

## **WEBINAR VIDEO TRANSCRIPT**

P4C HIV TAC Webinar

### **HIV Testing and Non-Clinical Settings**

16 November 2016

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STEVE LUCKABAUGH: Good afternoon. My name is Steve Luckabaugh, and I'd like to welcome you to the HIV testing and non-clinical settings 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.

We have four speakers today. Our first speaker is Dr. Karen Wendel who is the director of HIV STD Prevention and Control at Denver Public Health slash Denver Health and assistant professor of medicine at the University of Colorado Health Science Center Division of Infectious Diseases. She received her medical degree at Johns Hopkins School of Medicine and completed internal medicine training and infectious disease fellowship at Johns Hopkins Hospital.

She has been involved in HIV and STD clinical care and research while on faculty at Johns Hopkins School of Medicine, Oklahoma Health Science Center, and the University of Colorado Health Science Center. While in Baltimore, she served as director of the early intervention initiative for HIV care in the Baltimore City Health Department STD clinics and, while in Oklahoma, served as the medical director for the Oklahoma City County Health Department STD clinic. In addition to her academic and public health experience, Dr. Wendal has also served several years of experience in infectious disease private practice. Please join me in welcoming Dr. Wendal.

KAREN WENDEL: Hi. Thanks for joining today. So my talk is about really ruling out testing into non-clinical settings. And I want to go through some of the specifics and then let some of the sites really tell you what their experience has been in performing these services.

So the objectives today are to review the CDC HIV testing models, discuss environmental services that you might consider when you're rolling out new testing services, outline the pros and cons of different HIV testing options, and review key features of staff training. We're going to go over the policies and legal considerations that you need to take into consideration as

you're starting a new testing program. And then finally how you follow up that program by doing quality assurance and program evaluation.

So I just wanted to stress that what we're talking about today really fits in line with HIV national strategy. And when we talk about NHAS, it's a document that first came out, first released in 2010, and has been updated since that time and is now updated with goals that extend out to 2020. And there are really 10 key indicators that been identified in the in-house strategy. And two of them are important for us as we're discussing today. If you could click forward, there are two items underneath.

So two of those indicators that are applicable to what we're talking about is that one of the goals is to increase the percentage of people with HIV who know their status over 90%. And that means really throwing out a broad net and really getting testing done, not only in people who are showing up for clinic appointments or are actively engaged in medical care, but for those individuals that might be a little bit harder to reach and aren't routinely obtaining medical care.

In addition, all HIV testing programs really need to have in mind that important and key feature of linkage to care. And so another key indicator for NHAS or the national HIV/AIDS strategy is linking folks who are newly diagnosed with HIV into medical care, 85% of them within one month. And that's a tall order, but part of what you need to be thinking about as you roll out these new programs.

So this is our first polling question. Is your health center conducting HIV screening outside of the primary care visit to your patients currently? And we'd just like to know where all of you are at this moment as we proceed along this instructional program. Please select one of the answers.

And this just helps give us an idea of where you are. And you'll see in the centers that are coming up how they've gone about implementing more expanded testing. And so Steve let's see what we've got in the way of responses. OK. So many of you are already doing testing outside of the primary care setting. So that is helpful, and we look forward to getting your comments as we move through this presentation.

So when we talk about testing models, the CDC has really broken this into two. And what we're going to see as we hear about what other sites are doing in this P4C program is that some things fall sort of right in the middle. They're not exactly a clinical setting, but they are in a medical service venue.

So in a clinical setting really what the CDC is promoting is routine testing of all individuals that fall into that age range of 13 to 64 years. Certainly, we would test anyone with a new diagnosis of tuberculosis or STDs. And all pregnant women are to be tested in the first trimester. And if at increased risk, we would retest them in the third trimester.

With positive and negative results, the further steps are outlined here. For a positive HIV result, we need to make sure that we adequately link them to care and give them some counseling as to how they prevent further spread of disease and how they do partner notification and also give them information about current treatment options and prognosis in the light of our highly active antiretroviral therapy.

In nonclinical settings-- and here the most kind of when we're really referring to nonclinical settings, we're really talking about outreach venues-- we tend to really target testing to those really high risk individuals who are not likely to be accessing health care and who are going to really benefit from an expanded reach of HIV testing. So needle exchange programs, bathhouses, CBOs with a high client volume of men who have sex with men and STD venues of outreach. So those are going to then need the same type of services when you have a positive or negative result, meaning that linkage to care if you have a positive result.

Or for an HIV negative person, they need to be able to do that next step referral for either non-occupational exposure, post-exposure prophylaxis if they have a high risk event within 72 hours or pre-exposure prophylaxis if they are a person who has continued exposures that place them at risk of HIV acquisition. And we also need to be providing that routinely, information to those patients about when they should be tested again. If they're persons who should be tested again at an annual interval, and those would include people who have an HIV positive partner or have multiple sex partners, people who are injecting drugs.

People who are pregnant obviously would be retested or are being diagnosed with an STD. So really being able to get them further counseling on when they might repeat their test is very important. And we at least would recommend annual testing in all MSM who are sexually active and persons who have exposure risks, including having an HIV positive partner or injection. For the men who have sex with men, the testing interval can go up as frequently as every three months, and certainly, that's what we're recommending if high-risk individuals are on pre-exposure prophylaxis.

So what are the goals of these programs? Really, we want to expand high-quality HIV testing. So you'll see in the slides that are coming up, I really want to talk to you about how you choose your test. And some of that has to do with the venue that you're in, and some of that has to do with really trying to promote the most accurate sensitive test that you can possibly use.

And so we're going to talk a little bit about that coming up. We want to identify clients with undiagnosed HIV infections, so we want to make sure we're testing the right folks. In those patients who test positive, we want to link them to care and have a very effective strategy to do so. And we want to reengage individuals that we find are HIV positive who are fallen out of care.

For our HIV negative diagnoses or test results, we want to educate or refer them for non-occupational post-exposure prophylaxis as I said if they're within that 72 hour window, pre-exposure prophylaxis if appropriate, STD testing and treatment, and follow-up HIV testing if

needed as I said in the slide previous. But in addition, we want to be able to react to other social and behavioral needs that might include further behavioral substance abuse referrals or even mental health services.

So when we're talking about testing outside the clinic visit, there are many different settings that we could be considering. Medical service menus might include testing at a pharmacy, testing at a dental clinic, or in a behavior a health clinic. Outreach sites are more classically areas where you could do more targeted testing to populations that you feel are at highest risk in your environment. So that could include bathhouses, bars, special events like PrideFest, needle exchange service locations, and even service sites for victims of human trafficking.

Other options and some venues and jurisdictions use mobile units that are really traveling to different areas where they might access folks that would be unlikely to be enrolled and other regular sources of medical care and then home testing options as well. So the benefits of rolling out these testing sites that are nonclinical settings is really trying to make them very easily accessible to our clients and really access a group of patients that wouldn't have that routine testing in a clinic visit.

So this is our next polling question. Is your health center offering HIV screening services to walk-in patients? So just go ahead and select our option. We'll give you a few minutes.

Let's go ahead and look at our responses. OK. Terrific. And so this really is I think showing a very accessible type of testing venue and really giving patients a lot of options. So that's great to see.

So when we think about rolling out testing services in nonclinical settings, there's a lot of items to consider. And so one of them is really considering where are you going to perform the tests. If you're going to be using point-of-care tests, it's important to make sure that you have appropriate lighting and appropriate bench space to be running the test and being able to read the results that are usually on a little strip.

You want to make sure that your temperatures are appropriate. And this really comes into play most when you're in an outreach setting. So for instance, we previously would test at a pride parade, but temperatures would get so high that we'd have to hold testing when temperatures were outside of our testing range limits for our particular task. So it's something to keep into consideration.

And then you want to have appropriate temperature monitors for where you store your controls and have minimum/maximum meters so that you can make sure that your controls are valid and that you're storing them in a proper way. You want to do proper intervals for control testing and make sure that all of your staff are trained on that. You want to keep track of lot numbers and keep testing logs so that you know who was tested with which batch of tests and keep a close eye on your expiration dates.

Equipment that you could need would include a refrigerator for the controls. If you're going to be doing lab-based testing and you're going to be storing the sample prior to lab pickup, you may need a centrifuge to spin down your sample. And then of course you want to be able to address prevention and give out prevention materials if needed or know how to refer an individual for that. So condoms, lubricant, or knowing how to refer them for a clean needle exchange.

Other supplies that you would like to have on hand, of course, are the data forms testing logs for the test that you're doing, referral forms for behavioral health, needle exchange, STD testing, and client feedback. So we tend to do surveys on a quarterly basis to sort of assess the kinds of services that we're providing and get some client feedback on how we might improve our testing services.

So in looking at these, I just would like everyone to consider how you choose your HIV tests that you're going to provide in your setting. And so when we talk about HIV tests, you can see the top is really lab-based tests. And so these are performed in a lab.

They're moderate complexity to high complexity. It's not something you can do right there in your clinic. You're going to draw blood; you're going to send it off to the lab.

And these are the most sensitive tests. When we're talking about fourth generation lab-based tests, these are the most sensitive. They allow you to move down that confirmatory pathway without obtaining a second sample, but they do take away your ability to give a result right there on the spot to your patient. And so you have to have built into your workflow then how you're going to deliver results.

In the bottom panel, you see the CLIA-waived rapid tests. So these are point-of-care tests that are available that you can use right there and then in your clinic, give the results to the patients right while they're there, and do linkage to care if needed or further blood draws for confirmatory testing as needed.

I want to highlight that, really when we talk about the generation of HIV tests, at this time, the fourth generation test tests for IgM, IgG, and p24 antigen. This really allows us to close the window down from time of acquisition to time of a positive test. So these are our best most sensitive tests able to pick up disease the earliest in the course of illness. And these are really our preferred tests, lab-based fourth generation.

There's only one point-of-care test currently that is marketed as a fourth generation test, and that's the Alere Determine Combo Antigen Antibody Test. And although it is marketed that way on whole blood, the performance of the p24 antigen component does not really compare to a lab-based and is somewhat limited.

When we're talking about third-generation tests that have IgG and IgM capability of detection and again have a smaller window, the only tests that have some capability to be called third

generation are the INSTI HIV 1, 2 and then UniGold. You'll see they'll also fall into that second generation. For all of these point-of-care tests, they're not quite as good as the lab-based tests. And so we've got those two in both columns because they're just not perfect in the way they perform in that IgM component.

Every other test that's point-of-care falls into this second generation group. And it should be said that for the OraQuick, the use of saliva-based OraQuick testing is going to have the least sensitivity and isn't going to perform as well as performing it on blood samples.

And so why is this important? I just want to review. If we look at time of the acquisition of HIV right here is 0.0.

The first test that's going to be able to pick up HIV is going to be the viral load, and that's shooting up around day 11. This period here is called the Eclipse period where no lab test could pick it up. The p24 antigen for a lab-based fourth generation test will start picking up around day 17. And then the IgM third-generation tests are going to start picking up at day 22.

But really when you're looking at second-generation tests, you're pushing your window all the way out to about six weeks. So if somebody is within that first or early HIV period of six weeks after acquisition, you're more likely to miss it with the second-generation tests, especially in a point-of-care. So one of the issues if you choose to move forward with the point-of-care test is moving forward to how do you get to that confirmation of the test.

So as I said, if you go with the lab-based test, usually the lab has built in a confirmation process, and so you don't have to worry about getting that second sample. If you go with a point-of-care test because you want to be able to provide those results immediately to the patient, you have the issue of how to address a confirmation of a positive. The CDC has outlined three different potential algorithms that you might consider.

So the first being immediate linkage to care with a clinical provider. So in other words, you're messaging to the patient, your preliminary test is positive. We're going to go ahead and provide you with linkage to care to an HIV clinic where they're going to do further testing to determine if your HIV test is confirmed as positive.

Or number 2, lab-based follow-up testing. So you move from a positive point of care to saying, we need to obtain a phlebotomized sample to do your confirmatory testing, and we'll give you further results based on these results. Or number 3, some clinics are doing a second rapid test on site. And if those tests are positive, they're moving straight to linkage to care. If only one test is positive, they're moving to the lab-based confirmatory pathway.

So some of this will depend on the prevalence of disease in your community and the ease with which you can access linkage services and phlebotomy. And so this is really a decision that needs to be made at the local level. So using these algorithms is also something that you have

to consider in the light of what your local health department requires. So that's a discussion that also needs to occur.

You really want to optimize early detection and linkage into care, and that's sort of got to be your number one goal. So in considering which type of test to use, a lab-based test or a point-of-care test. There are several things to consider.

With a lab-based tests, as I said, you're going to have the optimal sensitivity, the smallest window where you might miss a person after they have acquired HIV. And you have the benefit of having automatic lab algorithms that will move forward to a confirmatory test. And you won't have to give as many results that are unconfirmed and ambiguous results to a client.

It does, however, require a follow-up visit and arranging that follow-up visit for in-person delivery of results, especially if it's a positive result. The CDC currently recommends that if you have a negative HIV test that result can be given over the phone. If you have a positive HIV test by CDC recommendations, the best method of giving that result is in person.

For point-of-care tests, it doesn't require a venipuncture. You can do a finger stick and even saliva testing that as I said has lower sensitivity. So it gets rid of that necessity for having a trained phlebotomist on site.

The results are rapid and allow you to have that type of interaction with the patient about the result immediately and not have to schedule a follow-up. But you have issues with a slightly bigger window where you could miss acute HIV, and you have issues about getting that repeat testing done for confirmation. But in general, these testing methods are relatively low cost.

So once you've picked your environment and your venue where you want to roll out services and decided on the test that you want to use, you have to then proceed into developing protocols for your staff and getting them trained. And so things that the staff might need to consider or protocols that you may need to have in place would include the HIV testing protocol and how to do your controls and log your results, how you're going to log your refrigerator temperatures for your controls. Then managing the medical record and how you're going to document the results of the test or patient's decision not to proceed with testing. And then your processes for referrals and for linkage to care.

Code of conduct really becomes more of an issue when you're in unusual outreach sites, such as bars and sites where there could be alcohol and other types of difficult situations for your staff. And so it doesn't really come into play in general in medical service environments. You want to do practical hands-on training for your staff so they feel comfortable handling all of the equipment and performing the tests and reading the results. And oftentimes, the best source for that type of training is your local health department.

Other resources for you are the CDC guide for implementing HIV testing in nonclinical settings and the CDC Rapid HIV Testing Online Course. And you can see the link below.

Other considerations that we need to have is proper training for staff safety. So universal precautions-- using gloves, knowing where your biohazards are, knowing not to recap needles, having access to occupational safety, and being able to refer any staff members that have an exposure to bloodborne pathogens immediately for post-exposure prophylaxis. And all that needs to be in place before you roll out your testing so that you are appropriately protecting the safety of your staff. When you're in outreach venues, it becomes a little more important to think about the number of staff that you have on site, the hours that you're willing to have services at a location, emergency preparedness and as I said code of conduct in these sites.

In so far as client safety, one of the key issues is that we have informed consent. And in different states, there are going to be different laws regarding what age a client is allowed and is considered to be able to give informed consent, whether a minor is able to obtain an HIV test and provide consent without their parent. And so it's important to know your local laws.

In addition, health information compliance and data security and confidentiality. So in other words, complying with HIPAA and making sure that your records are secure, even your logbooks are secure. And making sure that you have a reliable HIV test result so that you're running controls appropriately, your staff were adequately trained, you're giving results that are valid, and you're using the best tests available. And then of course, being able to refer patients appropriately when you have a positive result or for negative clients being able to have good access and referral processes in place for PrEP and other prevention interventions.

So this is more of the logistics of setting up this kind of a program. If you're going to be doing point-of-care testing, your site is going to have to have a clear waiver for these point-of-care tests. You're going to have to outline the times that you're doing the tests, the locations that you're doing it, and which tests you're using.

And you want to make sure that all of your staff were properly trained, you have an informed consent criteria, and that all of your staff know what informed consent looks like. You want to make sure that everybody understands confidential testing versus anonymous testing if you're offering that at your site and appropriate recordkeeping and confidentiality of medical record. You want to make sure that your staff are aware of their reporting requirements for HIV testing to the local or state health department and how to get that testing result entered in.

So for our jurisdiction, that's a computerized system that we have to log into to report all of our positive test results and making sure that we have all the correct demographic information that's required at the state level. And then you want to make sure that you have appropriate linkage to DIS services, Disease Intervention Specialists who will be offering the partner elicitation notification services and quality assurance procedures. So let's look a little bit more into quality assurance.

So when you have your testing program up and running, it's important to be looking at the maintenance of that program and making sure it's a high-quality program. And doing that really makes looking back and checking the procedures and protocols are followed adequately for



testing procedures and logs, that the charts or documentation is good and confidentiality is being really protected, interventions with client conversations as well as their medical record.

You want to have team meetings and case conferences. And these are often very useful for staff to decompress about giving positive results and the interactions that they're having with clients and to get some feedback from their colleagues about difficult interactions and how to manage them. And you want to review regularly the materials that you're providing to clients to make sure that your referral sources and the information that you're providing patients about-- repeat HIV testing or STD referrals, behavioral health referrals-- are all up to date and active and appropriate.

And then finally, you want to be looking at how well your program is doing. How many tests are you running? How many new diagnoses are you making? And how successful are you in linking those new diagnoses into care? And how successful are you in moving patients from being an HIV negative at risk into medical preventive services such as pre-exposure prophylaxis?

Finally, there are just an ample amount of CDC resources in rolling out a testing protocol, and these are some of the best. And so I've got four different references here for you that can really supplement what you're hearing today. All right. Do we have a question now? Let's see what's next, Steve.

STEVE LUCKABAUGH: OK. We'll be taking questions at the end. If you want to enter a question, you can enter it now into the questions pane, and we'll go through those at the end. But you can go ahead and air them now if you want to.

All right. Thank you Dr. Wendel.

Our next speaker is Carrie Amoroci who is the HIV coordinator at community health center of Buffalo CHCB. She has a passion for learning new things and for inspiring others through her teaching efforts. More than a year after assuming her HIV coordinator role, Carrie has learned much about the world of HIV and finds herself balancing the task of building a strong HIV care curriculum and making connections with other HIV care entities in the community all while continuing to teach CHCB chronic disease patients how to more effectively manage their conditions.

Carrie earned her baccalaureate degree in nursing from D'Youville College in Buffalo, New York. In addition to being an emergency room nurse for many years, Carrie has developed job orientation programs for new nurses and two medical institutions and most recently created the diabetes education program at CHCB which she launched in the fall of 2015. Please join me in welcoming Ms. Amoroci.

CARRIE AMOROCI: OK, so HIV testing outside of primary care. In 2014, before I was here at the center, the community health centers of Buffalo became a P4C partner in this grant and were

awarded the grant to implement the HIV testing in the primary care setting. At that same time, our dental staff was trained as well, but I'll get to that in just a second.

So CHCB once obtaining the grant created the HIV care team. They hired an HIV coordinator, and that was the person before me. And I came in actually as the diabetes educator and became the HIV coordinator as well and joined the team of the HIV providers that we have here at CHCB. And the goal was to, of course, increase our screening numbers here in Buffalo and our at-risk populations.

Clinical staff were trained on how to do the OraSure test, which is what we use for the rapid HIV screening. And we do that for adult and pediatric patients as well as our family planning patients. So HIV screening at CHCB has taken root at all five sites.

When we began the grant, we had three sites. Two have since opened in the past year-- our Cheektowaga site and the Sanborn site, so getting bigger. But we have managed to fully implement the testing across all five sites where all the staff is trained, and the testing is considered part of our routine screening. We encourage patients, just like your lab work, we're going to know your HIV status along with your cholesterol. So our testing numbers hopefully will continue to grow.

Outside of primary care we also provide dental care for pediatric and for adults at the Buffalo location and the Niagara Falls location. The other three locations do not have dental care. But as I mentioned in the beginning, our dental providers were trained right from the start of the grant to also do the OraSure HIV screens.

So that was the easy part. Dental staff started out right from the beginning trained how to do the oral screen. They do not draw blood in dental.

So they do the oral screens only, but they are just one floor above us here and in Niagara Falls. And I'm sure they have a positive that contact us. And our dental numbers account for about 20% of the monthly screening totals that we do for HIV across all sites.

OK. Barriers to screening eligible patients in dental have come to the service. Dental has a different EMR than we have. They have a software, Eaglesoft program. And we use the eClinicalWorks program.

The two don't play well together. They are not integrated. So any data from a dental chart other than the patient's name and their appointment time doesn't translate over to a medical chart-- and of course, vice versa.

And one of the things that we're doing to increase screening numbers is, I go in and flag everybody's chart in medical who is due for their annual HIV screen or who has never had one. And I'm not able to do that with the dental charts because I don't have access to their

electronic charting system. And as I mentioned, the dentists don't order blood work. They don't do any kind of labs like our primary care providers do.

So if any HIV screen is preliminary positive, they're supposed to call me. And so I go upstairs and go get them and as well as Niagara Falls. We have a designated person there as well.

In addition, I made some HIV templates. In our eCW program-- so that medical electronic medical record. But that does not translate over to the dental electronic medical record. So as a result, dental is still screening for HIV. They have to do it on paper, and then at the end of the month, they give me all the paper, and I add them into our totals.

Oh, a little polling question. So does your dental program at your health center have the same electronic medical record? I sure hope so.

STEVE LUCKABAUGH: OK, this is our third poll. If you can answer it now-- does your dental program or your health center have the same electronic health record? Yes, no, not sure, or we don't have a dental program.

CARRIE AMOROCI: Oh, OK. Interesting. About 40% said yes, you do have the same record. About 40% said no, and about 10 and 10 are split between not sure and we don't have a dental program. So OK, interesting results there.

Our IT department is working to fix it. We were all set for this fall this last month to have Eaglesoft and eCW merged. eCW has just come up with an update to their entire program. So now we have been set back.

We're not going to integrate the programs until the eCW program has had its systemwide update. And then maybe we can work again to get the Eaglesoft better and integrate it into eCW. Sorry, lots of acronyms here, so I'm trying to make sure I get them straight.

And hopefully, we can then have those dental and medical systems talking to each other. The dental won't have to go through tracking the paper and giving them to me at the end of the month. And they can use the templates. The templates are pretty handy.

Made a couple of templates because in our electronic medical record, there are too many ways to do the same thing. So staff were not consistently documenting whether patients either had the test or declined the test in consistent places. So I decided to make two templates.

They're real simple. One of them is called yes to the test. If the patient accepts the oral screening test, the template is pulled over into the patient note. And if they decline the test, we still need to document that. So then there is a template for no to the test, and that is entered into the note as well.

And that also includes, even though they've declined the screening-- the harm reduction counseling is incorporated into that as well. And the templates are pretty nice, happy to share them (they) incorporate everything about the HIV screening process as it says from ordering the labs. You click on yes to test, and everything, all these fields are filled out for your labs with reduction counseling.

Follow-up, the lab work, should it be required, it's all in there. And same with our no to the test, it still includes the requirements for harm reduction, using condoms, avoiding risky behaviors, things like that, as well as links to harm reduction on the websites. So things about not sharing needles, condoms, the CDC website, information on there as well, which is kind of something new.

I was looking through some boxes of some old forms, and they were the harm reduction portion. But we have gone so far, that now I added the website so people can just go and click on there and not have to go hunt for them. And as I said, I'd be happy if anybody's using eCW and you'd like to look at those templates, we'd be happy to share those.

And I believe that's the last slide. Yes, OK. Thank you.

STEVE LUCKABAUGH: OK. Thank you, Ms. Amoroci. Our next speaker is Greg Byrd, a Rochester native. Greg received his bachelor's degree from Rochester Institute of Technology and his Master's in Business Administration at St. John Fisher College.

For the past five years, he has served as the program manager for Jordan's Health's Prevention and Primary Care department-- PPC. The PPC team provides care and treatment to individuals who are HIV or HCV positive. He's particularly proud of the achievements that the department has made in linking HIV/HCV positive individuals to care in 24 to 48 hours. He is thankful for the opportunity to assist in providing quality care to patients, to work with a dedicated staff, and to make a positive difference in the lives of others. Please join me in welcoming Greg Byrd.

GREGORY BYRD: Hi. Good afternoon. For us testing outside of primary care really focused on the dental even though we have ten sites and we do testing across all ten sites. But we really wanted to focus on dental, and that's been where the interest has been in the last couple of years.

So when we talk about testing and dental, when we look at the situation, we identify that not all dental staff are comfortable performing the HIV test. There are a number of individuals that were declining testing. So we wanted to ask the question, why and what was going on.

And so as we started looking at it, we wanted to understand that when you're considering dental, there is a number of dental-only patients that do not have primary care providers, and the opportunity for them to receive an HIV test is limited. So we wanted to be able to capture that. So if you look in terms of our priorities just being able to get the HIV testing up and running to be able to provide care and treatment for those that are affected and just to be able

to prevent new infections. So working closely with a department manager, the dental director, their practice manager, then the team itself in trying to understand where they're coming from, what their needs were.

So as we talk about with the staff and just trying to understand, why do we want to do HIV testing in dental? And what happens is, again, because the PCP may not be in place, it's convenient. They're coming. We're looking at a one-stop shopping from a health center standpoint.

We're looking at being able to reduce the barriers. They're here. We have an opportunity to test. From a cost standpoint, it's important that we can come in and just roll right into the process itself.

We have the infrastructure where they're already seeing a provider here if you will, they already have established patient care here. So that's a good setting. In terms of Jordan, obviously, for our expertise to be able to extend that, to get our staff comfortable just offering the test. Looking at it in terms of just simple efficiency that we're able to do, again, one-stop shopping, having a knowledgeable staff, understanding from a patient satisfaction some of the issues that they're experiencing and why.

As we take a closer look in terms of what was going on, obviously, additional staff. The training that was required. We want to make sure that everyone was up and running, knew what was going on. We wanted to understand how do you go about ordering the kits?

How do we market this service? How do we make sure from a billing standpoint that pieces were in place? And then, how do we even collect the data behind it?

It's important for us we use eCW and dental just came on board within the last couple of years. And so that was important for us to make that transition be able to capture the data as well. Prior to that, a lot was done on paper. So that's good moving forward.

If we look at it in terms of potential obstacles, it's really staff. When you're dealing with the stigma of HIV, you want to make sure that your staff which is comfortable asking the questions. A number of staff had acknowledged that they did not want to ask the questions with the ideal that if they did have a reactive individual, how am I going to respond to that individual. Do I really want to show that individual that they may be reactive?

And so we wanted to take a look at how they were asking the question, if you will, so we wanted to train them on that. We wanted to make sure that they understood about ordering the kits and understand about the willingness. Understanding the needs of patients, where patients who were, and them being receptive to it. We also wanted to make sure that in the electronic medical record system that there was a template in place that they would be able to capture the data.

Obviously, around policy development, we look at New York State HIV testing law, the pre and post-test counseling. We wanted to make sure that individuals were aware of that, what needed to happen if you will. Understanding about discrimination given the fact that the law said, we should be offering everyone 13 to 64 and, in our case, above 64 the test to make sure that it is documented.

As we register patients coming in, all the patients sign an HIV consent form so that piece is taken care of. As stated before, we use OraSure, OraQuick in terms of the testing if you will, that whole process there. Making sure that the dental staff understood how to store then run the controls, store the kits.

And then the other thing that was really important for us is our captain process, where our particular team comes [? along ?] our front providers to be able to provide support for those people that happen to be reactive. And so we have a team in place that will service all our 10 sites that we would go out. If there is an individual that is found to be reactive, then one of our staff will go and support that individual.

And we will make sure that individual, if they are not registered for Family Medicine, we will make sure that happens. They get registered into the system. If they have issues with their finances, we make sure they see a financial counselor. And we make sure that they get to see a HIPAA provider within 24 to 48 hours. So that process has been working very well for us.

And basically, just to kind of follow through to make sure that everyone is aware of the process and that we're following through. So we work very closely with the dental staff and make sure that they feel comfortable. And we provide the training as needed.

So what we've done over the last couple years is we currently have dental in three of our comprehensive sites. And so what we've been doing is to track those, basically, year over year, month over month to see, basically, how things are going. And so we work with the dental staff at each site to provide the training that's necessary.

And as you can see by the graph, we've been on the decline. So we want to bring those numbers back up. So we're currently working with our dental staff to make some things happen to improve the amount of testing that occurs in dental.

So polling questions. What would you consider to be the biggest barrier to HIV screening in your dental environments? Check all that applies.

STEVE LUCKABAUGH: Hence our fourth poll, what would you consider to be the biggest barriers to HIV screening in your dental environment? You can check as many as you need to and also, the last one there, other. If you want to enter something different, you can enter it into the questions pane and then go to it on our toolbar.

GREGORY BYRD: OK? OK. So in terms of the training, yes, very important.

One of the things that we were able to do, we worked with Howard Levine. And he was able to come in to our dental staff-- we'll talk a little bit about it-- and to provide training on how to ask the question. Sometimes what we found initially that individuals were simply saying, would you like an HIV test. The person would say, no, and that would be the end of the conversation.

What we wanted to do was to have staff simply say something to the extent that, it's part of our protocol that we offer HIV testing for individuals that have not had one within three months. That's what we're going to do today. Is that OK? And I think being more forward, it will help them to move forward.

The training also simply says, the more that you do it, the more you become comfortable doing it. And so that's major. I think it's also partnering, identifying champions within the department to help those individuals that are just learning or new to staff. The other fun that we have is turnover. For dental, there seems to be a high turnover. And because there is high turnover, then how do you make sure that those new individuals get trained?

So when you think about it it's important that we stay current, one, with the training. We focus on the testing, not the conversation. It's also wanting to pull back-- or I should say, peel back the onion in terms of if someone said, no, I don't want to be tested. It's OK to ask why.

You want to make sure because if someone-- there's been stories of individuals where they've been coming to clinic year after year, year after year, and they've not been tested only to find out down the road that they've been positive for a while and no one simply asked the question. So it is important being able to, again, just address some of the things that are going on from a patient's perspective as well as from a staffing perspective. And so what we look to do is say, from a management standpoint, we wanted management to come in and to provide a little additional support from direction.

One of the things that we noticed that from a target standpoint, there was really no target. It was just as individual did the testing, they did the testing. And that's how they did it.

And so we thought it would be important to be able to say, gee, if you at least had set the expectation of each office to do a certain number of tests, then that would at least heighten that awareness for staff coming in. Again, there's specific training in terms of how to offer this so it's really important. So we took a time with each of our comprehensive sites to train them individually. Howard Levine came in. He did an afternoon training for everyone. It was really, really good.

The ideal was, gee-- we also looked at, from a documentation standpoint instead of we had individuals providing their initials. The fun that we had there were a number of individuals were using multiple initials. So it made it harder for us to track.

So we also said if we can go with a time stamp that has a specific name and date associated with it, we would be able to identify exactly who's doing the test and who's not. Now someone

said that we're looking to find individuals that were not testing, but possibly those individuals that need a little help. It also helped us to identify the champions.

And so there are a number of individuals that stood out that were doing extremely well with testing the dental. And we were able to use that expertise to work with those individuals that were not as productive if you will. So that worked out really good. And then also from a reporting standpoint to be able to provide information data to the dental directors for their other review that they can review back with their staff also makes a difference.

So at the end of the day the funding that we have. Training-- we need to make sure that we're consistent with training, and it needs to happen on a regular basis, again, especially if staff is changing. So we want to make sure that everyone is current.

Being able to have a control plan in place in terms of, what our monthly targets? What are we shooting for? It just helps to make the staff aware to be mindful that they should be not only asking the questions, but, where appropriate, completing the tests.

Once a month we go through all the numbers. We're able to pull that information out to share it with the dental managers if you will, that they can now share that information with their staff. We're also looked at from an electronic standpoint to be able to use the process of alerts, where as patients come in, if they are in the systems if you will that there's an alert that can be triggered to identify, OK, this person has not had a HIV test within a year. And so that gives the staff the means to say, yes, we need to be able to do the test.

We also wanted to be able to identify the specific reason associated with individuals that refuse to test, whether they were tested at a primary care provider outside of Jordan or even within Jordan. Whether they just had a test three months ago or six months ago. But we wanted to understand specifically why individuals were not being tested or were refusing the test.

We wanted to also understand different ways of, how do we overcome the barriers? And so talking with staff and being able to identify with some of our patients asking them, what are some of your issues? What are some of your concerns? And then how do we address those concerns?

So by being able to do that, we've been able to put a plan in place, and it's working effectively. There is some room for us to continue to improve, and we're continuing to do that. So that's all. Question?

STEVE LUCKABAUGH: All right. Thank you Mr. Byrd. If you have questions for Mr. Byrd or any of our other speakers, you can enter them now end of questions pane, and we will take questions after we have finished for today.

Our final speaker today is Dr. Chianta Lindsey. Dr. Lindsey has worked in the field of nursing for over 20 years earning her bachelor's of nursing degree from Florida A&M University. She has



had the opportunity to provide nursing care in a variety of specialties, including mental health, cardiac care, nephrology, and gastroenterology.

She achieved her master's in nursing from the University of Central Florida with a focus on adult health to become a nurse practitioner. She returned to the University of Central Florida and achieved her doctor of nursing practice degree in the inaugural class of 2010. Her doctoral research focused on community health programs within faith-based organizations and the impact these programs have on improving the health and wellness of the homeless and uninsured, while reducing unnecessary emergency room and hospital visits.

For the past seven years, Dr. Lindsey has been employed at Orange Blossom Family Health where she is the Vice President of Quality and Performance Improvement. Dr. Lindsey is responsible for improving access to primary care services and implementing and evaluating strategies to improve the health outcomes of patients at Orange Blossom Family Health. Dr. Lindsey serves on several nonprofit community boards that primarily provide service to close health and social disparities within the community. Please join me in welcoming Dr. Lindsey.

CHIANTA LINDSEY: Good afternoon everyone. And thank you for taking time out for this presentation today. So I want to talk about HIV testing at Orange Blossom Family Health and start out with what our philosophy of testing is.

And basically, at Orange Blossom Family Health we believe that HIV can be prevented from early intervention and testing. That HIV is a chronic disease much like diabetes and hypertension and it can be managed. If HIV can be prevented and managed, then screening every patient must be an organizational-wide endeavor to screen every patient at minimum once a year. And screening initiatives will occur with every patient who does not have a documented HIV test regardless of where that care visit occurs.

So our HIV care team is made up of myself, our chief medical officer, our chief dental officer. We have an HIV specialist who is a primary care physician but achieved her certification in HIV treatment and management. Our chief pharmacy officer.

We also thought it was important that we have someone from our behavioral health department on the HIV care team because we know that the diagnosis of HIV can be traumatic initially to the patient and to patient's family. And so having someone there when a result is reactive to provide immediate counseling to that patient is imperative in our opinion. We also have an HIV coordinator, and we work closely with our local health department's disease intervention specialist.

So when we began this endeavor, in the partnership for care endeavor, and actually becoming more aggressive in HIV testing, I thought it was important that we train our board of directors because the ones that have buy-in from everyone on why we were doing this. So we took them through a very rigorous training. And then we again began to go department by department training each staff member on our philosophy of testing. Then we partnered with the AETC and

the Florida Department of Health to provide ongoing training regarding screening, testing, linkage, and treatment. And then we have some of our providers who have taken a vested interest in becoming HIV specialists themselves in a primary care setting. And so they are currently working towards CMEs to help them achieve that goal.

So in our initial implementation we started out where we were doing rapid HIV testing through ClearView. And so instead of having one designated person to be able to do HIV testing, it was important that all the medical clinical support staff received what at the Florida Department of Health is called 500 and 501 HIV training. So that just because one person was out of the office that did not limit our ability to test as many patients or it allowed us to reach a lot of patient.

The 4th generation testing was added to our comprehensive lab panels along with lipids and CBC and CMP because we wanted to introduce this to the patient as part of a normal screening examination and not something that was out of the normal or unusual or because there was a concern. We continue to make rapid testing available for our walk-in patients and through our mobile unit when we were participating in outreach activities and also for patients who were non-health center patients. So we allowed people who were to come in and they didn't want to register to be a patient, but they wanted to have a test.

We offered this service to them to be able to come in and sign their name up, get the test, get the result, and then if there was a reactive test, we can provide them with how they can come back and receive the confirmatory results. And then we also made the rapid testing available for those who had a high-risk exposure. And now we are working on developing a workflow for testing and our dental department.

So we have a polling question number five. Are your primary care physicians comfortable discussing HIV testing with patients?

STEVE LUCKABAUGH: OK, this is our final poll here. Are your primary care physicians comfortable discussing HIV testing with patients. Yes, no, or not sure. Please take a second to answer, and we will share the results.

CHIANTA LINDSEY: OK. That's pretty good. Most of you noted that your primary care physicians are comfortable with discussing that, but 27% of you are not really sure if your providers are comfortable with it.

And I think that was what we considered to be a challenge at our organization. You said whether providers do not feel they had enough time in their day to discuss HIV testing and the importance of it as they would talk about the importance of colorectal cancer screening or a breast cancer screening. And so as a result and initially, we felt that testing initiative in the primary care was low because of this low level of comfort. And then again having quasi-HIV testing limited to a medical department has prevented us from being able to expand this over into the dental department.

An additional challenge that we found with that if we had the tester, how would we incorporate testing within the dental workflow as dental procedures are typically the priority for the dentist as well as the patient. And then because of our health center setup, oftentimes, there are patients that are accessing care in dental who may or may not be a patient in the primary care clinic. And therefore, how do we link those individuals to resources in the community and ensure that they follow up?

So some suggestions and how we could meet some of the challenges is that we found that our medical assistants actually had great rapport with our patients and that our medical assistants were actually very comfortable in asking a sexual history question as well as encouraging patients on the importance of getting the HIV test when compared to our provider.

This is interesting because our patients stated-- when we looked at this-- that the medical assistants were typically the ones that they talked to on a consistent basis rather than their provider. So that therapeutic relationship was actually stronger with our patients and the medical assistants than it is with our providers and our patients.

Secondly, another suggestion is that we provide HIV testing to patients waiting to receive dental services. We don't want to interrupt dental services, so one of the suggestions in order to incorporate patients getting tested over at dental, was while they were waiting to come back for their appointment, we would have that patient take a rapid HIV test. And then-- with the hope that by the time the test was complete, they would be ready for their appointment, and we could then have that results discussed with the patient and the dentist caring for the patient.

We want to now expand our training to our dental assistants, so that we-- the dental assistants-- can actually conduct the rapid HIV testing in their department. But again, we want to make sure that we do things in a manner that does not disrupt the work flow. And then having a strong relationship with your local health department and DIS is imperative in ensuring that patients are linked to the appropriate resources in the community. Being able to provide prep and pep in your health center is also a recommendation for individuals who have high risk behavior.

But more importantly, ensuring that the relationship between the provider and the staff-- I'm sorry the provider and the patient-- is heightened because oftentimes when that relationship is heightened, what we've noticed is patients will more than likely continue to follow up with their care. Having a HIV specialist in our office has actually somewhat improved our follow up with our patients, because patients feel comfortable in accessing their care here because we also provide a wide range of services such as pharmacy services. So having that one stop shop has been a key to improving the follow-up and linkage that we are looking to continue to evolve. So

In closing, recommendations for the testing outside of the primary care-- and just improving primary care testing strategies-- making testing procedures easily accessible, and not having the

patients sign a lot of forms. But just-- if they want to come in and have that test, they can come right in and receive those services. Enhanced training for support staff on patient engagement, sexual history interviewing, and initiation of testing through standing orders, because they are usually the first point of reference for patients, and they have established rapport with those patients in addition to the clinician.

And then a strong collaboration between local health departments and providers of HIV care. Because again, linkage is important. We want to make sure that patients can access the services that they need in a timely manner without having to go through a lot of red tape. So having great relationships and knowing how you can get your patients in to be seen for treatment is critical. Thank you.

STEVE LUCKABAUGH: OK. Thank you Dr. Lindsey. And now we have a little time here for Q&A. So if you have any questions, you can enter them now into the questions pane on Go to Webinar toolbar. And we had a few comments and things that came in. And I'm going to unmute you guys' microphones, if you need to answer any of these.

So let's see. The first one was, we had a separate dental record for the first three years of our eClinicalWorks initiation. But now we are all using eClinicalWorks. We had to do a similar paper process before they got up to speed.

OK. We also have one that says, our dental department has access to patient EHR, but no other department has access to their dental records. Sounds like they might be having some similar problems.

KAREN WENDEL: Can I ask a question of the sites? I'm wondering for our sites, how many of you know-- how many positives you've detected and your percent positivity in the dental clinics? When you're assessing your testing protocols there.

STEVE LUCKABAUGH: OK, if you have an answer you can enter that into the Go To in our toolbar.

KAREN WENDEL: And Craig, I don't know if you could speak to that.

GREGORY BYRD: Right now we've done the testing-- we're basically around 500 tests. And no, we've not identified any positives. Not in dental at this point. We've been able to address other newly diagnosed individuals coming into the clinic from a family medicine standpoint, but none in dental. So

CARRIE AMOROSI: We haven't identified any in dental either. All our positives have been in the primary care.

CHIANTA LINDSEY: And we are currently not testing in dental, but we do treat a lot of patients who have HIV who are referred to-- who need primary care services, who are referred through dental, and then subsequently are referred to primary.

KAREN WENDEL: And then are they-- in the dental clinics-- doing any assessment to see if testing is indicated? In other words, when their last test was, and their risk factors to determine whether they're really appropriate candidates to perform testing on?

GREGORY BYRD: This is Greg again. For us, the staff is trained to review the medical records if that patient is there, because if they do a testing, it is documented accordingly. So that's one reason why we wanted to use the alert system. Because the alert can try to measure whether or not that person is in need of a test.

KAREN WENDEL: So that automatically triggers in eClinicalWorks?

GREGORY BYRD: Yes.

KAREN WENDEL: Great.

STEVE LUCKABAUGH: OK. We have a question for Carrie. Can you talk a little more about your approach to screening of all persons over 13? Specifically, the age of consent for HIV testing in New York State.

CARRIE AMOROSI: OK. Over 13. We essentially took this in particularly building a program around this-- the initiatives by New York State to offer the test to everyone over the age of 13 and under-- well it was under age 60, but now they've removed the top age limit from there. So that's kind of where we started from.

And that was a good question initially about dental. If you can't see their record, how are you screening them? But that again, we were doing this all inclusive, offer the test as a normal kind of thing to absolutely normalize HIV testing and stop making it the test, as opposed to just part of our normal screening procedures.

For the age of consent, I do have a little-- we've made some information sheets too that are simple flyers. And one of them is about AIDS and HIV testing. And while they can be tested, we don't-- I don't see a lot actually of our peds being tested.

I think it needs to work into kind of the providers psyche a little. It's our MEs that do the testing as well as the other center. It's not the physicians. But even the physician's attitude of course, is going to kind of trickle down to your staff.

So I'm not saying they have a bad attitude, I'm just saying they don't probably see as much-- don't think of our teens being at risk. Especially our younger teens-- 13-year-olds-- some of them are very, very young looking. But that doesn't mean that they couldn't be more involved

in the behaviors that lead them to an increased risk of becoming infected with HIV. Did that answer your question?

STEVE LUCKABAUGH: Yeah I think so.

CARRIE AMOROSI: OK.

STEVE LUCKABAUGH: All right, I have one for Dr. Lindsey. National guidelines for routine testing do not require annual testing for patients. Why is that a goal for your H.C?

CHIANTA LINDSEY: Because we sometimes-- we may only have one opportunity to capture a patient. We deal with the homeless, who are oftentimes transient. And so when they come in for that and initial visit, why not? If we're going to screen to see if they have diabetes, and if their cholesterol is out of whack, why not screen to see if they are positive for HIV so that we can educate them on that, get them linked to services so that this doesn't turn into a chronic-- or develop into AIDS or other complications. Just like again, we do this yearly because we don't want to miss anything.

Just like we wouldn't want to miss getting [INAUDIBLE] on insulin or medications for your diabetes. So it's about normalizing their screening and not have-- as Carrie said earlier-- the test.

STEVE LUCKABAUGH: All right. Thank you. We have another one. Not only do I feel that some of the providers aren't comfortable with talking about HIV, but also we're having a tough time getting them to give routine HIV tests to our patients. Any tips? And that can go to anybody.

GREGORY BYRD: Well we look at it as working with our nurse provider-- our nurse practitioner-- who meets with the providers and being able to offer the providers just routine testing on HIV. And also to address the importance of doing it, in terms of doing the test, if you will. So it's really about making people feel comfortable, and it's just a part of it. And again, it's how you ask the question.

The other thing is, us being able-- just to pick a particular department-- being able to provide the support such that they know-- that even if they do find someone reactive-- that we are there to support them. So in terms of if the person has some emotional challenges at that particular time, we are there to support them. Just as the provider is free to go on and do the other things that they are required to do. Thank you.

STEVE LUCKABAUGH: So did anyone have any closing thoughts, I guess? Before we wrap it up here?

GREGORY BYRD: No, simply to say, thank you for the opportunity.

STEVE LUCKABAUGH: OK.

CHIANTA LINDSEY: Again, I think it's important that we just understand that the more individuals that we can identify who are HIV positive, and provide more education to those who have high risk behavior, we have a potential of changing the face and the stigma surrounding HIV. And I think that's our obligation to the community, to help people understand that this is not a dirty disease. So the more we normalize this-- as everything else we've normalized, having a colonoscopy-- then we begin to educate the public on how they can also prevent this from occurring.

GREGORY BYRD: The other thing that I will add, is that from here in New York, we're working on our Governor's initiative really to reduce the number of reactive persons by the year 2020. And so for us to do the testing in general, is just an extension of that, and for us to be able to do testing outside of primary care. So being able to identify-- in our particular area, there's roughly an estimated about 300 people that have not been linked to care.

And so they may come in to dental. And so to be able to provide that testing, to be able to identify those individuals, that's a good thing.

STEVE LUCKABAUGH: OK. All right, well I'd like to thank everyone for participating in today's webinar. Take care everybody, and we'll see you next time.

CHIANTA LINDSEY: Thank you.

GREGORY BYRD: Thank you

CARRIE AMOROSI: Thank you.