Integrating and Improving HIV Routine Testing in Illinois Community Health Centers

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Learning Objectives

- Highlight lessons learned from implementing HIV routine testing in primary care clinics.
- Review and discuss issues related to staffing, counseling, consent, linkage to HIV care, and payment for HIV screening tests.
- Discuss PDSA cycle approach to improving outcomes of testing programs in the primary care environment.

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- Illinois
- Indiana
- Iowa
- Minnesota
- Michigan
- Missouri
- Wisconsin

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Project History – HRSA to AETCs

- CDC 2006 Revised Recommendations for HIV Testing of Adults, Adolescents, and Pregnant Women in Health-Care Settings
- HRSA 07-146 (July 2007) funds AETCs to support health-care providers in adopting CDC's Recommendations, "especially among populations disproportionately affected by HIV infection, such as African-Americans":
  - development of curricula, provider tools
  - training
  - technical assistance, including clinical consultation resources

Project History – Built on MATEC Strengths

MATEC proposal:

- **Goal I:** Expand HIV testing in clinical settings funded by CDC through state/local health departments (Chicago, Michigan, Missouri)
- **Goal II:** Expand HIV Testing in non-HIV funded targeted Community Health Centers.
- **Goal III:** Expand HIV Testing in STD Clinics in Minnesota, Wisconsin, and Missouri.
- **Goal IV:** Coordinate and collaborate with local and state health departments, community health center clinical leadership, and Prevention Training Centers serving MATEC's region.

MATEC Illinois:
Illinois HIV Routine Testing Initiative

- Built on strong relationships with the Illinois Department of Public Health and the Public Health Institute of Metropolitan Chicago
- To support the implementation of routine HIV testing in seven community health centers outside of Chicago
- To test 6,000 people between August 1 and December 31, 2009. (Test kits and TA extended to Dec. 31, 2010)
- To identify newly diagnosed HIV+ individuals and link them to care and services

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Why Increase HIV Testing?

Several reasons…

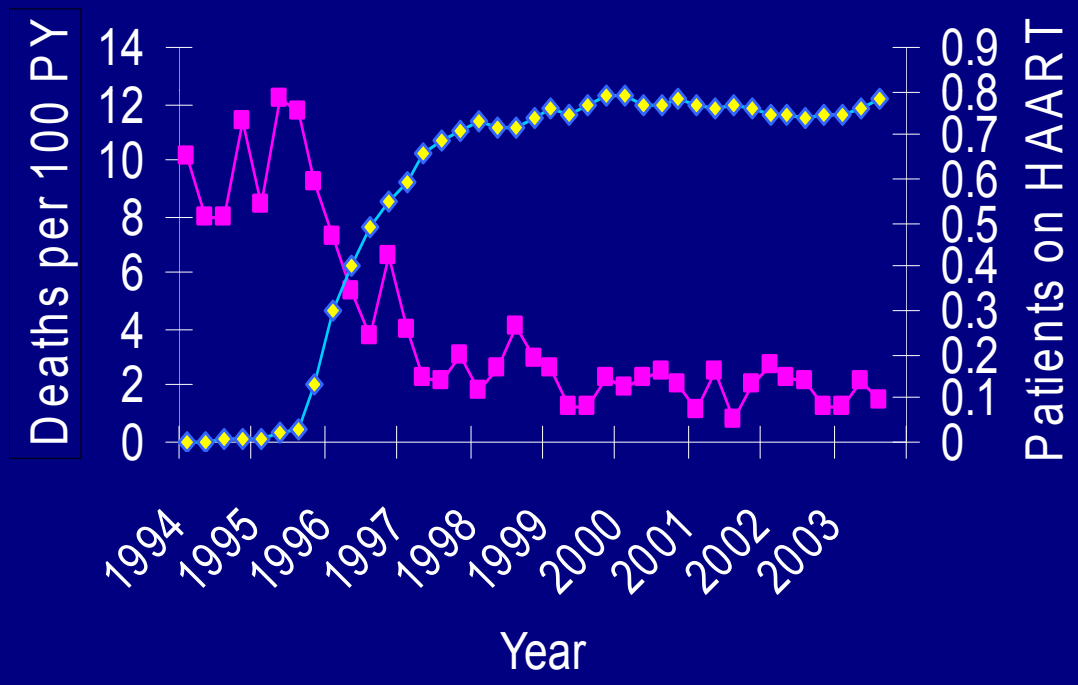
- Because the earlier an infection is found, the better the chances of a full healthy life (disease management)
- Because new infections can be prevented if people know how they are infected (behavior change)
- Because reaching people early in the infection and beginning treatment may decrease transmission (seek-test-treat)

Awareness of HIV Status among persons with HIV, United States

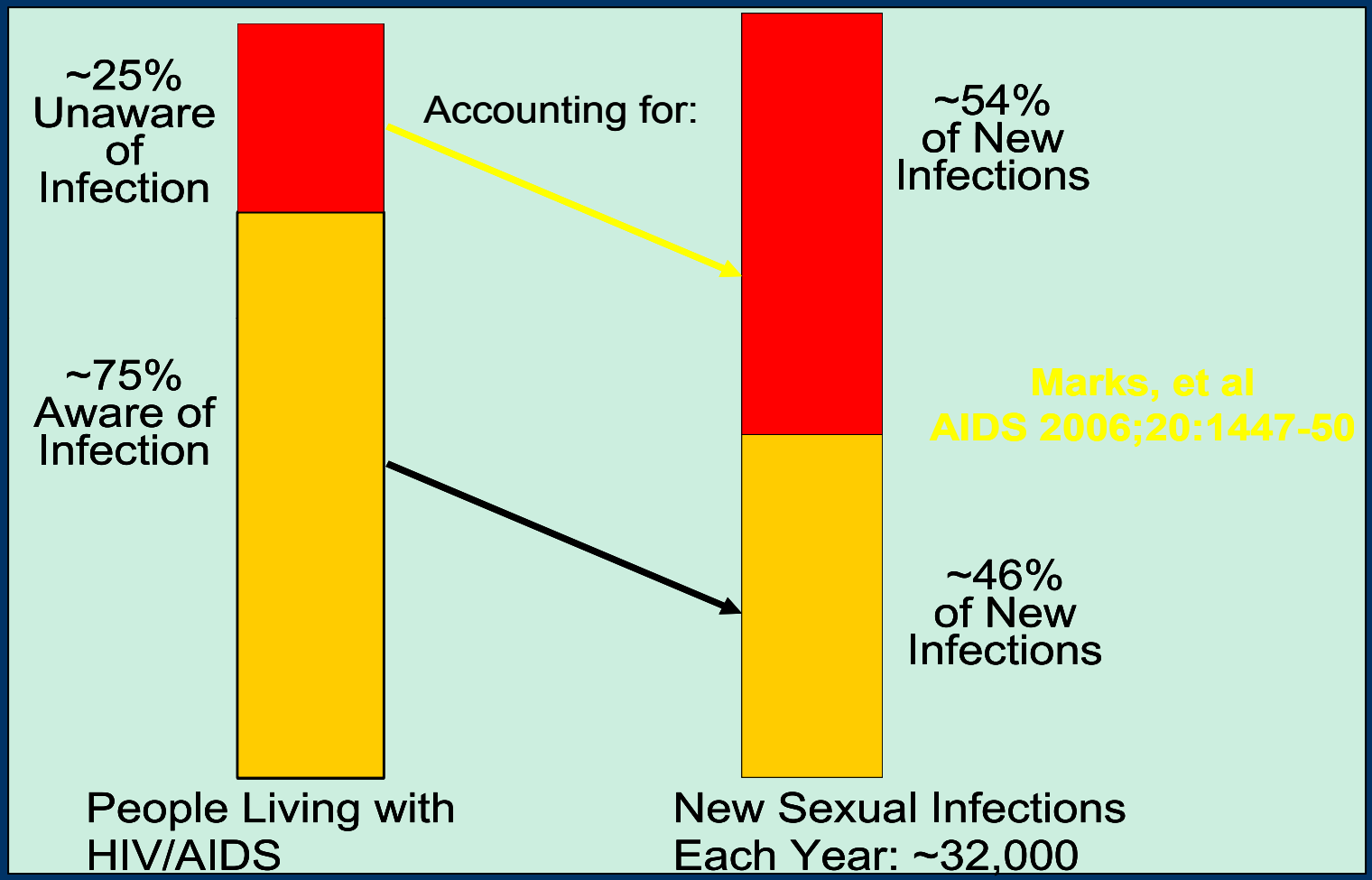
Number HIV infected	1,056,401,156,400
Number unaware of their HIV infection	232,700 (21%)
Estimated new infections annually	56,300

New Estimates of U.S. HIV Prevalence, 2006, from CDC STATISTICS IN MEDICINE, Statist. Med. 2008; 27:4617–4633

Mortality and HAART Use Over Time
HIV Outpatient Study, CDC, 1994-2003



Awareness of Serostatus Among People with HIV and Estimates of Transmission



Rationale for 2006 Revised CDC Recommendations

- Many HIV-infected persons access health care but are not tested for HIV until symptomatic
- Effective treatment available
- Awareness of HIV infection leads to substantial reductions in high-risk sexual behavior
- Inconclusive evidence about prevention benefits from typical counseling for persons who test negative
- Great deal of experience with HIV testing, including rapid tests

Illinois Routine Testing Initiative and Illinois Law in Support of Routine Testing

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Illinois Routine Testing Initiative

- CDC - funded the Illinois Department of Public Health, who collaborated with Public Health Institute of Metropolitan Chicago (PHIMC) and MATEC
- GOAL: To support STD clinics and community health centers in integrating routine HIV testing into their regular services
- Pilot project with CHCs began June 2009
- Hope to lay the foundation for routine testing in Illinois

Illinois Law Supports Routine Testing

- AIDS Confidentiality Act changed in 2008 to facilitate routine testing
- Allows a site to conduct “opt-out” testing
- Consent can be given in writing or verbally
- Verbal consent must be documented in the chart
- Consent for HIV Test can be part of the general consent for care

Pre-Test Information

- Meaning of test results including its purpose, potential uses and limitations
- Voluntary nature of the test and the right to withdraw consent at any time
- Right to anonymous testing and confidentiality. If anonymous testing is requested but not performed onsite, the individual must be referred to another site.
- Necessity of additional confirmatory testing
- Availability of referrals for further information or counseling

Illinois Sites

- Family Health Society (ACCESS)—*Chicago Heights*
- Community Health and Emergency Services of Southern Illinois (CHESSI)—*Cairo*
- Crusader Health Services— *Rockford*
- Family Christian Health Center— *Harvey*
- Lake County Health Department—*Waukegan*
- PCC Community Wellness Center— *Oak Park*
- Southern Illinois Regional Wellness Center— *East St. Louis*

Model and Findings to Date

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Community Health Centers and HIV Experience Nationwide

- 33% RWCA Part C grantees are community health centers
- 10% of all health centers receive RWCA Part C funding

HIV services are available at both

RWCA-funded and non-funded sites

Terminology

- *Diagnostic testing:* performing an HIV test based on clinical signs or symptoms
- *Targeted testing:* performing an HIV test on subpopulations of persons at higher risk based on behavioral, clinical or demographic characteristics
- *Screening:* performing HIV tests for all persons in a defined population
- *Opt-out:* performing an HIV test after notifying the patient that the test will be done; consent is inferred unless the patient declines
- *Anonymous Testing:* patient-initiated, usually through a public health clinic
- *Outreach Testing:* performing tests at events and non-medical locations, usually for education and prevention

Guiding Principles for Change in Community Health Center Model

- Unit of analysis is the PATIENT
- HIV is treated as a chronic disease (long term, manageable)
- Routine testing is implemented across the organization
- Apply redesign and collaborative learning models, change theories, and lessons learned
- Build on existing infrastructure
- Leverage communities and state partnerships
- Intense coaching to create momentum, trust, support and quality outcomes

Implementation Plan: Identifying sites

- **Partnerships** : IDPH, PHIMC, MATEC, Illinois Primary Care Association (IPHCA)
- Letter to IPHCA membership with invitation to participate from state HIV/AIDS Director
- Identify benefits and services for CHCs ($10,000 stipend and tests)
- Identify areas of higher prevalence
- Identify “champions”, and agencies willing to change
- Build/enhance referral arrangements, especially with RWCA Part A and Part B

Implementation Plan: Training Event

1. **MATEC and PHIMC Working Session with all sites**
   June 18, 2009—
   - Leadership teams from each site
   - Presentation with Dr. Branson
   - Handbooks, planning tools, resources provided
   - NACHC model and worksheets
   - Initial plans developed for each site to take home

Implementation Plan: Pre-Launch with Sites

2. **On-Site MATEC consultation**

   - Site Kick-off: All-staff workshops and educational forum, including RWCA Part A and B resources

   - Observation clinical flow and discussion of provider support, policies

   - Staff Training: HIV Rapid Testing technology (manufacturer representatives)

   - Staff Training: Illinois law and data collection, clinical flow, referral resources (MATEC on site)

3. **Data Collection**: Initiate data collection process

Implementation Plan: Launch and Ongoing

4. Launch

- Implement Routine HIV screening and data collection with a clinic session/area and/or selected providers
- First: Lake County Health Department – August 14,2009
- Last: Family Christian Health Center – November 2, 2009

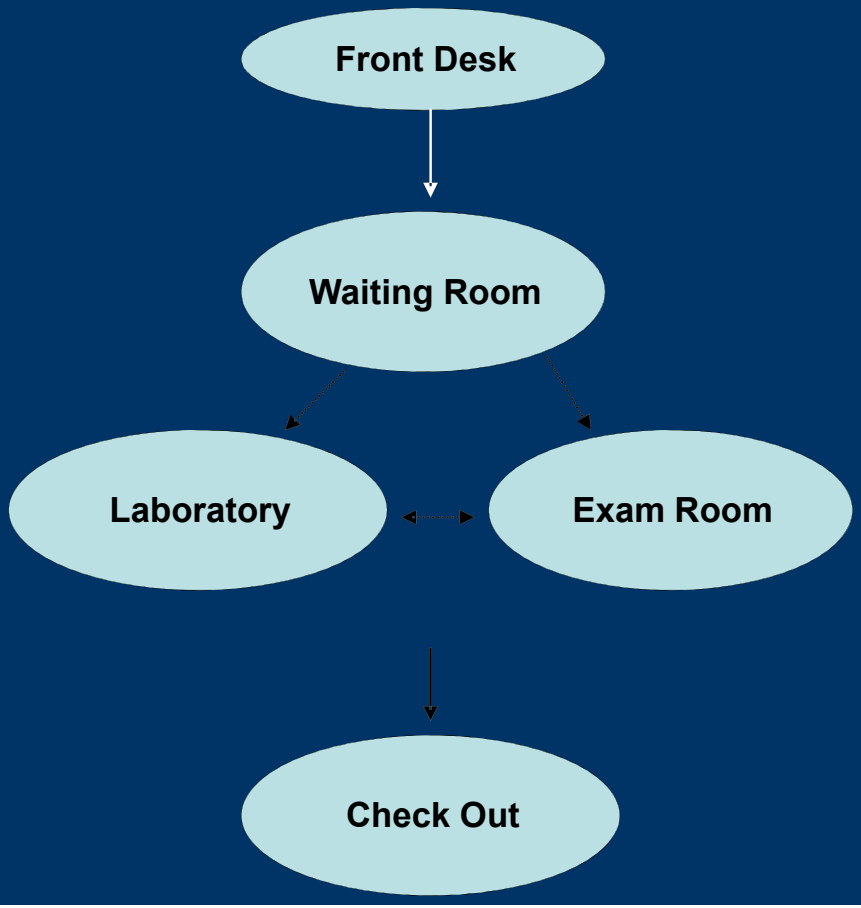
5. Maintenance

- Monthly Technical Assistance Calls
- Review, feedback and correction of data
- Periodic site visits
- Intensive coaching
- PDSA (Plan, Do, Study, Act) cycles for process evaluation

Community Health Center Planning Issues

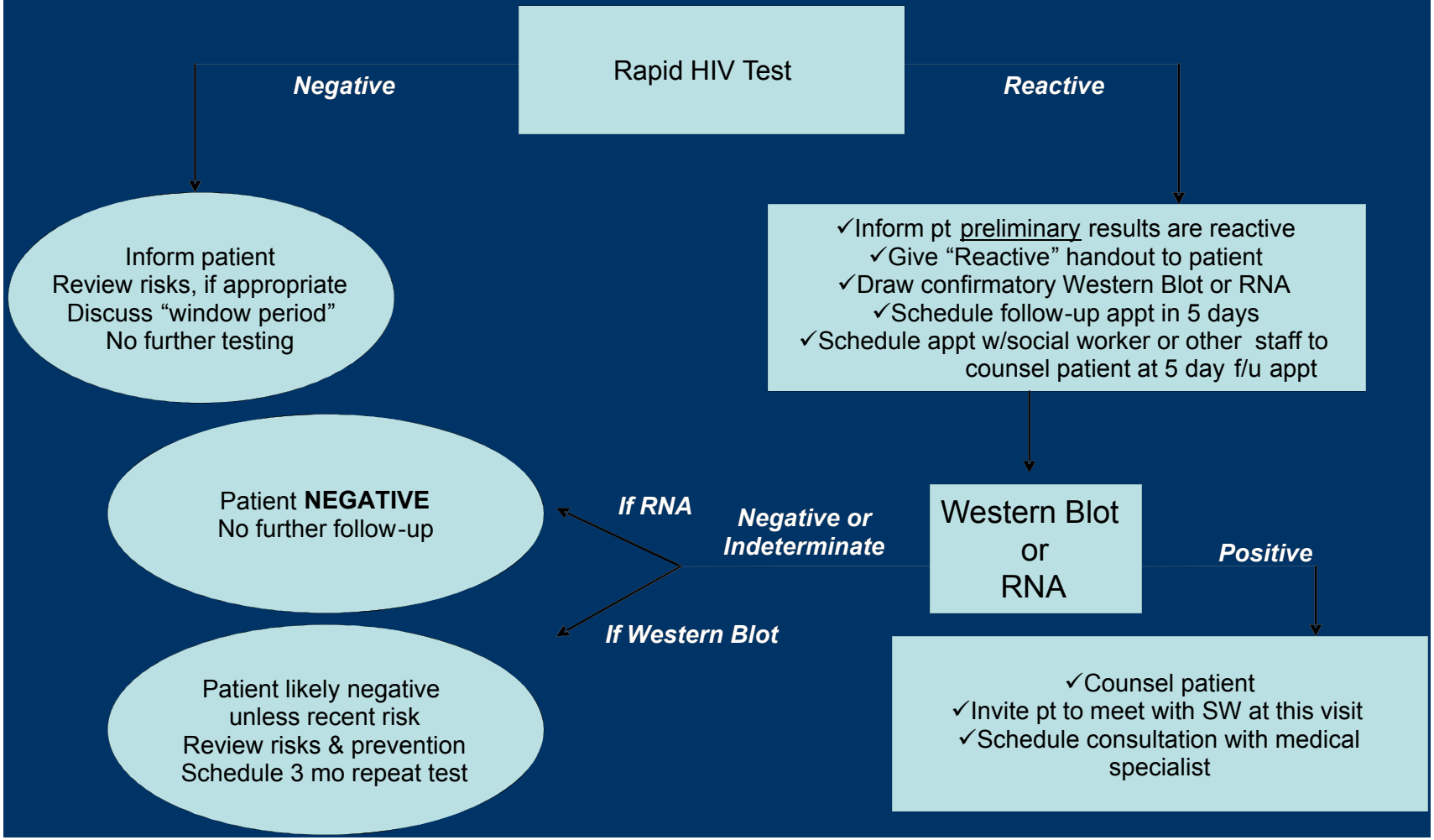
- **Business Plan**
  - Test kits—How many, what type, inventory?
  - Western Blot—state lab or private?
  - Reimbursement—what billing will make routine testing sustainable?
  - Budget—one-time funding, no new staff
- **Infrastructure Considerations**
  - Documentation—Electronic Medical Records?
  - Staff Responsibility and Training
  - Linking to Care—Capacity of local resources
  - Traditional HIV sites with primary care sites
- **Changing the Paradigm**
  - Patient flow
  - Routine screening vs. diagnostic or opt-in
  - Confidentiality and consent

Clinic Flow for HIV Screening



Health Centers need to examine patient flow, and the appropriate staff for testing responsibilities

HIV Screening Algorithm



Adapting Training for Medical Assistants

- GOAL: Accurate pre-test information and informed consent process that is compliant with the revised IL AIDS Confidentiality Act and adds minimal time clinic flow.
- Curriculum:
  - Facts Practices
  - Pre-test counseling demonstration and practice
  - Post-test demonstration for negative, positive, non-reactive tests
  - Review of test technology with manufacturer

Approaching Physicians to Gain Support

GOAL: To engage physicians in implementing routine HIV testing and providing test results:

Strategy:

- Identify physician “champion”
- Physician/clinician only introduction session:
  - Rationale
  - Clinical information – CDC slides
  - Physician testimony

LAUNCH!

Lake County Health Department and Community Health Center (RWCA Parts A & B)

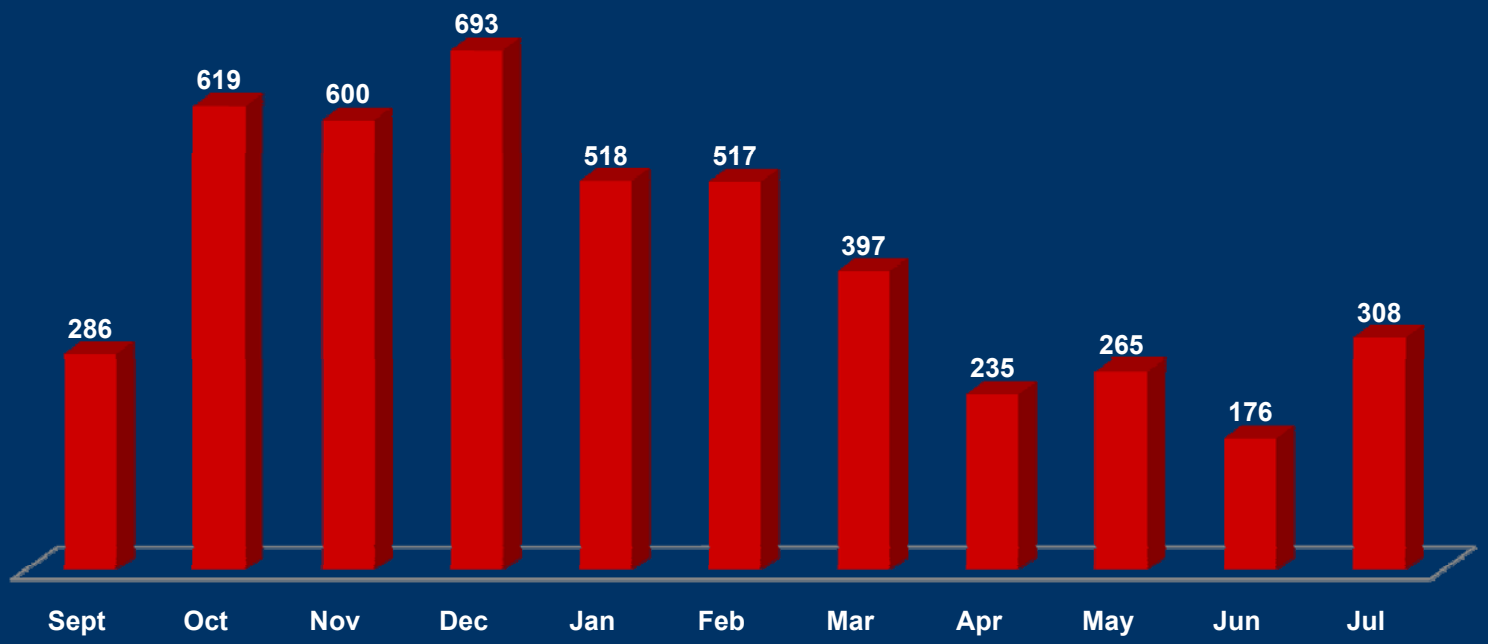
- Launched September 13
- 51 tests in first 3 days; 1 new HIV+ person
- 4 people opted out
- Training for medical assistants
  - Written test
  - Interpretation of test results
  - Observed pre-test session

Results in 10 months…

- 4,614 tests conducted
- 6 positives
- 0.13% seropositivity
- Confirmed positive tests were identified in Lake (2), Suburban Cook (3), and Winnebago (1) Counties

IRTI Results: Total Tests (n=4,614)

Sept.'09 – July '10



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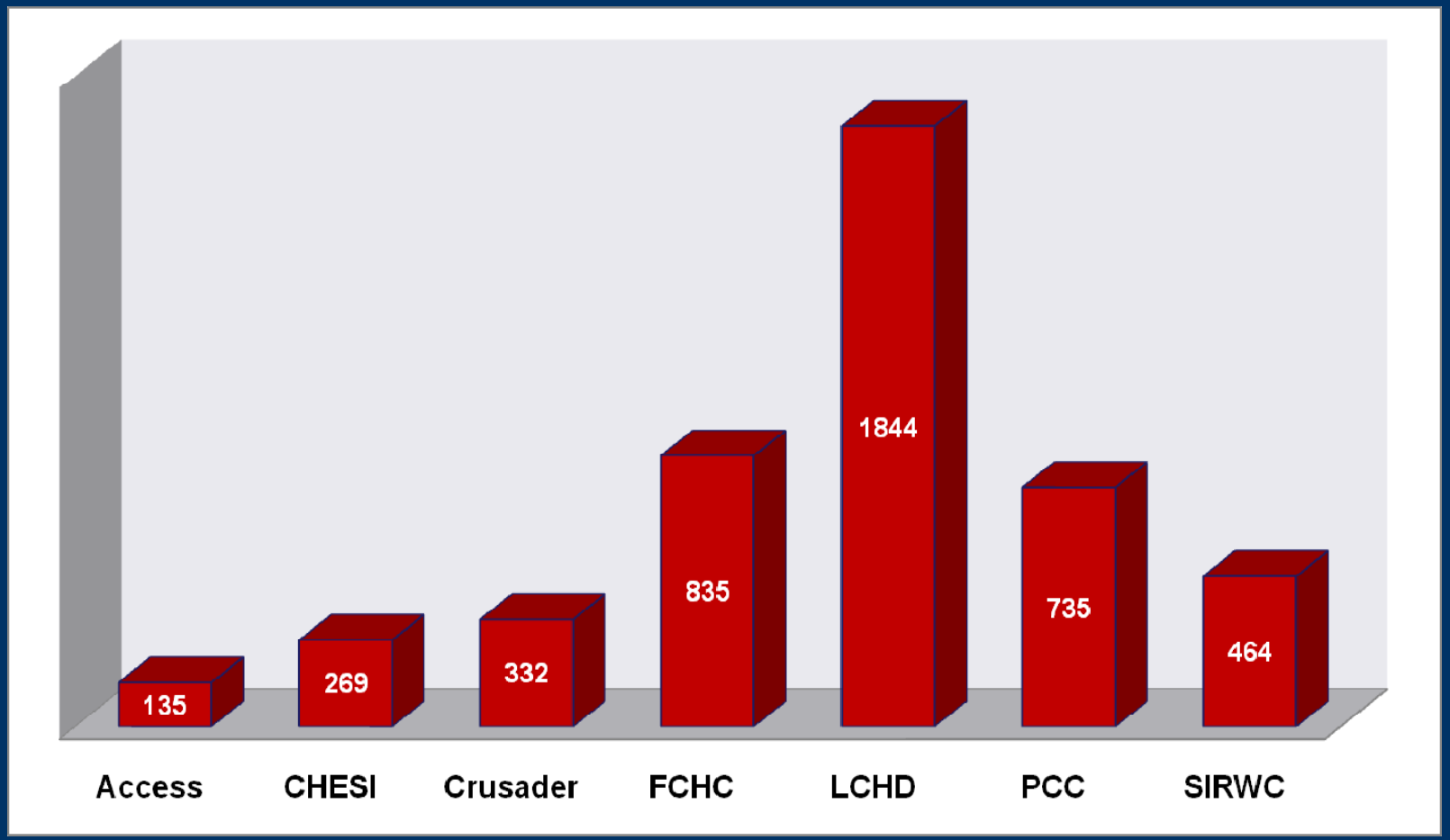
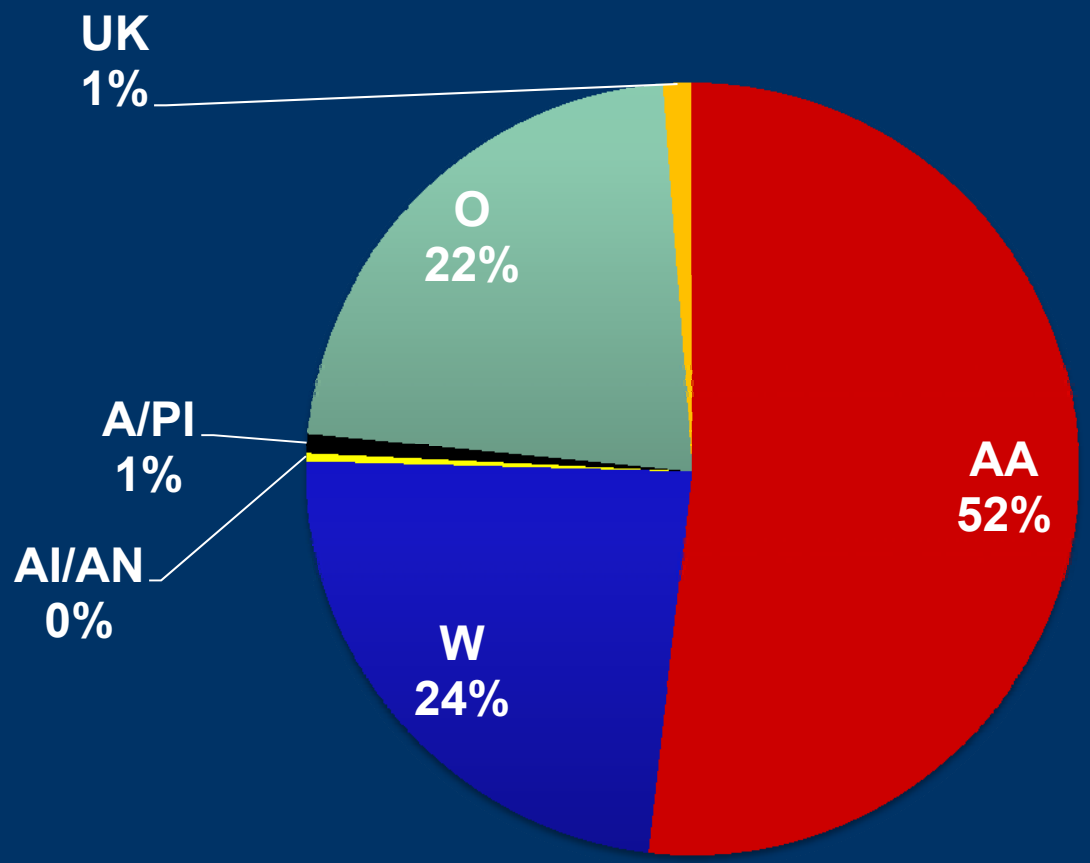
IRTI Results: Tests by Site



IRTI: Total Tests By Race



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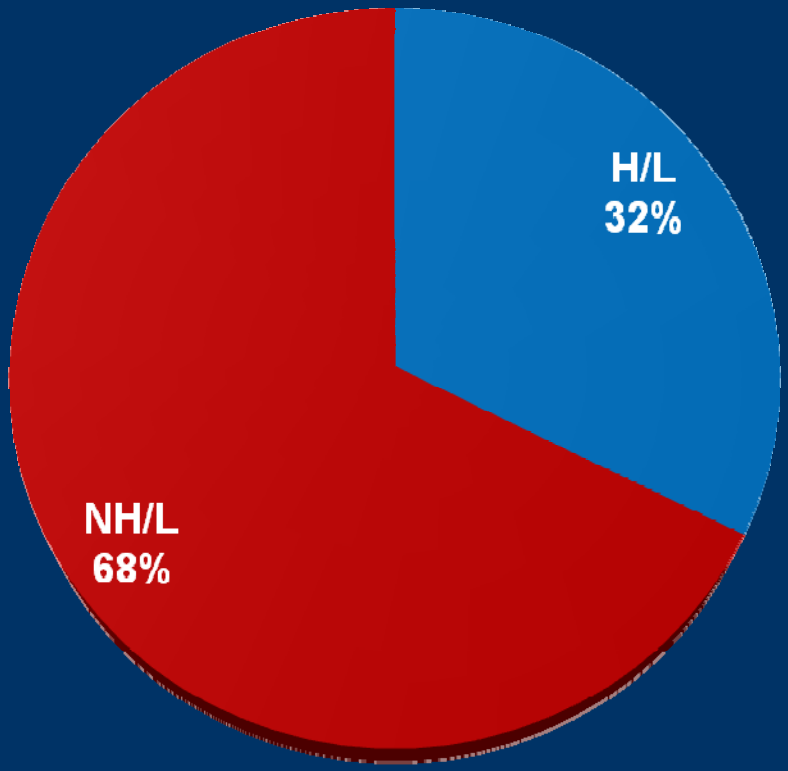
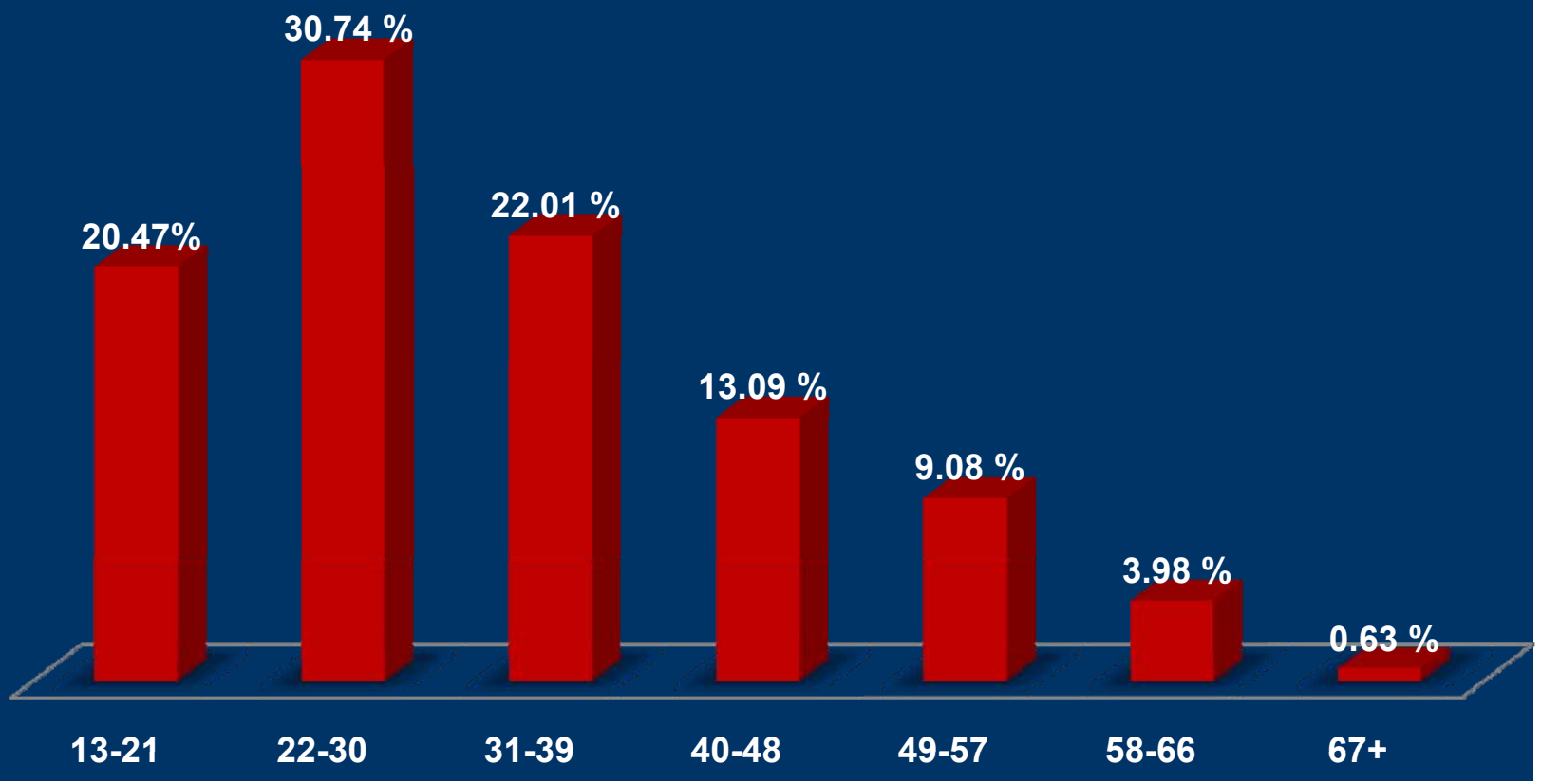
IRTI Results: Total Tests by Ethnicity



IRTI Results: Tests by Age



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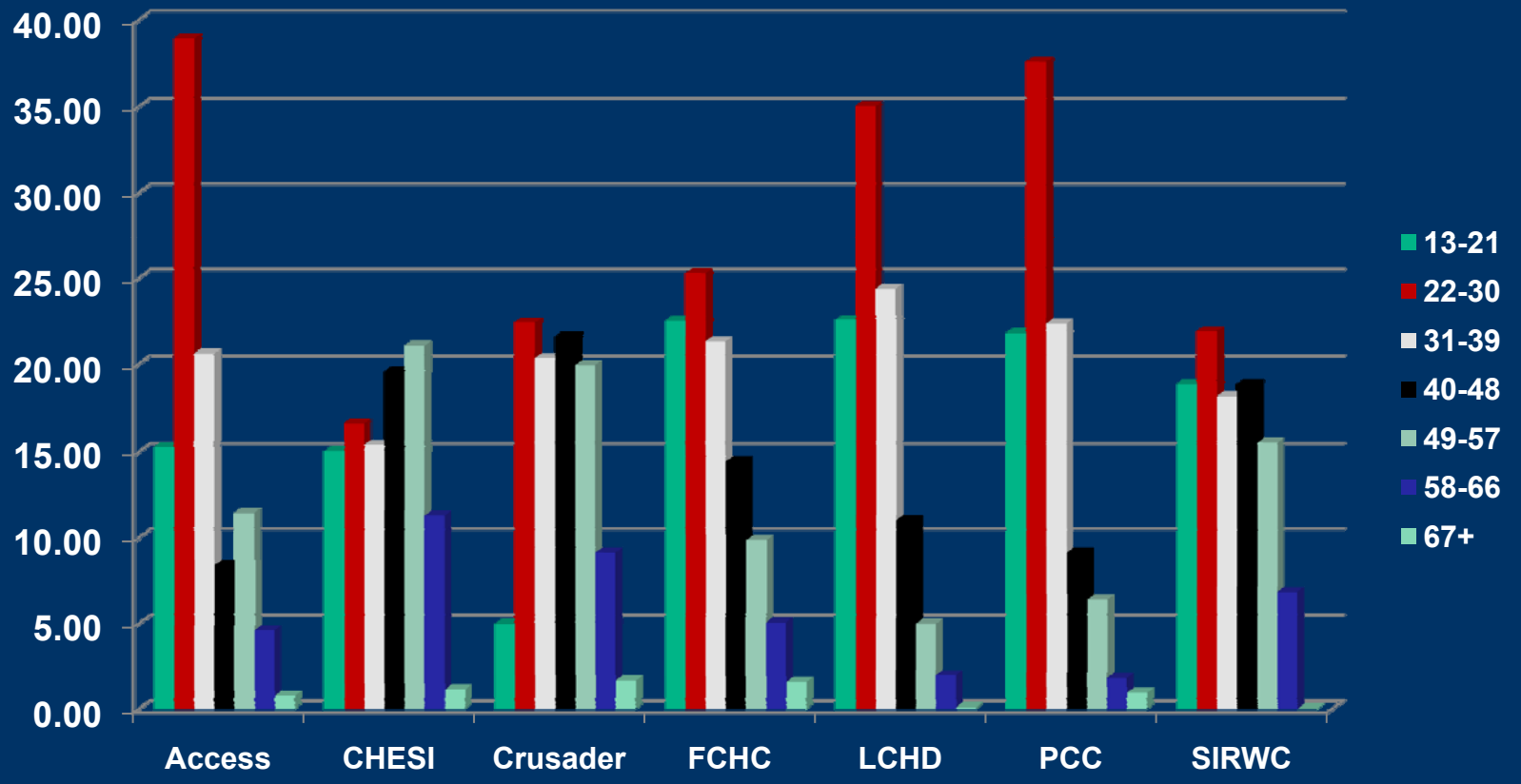
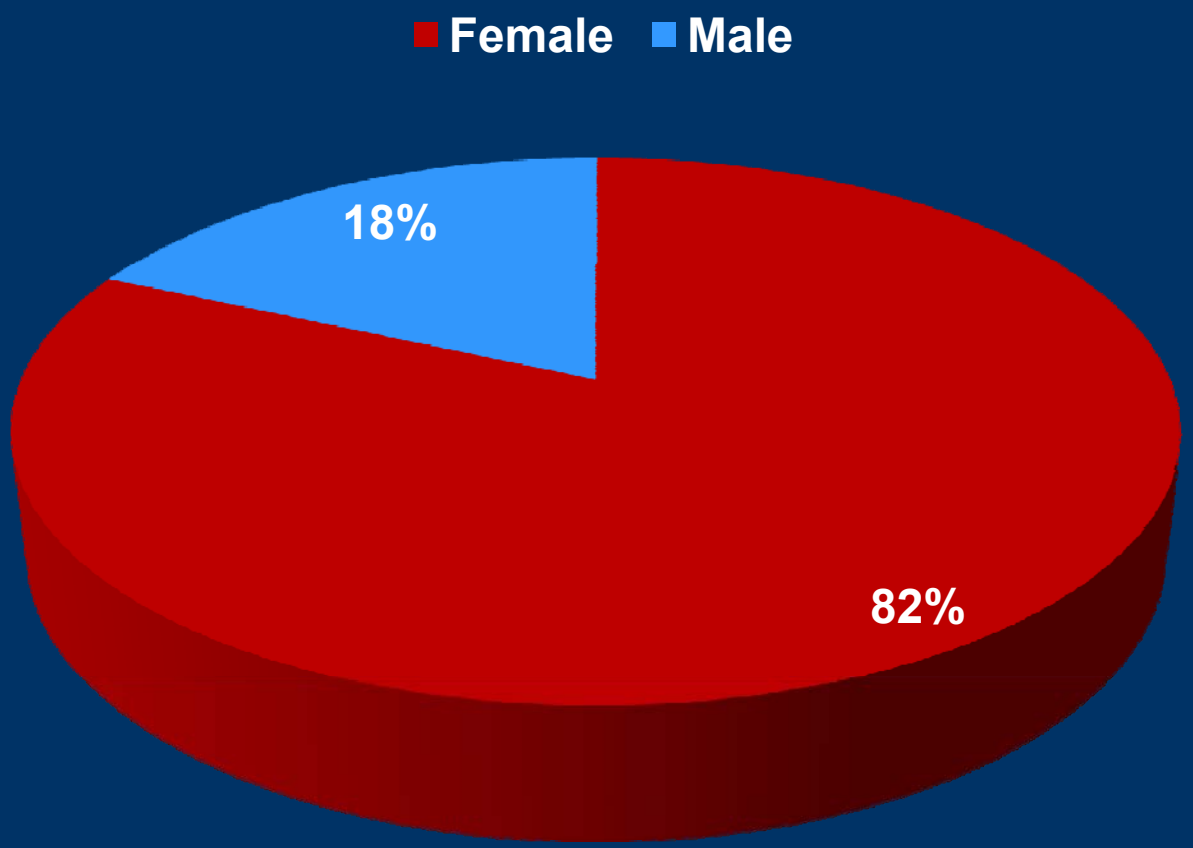
IRTI Results: Age by Site



IRTI Results: Tests by Gender



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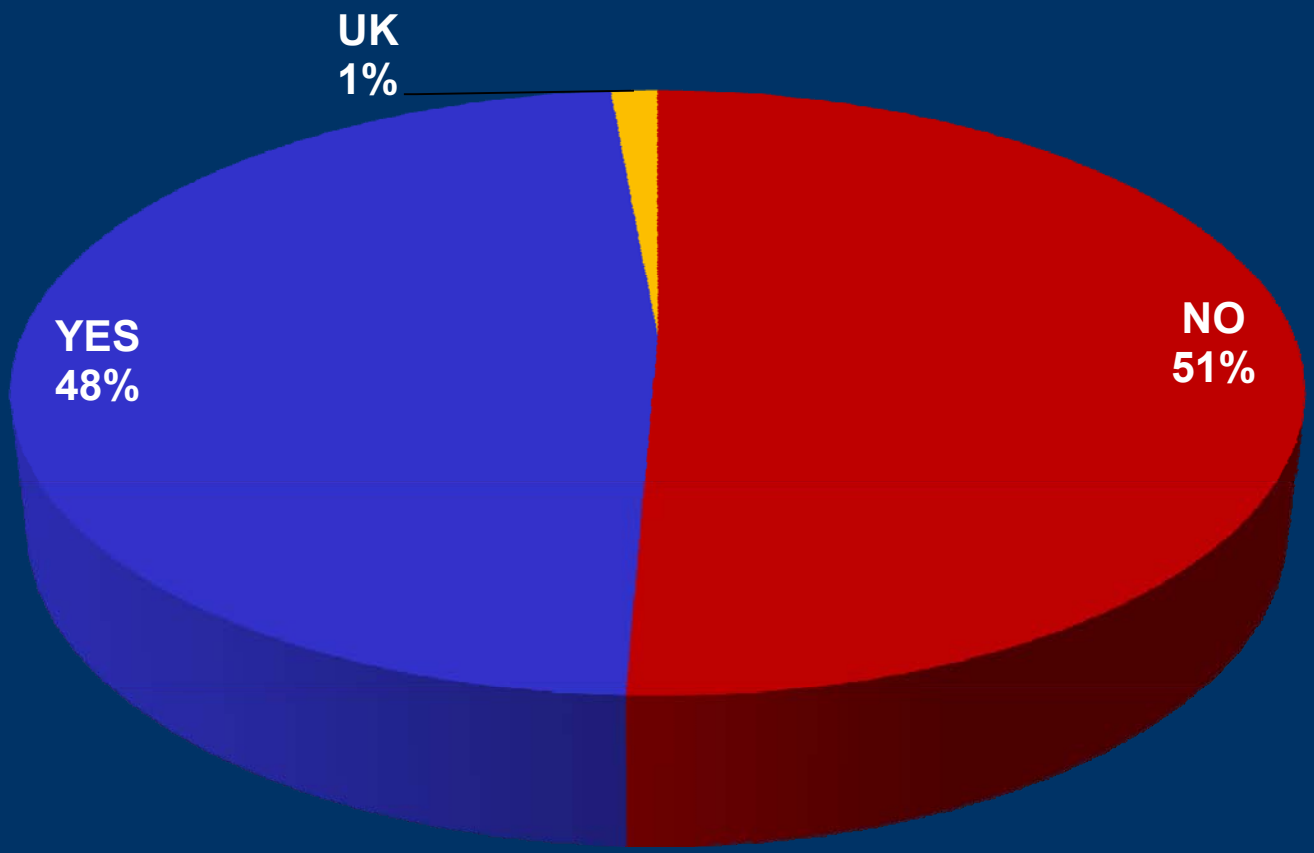
IRTI Results: Prior test?



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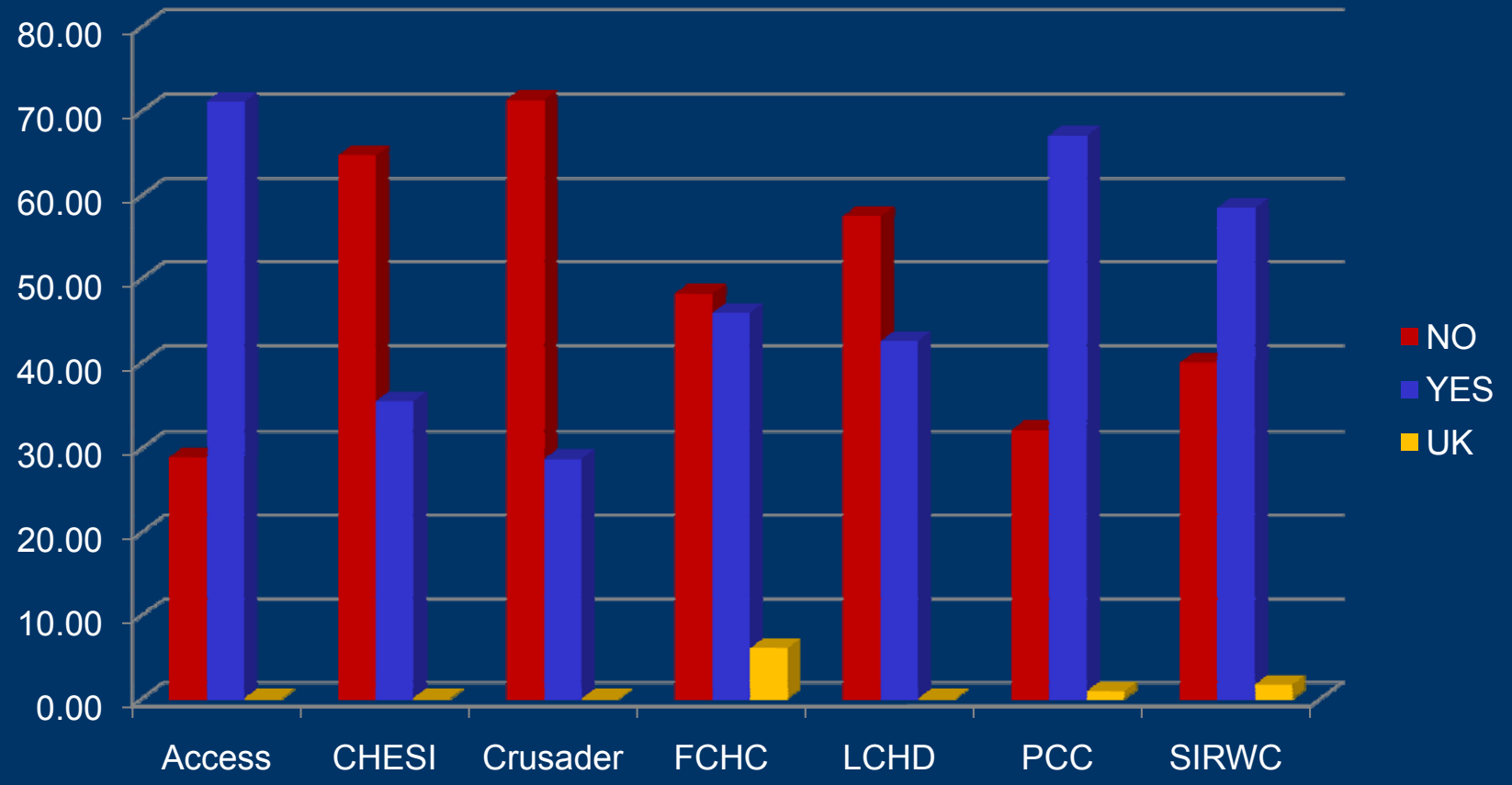
IRTI Results: Previous test by site



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IRTI Results: New HIV+ Patients

Site	Test Date	Age	Race	Ethnicity	Gender	Referral?
LCHD	9/16/09	28	W	H/L	F	RWCA A,B On site
Access	12/10/09	22	AA	NH/L	F	On site
Access	1/29/09	29	AA	NH/L	F	On site
PCC	2/4/10	29	AA	NH/L	F	CORE
Crusader	1/19/10	54	W	NH/L	M	RWCA C On site
LCHD	5/11/10	21	AA	NH/L	M	RWCA A,B On site

Challenges…

1. LATE START: The project started recruiting sites in May, leaving just five months to select and train the sites, launch the program, and achieve the testing goal.

2. SITE ATTRITION: The project is operating with one site less than was originally enrolled.

3. LEARNING AS WE GO:
   - Legal clarification for consent to test
   - Clinic flow and staffing
   - Storage, use, and interpretation of rapid tests
   - Local resources and referrals into care
   - Ordering and documentation of tests from the state
   - Confirmatory testing procedures with the state laboratory
   - Contract, budget, and stipend questions
   - Submission of data, data sharing agreement, and fax-in database

Challenges (continued)

4. TESTING “CHAMPION”: At some sites, the medical director needed to identify a “testing champion” *other than themselves* more quickly.

5. ADMINISTRATION BUY-IN: The sites where the administration invested more time for comprehensive training for providers and medical assistants are producing the highest and most consistent numbers of tests.

6. INACCURATE PROJECTIONS: Many sites used their overall number of patients as the basis for their estimate of the number of tests they would complete.

Challenges (continued)

7. PROVIDER RESISTANCE/RESULTS “NOT GIVEN”: Physicians were not uniform in their agreement that routine rapid testing should be provided to all patients, and sites experienced variable results depending on the provider.

8. MAKING TESTING A PRIORITY: Site coordinators have reported that they continually must remind medical assistants and providers that the routine testing project is ONGOING.

Opportunities for Improvement

- Recognize implementation pattern: “jump,” “slump,” then ongoing results with occasional “bump”
- Provide real time feedback to staff
- Identifying “routine” opportunities, e.g. testing all NEW patients
- Ongoing availability of test kits/affordability of technology
- Staff Incentives

Evaluation Questions

Routine screening in the real world of health centers does not mean every patient:

- Is offering tests to one third of patients “routine (enough) testing?
- What does it mean if patients opting out are different than those receiving tests?
- What does it mean if there are different rates of offering tests across health centers?
- How does prevalence fit in?
- Can training catalyze more universal access?

The Future of HIV Testing

- Routine testing is a significant philosophical and practical shift in the HIV world
- Non-HIV specific medical providers have a critical role to play in fighting the epidemic
- The costs of testing every American at least once a year are daunting; need coverage for screening
- Outreach testing and testing of social networks is critical in high prevalence communities
- Treatment as prevention, finding acute infections, prevention for positives are important initiatives

More Information

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- CDC HIV Testing Information Webpage

http://www.cdc.gov/hiv/topics/testing/index.htm