Moderator: Welcome to today's webcast which will provide you with an update on HIV tests, consumers and advocates. We'd like to thank you for helping us progress as far as we have. I've been involved in countless meetings with you, over the last year and a half, the Aids Institute has hosted regional state meetings, met with hospitals, discussed implementation with groups, collaborated closely with New York City and other health departments and listened to consumers.

We've heard from literally hundreds of individuals as we crafted the regulations that were finalized and adopted on February 22nd of this year. The HIV testing law was enacted to make HIV testing a routine part of health care. Key components of the law included required offering for an HIV test searching from 13 to 64 years old, the requirement to arrange for HIV care for patients for HIV positive test results. The Health Department has been able to address many of the barriers to HIV testing that providers have brought to our attention over the years. The providers have developed practical real-world strategies to make routine HIV testing available on their sites. You'll hear from a community health center with many sites and a pediatric process. I applaud them for their efforts.

During this webcast, you'll learn about a tool kit that the Aids Institute has helped implement routine HIV testing. Over the last two years, the Aids Institute has received hundreds of questions from the field and updated our website with frequently asked questions. You can find a link in the tool kit and find many links. The adoption of this last February paved full way of implementation. The parties addressed in the law have either implemented the mandated activities or made their technical assistance known to us. HIV testing has a central place in the HIV/aids strategy. Implementing the 2010 amended law is to improve the goals of the strategies of reducing the number of people that become infected with HIV. Optimizing health outcomes living with HIV and health disparities, we have noted a 13% increase in New York State laboratory testing levels since the law went into effect, but clearly there is much work to be done.

Thank you for joining us in this important effort, I hope you find this webcast useful. Hello and welcome to Public Health Live, this Thursday's broadcast. I'm Joelle Alexander and I'll be your moderator today. Please fill in your online evaluation at the end of the webcast. Continuing Education credits are available and your feedback is helpful in planning programs.

We want to know what topics are of interest to you and how we can best serve your needs. As for today's program, we will be taking your questions throughout the hour by e-mail only. Please e-mail us at phlive.com. The school of Public Health is excited to announce the development of a new Companion Live for the public health program. The guide can be found on our website, phlive.org. We'll provide discussion points and activities on how to enhance their learning experience with their program. Please visit our website as phlive.org to download the guide. There's a section in the guide asking for audience feedback for how we can improve this product. We look forward to receiving your fax or suggestions of this guide.

Today's program is HIV update, New Strategies from the Field. Our guests are Daniel Egan, an Associate Program Director from St. Roosevelt Hospital, Debbie Lesser, a Director at the Urban Health Inc. and Dr. Schatler from the Albany Medical Center. Thank you all for being here today.

Dr. Egan, let's begin with you. Hospitals are addressed in one of the amended public health laws. Give our audience a feel for the emergency department from St. Lukes.

Dr. Egan: We are relatively busy. We see at Roosevelt a little over 170 thousand patients each year. We have 40 full-time medicine attending, and with a site and emergency residency for training, 40 emergencies and training in emergencies. The amended law requires offering an HIV test to all individuals
age 13 to 64 so the law clearly applies to pediatric settings. It's a busy pediatric group. We have about 100 patients coming through our day. We provide service from birth to 13 years old. We have ten attending pediatrician and one nurse practitioner. We have 30 residents who spend a full day at the clinic every day of the week.

Moderator: Debbie, let's bring you into the discussion, Urban Health Plan Inc. Tell us about the scope of services provided by Urban Health?

Debbie Lesser: Urban Health Plan is a health center located in Queens. We have four health centers in the South Bronx and one in Corona Queens. We have school-based clinics and two homeless shelters. We generate 250 thousand visits annually and over 50% of our patients prefer to speak Spanish.

Moderator: Dr. Egan, let's bring you back here, let's review the rational for offering HIV testing for a routine part of medical care.

Dr. Egan: I think that is a multi-faceted answer. In New York State, we have data that's a little bit disheartening in terms of a public health problem. People who are HIV positive are not even aware of it. We have patients who have not been diagnosed until they're already at the stage of having aids. We call them late testers or late diagnoses. About a third of infections in New York State have aids at the time of their diagnosis. So with that, we also have had significant advances in the technology of treating aids and the medications available so there are a lot more medications available to get it under control, all of which we now know are beneficial the earlier that they're started. There's also come compelling data, mostly in different regions in the country, particularly in South Carolina with one of the largest series represented which was publicized in the news a couple of years ago. They looked at all of their diagnoses over a period of 4 years. There were a little over 4 thousand of those patients; about a third of those patients, about 1800 of them had aids at the time of their diagnosis. A lot of those patients, in fact 77% of patients made visits to the emergency department in total. So they're seeing people not having the diagnosis made. So we're saying those are missed opportunities for testing.

Dr. White in California in Oakland, a very busy urban setting also showed that people that had been diagnosed with HIV had been seen in their emergency departments multiple years prior to their diagnosis. I looked at all of our patients who had been diagnosed with HIV, both inpatient and outpatient and tried to identify how often they had seen providers in our system as well. We have almost 60% of our patients who have aids at the time of their diagnosis, so almost double who's quoted in the state. So we have a significant burden of disease and late testers. Of our patients that have been diagnosed, 60% of them have had contact with a provider and 42% of those had been to the emergency department, so I think it's obvious that there's a need to identify more people and to try to get them found earlier.

Programs like this certainly help with that because we've made inroads but we still have a great way to go.

Moderator: Exactly! Debbie, tell me about the initial experiences when you make HIV testing a routine part of medical care.

Debbie Lesser: Sure, one of the initial challenges was more. Many, many years, we had a counsel-driven model; they would refer to a designated counsel, getting them out of the mind sight is a little challenge. That model limited the amount of patients that could be tested. In addition, our busy community-health center setting and limited space for challenges that we needed to look at in plan thing process out and finally our competing priorities provided at any given time. Our providers are working on various quality
improvement processes or making changes to the practice. So we didn't want this practice to overburden them, we wanted to make it user friendly and simple so they would be able to learn from it.

Moderator: I understand Urban Health Plan used the infrastructure as a way to tackle the channeling of implementing HIV testing. Tell us more about this.

Debbie Lesser: Yes, we did, back in 2001. Urban Health Plan participated with an important improvement collaborative. That's where we learned the methods we used today. One of the methods is the plan to rapid act improvement standard. Basically it is a quality improvement team that thinks of an idea of how they would like to improve care. They test it on a small scale first, learn from the process and build from there. Another key success strategy for us is we’ve had a fully-implemented electronic health record system since 2006. This allowed us to basically place the HIV test offer and the, HIV testing in the electronic health system and allowed us to document and report out on our measures. We just finally, put an expert panel together of internal experts to process it out.

Moderator: Tell us about the expert panel and who comprises this expert panel? We thought it was important to have our senior leaders on the panel. They’re the ones that strive for improvement in our organization. We included the Chief Technology Officer, the Clinic Systems Director, the Director of Nursing, our Section Head of Adult Medicine who's also an Infectious Disease Specialist and I.

Debbie Lesser: Terrific! An integral part of quality improvement is having clear measures.

Moderator: What were the measures Urban Health Plan used and how they were established?

Debbie Lesser: I’m going to talk about the measures in a second. I just wanted to discuss the work that the expert panel performed. So what we did was first we studied the new HIV testing legislation very carefully to make sure we understood it. We educated Aids HIV training and consulted this person about the process. We developed a team structure and hired an HIV Testing Coordinator. We developed protocols in the form of flowcharts so we could map out how we thought this process would work best at all of our sites. The flowchart is great because not only can we identify gaps in the process and see how the flow would work, but we used them as training tools. Once we kicked off the quality improvement tools, we used the flowchart to test them. We created fields with the electronic health record to capture and report on the measures. So far as the measures go, we decided that our measure would be that 90% of patients, ages 18 through 64 would have an aids test offered. We chose that 40% of our patients would have an HIV test, then we calculated our baseline. We were only at 8%, so we realized that actually 40% would be a good stretch goal for us.

Moderator: Okay, so walk us through the HIV testing offer as well as the protocol.

Debbie Lesser: Sure, this is a brief description of the protocol. Basically the medical system checks the electronic health record. They educate the patients on the key points of information which is required. The provider can then see that the HIV test was offered as they see the patient, so it reminds them. They verify with the patient that they would like the HIV test and of course if they agree to it, they will document the order of the test and if they refuse, they document the refusal, and then finally during the discharge process the patient is given. This lets them know that they can come in for their results on a walk-in basis or get their test results at the next visit.

Moderator: What about the testing team?
Debbie Lesser: Once the expert panel worked out the details of how we would like the HIV testing to be implemented, the testing with the people on the ground that would try out the process. So the way we did this was we took each of our sites and major departments and each had its own testing team. That testing had a provider champion, a site or departmental director. We brought these teams together and we basically trained them on quality improvement. We trained them on the HIV testing legislation and trained them on the protocols we were proposing. We shared baseline data with them. All of the providers use each other's data, so it was a good process because when the provider saw the data at the kick-off, they were very excited about the data and wanted to improve it. So, after we trained them, we had four meetings. For weeks, we had a one-hour team meeting. They told us how it was going, told us what was wrong and right and then we also during those meetings gave them their weekly data so they could see how they were doing along the way. We scheduled a learning session, after the kick-off, so the teams could report to the senior leaders how they're doing and get feedback from the senior leaders.

This was a multi-faceted approach that was taken -- active involvement in the team in the process. This requires getting feedback which sounds like it was an essential part of what the team did with you but how things are going and providing the team with regular updates as you just talked about.

Moderator: Can you give us more information about that?

Debbie Lesser: Sure, it was a really a good process because having these weekly team meetings provided them with how to feel about the process. They gave us good feedback. One of the first things they said to us was there were too many clicks in the system to do those HIV tests. They wanted us to minimize them; we did that. We coached along the way, so we were analyzing the data behind the scenes seeing which providers and medical systems that were getting it, needed a little more help and we were providing targeted coaching. We provided adequate feedback to the providers and this became an interesting issue because some of the providers weren't convinced the data was accurate. One provider in particular said “I know why I -- offer every single patient an HIV test”. She was right. We did find a little glitch with the data. We ran the data again, double checked it, showed the providers the new data because it was accurate and something they could use to inform themselves and drive the improvement. I guess the last thing that we did was one of the feedback we got was one of the providers wasn’t completely comfortable giving a positive report so we brought an aids expert for that. One, we knew if a patient was coming in to get their results and it was positive, we would offer them a counselor. So, this is our organization-wide graph, it shows as you can see from the graph, our baseline was about 8% and the light blue line represents our HIV test offer which through the team work process went up to about an 85% HIV test offer rate and the HIV test itself went to about a 52% testing rate.

Moderator: Debbie, a requirement of the amended HIV test laws care for patients with confirmed positive test results, tell us how that worked in your facility?

Debbie Lesser: Our HIV Testing Coordinator tracks every HIV positive patient, gets them their results and gets them in HIV primary care, so 98% of our patients have received a primary care appointment, and of those 76% kept their first appointment, so we track them through their first or second appointment.

In addition, we were pretty pleased with the process because routine testing not only allowed us to identify new positives but there were patients that were disengaged for care, we were able to use this process to get them back into care.
Moderator: Share with us some of the lessons learned from the process.

Debbie Lesser: I think the best lesson for us was the planning was worth the time to do it. This planning body really mapped everything out and that helped it be pretty successful. The Senior Leader endorsement of the project, all of our quality improvement projects, we have that senior leader saying, yes, that's important. I think that's crucial, the building of the momentum, the weekly team meetings and weekly data graphs kept people going and interested. People were looking for their data looking at how they were doing. Incorporating the testing team feedback was really important and knowing -- we did incorporate their feedback and institute the process through finalization of policies and procedures and adding these data elements into our clinical dash board.

Moderator: Very impressive work and thank you there sharing that work with us today. Let's turn our attention into how we integrate the testing into the pediatric health care testing.

Dr. Schatler: Along with the physicians, we have other very important members of our team, our nursing staff; we have one on-site nurse manager, four registered nurses, two licensed practical nurses, three medical assistants, and our medical staff upfront.

Moderator: Your offering of HIV testing and screening has evolved over the years.

Dr. Schatler: Yes, pre-2005, adolescent physicals were given the same amount of time as other age's physicals, 24 month physical, 3 year physical, all physicians were instructed to ask about sexual activity and risk taking behavior with our adolescents but we didn't have a standardized form in which we could use. HIV testing at that time was done via blood draws, most patients were instructed to go out of the office and get their testing done out of the office, HIV pre and post testing were done out of the office and it was done by providers, urine were sent for gonorrhea and chlamydia.

Moderator: What was your protocol?

Dr. Schatler: In 2005, we started developing a protocol. We started talking to parents in the exam room about what would happen at the next 12-year physical. We wanted to share with parents what we would be doing. We would probably be asking them to leave the room, to prepare them and give them a year in advance to talk to their adolescents about it and then we started. Before we started the protocol, we started sending letters out explaining the protocol to the parents before their 12-year physical and then in 2005. We started it, when the adolescent was checked in for their 12-year physical, the nurse explained what was going to happen to them and we found our nurses found it very, very helpful to have a script that they could all use that they remain consistent with their message to parents and adolescents. They instructed the parent that the child would be given a questionnaire to fill out and the doctor would meet with the adolescent alone before the parent is allowed in the room and the nurse then told the parent to wait in the waiting room and they were done and they would get them, they explained how to get the urine specimen, the adolescent was given time to fill in the questionnaire and the doctor entered in after the questionnaire was finished.

Moderator: You mentioned the parent being asked to wait outside in the waiting room. Have there been instances about expressing concern not being in the same space with their child and the provider during the screening process?
Dr. Schatler: Yes, especially if they hadn't met the provider before, so if that was a concern, the nurse was instructed to let the doctor know and the doctor would meet with the parent beforehand and explain the procedure to them.

Moderator: Calming them down?

Dr. Schatler: Yes. And the doctor would go in the room, review the questionnaire with the patient and by the answers on the questionnaire and the answers that the adolescent would provide us, we would send the urine sample for gonorrhea and chlamydia, HIV testing was offered if they thought the patient would be at risk and protesting was done and a script was given for an HIV test, hepatitis c testing and HPR testing was also included with that. At that time, the patient was on their own to get the testing done off-site and post counseling was done at a follow-up visit.

Dr. Schatler: Can you tell us about the questionnaire that's used in your office?

Dr. Schatler: Yes, it's a questionnaire that we have amended over the years. One of the reasons we amended it was for adolescents to understand it better. We want to make sure we take health literacy in mind. We also want to improve the quality of care, with the new HIV law. We wanted to make sure we amended it to add if they wanted to get an HIV test done. We added that question in. Some of the things in the questionnaire, we deal with benign questions in the questionnaire, questions about their diet and exercise and then we get into the big stuff, STD's. We call it sex, drugs and rock and roll type of questions and we get into that stuff and have them fill that out as well, a key component of our questionnaire is asking the teenager for their cell phone numbers, if we ever have confidential information that we can give to the teenager, we can do it by their own cell phone.

Moderator: In 2009, you were still dealing with issues about patient compliance?

Dr. Schatler: Yes, it was very frustrated, we had an awesome questionnaire but we were really frustrated because it was difficult to get adolescents to follow through with the testing, even if the testing was done off site. It was difficult to get them back in to do post-test counseling and adolescents are sometimes reluctant about blood draws, the minute they heard about a blood draw, they tuned us out, so in March, 2009, we developed a team with Albany Med Pediatrics, Infection Disease, and our laboratory at Albany Med to discuss rapid testing to be done.

Moderator: Rapid testing, I've heard about rapid testing, can you tell us about that? What is that term?

Dr. Schatler: Rapid testing is needle-free; it's done by swabbing the buckle mucosa of the patient. It takes about 20 minutes to get the results. It is a screening test so we do confirmatory testing if it is positive, but it's been very helpful, especially for those needle-afraid adolescents. So to tell you a little bit about the story, it was originally grant funded. We had an HIV counselor, a social worker and we purchased test kits. The testing team had one session a week where they offered evening appointments to adolescents to get testing done. We had to advertise a lot to our adolescents about this testing process. We put signs up in the exam rooms. If providers did notice that the patient might be at risk during the visit, they would explain to them about this session. Appointments were scheduled by the front staff. Appointments for testing were not charged to the patient and if a positive test turned out, a confirmatory blood test needed to occur the next day and could be ordered by the doctor present during evening hours, then the employee from the grant would arrange follow-up as needed.
Moderator: Was the entire staff involved with this?

Dr. Schatler: Yes, however, we noticed that only one session a week really wasn't enough and my nurses became very, very proactive and decided, why can't we offer this all the time and why can't we get trained to do it, so they loved having it, we always want to make things better for our patients, especially adolescents, and the nurses stepped up to the plate and became involved.

Moderator: Are there still varies that exist?

Dr. Schatler: Just to let you know what our nurses did. They were trained how to conduct HIV testing. Medical assistants were trained on key points on HIV testing and we offered HIV testing any time of the day. There were web visits. Providers could leave and we could have pre and post testings done. Our associates were still on call for any positive results but there are some barriers, payment, our grant ended. We bill it under viral testing. We still have continued concern about patient confidentiality, especially when explanation of benefits is sent home to the patient. The test takes 20 minutes. Parents become very curious while the adolescent is getting this test done. We have to tweak patient flow. We are busy and we have to make sure our staff have enough time to do post and pre-counseling with the adolescents.

Moderator: Based on your opinion, your experience and the lessons learned from them, what other pediatric provides should we be aware of?

Dr. Schatler: Yeah, we do have a lot of lessons that we learned, first of all, all offices can evolve, and you can do something about adolescent compliance, especially when you have a captive audience. We had great big ideas but we had to take small steps as you saw from the story I presented. It's good to critique a plan. At first, we had a lot of critiques having an HIV counselor one day a week, you have to start somewhere, you have to start and do something and never underestimate the power of your nurses. They really want to become involved and they're wonderful patient advocates.

Moderator: Thank you so much. Dr. Egan, I imagine there's been an evolution of ideas and practices around offering HIV testing in the emergency department, give us an overview.

Dr. Egan: That's exactly right, it's changed and it started back in 2006, so the first time that we even heard the concept of HIV testing was from the CDC in September of 2006 when they published recommendations essentially strongly recommending that HIV testing be offered in the Emergency Department, particularly in areas where there's an undiagnosed prevalence of greater than 0.1%, in many regions in the country. That's what it is. This recommendation was put forth and it came from data similar to what I told you about before in South Carolina. There are multiple people seeing providers in the Emergency Department with undiagnosed HIV and having multiple encounters with those providers, the other thing they recommended at that time was patients that were getting evaluated for sexually transmitted infections should get tested. The big change in 2006 was they wanted the frame work to change from an opt in test to an opt out test, meaning that someone can come in. Part of their general consent for treatment was knowing that an HIV test would be done today unless you opt out of the test. About a year later, the American College of Emergency Physicians changed or released a policy statement. I think taking into account the compelling data of the emergency department and coming on board and saying HIV testing is an important thing and you'll see on the slide there's a code on the policy, embracing this policy that this is an important public health measure that should take place in the emergency department and it should happen in the same way that we provide expeditious results to other tests. The patients we know who are at most risks are marginalized from society, don't have great access to health care, those are the people
that we take care of. In major urban settings, we provide that, we are that safety net where people go when they don't have another place to go. These people are at risk. It is an ideal place to provide that testing, that was in 2007 then, in 2010. The main reason that we're here today, is New York State passed a legislation, and as part of that legislation for HIV testing, it's required that all patients that come to the emergency department from 13 to 64 be offered an HIV test. It was explicitly stated that it include the emergency department. People need to embrace this and figure out ways to develop programs to offer testing in the department.

Moderator: I understand you have some case studies to share with us today.

Dr. Egan: Yeah, I think it's helpful to give real examples of people. These are two patients that I saw to just emphasize the reason that this is important. The first case was an adolescent which you've heard about. Someone I saw in the shift on the Pediatric Emergency Department, an individual who came in thinking he had a hemorrhoid. He had several abscesses in his rectal area. I assessed risk because it was a little bit of a risk. He said I'm negative. I was tested a year ago, so I offered an HIV test and I said, let's not worry, we'll just get one today, and he agreed. So his rapid test was positive and then on further questioning, it turns out he says, sometimes I do use crystal meth around the time of sexual activity and I don't always have safe sex, so really the information he gave up front was not truthful which I think probably you see a lot in adolescent medicine where they're not forthcoming right away. If that has been a targeted test, it would have been missed. The second one is more compelling which was a 52 year-old woman who I saw who didn't speak any English and she was a very traditional Muslim woman and she had come in with shortness of breath and on her exam, it was suspicious pneumonia, her oxygen level was low and it looked like PCP which is an aids associated illness, when I went back to her to talk through the interpreter phone and asked about risk factors, she was emphatic, she said I'm Muslim, her test was positive, her partner it seemed was not being monogamous, nobody would picture this woman at being at risk, she came in, while we missed the opportunity through triage, we were able to test her, she's been positive for 8 to 10 years at that point so likely been to the doctor and maybe never opted in or was never offered one, we're not sure.

Moderator: Thank you for sharing those. Clearly the emergency department can be a busy, challenging place and I don't have to tell you about that. That's something you're experiencing just about every single day. Tell us how did the Emergency Department Staff handle the notion of being required to offer HIV testing?

Dr. Egan: So, you could imagine there's resistance. In my place, we had testing before the law but I have talked to a lot of people who deal with this sudden need to implement testing. Even when we were doing it before the law, there was clearly resistance. Many people don't think this is an emergency, so is it really worth the efforts to do this public health measure for potentially a small portion of our patient population. So, not everyone agrees with this since we're supposed to be dealing with more emergency cases. We're already so busy and we're already under the regulations of a lot of outside agencies for patients in the emergency department which are set forth by people who don't do our job every day, so things that we have to do that don't always make sense from our perspective that we're forced to do by outside regulators, there's already that frustration factor. I love the expression competing priority, that's a good way to capture what we all face every day. When I'm busy and taking care of someone with a stroke, the last thing I'm thinking about is offering HIV testing. Everyone's busy; they have a lot of things going on and in my environment, we see HIV and aids, but not everybody does. So, people don't think that we have enough HIV positive patients and they're not comfortable asking about it. There's still stigma attached to talking about HIV, there's not a comfort level talking at the test and even more so, there's not a comfort level in delivering positive results. I think that's often the big barrier, although my response to that is
always that for a living, we deliver that news, we routinely tell people that their closest family member has passed away or deliver horribly unexpected news of a new malignancy or metastatic process that nobody's expecting when they come into the emergency department and we do it all the time. HIV no longer carries with it that same prognosis like a lot of other things do, this is like hypertension, your life is going to change, but with medication, you're going to have a normal life expectancy, the news is not as hard to deliver I think than some of the other things we do.

Moderator: Absolutely! What were some of the key elements that emergency departments have to consider as they develop a model for offering HIV testing with the public law regulations?

Dr. Egan: It's all about the planning. So, it's all about how are you going to design a program that's effective in the environment for which you work, who's going to ask, so is it going to be the nurse in triage where a lot of questions take place so it seems like a natural environment or is it going to be the provider. There's a lot of literature to show that that doesn't work, that the provider ask, and after it's offered, who's going do it, is it going to be the nurse, the provider, are you going to have an outside counselor which requires additional funding or are you going to use existing staff? It used to be something that had the able toed -- ability to go to the patient's bedside. Then there's issues of training and with the training, what kind of testing you're doing, are you going to use the oral swab which is what we use and I think very easy for a quick turn around and ease of patient acceptance, but some of the rapid test use fingers sticks to obtain a sample, and then you can make an agreement with the lab so you can test samples to the lab, and then once you've done the test, how do you deliver the results, so confidentiality is key here and it's difficult in many emergency environments to ensure a level of privacy. Many rooms are separated by a curtain which may not be fair to the person receiving this positive result. How do you do that and keep it private? Then there's the logistics of ordering supplies and turnover and maintaining the kits and providing and doing the quality improvement. Then, I think the biggest element of this that is required ahead of time for timing is what's the linkage to care and follow plan which is the hugest challenge of our job is able to contact a person after they left when they've given you an inaccurate phone number to find them to make sure they get follow-up care.

Moderator: Who are some of the key players involved?

Dr. Egan: I think it's similar to what we've heard. There are key players in every practice environment, so, clearly nursing leadership needs to be on board of this, especially if you're going to ask your triage nurses to be involved in this. You're your staff, there needs to be somebody who's the champion. I use that word because I think it's true and I guess I'm the Ed champion at the hospital. I remind people of it and I think someone takes that on as kind of the project. The lab, most institutions have clear point of test, rules and regulatory testings and QI processes that need to take place and you need to have the involvement in the lab to make sure you're following the procedures that are required by your institution's own policies and procedures. Social work is incredibly helpful and so their ability to deliver bad news and to spend time with patients and to sit down and not necessarily need to follow up with another person. They can just be an amazing ally. The colleagues who you're going to refer your patients, if you don't have those people on-site, you have to identify who in your region are the providers who are able to accept their patients into their practice as their follow-up if they do test positive.

Moderator: They spoke barriers specific to their settings. What are some of the barriers you're seeing specific to the law?
Dr. Egan: I think these barriers can be overcome but it's about the planning mechanism so documentation is always an issue. Depending on your system, many people are still writing charts handwritten and there are multiple things that need to be documented in the record, the consent, the results, the patient's informed and the fact that you followed all the steps that are required by the law, and so I think that plus the delivery of the key points is challenging. So you can have them done verbally, have them on paper, or if you're going to give patients something to read, and then the linkage to care is the biggest challenge.

Dr. Egan, I wanted to talk about follow-up, you've underscored the importance of follow-up. When a person goes to the emergency department, that doesn't usually occur unless there's an emergent concern. How does follow-up, making appointments for HIV care, etc.?

Dr. Egan: So, I think this is one of the biggest challenges in the law because the law specifically says that you can't just refer, you have to secure an appointment for someone for follow-up care. For us, it's actually having the place where you can identify a location where a patient can go and they can leave with a date and a time that they can be there, and so that's a tough thing. It would likely need to involve other members of your staff; social workers are amazing at this time, so it needs to happen before they leave, since it's a 24 hour operation. If the test takes place off hours, then the process can happen the next day to secure a specific appointment. This can't be done alone; it needs to be a collaborative effort if you have HIV providers at your institution, and they need to be involved with this or a referral center to which you can send your patient.

Moderator: So, tell us how were you able to operate HIV testing in your emergency department?

Dr. Egan: So, we've decided on the rapid model and I think in our setting, that works best because everything people like to get answers and giving people results before they leave is the best mechanism in the emergency department, so anybody who arrives essentially asks the painted, because we offer HIV testing that comes in, would you like an HIV test today, we have them displayed on posters in the triage room so they can receive that information. It flags our electronic medical records, the provider sees there is a patient that likes to have an HIV test and that prompts them to go and ask for verbal consent, they document that into the record and that flags our technician to go in and do the test. If it's negative, they can enter that into the electronic record and we see that, if it's a positive, they need to communicate that with the provider so we are obviously aware and we have -- obviously the patient is informed and everyone receives instructions that say positive or a negative result. We have it linked with our electronic system which defaults into the instruction system. The positive is the biggest issue and everybody gets nervous, how do you bring that into the practice, so we have a wonderfully comprehensive center for HIV at our institution and during the day, we can page their social worker who has a five minute response time and they help us deliver the news, in off hours. We have a premade packet of information we provide to patients, we call it our positive packet and we give them all that information and then next day, we reach out to them via a daily word that takes place in our electronic center and the HIV center will find them.

Moderator: What about suggestions for other emergency departments for success?

Dr. Egan: I think it's helpful to tell the stories. I think when I can give feedback to particular news to a particular nurse that we found them, it's a powerful message. I think people respond sensitivity because it's not expected, show them the evidence that it works, the reports, the feedback, those are all key elements, keeping your staff informed of what the changes are and how they're doing and providing numbers and quality improvement measure. I think as a department, incorporating this into your routine measures of QI, we all have core measures that we have to follow, and I think if this is part of that, that it
just helps to make it more streamlined and use your information technology to your advantage. If you're in a busy place where everybody's busy these days, having the ability to use your computer system or electronic record to facilitate this process and minimize paper I think just maximizes efficiency.

Moderator: We're coming to the end of our time together today. Dr. Egan, let's wrap up with your taking home messages.

Dr. Egan: There's lots of care for people, there's different success models in different places, people need to know this is important and take part in the mission and it can't happen if it's not a team process and involving team work and collaboration of multi-specialists as well as the number of care providers in the department. The positive happens infrequently so while people are so nervous about those, it doesn't happen as often as we think and there are a lot of resources available through the Aids Institute and through other people who have done this to help you in the process.

Moderator: Thank you. And Debbie, are there key take-home messages with your urban health plan that you can share with our audience today?

Debbie Lesser: Yeah, one of them would be to use the quality improvement structure, it's -- not everybody goes in this direction but we feel it's a really effective way of doing the work. A lot of people are nervous about doing this work still, so if you do it as a quality improvement team, that team works out the kinks and then you can speed up the process, it takes away some of the anxiety, it's a great process, the other thing is a senior leader endorsement is key, they need to see the senior leaders are on board and they're asking us to do this work. The EHR is a wonderful tool, the prompt, the ability to be able to see the HIV test and the provider to see that and remember, okay, and let me talk to this patient about an HIV test; it really works out very well. I think for us, the whole quality improvement team structure created a healthy competition amongst the provider getting their date every week and see how they're doing, it drove excitement into the process.

Moderator: Thank you so much. Dr. Schatler, closing remarks from you?

Dr. Schatler: I think to remember that adolescents are at risk and rapid screening is really helpful, especially with adolescent compliance. I think it's so important to establish the practice of provider and adolescent meeting alone without the parent and establish that early on. Adolescent questionnaires have been helpful and we've gotten a lot of information from adolescents this way and train your nurses and medical assistants to really help with your process.

Moderator: Well, Dr. Schatler, Debbie and Dr. Egan, I want to adopt your word, you're all champions, not only champions in your specific settings but you're global warriors in terms of the important work you're doing and it's been an honor to have you here today, thank you so much.

Dr. Schatler: Thank you.

Debbie Lesser: Thank you.

Dr. Egan: Thank you.

Moderator: At this point, we will wrap up the broadcast by hearing about the tool kit that Daniel O'Connell referenced at the beginning of this webcast, but first, thank you very much for joining us today and please
remember to fill out your evaluations online. Your feedback is always helpful to the development of our programs and continuing education credits are available to obtain nurse continuing education hours, CME and CMETS credits, they must visit www.phd.org and the post test for today's offering, as a reminder, you can download the companion guide from this broadcast on our website, phlive.org. It will further your knowledge and understanding of topics covered in today's program. An archive of this webcast will be on our website in two weeks, please join us on June 21st for our next webcast on the rising adults living with Alzheimer's. Thanks for joining us on Public Health Live, now here's Daniel O'Connell.

Daniel O'Connell: It's an easy to use one-stop resource for implementing HIV testing, the tool kit includes numerous documents saved in pdf format. The first page of the tool kit is a table of content described on what you'll find. You can easily navigate within the pdf by going to the gray column on the left and clicking on the icon that looks like a ribbon, this will open the bookmark, section. It provides an overview of the law and providers affected and review the consent process. The overview provides the key points a patient must receive before testing and offers recommendation for HIV testing among young people aged 13 to 18. Important HIV information resources are outlined. Section 2 provides detailed information with a confirmed positive test result, the requirement to arrange follow-up HIV care and reviews case reporting requirements and issues related to partner notification. Section 3 provides a summary of HIV testing with occupational exposure, section 5, 6 and 7 are print ready pdf's, clinic processes and a handout for parents of HIV including information about oral consent when offering a rapid screening, incorporating HIV screening into the medical consent form and pdf's of model consent form. They are used to authorize the release of HIV related information. A technical assistance document is also included. Section 10 is a coding guide from the Medical American Association that lists Medicare, CPD and Icd9 codes to facilitate appropriate billing. Finally, section 11 is a list of associate resources so the links department HIV testing, a list of HIV care providers to facilitate making appointments for HIV care, and other important links and resources. The health department hopes this tool kit will facilitate the routine offering of HIV testing, any comments can be sent to HIVtestlawandhealth@stateandny.ds, it is available on the website.