HIV Health Care Reform Recommendations

Goal #1: To maximize the potential of Healthcare Reform to decrease the disproportionate impact of HIV on historically marginalized and disenfranchised populations.

Populations of significance include people and communities of color, men who have sex with men, people who inject street drugs, individuals who trade sex for something needed, people living in poverty, transgender people, those who are currently or formerly incarcerated, and people living with mental health and substance use concerns.

GOAL 1 OBJECTIVES

A. The benefit should be marketed to each of the different historically marginalized and disenfranchised populations. Marketing materials should be accessible. Marketing should occur through community partners that have existing access to and credibility with these populations.

B. Colorado Department of Public Health and Environment (CDPHE) and its funded contractors should streamline the enrollment and eligibility determination processes as much as possible.

C. Improve the proficiency of healthcare providers to include comprehensive sexual health, mental health, and substance use history, offer testing, immunizations, other needed health services and referrals for follow up care.

D. Resources should be devoted to addressing the financial barriers that remain after implementation of healthcare reform, such as required copayments.

Goal #2: Address stigma that impedes enrolling in services, accessing high quality services, and following through on services.

GOAL 2 OBJECTIVES

A. Improve the proficiency of healthcare providers to include comprehensive sexual health, mental health, and substance use history and offer testing, immunizations, other needed health services and referrals for follow up care.

B. Promote participation in the Human Rights Campaign Healthcare Equality Index, a unique and invaluable resource for healthcare facilities seeking to provide equitable, inclusive care to lesbian, gay, bisexual and transgendered (LGBT) Americans—as well as for LGBT Americans seeking healthcare facilities with an explicit commitment to their care.

C. Enrolling in services:

1. Ensure that language and word usage is easily understood (3^{rd}-6^{th} grade reading level) and utilizes terms that are familiar to the target population
2. Ensure that awareness materials are provided in ample amounts to providers relevant to the target population
3. Ensure that materials are offered in a variety of modes (print, online, radio, television, smart phone, billboard, social media, etc.).
4. Materials promoting enrollment should be in English and Spanish primarily, and other languages based on target populations
5. Media pieces should positively depict common features of a target population
6. Messages should be positively focused, not demanding, assumptive, or fear-based

D. Accessing high quality services

1. Providers sharing the information with the target population need to be educated and trained in the best possible provision methods
2. All relevant populations need to have equal access that is not based on race, ethnicity, religion, gender identity, sexual identity, socio-economic status, or other similar factors.
3. Services at a minimum need to be offered in both English, Spanish and other languages should be considered based on the target population.
4. Culturally sensitive and culturally proficient staff should be utilized when working with disparate target populations. This should include staff who directly identify with the target population whenever possible.

E. Follow-through on services:

1. Provision of service should include active follow-up plans by the provider. Providers should be trained in timely and effective follow-up mechanisms.
2. Providers should empower the target population to become educated about their health benefits and their rights to health care, and to advocate for said benefits and rights.
3. Services and communications should be provided in a variety of ways that meet the needs of different population groups. Things to consider are reading level, adequate time devoted to patient/client understanding of information, transportation barriers, navigation of phone systems by patients/clients, email and other electronic forms of communication, and language/cultural differences.

Goal #3: Eliminate geographic barriers in accessing prevention and care services

GOAL 3 OBJECTIVES

A. Start with an inventory of providers willing to accept new clients living with HIV or AIDS, including HIV positive clients with Medicaid coverage, by each region. This

inventory should include the comfort level of providers serving PLWH/A and what would help providers feel more comfortable serving PLWH/A (such as collaboration with an HIV specialist).

B. Understand the limitations of distance and stigma in the enrollment and eligibility determination processes. For example, it may be an extra burden for a rural client who is asked to obtain corroborating evaluations from multiple physicians.

C. Strategies should be implemented to address limited transportations options, such as the expansion of telemedicine.

Goal #4: Ensuring Access to HIV Specialty Care within the Medical Home Model

GOAL 4 OBJECTIVES

A. Determine/ensure that in the Medical Home model, attention is paid to the accessibility and availability of HIV specialty care.
    1. (i.e.: considerations for rural areas, Medicaid waitlists)

B. Push toward web-centered information and access to care via telemedicine.
    1. Conferencing online with specialists as a cost-effective and efficient option, if billable.

C. Further incorporate patient portals, through which patients can ensure their own care is adequate and have up to date health information available to them.

D. Make sure that specialty care is maintained in the medical home assuring that no additional barriers are created when accessing HIV Specialty Care
    1. Ideally, there would be a tier-1 level of access, meaning that an Infectious Disease Specialist is an integral part of the onsite medical home, and completely integrated into a patient's care.
    2. As a tier-2 option, rural areas would be prioritized as having access to specialty care with periodic HIV clinics on-site or using telemedicine to help minimize travel time. Ideally individuals would not have to travel more than 50-100 miles to access care.
    3. The tier-3 option would also work to minimize distance to care, and asks for realistic referrals within the medical home model. It asks that there is at least some arrangement with a clinic within 50 miles if on-site or telemedicine is unavailable, as long as quality primary care is nearby. Ensure that there are no waiting list barriers.

E. Ensure good primary care is available and that it is comprehensive and accessible care per HRSA guidelines (i.e.: women have access to well-woman care and contraceptives).

F. Oral health care should be integrated within the medical home model.

G. Ensure there is reimbursement of telemedicine services by insurers.

H. Make sure the definition of 'primary care provider' is defined accurately and that this definition is accessible to and understood by patients.

Goal #5: Coordinate the efforts of the relevant Executive Branch State agencies and other relevant policy-setting bodies.

GOAL 5 OBJECTIVES

A. CDPHE needs to point out negative impacts of implementation.

B. CDPHE to provide to other agencies the knowledge of prevention issues.

C. CDPHE to be an advocate for specialty needs.

D. CDPHE should be at the forefront of addressing outreach needs due to its extensive provider network.

E. CDPHE to share expertise in chronic disease management, substance use and mental health issues as well as experience with cost containment issues.

F. First tier of relevant agencies includes Heal Care Policy and Financing, Division of Regulatory Agencies and the Health Exchange Boards.

G. Second tier of relevant agencies include the Department of Human Services and Department of Corrections.

Goal #6: Coordinate the Health Care Reform testing benefit with other targeted public health benefits.

GOAL 6 OBJECTIVES

A. Coordination of knowing what CDPHE pays for, Medicaid pays for in HIV testing, or what other third party payers are providing, by using the All-Payers Claim Database (CIVHC) to identify gaps in testing. (CIVHC provides demographics; information is de-identified but should be unduplicated.) Currently 60% of testing is paid for privately; 40% through public funds. CDC is pushing for federal funds to be the payer of last resort. CDPHE to coordinate with the Colorado Department of Health Care Policy and Finance to determine what testing services each agency is providing.

B. Conduct focus groups and other data collection surrounding why/where/how people are getting their HIV tests and identify barriers to accessing testing and prevention services

C. Testing should be not for only at risk individuals but included in routine blood work. Identify within which setting testing should be conducted.

D. Since 2005, the U.S. Preventive Services Task Force (USPSTF) has strongly recommended that clinicians screen for HIV all adolescents and adults at increased risk for HIV infection. USPSTF has rated this recommendation at the "A" level. The task force is currently considering whether to change this recommendation, eliminating the "increased risk" stipulation and moving toward routine testing. This is of particular significance because, under ACA, USPSTF "A and B" recommendations must be covered by health plans at no cost to the insured client. CDPHE should monitor this situation and be prepared to promote health plan coverage for HIV testing at the greatest level possible under the law.

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