HIV Testing Update:
New Regulations and Strategies from the Field

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Featured Speakers

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Conflict of Interest Statement

The speakers and their viewpoints represent no conflicts of interest.

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After viewing this broadcast, participants will be able to:

- State the main objectives of the 2010 Amended HIV Testing Law and finalized regulations
- Recall straight-forward strategies for implementing routine HIV testing in:
  - Community health center
  - Pediatric setting
  - Hospital emergency department
- List the contents of the New York State Department of Health's “HIV Testing Tool Kit”

St. Luke’s Roosevelt

- Two sites in Manhattan
  - St. Luke’s >120,000 visits/year
  - Roosevelt >70,000 visits/year
- Teaching hospital of Columbia University
- St. Luke’s: Level 1 Trauma Center
- Large Medicaid and uninsured population
- EM Residency with 42 residents
- 40 Full-Time EM Attendings, 10 PAs

Albany Medical Center Pediatric Group

- Providing well child care and sick visits for children, from birth to 21 years
- Affiliated with the Children’s Hospital at Albany Medical Center
- 10 Attending Pediatricians
- 1 Nurse Practitioner
- 30 residents (each spend one full day at the Practice for their Continuity Experience)
Urban Health Plan, Inc.
HIV Focus Team

Debbie Lester; LMSW
Director
Urban Health Plan’s Institute for the Advancement of Community Health

Rationale for Amended Law

• Approximately 20% of HIV-positive New Yorkers are unaware of their status
• Late HIV diagnosis in NYS:
  – 33% of newly diagnosed HIV cases already have or will have an AIDS diagnosis within one year
• Advances in HIV testing technology and medical treatment for HIV/AIDS

St. Luke’s Roosevelt Hospital Data

• 2006-2009
• 253 new diagnoses of HIV
• 59% late testers (CD4 < 200)
• 154 (61%) had contact with healthcare providers in 3 years before diagnosis.
• 42% of those visits to the ED.


• Federally Qualified Health Center
• Health Centers; 6 School Based Health Programs; 2 Homeless Shelters
• Adolescent Health / Wellness Center
• Additional 54,000 sq. ft. facility to open in 2012/2013
• 450 FTE staff and 88 FTE providers
• Live with EHR – February 2006
• Annual number of patient encounters: 250,000
• Grant Support from Gilead Sciences Inc. to integrate routine HIV screening

Best Served in Another Language – 51% Language - Spanish
• 30% of patients diagnosed in the ED had made previous visits. (Oakland, CA)

### Initial Challenges

- Embedded Counselor Driven Model
- Busy Community Health Center Setting
- Limited Space
- Competing Priorities
- Provider Buy in

### Key Success Strategies

- Building on Success of Quality Improvement Infrastructure
- Utilization of Evidence Based Quality Improvement Models (Plan, Do, Study, Act)
- Fully Implemented Electronic Health Record since 2006
- Proven system for implementing Quality Improvement Teams starting with an Expert Panel

### Comprising an Expert Panel

Comprised an Expert Panel
- Senior Leaders: CEO and Chief Medical Officer
- Chief Technology Officer
- Clinical Systems Administrator (EHR)
- Director of Nursing
- Section Head of Adult Medicine/ID Specialist
- Director of the Institute for the Advancement of Community Health (internal Quality Institute)

### Work Performed by the Expert Panel

- Study the new HIV Testing Legislation
- Engaged AIDS Institute Expert to train on the new legislation
- Develop Team Structure
- Hire an HIV Testing Coordinator
- Develop protocols (flow charts)
- Draft policies and procedures
- Create fields in Electronic Health Record (EHR) to capture and report on HIV Measures (test new fields)

### Population of Focus and Measures

- All patients ages 13-64 seen in primary care at any UHP health center site
- 90% of patients ages 13-64 will have an HIV Test Offer
- 40% of patients ages 13-64 will have an HIV Test

### HIV Test Offer and Testing Protocol

- Medical Assistant checks the practice alert and offers patient the HIV Test
- Medical Assistant educates patients on the required key points of information
- The Provider reviews the HIV Test offer, documents acceptance, and orders the HIV Test (or documents patient refusal)
- During discharge, Medical Assistant or Provider informs patient that they can walk in for results or obtain results at next patient visit
Testing Team

- Implement a multi-site Testing Team to PDSA the process comprised of:
  - Provider Champion
  - Medical Assistant
  - Site Director or Dept Coordinator
- Share Baseline Data with the Team
- Train the Team
- Creates Healthy Team Competition
- Conduct Weekly Team Meeting with Provider Level Data Feedback on offer and testing rates
- Schedule Learning Session

Respond to Provider and Medical Assistant Feedback

- Openly discuss challenges in implementing routine testing
- Minimize clicks and new screens in EMR
- Coaching: Reinforce where those fields are in the EMR
- Provide accurate feedback data to providers
- Provide training on giving a positive test result
- Provide Support Team for newly diagnosed positive patients

HIV Test Offer and HIV Testing Results

![HIV Test Offer and HIV Testing Results Graph](image)

Arranging HIV Care for Confirmed HIV positive patients

- 51 positive patients identified (2011)
- 47% male, 53% female
- Routine HIV Testing helped us identify HIV positive patients who needed to get back into care
- 98% with an appointment for primary care
- 76% kept first HIV primary care appointment

Recommendations

- Expert Panel Planning
- Senior Leader Visibility and Endorsement
- Build Momentum: Weekly Team Meetings, Weekly Data Graphs, Healthy Competition!
- Incorporate Testing Team Feedback
- Institutionalization of New Process

AMC Pediatric Group

NURSING STAFF
- 1 On-Site Nurse manager
- 4 Registered Nurses
- 2 Licensed Practical Nurses
- 3 Medical Assistants
HIV Test Offer and HIV Testing Results

HIV Test Offer and HIV Testing: Organization Wide

Offered
Tested

85.5%
52.6%
Pre - 2005

- Adolescent Physicals given the same amount of time as other Childhood Physicals
- All physicians instructed to ask about Sexual Activity/Risk Taking Behavior with parent outside of the room (Providers asked the parent to leave)
- HIV testing done via blood draws and most patients instructed to go to outside lab to do so. HIV pre and post testing counseling done by providers.
- Urines send for GC/Chlamydia (just beginning to get done but no formal office flow, to get these specimens.)

2005: Office “Adolescent Well Child Exam Protocol” Developed (for all adolescents 12-21)

1) Parents informed by provider at the 11 year old physical that they will be asked to leave the room at the next 12 year physical.
2) Parents receive a letter prior to the 12 year physical explaining our “adolescent protocol”

2005: Office “Adolescent Well Child Exam Protocol” Developed (for all adolescents 12-21)

3) When adolescent checked in for 12+ year physical, nurse explains (script used) that the child will be given a questionnaire to fill out by herself. The nurse also explains that the doctor will meet with adolescent alone before the parent is allowed in the room. Nurse tells the parent to stay in the waiting room.
4) While nurse is checking adolescent in, she explains how to collect the urine specimen and sends the adolescent to the bathroom.
5) Adolescent is given time to fill in the questionnaire.
6) Doctor enters

Adolescent protocol (cont’d)

- Doctor reviews questionnaire with patient
- Determines if urine needs to be sent for GC/CH
- Physician discusses STD testing with those she thinks may be at risk.
- HIV testing offered if she thinks patient may be at risk.
- Pre-testing done and script for HIV test (and HepC, RPR) given.
- Patient is on her own to get the testing done off-site.
- Post-test counseling done at a follow up visit.

The Questionnaire

- The Handout is the one we use presently
- It has been changed over the years for the following reasons:
  1. easier for the adolescent to understand (health literacy)
  2. help improve quality of care
  3. help us to achieve new State guidelines/law
### 2009: Poor patient compliance

- Doctors/Staff becoming frustrated because adolescents often failed to follow through with the off-site testing
- Even if testing was done off-site, they also failed to follow up for post-test counseling
- Many patients reluctant about the blood draw

### March 2009

Rapid Testing for HIV at AMC pediatric Group
- Team Meeting with AMC Pediatrics, AMC Infectious Disease, AMC Lab, and HIV Counselors to discuss

### The Story of Rapid Testing....

- Originally grant funded: employed counselor, Social worker, and purchased test kits
- “Testing Team” - regular office hours one evening a week.
- Service was “advertised” to adolescents by provider
- Appointments were scheduled by front staff
- Appointments for testing were not charged to the patient
- If a positive test, a confirmatory blood test needed to occur the next day, and could be ordered by the MD present during evening hours.
- The SW would arrange to meet the patient at the off-site lab and arrange follow up appointments at MCATS.

### Staff Involvement

- All staff loved having the service available and we all wanted to make things better for our patients
- Nurses stepped up to the plate and wanted to become more involved

### 2010

- All nurses trained on how to conduct a rapid HIV test
- Medical assistants trained on key points for HIV testing
- Offer HIV testing just about any time of the day!
  - Reached adolescents at their Well Child Exams
  - Providers could leave the pre and post testing up to the Medical Assistants
  - Social Worker still “on call” for positive results.

### Continuing Barriers

- Payment: grant ended but we are able to bill for the test (continued concern to maintain confidentiality)
- Test takes 20 minutes. It can be difficult to get patients to wait that long (suspicious parents)
- Continue to require “tweaking” the patient flow to allow for nurses/staff to be pulled to do this
**Lessons Learned**

- All offices evolve
- You can do something about adolescent compliance!
- Have a BIG idea but start with small steps
- It is good to critique a plan BUT don’t fall into “analysis paralysis”
- Never under-estimate the power of your nurses! They are wonderful patient advocates!

**2006**

- CDC made recommendations specific to the ED
  - Strongly recommended testing in ED’s where prevalence of undiagnosed HIV >0.1%
  - Recommended testing in patients with STIs
  - Opt-out as part of general consent

**American College Emergency Physicians 2007**

- “HIV testing in the evaluation for acute care conditions in the emergency department (ED) should be available in an expeditious and efficient fashion similar to testing and results for other conditions.”
- The ED is the safety net

**New York State 2010**

- HIV testing must be offered to all persons 13-64 receiving hospital or primary care services
- Includes patients seeking care in the ED
- So now, no longer a choice....

**Case #1**

- 18 year old male
- 3rd visit in 2 months for “hemorrhoids.”
- PE: non-healing abscess
- “I’m negative. I was tested a year ago.”

**Case #1**

- Rapid test POSITIVE:
  - Well, sometimes I use crystal meth
  - Well, sometimes I have unprotected anal sex
### Case #2

- 52 year old Female.
- Muslim from Yemen.
- Two weeks of shortness of breath.
- Hypoxic, diffuse crackles.
- X-ray consistent with PCP.

### Any HIV risk factors?

- We’re Muslim. We’re monogamous.
- Rapid Test Positive.
- Both cases illustrate importance of routine testing.

### Staff resistance

- Not an emergency
- ED is not the place for public health effort
- We are already so busy - something else we are being forced to do
- Not enough HIV positive patients in our setting
- Not comfortable asking patients about testing
- Not comfortable delivering news

### Design Questions

- Who is asking?
  - Triage, Providers
- Who is doing the test?
  - Nurses, Physicians, Mid Levels, Techs, Counselors
  - Need time to read results
- Who is doing the training?
- What kind of test to use?
  - Fingerstick, whole blood, oral swab

### Design Questions

- Where will results be delivered?
- How do we ensure confidentiality?
- Who will keep track of kits and maintain stocking?
- What mechanisms are in place for linkage to care and follow-up?

### Key Players...

- Physician Leadership
- Nursing leadership
- ED Champion
- Lab leadership
- HIV/ID Colleagues
- Social work
- Medical staff
Barriers specific to the law

- Documentation of consent in the record.
- Delivery of the key points:
  - Verbally by person asking
  - On paper with pre-made handout
  - Signs on the wall
- Documentation of results in the medical record

Follow-up

- Specific appointment has to be made if testing occurs during regular hours. A referral is not good enough.
- Can be done the next day off-hours
  - How do you make sure this happens?
- Cannot be done alone
  - Collaboration with HIV providers
  - Clinic in large hospitals, community providers
  - Establish protocols ahead of time

Our model

- Triage nurse offers test
  - “Key Points” displayed in triage room
- Flag on electronic tracking screen for provider to consent patient
- After consent, ED technician performs test
- Provider made aware of results
- Patient informed
  - Written discharge instructions with results

Positives...

- Social Worker from HIV Center paged during daytime hours.
- Patient counseled and brought to center for follow-up appointment.
- Off hours, daily report generated from IT system.
  - HIV center social workers call patient to schedule follow-up appointment.
  - Patients also told in ED they can walk in at any time.
  - Given packet of information.

Suggestions for success

- Tell the stories
- Show the evidence that it works
- Oversight of dedicated staff member
- Discharge instructions, “positive packets”
- Keep your staff informed
- Positive feedback
- Incorporate into routine departmental reports/QI
- Use information technology

Take Home Messages

- It is feasible, even in busy departments
- It requires buy in of staff members
- Teamwork and collaboration is key
- Positives happen infrequently
  - ED providers deliver bad news every day
- Many resources available for help
Take Home Messages

• Use quality improvement infrastructure
• Senior leader endorsement
• Use of prompts in EHR
• Competition
• Constant Monitoring of data

Take Home Messages

• Adolescents are at risk
• Rapid screening
• Establish the practice of provider meeting alone with adolescent
• Adolescent questionnaire
• Train all nurses and Medical Assistants

Evaluations

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Thank you!