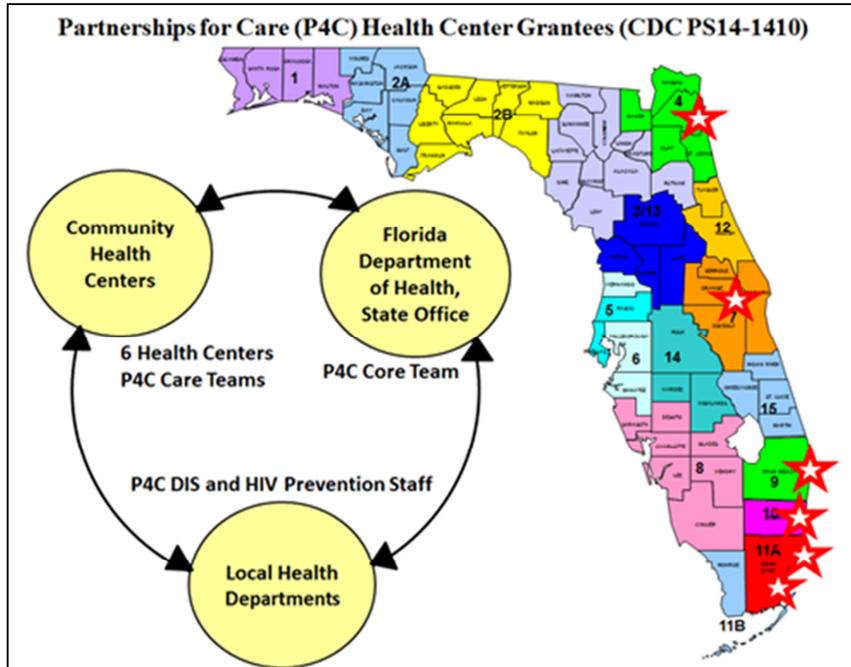


Partnerships for Care (P4C): Improving Health Outcomes for People Living With HIV

Florida is heavily impacted by HIV/AIDS, ranking second in the nation in new HIV infections and third in new AIDS cases. There are over 125,000 HIV-infected Floridians and over 4,100 new infections per year. Florida's HIV care continuum data show that in 2012, of the individuals infected with HIV, 105,627 (84%) were diagnosed. Of those persons living with HIV (PLWH), 85,051 (81%) were linked to care but only 66,868 (63%) were retained in care over time. Of those diagnosed with HIV, 61,986 (59%) were on antiretroviral treatment, and only 47,171 (45%) achieved viral suppression. These data highlight the need to engage partners that provide services to populations most at risk for HIV. Community health centers (CHCs) within our state serve populations at increased risk of HIV infection or transmission and are ideally suited to provide both prevention and care services. Historically, CHCs have been important partners in public health; however, in Florida, the level of collaboration with local health departments and the type of HIV-related services provided have varied widely by center.



Partnerships for Care (P4C) is a collaboration between Centers for Disease Control and Prevention (CDC)-funded state health departments and Health Resources and Services Administration (HRSA) funded CHCs to expand the provision of HIV prevention and care services within communities most impacted by HIV and to better serve PLWH. The Florida Department of Health's (FDOH) primary goal of the project is to develop and implement effective, replicable and sustainable programmatic models for collaborating with CHCs located in high HIV prevalence jurisdictions to increase CHC capacity to deliver HIV prevention and care activities. This demonstration project provides an important and much-needed opportunity for FDOH to expand the scope and reach of HIV prevention and care services provided by our CHC partners and increase the number of HIV-infected and high-risk individuals receiving services in the areas most heavily impacted by HIV.

The six CHCs collaborating with FDOH are in counties with the highest HIV disease burden. Local health department staff and Disease Intervention Specialists (DIS) are working with: Broward Community and Family Health Centers (Broward County); Genesis Community Health (Palm Beach County); I.M. Sulzbacher Center (Duval County); Health Care Center for the

Homeless (Orange County); and Community Health of South Florida and Care Resource (Miami-Dade County). These sites also represent five of Florida's six Eligible Metropolitan Areas – Ft. Lauderdale, Miami, West Palm Beach, Jacksonville and Orlando.

The development phase of P4C focuses on establishing a partnership between the health centers and state/local health departments. This phase consists of the following activities: developing health center infrastructure and workforce; developing the ability to use state surveillance data and electronic health record data to improve health outcomes for people living with HIV; and expanding partner notification, linkage, retention and re-engagement services for PLWH. Through readiness reviews, conference calls, webinars and site visits, P4C health centers have been able to, receive technical assistance, capacity building assistance and training to prepare for implementation. FDOH convened a data workgroup to assist with the development of a data dashboard. This dashboard will have the ability to match health center electronic health records (EHRs) with surveillance data, to develop reports that can be used to improve and expand P4C services.

In addition to using EHR/surveillance data to improve services, P4C requires health center HIV care teams and P4C DIS to participate in case conferencing as part of those same efforts. FDOH proposed two types of meetings, the frequency and location of the meetings to be decided by health center care teams and P4C DIS. The different types of meetings include more frequent and informal case conferences to take place on a weekly basis between the P4C DIS and health center HIV care teams; and more formal monthly reviews with all parties.



The ultimate goal is to have PLWH, who receive medical care at the health center or live in the service area of the health center, actively engaged in the continuum of care. By addressing PLWH along the continuum, the project seeks to maximize health outcomes and help individuals live longer and healthier lives, while at the same time reducing community viral load and transmission rates.