



NATIONAL ASSOCIATION OF
Community Health Centers



America's Voice for Community Health Care

National Association of Community Health Centers (NACHC)

Who We Are

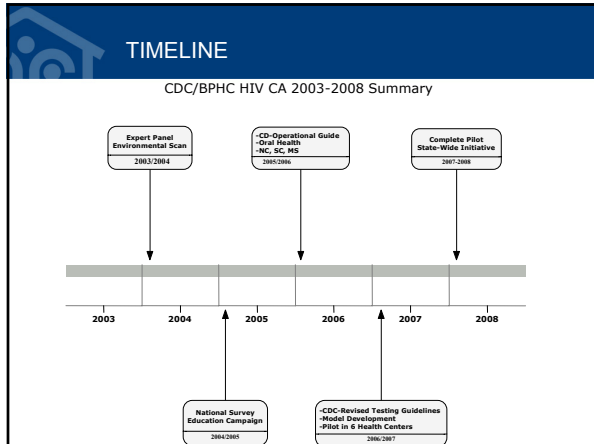
NACHC is the national trade association serving and representing the interests of America's community health centers

Our Mission

To promote the provision of high quality, comprehensive health care that is accessible, coordinated, culturally and linguistically competent, and community directed for all underserved populations

Agenda Implementing Routine Screening in Non-Ryan White Funded Health Centers

- Background
- Health Center Implementation Model
- The Reality
- Results



Health Centers cont. HIV

33% RWCA Title III grantees are health centers

10% of health centers receive RWCA Title III funding

HIV services are available at both RWCA-funded and non-funded sites

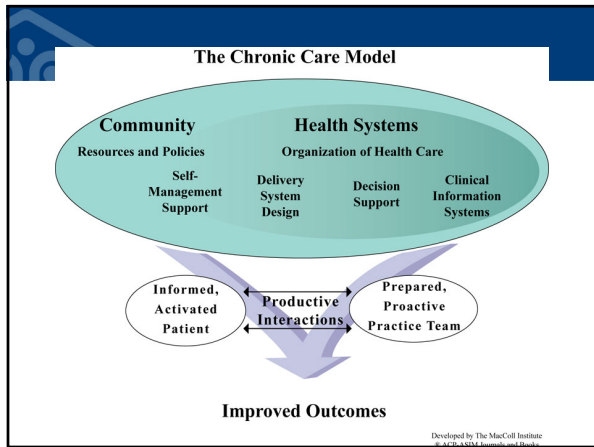
Health Centers cont. HIV

- 61,032 Health Center users with symptomatic HIV
- 25,035 Users with asymptomatic HIV
- 668 Pregnant users known to be HIV-positive
- 503,887 Users received an HIV test

2007 Uniform Data System (UDS)
-17 million patients
-6,300 sites
-1,150 organizations

Guiding Principles

- Unit of analysis is the **Patient**
- **HIV** is a chronic disease
- Routine testing across organization same day
- Apply redesign and Collaborative learning models, change theories, and lessons learned
- Build on existing infrastructure
- Leverage Community and State Partnerships
- Intense coaching to create momentum, trust, support, and quality outcomes



Redesign Principles

- **Don't Move the Patient.** This principle focuses on the importance of organizing the work of a patient visit around the patient rather than organizing the patient around the work. For instance, this means that a center should avoid moving patients from place to place during a single visit (e.g., check in area to a vitals room then on to the exam room). Rather, the goal is to deliver routine services to patients in the exam room.
- **Increase Clinician Support.** This principle assumes clinicians can be optimally productive only with optimum support. This requires that practices ensure the proper ratio of nursing or other support staff to clinicians as well as being sure clinicians are focused on clinical work, not other supportive services that can be delivered by other members of the care team.
- **Create Broad Work Roles.** This principle emphasizes the importance of cross-training staff to perform multiple roles. For example, nursing support can open the patient visit in the exam room rather than relying solely on front desk staff. Another example, relevant to our current effort, is having nursing staff perform the oral swab rapid HIV tests in the exam room. Similarly, we want to remove or reduce narrow specialization, such as an "HIV Counselor," when integrating HIV testing into routine primary care (with those patient testing positive or preliminary positive still requiring counseling by someone knowledgeable and experienced in this process).

Redesign Principles

- **Organize Care Teams.** This principle speaks to the high quality, integrated care that comes when a patient care team works together day in and day out to meet the needs of a defined patient population. This team learns to work well together, anticipate each others needs, and become more intimately familiar with their patient panel.
- **Communicate Directly.** Direct communication in real-time helps insure that patients need are met, and met in a timely manner. Direct communication also helps eliminate errors and misunderstandings that can occur when notes, voice messages or other indirect methods of communication are used.
- **Start All Visits On Time.** This principle speaks to the importance of a health center, and each care team, being prepared for the day that lies ahead and beginning the first patient visit of the day on time. Delays at the start of the day have an impact on all visits that follow.

Patient Flow Model

```

    graph TD
      FrontDesk[Front Desk] --> WaitingRoom[Waiting Room]
      WaitingRoom --> VitalsArea[Vitals Area]
      VitalsArea --> ExamRoom[Exam Room]
      ExamRoom --> Laboratory[Laboratory]
      Laboratory --> CheckOut[Check Out]
  
```

HIV Rapid Test

Mini Lab
Nurse escorts pt to mini lab for fingerstick/HIV Rapid test.

Front Desk
Front desk greets patient and determines whether they are an appt or walk-in. Walk-ins are offered a same day appt if available (then proceed as an apportioned patient). Front desk registers the patient, verifying insurance and demographics. Encounter form is printed and handed to patient who places it in a bin in the hallway for pick-up by nursing staff.

Waiting Room
Patient reviews HIV testing information available in waiting room.

Vitals Area
Nurse escorts patient to vitals area for height (pediatrics), weight, temperature, and blood pressure. Nurse/MA carries timer to alert them test is complete.

Exam Room
Patient escorted into exam room by nursing staff. Provider performs clinical exam; orders necessary follow-up visits and/or referrals. All results, negative or reactive, are given by provider.

Laboratory
If blood work necessary, provider writes an order. Patient carries lab request to the lab for blood draw.

Check Out
Patient takes encounter form and proceeds to check out area for co-payment and scheduling of next visit.

HIV Screening Algorithm

```

    graph TD
      Start[Patient accepts test] --> Neg[NEGATIVE  
No action]
      Start --> Reactive[REACTIVE  
Draw Western Blot  
CPT#96689 Lab Corp test #005462  
(Do NOT draw Screening "HIV" test)  
Counsel Patient  
Give "Reactive" handout  
Confidentially notify Lab Director]
      Reactive --> WB_Neg[Western Blot  
NEGATIVE  
Repeat in 3 months]
      Reactive --> WB_Pos[Western Blot  
POSITIVE]
      WB_Neg --> WB_Neg2[Western Blot  
NEGATIVE  
No Action]
      WB_Neg --> WB_Pos2[Western Blot  
POSITIVE]
      WB_Pos --> Ref[SEE REFERRAL GUIDELINE  
Counsel patient  
Given "Day 1" handout  
Schedule ID appt  
Forward Medical Records]
  
```

HIV Testing Model

- Nursing offers HIV screening during intake process:
 - ✓ *Rapid HIV test offered to ALL patients 13-64 yrs of age*
 - ✓ *Patient has the opportunity to refuse testing*
 - ✓ *Sample obtained during time of intake*
- Data collected on acceptance/refusal and other key data
- Nurse or provider delivers results (all reactive results delivered by provider)
- Confirmatory testing done at time of visit for all reactive results


Implementation Model 3 Months

- **Pre- Work**
 - On-site needs assessment and Leadership buy-in
 - External partnership building
 - Assessment of current model; Design of Routine HIV screening model
 - Create data collection system and tool
 - Build/enhance referral arrangements
- **Kick-off**
 - Host an all staff workshop and educational forum
 - Train staff in HIV Rapid Test
 - Institute process for data collection

Implementation Model

- **Launch**
 - Implement Routine HIV screening and data collection organization wide
- **Maintenance**
 - Periodic site visits
 - Intensive coaching
 - Linkage to local/state training and support
 - Review, feedback and correction of data

Aaron E. Henry Community Health Center



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Clarksdale, MS 38614
(622) 624-4262

Aurelia Jones-Taylor, MBA, CEO
William L. Booker, M.D., Chief Medical Officer
Mary Burnett, Nurse Practitioner

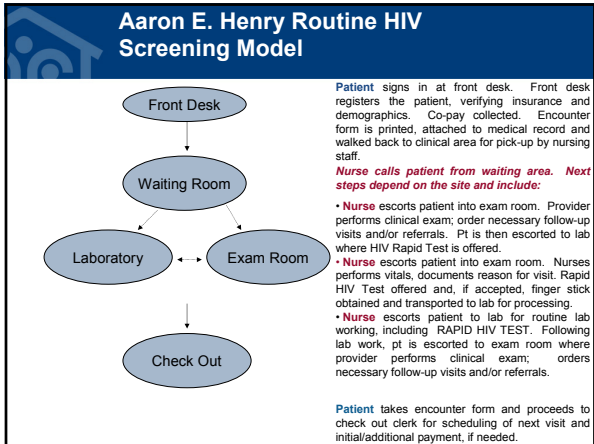
Who We Are

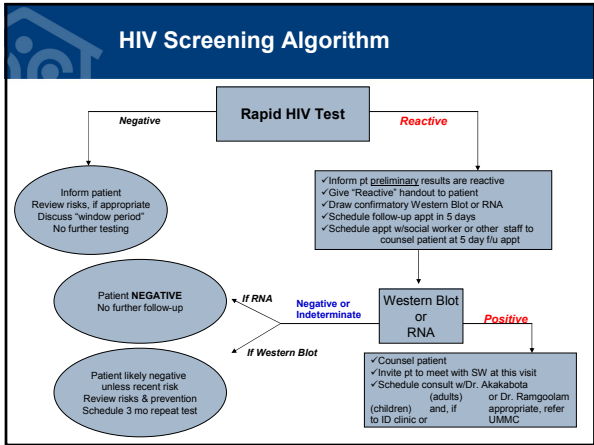
- Founded in 1979, the health center is a Federally Qualified Health Center with a mission to provide access to comprehensive primary and preventative health services.
- Located in the Northwest corner of the State of Mississippi, we have nine multi-specialty locations in five rural counties.

**Health Center Demographics
FY2007**

# of Clinical Sites	4
Urban vs.. Rural	Rural
# of Users	15,000
# of Encounters	29,000
Racial/Ethnic Breakdown	African American 99%
% Uninsured	46%
Distance(miles) to closest Ryan White Title III Program	24 miles

Routine HIV Screening Start Dates
February 7, 2007 Six clinical sites; One month Dental pilot
April 23, 2007 Two School-based clinics





HIV Testing Data

Pre Routine HIV Screening 2006		Routine HIV Screening February 8, 2007 - March 31, 2008	
# of HIV tests (Non Pregnant)	135	# of HIV tests offered	2,992
# of HIV tests (Pregnant)	141	# of pt population offered testing	30%
		# (%) of patients accepting HIV test	2,496 (83%)
		Composition of those accepting testing vs. not accepting*	Women 67% vs. 61% Men
		# (%) of HIV tests refused	496 (17%)
		Primary reason for refusal: Do not believe at risk	44%
		% of those tested for which this was 1 st HIV test	58%
		% of those who have had 3+ previous HIV test	12%
		# reactive to-date	16
		# reactive with positive Western Blot	8

*compared gender, race, and insurance status

The Human Impact				
Patient	Site	Positive Test Date	Patient Receiving HIV Care	Health Status At Diagnosis
1	Batesville	1.16.08	Akakabota	CD4 = 82 (1.1.6.08) Viral Load = 33,350 (1.16.08)
2	Batesville	6.11.07	Akakabota	CD4 = 311 Viral Load = 90,000
3	Clarksdale	7.30.07	Hill	CD4 = unknown Viral Load = unknown
4	Clarksdale	9.05.07	Akakabota	CD4 = 344 Viral Load = 10,180
5	Clarksdale	9.12.07	Akakabota	CD4 = 255 (9.17.08) Viral Load = 139,820 (9.17.08)
6	Clarksdale	9.25.07	Booker	CD4 = unknown Viral Load = unknown
7	Clarksdale	11.10.07	Hill	CD4 = unknown Viral Load = unknown
8	Tunica	5.11.07	Referred to DOH Pt refused treatment	CD4 = not done Viral Load = not done

- ### What Worked Well
- Simultaneous rollout of routine HIV screening at all clinic sites worked well.
 - Very high acceptance rate for rapid testing among patients.
 - A key cohort of staff persons offer the majority of rapid tests to patients.

- ### Aaron Henry Community Health Services :What We Are Doing Now!
- Complete Staff Buy-in
 - Staff Education
 - Partnerships: Keeping Patients in Care

Results

- Start-up of routine HIV screening took < 3 months per organization
- Six (6) health centers (19 clinical sites) in three southeastern states participated
- In one year, approximately 18,000 pts accepted HIV rapid testing as part of their routine primary care visit

Routine HIV Screening in Primary Care Settings:
Evaluation Results from
Six Non-Ryan White Community Health Centers (21 sites)

Janet Myers, PhD, MPH
University of California, San Francisco

Supported by Gilead

Patient Perspectives

"It was fine, easy, quick. Kind of like the idea that it's free and it's part of care like weight, blood pressure... When it was offered, she said it matter of fact. It's free, takes ten minutes."

Who Opts Out?

- Primary reason for refusal:
 - Patient doesn't perceive they are at risk (69%)
 - Recently tested for HIV (26%)
 - Doesn't want to today (10%)
- Providers indicate that walk-ins are less likely to test

Demographics of Patients Offered Screening

- Compared to general clinic population, African Americans and Whites were more often offered the test; Latinos were less often offered the test
- Uninsured were more likely to be offered testing
- Women and men equally likely to be offered testing

Demographics of Patients Receiving Screening

- Patients under 55 years of age were significantly more likely to receive testing
- Women were more likely to be tested than were men
- African Americans and Latinos were significantly more likely to receive testing than were whites
- This difference was more pronounced among Latinos. Three-quarters of Latinos received tests, compared to half of White men and 58% of White women
- A patient's insurance status was not associated with whether a patient was provided a test or not

Challenges - Technology

"It didn't occur to us to make a plan for false positives. We didn't hear that part during training. We panicked when we had our first one. We can't wait three months to do the screening again. We want to know now because the patient could really be positive."

-- Medical Provider

Challenges - Technology

"I am surprised by the data. I thought we would have more confirmed cases. I am surprised based on some judgments I made but now I wonder if we need to make more effort to reach those who are really positive. We know it is there. Do we need to offer the test to non-patients?"

--Medical Director

Conclusions

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 that patients opting out are different than those receiving testing?*
- *What does it mean that there are different rates of offering tests across health centers?*

Conclusions

There were demographic differences in offering and receiving tests:

- Can training catalyze more universal access?
- Translation/interpretation a barrier?
- Men are less likely to test – different strategies needed?

Conclusions

False positive results may be an issue in low prevalence settings:

- Can false positives be avoided? Anticipated?
- Do we need a new algorithm (e.g. two rapid tests)?

Conclusions

Implementing HIV screening is feasible and acceptable to patients and providers in community health centers, but cost is an issue:

- How can access to HIV testing be maintained in light of the issues and challenges identified?
- How can we fund screening?
- Who should be responsible?

Conclusions

Seventeen new confirmed infections were identified:


- *How can referral and retention in care be improved?*

Lesson Learned

- Design Systems to meet needs of the patient
- Infrastructure is a barrier
- Systems design needs to incorporate primary care and non Ryan White Funded Programs.
- Prevalence plays a role
- Keeping patients in care
- Where is the role of corrections and mental/behavioral health in HIV


Next Steps 2008 - 09

- Web-based page to access tools, resources, and ask the experts
- State-based Model with State Health Department as the Lead



“We live in this community, and know that this disease is not about someone else – it’s about our families and our neighbors. It’s about us.”

Ms. Aurelia Jones-Taylor



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