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.
Illinois
Indiana
Iowa
Minnesota
Michigan
Missouri
Wisconsin
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
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

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

Deaths per 100 PY

Year

Patients on HAART


0.9 0.8 0.7 0.6 0.5 0.4 0.3 0.2 0.1 0
Awareness of Serostatus Among People with HIV and Estimates of Transmission

- ~25% Unaware of Infection
- ~75% Aware of Infection

People Living with HIV/AIDS

New Sexual Infections Each Year: ~32,000

Accounting for:

- ~54% of New Infections
- ~46% of New Infections

Marks, et al
AIDS 2006;20:1447-50
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
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
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

Rapid HIV Test

- Inform pt preliminary results are reactive
- Give “Reactive” handout to patient
- Draw confirmatory Western Blot or RNA
  - Schedule follow-up appt in 5 days
  - Schedule appt w/social worker or other staff to counsel patient at 5 day f/u appt

Positive

- Counsel patient
  - Invite pt to meet with SW at this visit
  - Schedule consultation with medical specialist

Western Blot or RNA

Negative or Indeterminate

If RNA

- Patient NEGATIVE
  - No further follow-up

If Western Blot

- Patient likely negative unless recent risk
  - Review risks & prevention
  - Schedule 3 mo repeat test

Inform patient

- Review risks, if appropriate
- Discuss “window period”
- No further testing

Negative
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
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

<table>
<thead>
<tr>
<th>Month</th>
<th>Tests</th>
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<tr>
<td>Sept</td>
<td>286</td>
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<tr>
<td>Oct</td>
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<tr>
<td>Nov</td>
<td>600</td>
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<td>265</td>
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<tr>
<td>Jun</td>
<td>176</td>
</tr>
<tr>
<td>Jul</td>
<td>308</td>
</tr>
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</table>
IRTI Results: Tests by Site

Access: 135
CHESI: 269
Crusader: 332
FCHC: 835
LCHD: 1844
PCC: 735
SIRWC: 464
IRTI: Total Tests By Race

- AA: 52%
- W: 24%
- O: 22%
- A/PI: 1%
- UK: 1%
- AI/AN: 0%
IRTI Results: Total Tests by Ethnicity

- NH/L: 68%
- H/L: 32%
IRTI Results: Tests by Age

<table>
<thead>
<tr>
<th>Age Interval</th>
<th>Test Result</th>
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<tbody>
<tr>
<td>13-21</td>
<td>20.47%</td>
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<tr>
<td>22-30</td>
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<td>31-39</td>
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<td>49-57</td>
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<td>58-66</td>
<td>3.98%</td>
</tr>
<tr>
<td>67+</td>
<td>0.63%</td>
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IRTI Results: Prior test?

- YES: 48%
- NO: 51%
- UK: 1%
# IRTI Results: New HIV+ Patients

<table>
<thead>
<tr>
<th>Site</th>
<th>Test Date</th>
<th>Age</th>
<th>Race</th>
<th>Ethnicity</th>
<th>Gender</th>
<th>Referral?</th>
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<tbody>
<tr>
<td>LCHD</td>
<td>9/16/09</td>
<td>28</td>
<td>W</td>
<td>H/L</td>
<td>F</td>
<td>RWCA A,B On site</td>
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<tr>
<td>Access</td>
<td>12/10/09</td>
<td>22</td>
<td>AA</td>
<td>NH/L</td>
<td>F</td>
<td>On site</td>
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<td>1/29/09</td>
<td>29</td>
<td>AA</td>
<td>NH/L</td>
<td>F</td>
<td>On site</td>
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<td>PCC</td>
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<td>29</td>
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<td>NH/L</td>
<td>F</td>
<td>CORE</td>
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<td>Crusader</td>
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<td>54</td>
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<td>NH/L</td>
<td>M</td>
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<td>21</td>
<td>AA</td>
<td>NH/L</td>
<td>M</td>
<td>RWCA A,B On site</td>
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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
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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• Shelly Ebbert, at MATEC: 312-996-0180
  shellye.matec@gmail.com

• CDC HIV Testing Information Webpage
  http://www.cdc.gov/hiv/topics/testing/index.htm