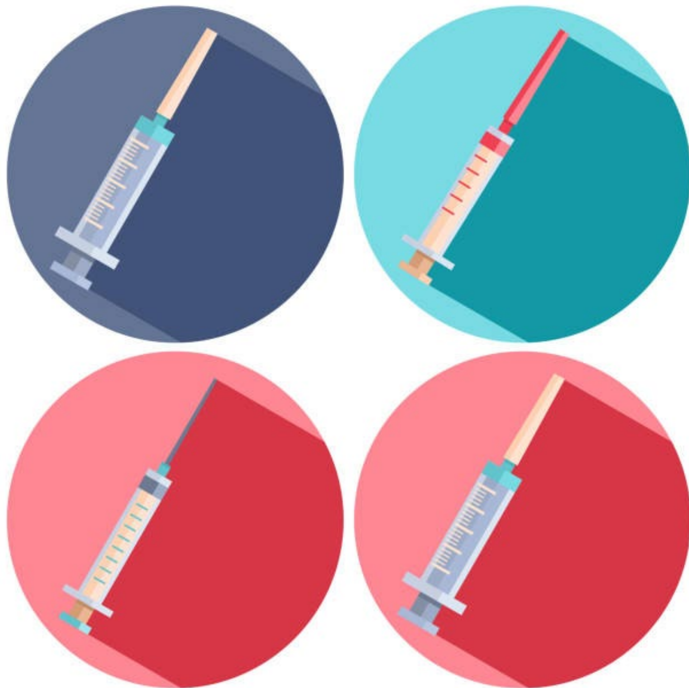
EHE-PCHP Partners at Work

- PCHP Investment Team
- National LGBTQIA+ Health Education Center
- HITEQ Center
- Primary Care Associations (PCAs)
- AIDS Education and Training Centers (AETCs)
- National Association of Community Health Centers

HRSA Health Center Program

Health Centers at Work

Examples of Early Adopters of Injectable PrEP Among FY21 PCHP Award Recipients*



- **Primecare Community Health, Inc., (IL)**
  - *Recently initiated injectable PrEP administration; leveraging integrated care teams to support compliance and adherence.*
- **HealthPoint (WA)**
  - *Now offering injectable PrEP to limited patients to inform strategy for increased adoption among eligible patients*

** - Per FY 2021-Initiated Award Recipient Progress Reports for September 2021 – December 2022 Reporting Cycle.*

Thank You!

Ernia Hughes, MBA

Director, Office of Health Center Investment Oversight

Bureau of Primary Health Care

Health Resources and Services Administration (HRSA)

EHughes@hrsa.gov

Health Center Program Support

877-464-4772, 8 a.m. to 8 p.m. ET, Monday - Friday (except federal holidays)

bphc.hrsa.gov

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Gebeyehu Teferi, MD

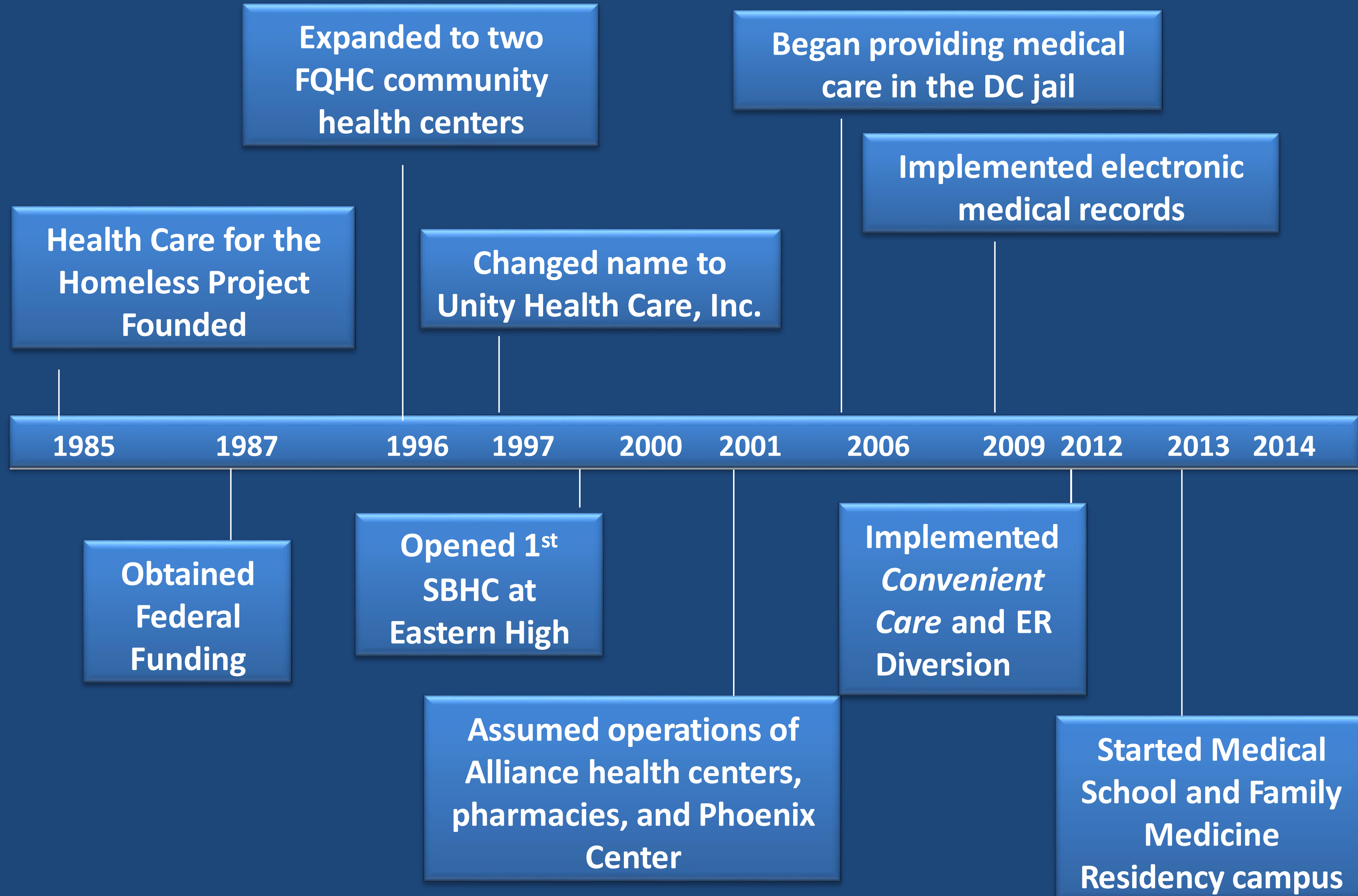
Chief of Infectious Disease

Unity Health Care

Unity Health Care

HIV care: testing, treating and prevention

Geb. Teferi, MD
Chief of Infectious Disease
March 9, 2023



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UNITY Growth
Health Care for the Homeless Project Founded
Expanded to two FQHC community health centers
Changed name to Unity Health Care, Inc.
Began providing medical care in the DC jail
Implemented electronic medical records
1985
1987
1996
1997
2000
2001
2006
2009
2012
2013
2014
Obtained Federal Funding
Opened 1st SBHC at Eastern High
Assumed operations of Alliance health centers, pharmacies, and Phoenix Center
Implemented Convenient Care and ER Diversion
Started Medical School and Family Medicine Residency campus

Unity Health Care

Our Mission
Reaching people wherever they are to provide compassionate, comprehensive, high-quality health care that is accessible to all and advances health equity in Washington, D.C.

Our Vision
Unity Health Care will be recognized as the health care provider and employer of choice by establishing a culture that champions patient-centered care, promotes staff engagement, embraces the latest technology, and pursues community partnerships and strategic alliances .

UNITY HEALTH CARE
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Sites

36 Facilities

2 Administrative Sites

11 Community Health Centers

- School Based

17 Homeless Service Sites

- Pandemic

2 Correctional Sites

- Central

1 Mobile Medical Unit

3 Sub-recipient Locations: So Others Might Eat (SOME)

1. Friendship Place
2. Upper Cardozo Health Center
3. Christ House
4. Columbia Road Health Center
5. Cardozo Student Health Center
6. Brentwood Health Center
7. New York Avenue
8. Harbor Light
9. Unity at Pathways to Housing
10. N Street Village
11. Downtown BID
12. Central Union Mission
13. Federal City (CCNV)
14. Parkside Health Center
15. Woodson School Based Health Center
16. Minnesota Avenue Health Center
17. East of the River Health Center
18. DC Jail Facilities (CDF/CTF)
19. Southwest Health Center
20. Anacostia Health Center
21. Stanton Road Health Center
22. SOME O Street and Isaiah House
23. SOME Conway BHS
24. Hope Has A Home

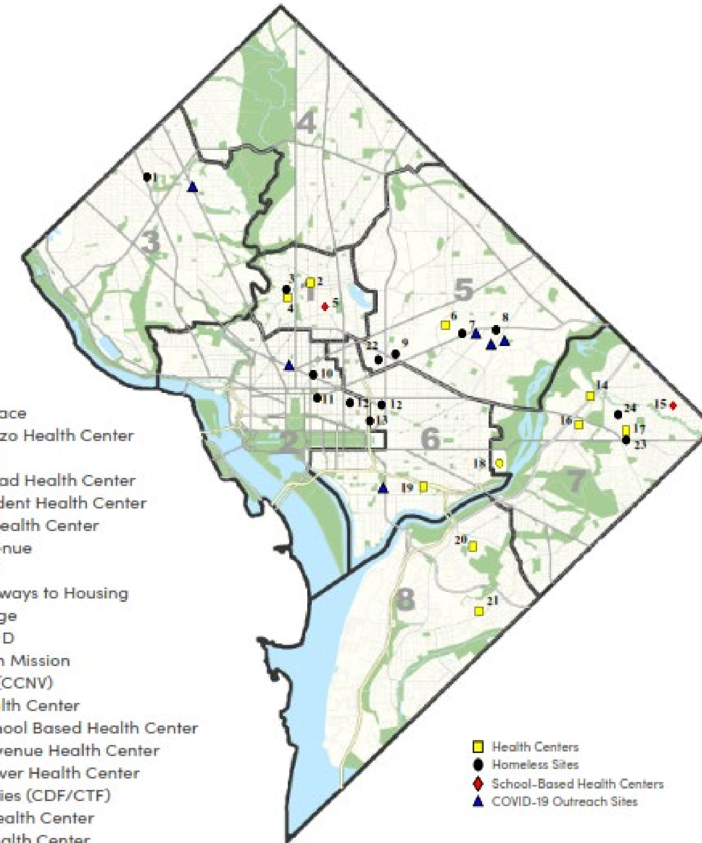

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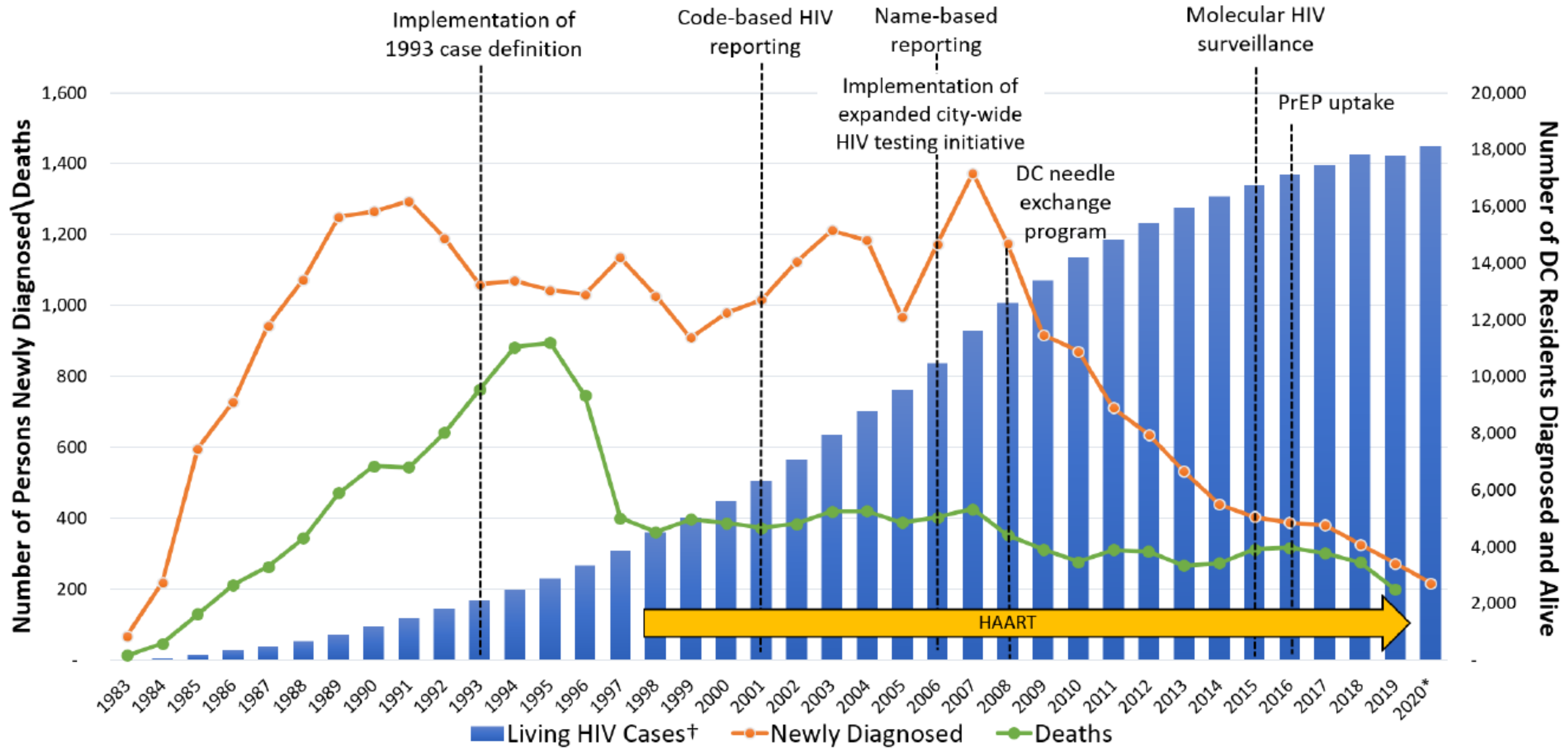
Figure 2. Newly Diagnosed HIV Cases, Deaths, and Living HIV Cases, by Year, District of Columbia, 1983-2020



† Living HIV cases who were DC residents at diagnosis * 2020 deaths not available at time of publication

Unity Health Care HIV program

* HIV Testing
* HIV linkage to care
* HIV Care and Treatment
  * Integrated with primary care
  * Provide care at patients Medical home
  * Provide quality care
  * **Increasing access to HIV and other care**
  * HIV perinatal care
  * HIV/Hepatitis B/C coinfection management
* HIV Prevention
  * Preexposure Prophylaxis (PrEP)

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HIV Testing

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* Washington DC has the highest rate of HIV infection in the nation
* Unity implemented a routine HIV testing called 5th vital sign
* Program is based on rapid HIV testing to all patients age 13 -84(District program) regardless of risk factor.
* HIV test is done by medical assistants during vital signs and result is delivered by providers
* "Double knock" If patient declines to HIV test, provider is alerted and follows through
* Based on rapid HIV testing; modified to provider initiated blood draw
* Rapid testing is maintained for groups who benefit with the rapid test.

Methods used to enhance HIV testing in Health Centers

Flash Cards used as reminder for staff

Remember

To offer HIV test when taking vital signs

- ★ HIV Test once a year
- ★ All patients age 13 –84

DO NOT OFFER

- If Patient is known HIV positive (check diagnosis in the problem list) HIV codes V08 or 042
- If tested for HIV within a year
  check alert: if all HIV tests are not seen
  If one of the three tests is missing

May also check the lab section for past HIV test

Exception: positive urine pregnancy test

OFFER AND TEST

- 13 –84 with no diagnosis of HIV and with no HIV test within a year
- Any time urine pregnancy test is positive regardless of HIV test
- Any time HIV test is requested by provider
- Any time a patient asks for HIV test

HIV Test type

SITES

- All CHC use primarily serum HIV test ordered by providers
- Designated sites will use Rapid test (routine 5th vital)

Patients

CHC established patients serum HIV test ordered by providers *(use UHC– HIV Antigen/ antibody 4th generation)* may also be ordered as future test

For the following patients use Rapid tests regardless of site

1. For positive Urine pregnancy test (Insti - 1 minute)
2. Self pay patients (Rapid - Clearview)
3. Partners of patients (Rapid- Clearview)
4. Post exposure prophylaxis (Clearview)
5. when provider decides to use rapid HIV test in exam room (Insti-1 minute)

eCW

Medical assistant

- Checks if patient is eligible for HIV test
- Documents in chief complaint section
- Addresses alert

Provider

- Looks at chief complaint section
- Orders blood for those accepting serum test
- Offers and tests those who declined test

Signage posted in Health Centers For patients

Routine HIV Testing

As a routine part of your care Unity Health Care offers rapid HIV testing to all our patients during vital signs.

The test results will be delivered within 20 minutes by your doctor/ provider.

If you have questions, please ask a member of the clinical team or your provider .

HIV Testing – Fifth Vital Sign

Advantages

* Patient flow was not disrupted
* Minimized stigma as it is offered to every one
* Immediate linkage to care for those who tested positive
* Over the years increase the number of HIV tests

Observed results

* High rate of linkage to care
* Most of newly diagnosed were patients new to Unity.
* Until the last few years yearly newly diagnosed patients were 85 in average.

HIV Testing Two years of experience

- *In 2010 and 2011 total of 45532 HIV tests were made of these 23020 were rapid oral swab tests
- 13 patients had declined the first offer but were tested through double knock approach
- 14 patients had prior negative HIV tests in the preceding year

Table 1. HIV positive patients tested by rapid and ELISA in years 2010 and 2011

HIV test by Rapid and conventional	N	%
total positive	177	100
Female	61	34.5
Male	116	65.5
African American	164	92.7
others	13	7.3
Median CD4 count	372	-
Mean CD4 count	392	
CD4 count < 200	38	21.5
New patient to Unity	127	71.8
linked to care	153	86.4

Table 2. confirmed HIV positive patients tested by rapid HIV test in years 2010 and 2011

Rapid HIV Test	2010	2011
confirmed positives	65	42
female	24	12
male	41	30
African American	60	40
other races	5	2
median age	35	33
median CD4	376	354
CD4 < 200	12	9

Table 2. confirmed HIV positive patients tested by ELISA in years 2010 and 2011

Serum HIV Test (ELISA)	2010	2011
total positives	33	37
female	14	11
male	19	26
African American	31	33
other races	2	4
declined first offer	6	7
median age	30	38
median CD4	391	320
CD4 <200	6	11

* IAS Poster presentation, 2012 Washington DC

HIV Testing – Newly Diagnosed Across Unity Sites

Month	2011	2012	2013	2014	2015
Jan	10	9	11	8	7
Feb	6	9	6	6	8
Mar	12	10	9	5	8
Apr	5	3	13	9	6
May	10	4	11	5	6
Jun	3	11	7	6	6
Jul	8	9	9	5	8
Aug	8	11	8	10	7
Sep	10	8	11	2	6
Oct	6	7	7	6	6
Nov	9	6	6	3	5
Dec	8	9	7	4	
Total	95	96	105	69	73

HIV Testing

Year	Rapid	Conventional	Total	New Cases
2016	5968	22523	28491	76
2017	4740	23063	27803	61
2018	2209	19603	21812	45
2019	2588	20521	23104	40
2020	1059	13131	17488	23
2021	1196	14979	18831	24
2022	1624	13496	17832	31

HIV linkage to care

- HIV test result is delivered by providers to ensure linkage to care
- Providers, once confirming HIV positive results
  - Can easily schedule patient to ID/HIV at their site
  - Can hand walk patients to members of ID team
  - Having an ID provider and team on site facilitates this activity
  - Reduced the anxiety by providers when there is a positive test result.
  - For this purpose, ID team keeps open schedules for new patients.

HIV Care: Integrated Care

* Standard of care requires each HIV patient to have both Primary and HIV provider
* Provide care with a concept of "**one stop care**" from primary care to infectious disease including social services, dental and ophthalmology and OB GYN when possible at the same site.
* Uses trained Medical assistants – **HIV Care associates**
  - **Center of access to care to all HIV patients within Unity and outside Unity**
  - **Linkage to care**
  - **Coordinate care (integrate)**
  - **Retention to care, Recapture to care**
  - **Each has a Unity phone number for patient access and coordination $$$**

Provide care within the reach of patients

- Unity has created a team of providers
- Primary care providers are from the local sites
- Travelling Infectious Disease providers paired with **Nurse care mangers** and **HIV Care associates, community Health workers, Community Health Care workers**
- Site social services worker (case manager)
- The traveling team covers 3 to 5 sites,
- Sites with very few number of HIV patients refer their patients to one of the closest sites with HIV/ID providers

Nurse Care managers

- Nurse care managers are RN/LPN with experience in HIV care
- Main role is educating patients one to one
- Focused on newly diagnosed, and patients with history of non adherence and virologic failure or who are labeled **high risk**
- Adherence sessions with each patient one to one
- Assist patients with medication :
  - **One to one via phone, clinic visit and if necessary home visit**
  - **Assist with medication, working with pharmacies, using pill boxes and bubble pack etc.**

HIV positive pregnant women are considered high risk and each woman has one assigned nurse who ascertains appropriate care is delivered.

Unity: Patients with HIV male to female ratio: 56% to 43 %

HIV Care: MTCT Prevention

HIV perinatal care Program

Unity implemented enhanced steps and procedures in place

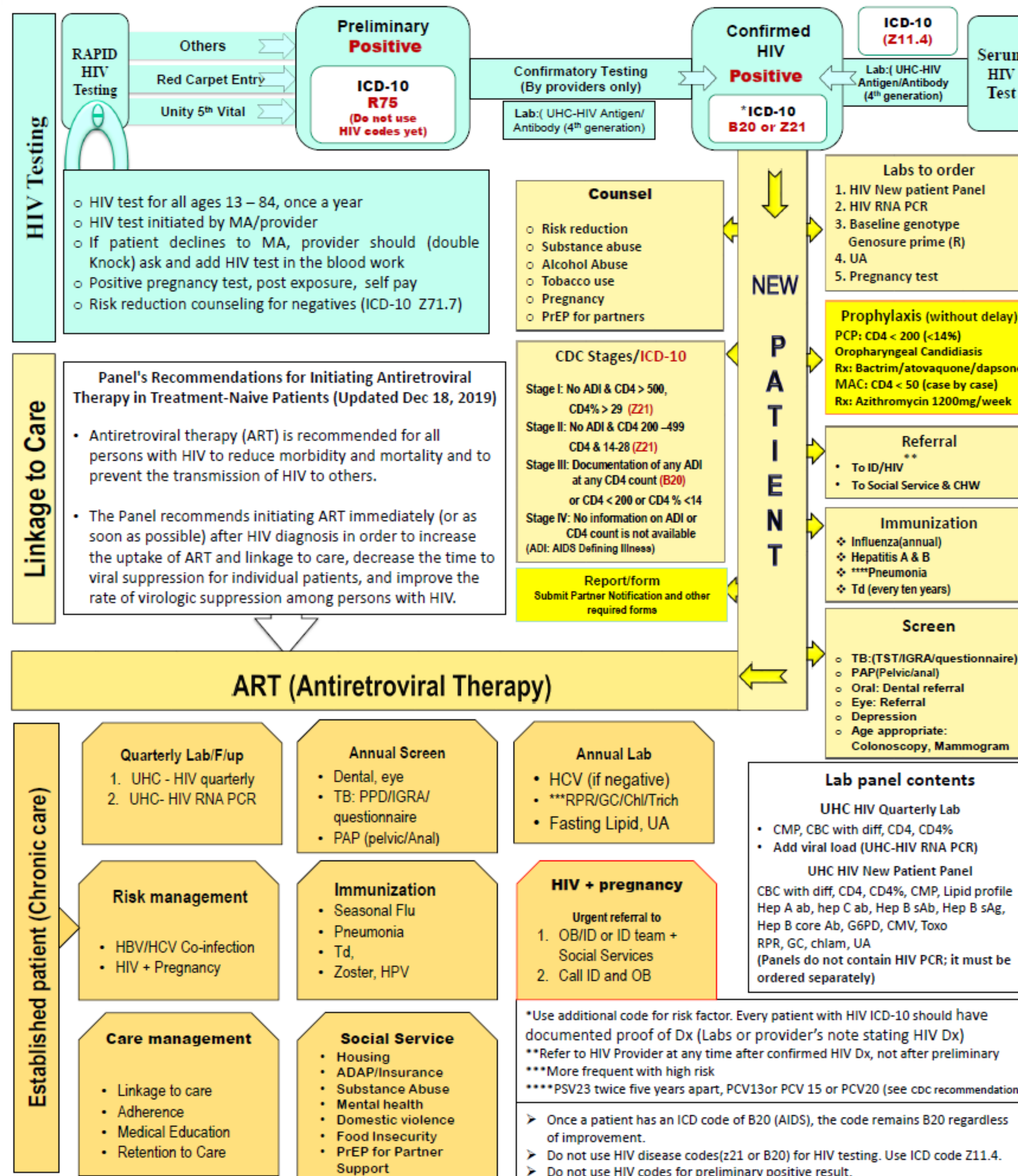
- ✓ HIV and pregnancy is an urgent case hence providers are asked to call OB and or ID, hand walk patient to ID team
- ✓ Every pregnancy positive result is right away accompanied by rapid HIV test
- ✓ When patients are recognized the ID/HIV team gets involved proactively (without waiting for referral)
- ✓ ID team in turn accepts these patients regardless of scheduling status (overbook if needed)
- ✓ Each HIV positive pregnant woman will have a nurse care manager working with her ID/HIV
- ✓ monthly round on each pregnant HIV positive patient until delivery
- ✓ Monthly average 8-10 HIV positive pregnant under Unity care
- ✓ keeps tracking even when patients transfer care to non Unity sites
- ❖ Challenges: High risk and difficult task because of **late entry**, **substance abuse**, **mental health problems**, **moving out of area**, **lost to follow up** and **homelessness**
- ❖ Constant communication with DC HAHSTA for assistance

Quality care: Standard of Care

Guidelines/Education (standard of care)

- Follows DHHS guideline, incorporates grant requirements
- Educates providers and uses manuals and algorithms

1. HIV providers manual (Unity)
2. HIV care algorithm (Unity)
3. Annual HIV in-service or update
4. Monthly meeting for HIV providers
5. Patient HIV care manual
6. Research: collaborate and work as a Site PI, with NIH, University of MD, GW



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Provider HIV Pocket Guide

Introduction to CARE

We treat you well

Unity HIV patients

Ethnicity:	Non Hispanic	94.2%
Race:	Black	94%
Poverty:	below 100%	84%
Housing:	Unstable	16.2%
Gender:	male to female	56 to 43%
CD4 status:	> 200	88.7%
On ART:	ART prescribed	97%
Viral suppression:	<200	85.4%

Per DC cohort report: More comorbidities

PrEP at Unity

- PrEP as a program was supported by HRSA as of 2020
- Service is provided in all health centers by all primary care providers
- A PrEP coordinating team
  - Director, Family Medicine, Director and Ass Director Social Services, VP of Nursing, Director of Clinical Nursing & Program Managers ID and FP
    - ➢ Planning, monitoring and reporting of activities
    - ➢ Developing and reviewing policies and procedures
    - ➢ Advocacy
    - ➢ Resource mobilization
- PrEP Champions
  - Volunteer providers from all HCs
  - Convene monthly
  - Address technical issue

PrEP at Unity

- Community Health Workers (Four)
  - Coordination and conduct of outreach activities
  - Counseling clients referred from providers
  - Support for medication adherence and continuation in follow-up PrEP care
  - Tracing lost to care
  - Patient navigation

Grant support from HRSA since 2020 for

- Purchasing PrEP medicine for the uninsured
- Purchasing HIV rapid test kits
- Printing of brochures and flyers
- Currently 359 clients under PrEP treatment and care - target 500 by 31st Dec 2023.

Thank you

Questions?

THANK YOU!

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Community Health Centers®

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