WEBINAR VIDEO TRANSCRIPT

Partnership for Care HIV TAC

Sustaining Integrated Care:
Making the Business Case for Routine HIV Screening and Care

15 March 2017

STEVE LUCKABAUGH: Good afternoon. My name is Steve Luckabaugh, and I'd like to welcome you to the Sustaining Integrated Care, Making the Business Case for Routine HIV Screening and Care webinar. This webinar is brought to you by the Partnerships for Care, HIV Training Technical Assistance and Collaboration Center, HIV TAC. The Partnerships for Care project is a three year, multi-agency project funded by the secretary's Minority AIDS Initiative Fund and the Affordable Care Act.

The goals of the project are to expand provision of HIV testing, prevention, care, and treatment in health centers serving communities highly impacted by HIV, to build sustainable partnerships between health centers and their state health department, and to improve health outcomes among people living with HIV, especially among racial and ethnic minorities.

The project is supported by the HIV Training Technical Assistance and Collaboration Center, HIV TAC. Our speaker today is Malinda Boehler. Malinda earned a Bachelor of Social Work and a Master of Social Work from Indiana University School of Social Work in Indianapolis. She is a licensed clinical social worker and she practiced at the Wishard Infectious Disease Clinic as an HIV Care Coordinator for nearly 10 years, before accepting a position at the Midwest Aids Training and Education Center, MayaTech Indiana.

In addition to her role as director of MayaTech Indiana, Malinda also serves as the original coordinator of the clinicians Scholars Program, a program designed to build HIV care capacity in the Midwest. In late 2014, Malinda was selected to lead an innovative project at Eskenazi Health to implement routine HIV screening at 10 community health centers and to take expert HIV care into the community.

She is also a member of the Marion County Public Health Department's Ryan White Planning Council, Part A, Part C, and the Indiana State Department of Health Comprehensive HIV Services Planning and Advisory Council, CHSPAC. Please join me in welcoming Malinda Boehler.

MALINDA BOEHLER: Good afternoon, everyone. This is Malinda. I look forward to doing that presentation today, and again, if you have any questions at all, please type those in and I will perform. As for disclosures, I have no financial interest to disclose.

Learning objectives, so at the conclusion of this activity today, I hope that everyone who's participating will be able to describe the HIV expansion project at Eskenazi Health with a focus on routine HIV screening, and I hope to do that so that you're able to compare your organization or your setting, to what we've done here.

So that's why I'm talking about it, but also to discuss the importance of engaged leadership. We'll talk about this more as the presentation goes on. But looking back, I think that is a major key and we'll talk about how we did that. And then finally, hopefully we'll be able to explain the elements of making the business case to support routine screening, because again, we've all worked so hard to get these projects started. We would hate to see them go away when the targeted funding goes away.

So I thought we should first just do a little overview of what HIV looks like in Indiana so you can understand what we we're up against as we started this project. So as of December 31st of 2016, we had about 12,175 people total living with HIV and AIDS in Indiana. So again, not a super high prevalence state, but again, not a super low prevalence state.

Some of you might recall that Indiana was boosted into the Spotlight in mid December with an HIV outbreak in southern Indiana. Through today, we have had 214 identified HIV infections. These are new HIV infections, primarily related to IV drug use and sharing of needles in southern Indiana. And this was a big deal because this town only has 2,000 or 3,000 people total in their population, and through 2013, they had had less than five cases total.

I have put the link to the Indiana State Department of Health website and they have more information about the outbreak. I know that there was a lot of media attention. Somethings were maybe blown out of proportion more than others, but this is a really good place to go to look for what the state health departments was releasing, which was good information about the outbreak. And the little plus there is we do have a couple of pulmonary positives, but again, every preliminary positive we've had, has turned into a new infection.

So I thought, again, to give you a little perspective I would talk about Eskenazi Health. This is an image of our brand new campus. We just moved into this building in 2013. But before you get jealous, I want you to see where we came from, which was we used to be called Wishard, and this is a picture of part of the older part of our campus.

Our building was over 150 years old and our medical director used to say, "If you're in the hallway and you feel a leak, get out of the way because we don't know what's coming." So again, it hasn't always been so fabulous, but it is pretty fabulous in the new building, and we did have a name change because when you donate $40 million to a new hospital, your name goes on everything.

So a little bit about Eskenazi Health. It's called the Sidney and Lois Eskenazi hospital for the reasons I've explained earlier. We are a teaching hospital. We have the first level one shock trauma center. We have a regional burn center.

Our midtown community mental health centers are a huge component of the mental health system here in Indiana. They have 21 sites and approximately 400,000 outpatient visits per year. We also have some inpatient. And that what we'll talk about, primarily, is our Eskenazi Health Center.

We have FQHC designation and we operate at 10 sites, and we have approximately 1 million outpatient visits per year. So again, I say all this just so you can kind of tie what I'm talking about to how closely it relates to your own organization.

The payer mix, I thought that was important because again, it always, when you talk about sustainability, come back to money, and this gives you a little bit of an idea of where our money is coming from, primarily Medicaid and uninsured.

The uninsured, we still are getting some disproportionate share money to help with those folks. We are trying to move them onto HIP 2.0, which is Healthy Indiana, which was our answer to not expanding Medicaid here in Indiana. But you can see very little commercial, very little other. We're mainly surviving on public insurance.

So why Eskenazi? Why did we do this project here? We've been serving the residents of Marion County for over 150 years. We're one of America's five largest safety net hospitals and we feature-- it's a public hospital with acute care and also pharmacy.

So in our situation, we not only can care for people and provide specialty care and primary care, they can also get the prescriptions they need here, regardless of their ability to pay. And the mission is really to serve the most vulnerable populations of Marion County. With that said, we don't really turn anyone away, even outside of Marion County.

So we were lucky enough to be awarded $1 million to expand HIV screening, here at Eskenazi Health. We received the notice of grant award in October, and of course, they wanted us to start right away. And the initial project period was November 2014 through December 31st of 2015. So they wanted us to accomplish all of the goal within 13 months, which I'm sure you all know how crazy as that sounds because you've been there and done that.

Our project objectives were to implement routine HIV screening at six health center locations, develop a traveling HIV care team to provide HIV care at these six locations, and begin offering PrEP. Again, we've talked about that we ended up expanding to 10 and I think we talked about that a little bit later.

To talk about the successes of our project and we actually had to extend our project twice. So of course, in December 31st, we weren't anywhere near the completion of our project. It took much longer than the grant writers anticipated for us to do this project, but we accomplished a lot in the time that we had. We trained over 200 nurses and medical assistants to offer, conduct, and interpret routine HIV screening.

We ended up implementing routine HIV screening at 10 Eskenazi Health locations and then two of the midtown locations. And you might ask, how did that happen? Well, it happened because of a miscommunication and all health centers were invited to the kick off meeting, not just the six that we had targeted. So once that happened, we felt like we needed to move forward because we had people who were interested at those sites in championing testing. And once you have that buy-in, you don't want to say oh, we really didn't mean you. So we were able to take on the 10 centers.

And then four of the midtown locations, that happened when we asked for our second extension because we had money left. We had not spent down our million dollars, and again, we just had this huge HIV outbreak all related to substance use and needle sharing. We thought it would be a mistake not to expand to our addiction treatment centers. So that's when we proposed adding those two locations.

And through June of 2016, we had screened almost 12,000 patients for HIV. And this was huge because at baseline, we were screening very few non-pregnant patients, even in cases where they had been assessed for other STDs. So they could come in and get a full STD panel that did not include HIV screening. So we were very pleased to see these numbers in such a short amount of time.

We also identified 15 new cases of HIV infection. So definitely meeting the CDCs threshold for positivity rates. And again, in many of our health centers, the ask rate was still only at about 30% or 40%. So we always look back and think wow, how many cases would we find if we were optimally offering HIV screening at thee sites?

What happens when the funding ends? So we had put blood, sweat, and tears into this project developing policies, and protocols, and training. And we just weren't sure what was going to happen when the funding ended. So in the beginning, we started thinking about sustainability and evaluation.

So our approach in this was to focus on sustainability from the start, recruit and engage our leadership at all levels, and learn as much as we could about how much routine HIV screening cost in your system. When I say focus on sustainability from the start, we had three primary work groups on this project. A model of care team, a testing and training team, and a sustainability evaluation team.

Sustainability evaluation was responsible for keeping the project going post funding. They were always looking at testing data from the clinics, selecting a device, how much was it costing, and reporting on challenges and successes as we've gone along. So this was really important, because we knew from the start if we were going to ask our hospital in this financial environment to carry this on, we had to keep our costs low and show that we were making a difference.

Recruiting and engaging leadership, crucial to our project, and I'm sure crucial to yours. But it's really getting leaders from all levels of your organization and service lines involved. So we had senior leadership, we had CMO, COO, we had service line leaders. So people from infectious disease, people from billing, people from the lab, people from primary care, and when I say engage them, I mean get them to your meetings. We had to do things like provide snacks, have the meetings over lunch, provide lunch, send them updates via email.

One of the things we did was created a project newsletter, which was a great way to share our successes, really highlight some of our centers that were doing exceptionally well, and talk about best practices or changes because of course, throughout this project, we had a lot of changes. Update them in the elevator. So everybody who's working on your team should have like a three minute elevator speech.

Hi, how are you doing? I just wanted to let you know that the routine testing project is going exceptionally well. We found another positive last week. Saved another life. That kind of thing. And then if there's a problem, they should be the first ones to know and to know how you're managing it so that things don't crumble around you, because a small problem or a misunderstanding, can really spread through your project and do a lot of havoc in a very short amount of time.

Know the cost. And I almost want to laugh when I say this because trying to determine what things cost in a health system is pretty ridiculous. It's very hard to get a clear answer about what things cost versus what we bill. So know the price of the rapid test that you're using. That's pretty standard. Know that the manufacturers of these tests will be very competitive to keep your business.

We were able to lower our price by nearly 30% by just making a phone call and having a meeting to say that we were looking to change. Know what your reimbursement is for the rapid test. Know how much the cost of confirmatory testing is. Know what your reimbursement for confirmatory testing is and then the cost of any new staff that's part of the project.

For our project, we had no new staff doing testing. The staff we had was the care team that was going to go out and we had one person that was the training quality control person. And that is a full time job because what we realized, if you don't have someone minding the shop all the time, it's really easy for health centers to go in a different direction, or focus their attention somewhere else if they think that you're not watching something.

Thinking in terms of a business plan. This is something, again, you heard my background is social work. I did case management. Now I do training. Nowhere in my education have I ever been taught to develop a business plan, yet when we were coming to the end of our funding, we were told we needed to develop and submit a business plan that we would present to what's called A New Site New Service Committee. And this committee is made up of leaders from all throughout the hospital, I mean everywhere from food service to emergency, and they want to know all of the details.

So we had to draft a business plan. I would say the first thing I would suggest is to talk with other departments in your organization and see if anyone has done this before you because for me, getting a copy of a business plan that had been approved was a priority for me. I needed to see what the committee might be looking for.

But here, you will see some major components of what we included, which was background and service description. Don't assume that the people you're writing to know anything about HIV or why this is needed. Accomplishments, all of those things that we have done, how it aligns with your organizational mission and strategy, a SWOT analysis, a marketing plan, targeted metrics, how do you know you're making a difference, what are you measuring, and then return on investment.

Again, background and service descriptions, you need to remind the people that are reading it that HIV continues to be a problem in the United States and your state. Back this up with the latest data. I mean, it's hard to believe, but until we experience that HIV outbreak that I talked about earlier, many people believed that HIV was no longer a problem in the United States or Indiana.

So when you write this plan, back it up with your state data. Explain that we know now that early diagnosis and treatment improve health outcomes, saves money, and reduces transmission, and all of those things you can back up with resources and references in your plan.

Pilot accomplishments. You can consider everything you've done up until the time that you're submitting a plan to move forward, making something permanent that you're asking them to fund, considered a pilot, and they should know about all the accomplishments, no matter how big or small. The number of staff trained, the number of sites that are now testing, the number of tests done, the number of HIV cases identified. Everybody on your team should, again, know these, and share these successes when they're interacting with anybody in the hospital, even before and after you present the plan.

It's also important to wrap some details in these new cases. One of the first cases that we identified is someone we had been providing care for more than 10 years and she was misdiagnosed with lupus. That hit home when they realized that we missed something, and that because of that miss, this person has not had the access to the treatment and the care they need. That hits them really hard.

Alignment with mission and strategy. I know right now many health systems are struggling, financially, and we all have strategic plans. We all have a well-defined mission. You need to let him know how routine HIV screening aligns with that mission. Quality, we want to decrease the likelihood of missing an HIV infection or having a missed diagnosis.

Financial stewardship, earlier diagnosis and treatment improves outcome and saves money. One of the things we tried but were unsuccessful at, was trying to track the number of people

who get hospitalized with a new infection and how much that costs the system. Meaning if we would have identified them out in their primary care site before they went to the ED with an opportunistic infection, we would save the system money.

SWOT analysis. So I know that this is actually the SWOT analysis that we submitted. I think most of you are probably familiar with this. Strengths, weaknesses, opportunities, and threats. Some of the things that we identified as weaknesses were varied levels of support with senior leadership. So we had some leadership changes right after the project began, and it kind of got passed onto someone else Well, that new person doesn't have the enthusiasm for the project that the original person does.

Many primary care providers were not really embracing routine screening versus risk based. They felt like oh, I can't ask my patients about this because they're not at risk, even though we've established they can't assess that. Threat, the stereotypes and generalizations again, a lot of these might be similar for what you have experienced.

Marketing plan. Think about how you can market the new service, both internally and externally. Again, the e-newsletter was really important to us. It lets our internal partners know what's happening and know who to contact with questions. So every e-newsletter highlighted a success that was happening. It also provided phone numbers and emails to everybody who was on the team, and so that was really important.

We also used some of our money to do community campaign. So some of your current funding to bring more people into your system. Grant funds to promote HIV services in whole. So we've wrapped a lot of things together. So we've wanted press, we want routine testing, we want our HIV care. So we are currently working with an external marketing company with some of our grant funding from that original grant to do this. So it's really exciting, that again, it's a way to grow a service line within your hospital.

Targeted metrics. So we need to always be clear when we're doing these projects that successes are measurable. Sometimes I feel like I'm working really hard and there's no way to actually prove that I've done anything or I've made any kind of change, and I had to rethink that for this project. So we want to talk about the number of staff trained, so the number of people who now are capable of doing routine HIV screening and offering PrEP.

We want to be able to track the offer rate for routine screening and we did that by they have to document in the medical record whether they've offered or not. We looked at acceptance rate for screening. We looked at the number of new cases of HIV that we had linked into care. We looked at the new cases that we had engaged. We looked at the new cases we had virally suppressed. We also looked at the number we had engaged in PrEP.

And then what I left off of this slide, which is of critical importance, we were able to show that by increasing the awareness of HIV, we were able to bring some people into care who knew that they were HIV positive already. They knew they were HIV infected. They were kind of living

at our health centers getting their primary care, but had not fully engaged in HIV care. So that was an important group that we reached.

And then we also worked with the infectious disease clinic because then again, we have this new care component and they had no caseload. So we worked with the infectious disease clinic and said, give us a list of everybody who is not in care right now, who's fallen out of care in the last 12 months, and they were able to reach out to that group of people and say hey, we are now offering care at your local community health center. Would you be interested in having a visit? So things like that. So anything that you can actually measure, start measuring now, or try to go back and do some measuring.

Return on investment. So this was probably, again, the most foreign concept to me. It's the total process of looking at the total cost of the project compared to expected return on investment, like how we can bring in funds. This is where knowing those costs are important. Revenue from testing. Did you get an increase in Ryan White funding? I know here we have Part A and Part C. They have some EIS money that they have now given us some additional money to support testing that we hadn't got before.

Increased ambulatory visit. Again, now that those folks are diagnosed, they're coming to the doctor more. So that equals more money to the health system. Increased revenue from HIV drugs. We send them through our pharmacy. HIV patients typically have a payer, so that's revenue from drugs. Increased revenue from a Hep C, again, because we have such high co-infection rate, cost savings from earlier diagnosis and treatment.

So that cost avoidance, how we can avoid a hospitalization, and again, the cost of having a pharmacist on our team. So that was part of our traveling care team as a pharmacist. And having him look at things, again, how are we avoiding additional costs? So you've got to look at it twofold. How have you increased, and then also how have you avoided new costs, and that gives you your return on investment.

So final thoughts then lessons learned, I think that it's kind of difficult to put together a presentation like this and not know really who's on the other line. So I'm hoping people have questions or they have experiences that they would like to share because again, I'm not an expert on this as much as-- the CDCs advertising right now pretty heavily because we've presented on this at the Ryan White Conference. But again, we just wanted to share our experiences so that others might not have to recreate the wheel.

So again, even when you're focusing on sustainability from the very start, it's tough in the current health care environment. Again, hospitals, health centers aren't looking to add new services unless they're either going to break even, and that's here at our hospital. They're willing to do it if you can just not cost them money. But I think even most hospitals or health systems are looking to make money, but if you can make money, that's even better.

And it's important that leaders are engaged to the point that they take some ownership in the project. You want it to look like if it doesn't get funded, then it's some kind of representation of them. Again, you want them to have ownership. Make the case that they feel like it's their project, they'll support you in a different way. And then again, each time you identify a new case, make sure your leaders know and let them know how you might have missed them without routine HIV screening.

So every person-- well, I say every person. Minus one person that we identified through this project would have never been diagnosed with HIV had it not been for the project. They weren't people who were going to walk into a traditional testing and counseling site and get tested, with the exception of one, and it was a 17-year-old who actually came to us saying I am very sexually active, multiple partners, I have flu like symptoms and they screened him, and he became-- but again, I think if we wouldn't have screened him, he might have gone someplace else to look for HIV testing because he was well informed and well educated.

But the other folks that we identified, a few of them had actually refused screening the first time and only did it the second time so that we wouldn't ask them again. That was the typical of how we were locating people. So just a little FYI there. So that is my presentation. Is there any questions for me?

STEVE LUCKABAUGH: OK, we have a few moments here to take some questions. If you have any questions, please enter them into the Questions Pane on the Go To webinar toolbar. We had a couple that came in. What definition of routine testing was used? Was it once in a lifetime or annual testing?

MALINDA BOEHLER: We actually used once a year. So we are going for annual screening here unless there's a reason for more frequent screening. So we want to see an annual HIV test on file. Again, that's with our current plan. We're still actually using up rapid tests from our funding because there was so much money. That, I suspect, may change when that starts going to the health centers to purchase their own health. We may go to that once in a lifetime. But right now, annually and more often for people who identify risk.

STEVE LUCKABAUGH: And how did you sustain staff training?

MALINDA BOEHLER: It has been a real challenge. So when we started out, we of course, had to deal with all the existing staff. So we have the fully staffed-- well I can't say fully staffed, mostly fully staffed health centers. And what we did is we went out to the health centers, offered the training. It was a four hour training and we offered it multiple times on multiple days as not to disrupt clinic.

Once we got everybody trained and we went through all of the health centers, and again, that's what took so long. That's why we couldn't possibly accomplish in one year everything we wanted to. Then we worked with clinical education and now we're part of new employee hire orientation. So that has been key to keep the new people who are coming into the system. It's

not something new to them. It's just part of their job. So we've been doing that. It's the four hour training and we do that for every nurse and MA who stars in our health system.

STEVE LUCKABAUGH: Are all new HIV patients referred to the infectious disease department for follow up? Or are they followed by their initial providers?

MALINDA BOEHLER: Well, our dream with this expansion team, this traveling health team, was we were going to have an infectious disease nurse practitioner, pharmacist, and case manager. They would see the patient for HIV care at the primary care site in collaboration with the primary care providers.

However, that fell apart really quickly because the logistics just don't pan out. It's very hard to coordinate that when you only-- the traveling team would have to be at someplace at 9 o'clock, and then be on another side of team at 10 o'clock, and there were just certain days there's clinicians that are only in clinics certain days. So that just didn't work out.

So what we did do is say HIV care is offered at the community health center that they receive their primary care and there's just increased collaboration. So patients are no longer required to come down to the main campus for IV care. They get that care inside their primary care clinic, but not really in concert with their primary care provider like we had initially hoped. But that collaboration is much greater than it ever was before.

STEVE LUCKABAUGH: One attendee said, can we get a copy of the business plan?

MALINDA BOEHLER: I am happy to send that. I suspected that that might be a request. I have to go through and maybe do a little bit of redacting because there is some stuff that our hospital may not want out on this story like our reimbursement for certain things. So I can work on that and get that to MayaTech.

STEVE LUCKABAUGH: Do you offer fourth generation HIV testing or exclusively offer rapid testing?

MALINDA BOEHLER: As for our routine screening, right now we are using rapid screening only, and then of course when we do confirmatory, it's the fourth gen lab process. And the way it works is if you get a reactive, then immediately before you leave clinic that day, your confirmatory labs are drawn and you get an appointment to come back in like five days, and you actually get to meet with an HIV care coordinator who will then deliver your results and link you right into Ryan White services.

So again, not perfectly ideal, but we've tried to close the loop a little bit there. But we actually just had a meeting last Friday talking about is what we're doing the best use the resources. Is it time to consider a different kind of test? Is it time to go to blood work? So we're really toiling with those questions right now.

STEVE LUCKABAUGH: Do you use any incentive programs for patients? Were they helpful or effective?

MALINDA BOEHLER: We did not use any incentive programs for patients. We incentivized the health care staff. So what we did is we routinely held contests. A pizza party for the health center that had the most you know offered tests or accepted tests, a donut party. We acknowledged high performing testers through small kind of trinket gifts. Did not spend a lot of money on incentives, but we would see huge boost in testing.

The problem is, it falls right back down the next month. So it's not sustained over the long haul, but it shows us that it's possible because when there's an incentive they make it happen, but when there's not that incentive it just seems to fade off.

STEVE LUCKABAUGH: OK, one attendee asked, did you find that you broke even or were you able to make any kind of profit from HIV testing? If you're allowed to answer that, I guess.

MALINDA BOEHLER: Right, right. So, based on our business plan, it appears that you could actually make money because again, based on what our real costs are versus all the different components that we're reimbursed for. But again, it's a lot based on projection, and the landscape changes constantly.

So right after we submitted this business plan and said, oh Hep C drugs, the revenue from that will help. Well, how Hep C drugs are paid for changed, and our hospital was no longer doing those, so that doesn't exist anymore. So right now, I feel like until we can look back over five years and see what the net gain or loss is, in reality, we don't have a good idea. I hope that makes sense.

STEVE LUCKABAUGH: One attendee said great presentation and great program. Were you able to evaluate testing rates at the provider level and use that data for quality improvements on testing coverage?

MALINDA BOEHLER: We did. So I talked a lot about the training we did for the nurses and MAs, but we also did training with our clinical providers, and it was a much shorter training because again, we couldn't get four hours with them. So what we did was we gave them a what you need to know about this project in about 30 minutes. So that they would be comfortable answering any questions that their patients had, because here, we asked the actual clinician to deliver the reactive results and order the confirmatory.

So we wanted to make sure that they had all the tools that they needed to do that. We also learned throughout our project that we have this team based care, and we learned that if the clinician who was on that team, if they believed and thought HIV screening was important, the rates were higher. If they didn't believe it was important, they were extremely low. I mean on some teams it was almost nonexistent.

So we really tried to work with those providers and increase their knowledge around the product. And then we also-- our clinicians every year have to choose a CQI project, and many of our providers chose increasing the HIV screening rate on their team as their quality indicator. And again, what it showed was when the clinician invests and says it's a priority, it happens. So again, I hope that answers your question.

STEVE LUCKABAUGH: Did you consider integrating HIV testing into a standard blood draw versus a separate point of care test?

MALINDA BOEHLER: We did. When I first became involved with this project in November, it had been written up as everybody was going to get rapid test because everybody loves this oral test. You don't have to get a blood draw. I tried to get them to pilot half the site doing the oral, doing what we ended up doing using rapid test, and pilot the other half by using just blood, just adding it to the requisition upon discharge.

And I was shot down actually by our funder because the funder felt like that in our health setting, that people were as likely as our emergency department not to come back to primary care, and what if we couldn't find people once we had identified that they were infected, even though we have a very good disease intervention specialist group in Marion County that's actually on our campus. They just felt like it was taking a chance that we would find a positive and then not be able to link them into care.

So they shot down that idea. But we are revisiting that in some ways, because again, we're trying to figure out the clinic flow. We have our Epic as our medical records system now, and so we have these provider alerts since we've implemented those, testing rates have gone up 100% from what they were the month before.

And we think if again, it can just be added on as a blood test, that may even make it better. We've talked about the [INAUDIBLE] rapid test, which is a one minute, because again, we know that any time that you put something into the flow that slows things down, even though 20 minutes-- everybody's at the primary care office for more than 20 minutes, that 20 minutes can feel like a huge barrier to staff. So again, we've even looked at the blood issue, but we've also looked at the [INAUDIBLE] test, where you can get a result in one minute.

STEVE LUCKABAUGH: And has the Ryan White Part A or Part C program been approached about supporting HIV care in the health centers after grant support ends? If yes, what was their response?

MALINDA BOEHLER: Yes, we did approach them because again, our project was twofold. First we had the testing, but then we also have this care element. And what they did is our traditional infectious disease clinic was already funded on a fee for service basis.

So we just wrapped a traveling team into that fee for service structure and we were able to get an increase in funding to account for that. So it does help us to be able to bill for some of the

services. But again, I would say that, again, it's still my covering. Pharmacists are expensive, nurse practitioners are expensive, but at least it helps to cover some of it.

STEVE LUCKABAUGH: What were the biggest challenges you faced when approaching your leadership to get them on board and how did you overcome those challenges?

MALINDA BOEHLER: I think the biggest challenge we had was people not understanding why it was so important. Because really, they are tied up in what they're being asked to report on. So until HIV kind of moves up the chain at HRSA and gets to be a big quality measure for health centers, they're totally focused on what HRSA's is looking at for their FQHC quality measures.

I think the fact that they're now asking how many people are you testing, I think the health center feels like it's coming, but it's still not a big area of concern. But I think as that become more evident, that people will care more about this. There are so many competing demands, that seems to be the problem, and they're constantly needing to prioritize. So it's hypertension, it's diabetes management, whatever.

HIV usually doesn't make the list, but it's just kind of keeping that constant contact with them, letting them know what's going on, again, sharing specifics, but not too much specific on the cases that you're finding.

So in our newsletter, I would say new case identified, 36-year-old Hispanic male, baseline lab indicated an AIDS diagnosis. Saying thanks to routine testing, he's been identified. And again, that really hits home with them. Linking your project to the quality of care that they're providing. Letting them know that not doing HIV testing is a huge disservice to their population.

STEVE LUCKABAUGH: Any helpful thoughts on shifting a provider's mindset from a risk based screening approach to a more routine opt out approach so that the patients have at least one HIV test in their lifetime?

MALINDA BOEHLER: I think, again, that is such a huge challenge and like I said, you would see it when we would go in to do these training, especially on the pediatrics side. We had people say no, I'm not testing my kids for HIV. It's just not happening. Yet, half of their patients are pregnant or half of them have been treated for STDs. So it's obvious that they're sexually active.

So again, I think it goes back to sharing your state's statistics, sharing national statistics. Doctors are very evidence based. So when you can show them the evidence, that's what they're interested in. So when we have trouble with our pediatricians, we went to the pediatric group, their National Association, and we got their policy statement. Things like that.

Anything you can do, again, show them the evidence. Make the case. And here, when we identified that 17-year-old with a new acute HIV infection, that was enough. When we could then share with them because we found him, we're going to be able to change his life.

STEVE LUCKABAUGH: Do you have any marketing tools, posters, or brochures, et cetera in your waiting exam room showing patients that HIV testing is a routine part of primary care?

MALINDA BOEHLER: We do. The tag line we have is redefining routine. And I'm happy to share that information also. We created a brochure and the brochure just has all the information about HIV screenings, and resources, information for future testing, things like that. Because again, we know that the health centers don't have a lot of time.

So the goal was to have one resource that could be handed to a patient that would answer all their questions, and we have that in English and in Spanish. And then we also had what they call rack cards that would sit on the desk. Because again, my background is social work. We serve a high predominance of minority patients and I did not want anybody thinking that we were asking them to be screened for HIV because they were black, or because we thought they were gay, or whatever.

I wanted everyone to know that it is routine and we're asking everyone. We originally developed a poster. The poster could not be put up because they have all these restrictions here about what can be hung up on the wall. So we had to settle for the rack cards and the brochures, again, redefining routine.

STEVE LUCKABAUGH: OK you listed billing limitations within FQHC structure is a weakness in the SWOT. Why was that identified as a weakness?

MALINDA BOEHLER: Based on our understanding here, FQHCs are reimbursed a standard rate per visit, regardless of what you do during that visit. So adding additional tests does not add additional revenue. The FQHC have a rate, and I'm just making this up, of $30 for a return visit. You get $30 for that visit whether you do a pregnancy test, whether you do a urine dip, whether you do an HIV test.

So we were told that we don't get any additional reimbursement from the funder, from the payer, regardless of these tests, with the exception of now based on the new stuff that we're doing, we're able to go back to the funder and say hey, we're now doing all this. It really cost us this. Can we raise that rate? So again, there's probably people on this call that know a lot more about that than I do, but that's my very elementary understanding of it all.

STEVE LUCKABAUGH: Have any sites had any success with adding HIV 101 to core stuff competencies for relevant staff?

MALINDA BOEHLER: What we have done is-- so everybody who is trained to do the HIV testing has to do an annual competency that's through e-learn, but nothing that is system wide on just HIV in general. When I put on my MayaTech hat, my Midwest H Training and Education Center, we actually are working with one of our clinics on practice transformation, and that's one of our strategies, is to make sure that everybody in the clinic has some baseline HIV knowledge.

But as of now, we have not been able to get that to be a priority in the e-learn that are our annual education. But I feel like the tide is turning. We're starting to see more about bariatric, transgender, LGBTQ stuff. So I'm hoping that soon, I'll be able to convince clinical education to add a component on HIV.

STEVE LUCKABAUGH: And you mentioned that the offering rate was about 40%. How have you set up your system to trigger reminders for the routine testing?

MALINDA BOEHLER: So when we first started our project in 2014, we have this home grown medical record system called Gopher or G3, if we were being fancy, and we switched over to Epic. So everything in G3 was very manual and we had actually paid to develop this query so that when a person would check in at the front desk, the system would start looking to see if they had ever had an HIV test in the lab. If they were between the ages of 13 and 64, had they ever had an HIV test in the last year at our system? And if they had not, they would then pop up in the back with a reminder.

But the system wasn't always reliable, so then people stopped relying on it, and what they then started doing was just searching HIV as a search. The people that were really diligent about it, but we lost people with that. In Epic, things seem to be better, that we're able to develop the provider alert that make it-- they can still close them. They pop up, and some places do, but again, that has helped us to increase testing a lot at the site.

But again, I think it's going to be just a multi-- we're going to have to hit it from many sides to get this to work. So right now our testing coordinator person that does our training and QA, she's setting up meetings to go to every health center and talk to people again. Because the alerts have helped some, but now we need some face to face training.

And again, on the quality boards that they have in their clinics, we're going to start posting what their testing numbers again. Because again, they're very accustomed to looking at that and seeing how they're doing and what they need to improve on. So we need to be part of that.

STEVE LUCKABAUGH: How quickly have you been able to get newly diagnosed persons into HIV medical care? Can this happen on the day of their reactive point of care test?

MALINDA BOEHLER: It does not happen on the day of their reactive point of care test. It happens on that they get their confirmatory results. So the day they get their confirmatory results, they have a ton of baseline laboratories done and they get their psychosocial assessment done.

They get to apply for insurance, different things like that, and from that moment they're in care, and the pharmacist, and the nurse practitioner are monitoring them, and then they typically then have their clinical visit within a week. Because again, we want to wait until those labs are back. So that's kind of our model right now.

MayaTech actually does an annual conference and we're having somebody come and speak on Rapid Start, because again, we took heat when we started delivering results and starting them into care the same day, and that was with that delay between rapid and confirmatory. People said oh, patients aren't ready for this, but what we found was the opposite. Patients were more than ready. They were happy about it because they're longing to know what their cd4 count is, what their viral load is, what the status of their disease is.

But again, we took a lot of grief actually from care coordinators, from providers, saying it was irresponsible. And I said, well, we're not going to force anybody to do an intake and do labs if they need time, but we want to offer that to people that are ready and they're wanting to get into care. And like I said, patients we're ready, we weren't. And again, I suspect that my presenter on Rapid Start is going to get a lot of grief from the audience. But again, as a care provider, I buy into that. Let's take away all these barriers and multiple visits, and let's get them started.

STEVE LUCKABAUGH: OK, and have you used this as a launch point for PrEP?

MALINDA BOEHLER: We have used it as a launch point for PrEP. We have started educating just again, we've got that clinical team that's out in the health care centers. They're educating the clinicians. I think we have now like 75 referrals for PrEP only, and the goal is, again, we work with the primary care clinicians to start. We're like a consultant model. Get them started and then they monitor them to primary care, because again, you shouldn't have to wait for an IV specialist to get started on PrEP.

STEVE LUCKABAUGH: OK, a few other folks said great presentations and that's all the questions I have. Did you have any final closing thoughts or did we cover everything?

MALINDA BOEHLER: I think we've covered everything, but I would really like to thank everyone who's participated and thank everyone who asked questions. I was so nervous that when I was finished that there would be no questions for me. So thank you so much for asking questions and I'm happy to be part of this. So, thank you.

STEVE LUCKABAUGH: OK, thank you for participating in today's webinar, and thank you, Miss Boehler, for that excellent presentation. I'd also like to thank the folks that provided questions. Really great questions today. If you have any additional questions though for the P4C project or for Malinda, please email us at P4CHIVTAC@mayatech.com. Take care everybody and we'll see you next time.