WEBINAR VIDEO TRANSCRIPT

Partnership for Care HIV TAC

Routine HIV Testing: Communities of Practice Session #1

11 Feb 2016

STEVE LUCKABAUGH: Good afternoon. My name is Steve Luckabaugh, and I'd like to welcome you to the routine HIV testing community of practice session number one webinar. This webinar is brought to you by the Partnerships for Care, HIV Training, Technical Assistance, and Collaboration Center, or 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, one, expand prevention of HIV testing, prevention, care, and treatment in health centers serving communities highly impacted by HIV. Two, to build sustainable partnerships between health centers and their state health department. And three, 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, or HIV TAC. At this point, I would like turn things over to Victor Ramirez at MayaTech. Victor?

VICTOR RAMIREZ: Thank you very much, Steve. Again, my name is Victor Ramirez from the MayaTech Corporation. I'd like to welcome all the P4C health centers, health departments, and also some of the federal staff who signed up for today's first session of our Communities of Practice. This is the routine HIV Testing Communities of Practice Series. It will be led by faculty from the Denver Prevention Training Center.

As you can see, we will have four sessions under this Communities of Practice Series. One each in, well-- today, the month of February. Then March, April, and May. And please be on the lookout for additional information on other Communities of Practice that will be forthcoming very, very soon.

I also want to take the opportunity to thank the Whittier Street Health Center for agreeing to participate as our health center presenter for today. And I would like to also extend the invitation to the other health centers that are joining us today, that's for future Communities of Practice, both for the routine HIV testing series, and also for the ones that we'll be announcing shortly.

Please feel free to participate and nominate yourself to participate as a health center presenter. We want to hear from you. We want to hear from the health centers. You know, how they are going about their work and implementing, well, in this case, routine HIV testing. Things that work, things that don't work. You know, what you're doing on the field. I think that's

very important to get that health center perspective. So again, thank you very much to the Whittier Street Health Center for participating today.

At this point, I'd like to welcome Dr. Karen Wendell and Helen Burnside, both from the Denver Prevention Training Center. I'll just say a short introduction for both of them. The bios are available. You can download them at this moment via your panel link.

Dr. Wendel is the director of HIV/STD Prevention and Control at the Denver Public Health, Denver Health, and assistant professor of medicine at the University of Colorado Health Science Center Division of Infection Diseases. She received her medical degree at Johns Hopkins University School of Medicine, and completed internal medicine training and infectious disease fellowship also at Johns Hopkins at the Hospital. She has been involved in HIV and STD clinical care and research while on faculty at Johns Hopkins School of Medicine, also at the Oklahoma Health Science Center and the University of Colorado Health Science Center.

Ms. Helen Burnside, she is the manager of Denver Prevention Training Center, HIV Capacity Building Assistance program, and is responsible for the administrative, reporting, and clinical program oversight of the CBA SHIBA program and continues to support the national network STD clinical prevention training centers. In addition to her five years of experience managing the National Coordination Center for the STD Clinical Training Centers, Ms. Burnside has been a trainer for over eight years with a focus on HIV prevention in clinical care interventions, an expert in the STD/HIV field for 12 years.

So without further delay, Ms. Burnside and Dr. Wendel, both of you are a un-muted.

HELEN BURNSIDE: Great, thank you very much, Victor, and I just want to thank you all as the audience and participants for joining us today. I know that you have incredibly busy schedules, so we really appreciate your participation in our Community of Practice.

As Victor mentioned, I'm Helen Burnside, and I just want to provide a quick overview of the Denver Prevention Training Center. We've been funded for over three decades, providing capacity building training, and medical consultation and technical assistance to providers nationally by an STD and HIV prevention and treatment, and funded by the Centers of Disease Control and Prevention.

We often collaborate nationally with other federally funded training centers, and we're super excited to work with MayaTech, today, to bring you this Community of Practice. This slide is extremely busy, but does touch on some of the expertise we have in-house at the Denver Prevention Training Center and some of the national initiatives that we are working on.

So we'll move to the next slide, and before we begin with the content, we have a couple of polling questions. We want to hear from you as the Partnership for Care grantees. If you are currently using HIV rapid testing or standard lab testing. And as Steve mentioned, we would love 100% participation.

You'll have about 30 to 60 seconds, so go ahead and choose, at your health center, if you're using HIV rapid testing or standard lab testing currently. And this will help us to get a flavor of those health centers receiving today where you are with rapid HIV screening.

All right, so according to this poll, it looks like 17% of you are currently implementing rapid quite care testing, 28% are implementing lab-based testing, and 55% are implementing both. OK, great. Thank you.

And we're going to move to our second polling question. So this question, we are wondering if your health center currently has a method to offer HIV testing services to patients outside of a primary care visit. For example, this may be an opportunity for patients to come in to your health center, not showing up for a routine visit, but showing up to specially to get each HIV testing services.

So if you could please select one of the following answers, yes, your health center does have an alternative way to offer HIV testing outside of the primary care visit. No, all HIV testing at your health center is done in context of the primary care visit. Or you are not sure. So please select what is most applicable for your health center.

All right, so 92% percent of you all are saying that you do currently have a method to offer HIV testing outside of that primary care visit, and 8% are reporting "Not Sure". OK, fabulous. Great.

All right, so our final poll before we get started here with the presentation, is asking if you, at your health center, have a champion that coordinates the HIV testing services, such as testing, delivery of results, and reporting. So, yes would mean that you do you have one particular person on staff who has dedicated time and effort to coordinating those HIV testing services. No would be you do not have a designated identified staff person, currently, who's coordinating testing results, or reporting, at your health center.

So I'll give you about 10 more seconds, yes or no. All right, let's see what we have. OK, so about 70% of you are saying that you do, indeed, have a designated staff person championing HIV testing services at your health center. 30% are reporting "No."

OK, great. So I just want to let you know how the rest of the webinar is going to go. I'm going to turn it over to Dr. Wendel, who's going to spend about 15 minutes overviewing the testing recommendations around routine HIV testing. As Victor mentioned, we're going to hear from Whittier Health Center, around their experience with integrating routine HIV testing into their services. And then we're going to have time at the end where we really want to hear from you all about challenges and successes in implementing routine screenings. So with that, I will turn it over to Dr. Wendel.

KAREN WENDEL: Hello, thank you, Helen, and thank you for completing those polling questions. It gives us a good idea of where people are as we proceed through this talk. So just to go over

our learning objectives for today, I'm going to briefly review the epidemiology of current HIV, folks living with HIV currently, and what our incidence looks like across the nation.

I'm going to go over the CDC guidelines that came out in 2006. Really, looking at two groups, the adults and adolescents, and then pregnant women. And then we'll review the indications and schedules for repeat testing of HIV after you've completed routine testing of all the individuals in those groups. And the rationale for instituting routine testing in health care facilities.

Opt-out testing, which is currently recommended by the CDC, is the favored method for addressing HIV testing with your patients and what that consists of. And then, finally, the components that you would need to implement this kind of routine testing plan.

This map represents current cases of HIV and you can see where things are really clustered. The map really represents numbers per 100,000 population, and you can see our hardest hit areas. Washington DC is an area, Maryland, New York, Florida, Georgia, and Louisiana are really bearing the brunt of active cases.

This map is the incident map for 2014, so looking at newly diagnosed cases, and you can see it's really very similar. Washington DC still having the highest rate per 100,000, at 66.9. And then Florida and Louisiana being very impressive as regards their continued high incidence rates for HIV. And I think for all the people involved on the line, you can look at your state and kind of get an idea of where you are. Where we want to be.

And then to look at newly diagnosed cases in 2014. What are the risk groups that we're seeing? Who are the new cases occurring in? And you can see that it's still primarily a male to male sexual contact risk group. The second biggest group being the heterosexual exposure, high risk exposure group, about 25%. And other risk factors for transmission really making up a far smaller component of new cases such as IDU.

I put this slide in just to make the point of how HIV is really one of the health issues that we face that really represents one of the disparities in medicine and disease in our country. Demonstrating the large number of African-American and Hispanic patients that make up our new diagnoses as evidenced in the 2014 data set.

And then finally, I like this slide because not only do you see that, well, of course our new cases are primarily seen in young folks, but as providers, sometimes we don't think of testing, and hence these routine testing guidelines. We don't think of testing people over 45 and they can make up 26% of the new cases as recently as 2014. And kind of go to why we need to be doing routine testing and avoiding potential provider bias as we look at patients and the risk factors.

So the guidelines that I'm going to discuss are 2006 MMWR guidelines. And they were really put out focused not on the CBO group, but primarily on health care settings to include primary care

clinics and community-based health care clinics, correctional institutions, public health clinics, substance abuse clinics, inpatient hospital wards, and emergency departments.

To begin, that first group, adults and adolescents, the guidelines recommend that we screen at least once all of the patients in the age group of 13 to 64 if we know that we are living in a prevalence area of undiagnosed HIV that is at least 0.1%. And I think for a lot of us, that's sort of hard to determine. I think those maps can give you a bit of an idea.

Patients being treated for tuberculosis should be screened. Patients who are being treated for sexually transmitted infections should be screened. And, of course, we should offer it to patients who are entering into new sexual relationships.

In the next group, pregnant women, it's recommended that we screen all pregnant women as soon as possible in their pregnancy so that we can Institute highly effective inter intra-viral therapy as soon as possible to try to avoid perinatal transmission.

It is also recommended that we consider testing every pregnant woman in the third trimester, but focused on really going through with these recommendations and focusing them strongly on women who would be at highest risk. Those would include women who have a high incidence of HIV infection in their age group in your jurisdiction, women who are pregnant and use injection drugs or have partners that use injection drugs, women who exchange sex for money or drugs, sex partners of HIV-infected men, women with more than one sex partner during the pregnancy. It's recommended all of those get a second screen in the third trimester, preferably before the 36th week.

We can see with these sort of routine recommendations to screen all women, and the highly effective inter intra-viral therapy that we have access to these days, what a dramatic decline we have seen in prenatally acquired HIV. And this is really a great success story for HIV testing and treatment, and you can see our rate's going to near zero.

So after we've and completed our initial routine screening of all patients that meet the guidelines, the next step is really who should we be offering repeat treatment to? What are our guidelines and how are we going to follow up on these patients? And the recommendations are that we screen at least annually in patients who have sex partners who are HIV positive, patients who have multiple sex partners, or using injection drugs, patients who exchange money for sex or drugs, and-- or, sorry, exchange sex for drugs or money, and patients who have ongoing diagnoses of sexually transmitted infections.

As we discussed, we would like to rescreen women in the third trimester if they have elevated risk. And in sexually active gay men or bisexual men who are actively engaging in sex with multiple partners. Recommendations are for repeat testing at three to six month intervals, along with RPR and other STI screenings. And then, of course, for all other patients, as I stated previously, engaging into a new sexual partnership, we should offer repeat HIV testing to the partners.

We touched on this a bit, what is the rationale for testing everyone? To begin, we know that targeted testing catches fewer people because of missed opportunities due to patients' own lack of understanding of their risk factors. And for breaks in providers, being able to identify high-risk individuals, either through problems with disclosure or with an incomplete sexual and risk factor history.

So routine testing, we believe, may lead to lower rates of late diagnoses that we will be able to hopefully identify people earlier on in disease. More people tend to accept HIV testing when they sense that it's being offered to everyone. It helps destigmatize the idea of HIV testing. Multiple studies have been done to look at the cost-effectiveness of routine testing and almost all have suggested that this is a good routine screening to implement. And we have examples of great success and routine screening from perinatal HIV transmission, which we just reviewed, and through blood donation.

When we pick somebody up early in these, when we make that early HIV diagnosis, it really affords multiple opportunities. And that is the ability to counsel and support, disclosure and prevent transmission in that patient to other individuals, to link them into a care continuum so that they have access to specific HIV care and inter intra-viral therapy, which then leads to decrease morbidity and mortality in that patient. But then also decrease community viral load, decrease transmission of HIV from that patient to others, which has been demonstrated now in very robust clinical studies.

When we proceed down routine testing, the mode that's been recommended to us by the CDC is opt-out testing. What does that entail? It entails that we inform the patient that HIV testing will be performed as standard care unless the patient declines. We provide them with oral or written information that includes explanation of HIV infection and disease and the meaning of their test results. We inform the patient that they may decline the test.

And it's important that part of this opt-out formula is that written consent is not really recommended and that prevention counseling is not required, although we feel that that's very useful in most settings. It's important to understand as we look at that type of approach to HIV testing that not all states have the same ability to proceed with opt-out testing. In specific, Nebraska, New York may have some state laws that may cause some changes to use of opt-out testing, and so it's important to know the laws in your jurisdiction.

Potential obstacles that we hear to HIV screening from providers is a question of whether this is a good use of resources. And clearly, as I've stated, there have been multiple cost-effectiveness studies that would suggest it is.

There is a concern that the patients will have a barrier to their relationship with the provider after this, that is there some sort of suggestion about their risk factors. And there is a concern that it will get in the way of the provider relationship with their patients. And that's really where opt-out and routine testing can help normalize that and destigmatize it.

There's sometimes difficulty and provider discomfort in obtaining sexual and drug use history, which is really a skill that needs to be promoted from medical school on, and something we all need to become very familiar and comfortable with, and it, I think, increases over time. And then, obviously, the concern of how much time each provider has with the patient, and how they can be drawn away by active health issues and away from screening in their visit. And where that screening message falls in the care visit. From patient's perspective, again, cost can be an issue, concerns regarding confidentiality, and perceptions of risk behavior by medical staff or family, where routine testing, again, can destigmatize to a certain extent.

So as we talked about in the polling questions, it's often useful given the rapid appointment styles that we have now, and the multiple competing draws upon a provider's time, to have a designated HIV tester. So in moving away from the thought that this is best place with the primary provider, it may be that using health care partners such as counselors, nurses, or medical assistants to, sort of, guide this screening process through. From initial identification of patients that need to be screened, to getting that testing done, to following up on the test and providing results, might be best served by someone who is a dedicated champion to that process.

So that brings us to that end component of the process, which is providing the results. For HIV negative results, it's OK to be providing these without direct personal contact. And I think with that message of a negative test, we always need to be prepared to provide recommendations regarding intervals of rescreening, prevention counseling, and referral to prevention counseling, if it's not available on site.

And finally, with the growing expansion of the use of PrEP and it's important in this role that it's been really well-confirmed at this time. It's important to know how to guide a patient into that process and provide them with information as well as link them into care if appropriate. For HIV positive results, we want to provide those directly in a confidential manner with a well-skilled health care provider. And we want to provide those result in a direct neutral tone, and providing the patient with information about infection, treatment, reducing their transmission risk to others, and giving them some tools to provide disclosure to their partners, as well as linking them to care and making sure they leave with the feeling that they know their path forward to sustain their health.

Finally, we have to document the whole process. And that needs to be incorporated into our EHR systems. Initially, of course, to be able to define whether a patient has been given opt out screening and whether they have declined and the reason for doing so so that that's visible to all the health care partners in the facility and can see that that has been provided and what the reasons were, to provide the HIV result and document that in the chart, to go over a patient's sexual and drug use history so that we can correctly provide them with information about rescreening and risk reduction, including PrEP, and then to document that plan for repeat testing so that we can keep them on track beyond routine screening and link them appropriately to PrEP and document our completion of that process. So we're going to open it up to questions now before we move on to Whittier Health Center.

VICTOR RAMIREZ: All right. Thank you, Dr. Wendel. Again, if you have any questions, any comments, please type them into your question panel. We do have one question. What reasons do patients give for opting out?

KAREN WENDEL: You know, I think that sometimes patients will state that they've been tested elsewhere, and that's fine, and obviously an important thing to document in EHR. I think many patients will say, I don't need that.

And it may be really an issue of not recognizing their own risk or not really having any risk. And that's something where I think a provider really does have to sort of intervene and provide information and just make it a very open dialogue. I don't think we want our pressure any client or patient. And we really want to make that an open kind of offer. But I think it's important at that point, if the client does decline, to really review some of the risk factors that we see associated with it.

VICTOR RAMIREZ: All right. Thank you. I've got one more, another question. For patients with negative results, what intervals should be used for rescreening?

KAREN WENDEL: So I think that's a fabulous question. And I think that a lot of providers struggle with that. And it really depends on taking an excellent sexual and drug use history. And a drug use and sexual history is only good for that one moment in time. So it's something we have to update on a regular schedule.

And so you want to know if they're patients that have been engaged with multiple partners, they at least want to be tested yearly, patients who have HIV infected partners at least yearly. If they become pregnant, they should be rescreened. For men who have sex with men, it's every three to six months if they have multiple partners. If they're in a steady relationship, it could be pushed out to once yearly. And so patients entering into new sexual relationships.

So as I said, this can be very fluid. And what you find that you would recommend at one point in time for a patient may change the next time you see them. So it's important update these things. And perhaps even as you're sort of discussing these issues with the patient to remind them that if your situation changes, we might change your recommendation as to how frequently you should be rescreened.

The default recommendations on rescreening are in my slide set a few slides back. And so those will be available to you to reference back to that are also included in 2015 STD Guidelines and on that original document in 2006, and then WR. I think the biggest change potentially between those documents would be the men who have sex with men recommendation of three to six months.

VICTOR RAMIREZ: Thank you. We do have a comment from one of our CDC project workers who was participating. Just to clarify the comment about New York and Nebraska testing laws, beginning in April 1, 2014, New York state public health law allows for streamlined oral patient

consent to an HIV test. The law no longer requires that patient consent be obtained in writing except in correctional facilities. So thank you very much for that clarification. We want to-- one more question, and this is from the health department perspective. What suggestions do you have for health departments to promote routine screenings?

KAREN WENDEL: You know, I think it could be incorporated into every clinic in the health department to be offered in all of the clinics to all patients as they come in. And that's sort of the way we approach it at Denver Health. It helps, I think, to have access to rapid point of care testing so that it really increases, I think, some of the patient's acceptance of it. When they know they're going to get the results right there in about 20 minutes, it's a powerful thing.

VICTOR RAMIREZ: All right. Thank you very much, Dr. Wendel. And we'll be coming back to Denver Prevention Training Center. And we'll have more time also to entertain more questions and comments at the end of the webinar. But right now, I would like to turn things over to Dr. Cyril Ubiem.

Dr. Ubiem received his Masters of Arts in Counseling Psychology from the United States International University in 1998. He also obtained a postmaster certification in chemical dependency from UFIU. He worked with the United Nations High Commissioner for Refugees in Nairobi, Kenya shortly after graduation as a community service assistant. And he later worked in Nigeria with USAID Family Health International under the US President's Emergency Plan for AIDS Relief as a regional program manager setting up voluntary counseling and testing centers in various hospitals within Abuja, Nigeria.

He earned his PhD in counseling psychology from Northeastern University in Boston in 2010. And his research interests include health disparities among men of color, post-traumatic stress disorder, HIV AIDS substance abuse disorder, and dual diagnosis. Dr. Ubiem joined Whittier Street Health Center in 2009 as the coordinator of the Structured Outpatient Addiction Program, and also as psychotherapist until October 2014.

In October 2014, he was promoted to his current position, Director of HIV Services. So I'd like to turn things over to Dr. Ubiem.

CYRIL UBIEM: Thank you, Victor, for the introduction. And thank you all for joining me. So I'm presenting our integration of HIV services into primary care from the Whittier Street perspective. I'm just sharing our own experience.

So if you look at the mission of Whittier Street, the mission is to provide high quality, reliable, and accessible primary health care and support services for diverse populations to promote wellness and eliminate health and social disparities.

Just to give you guys a little bit of the background of Whittier Street, we serve 28,000 people from very diverse populations and backgrounds. Over 90% of our patients are minorities. Most of them actually African-Americans and Hispanics, Latinos also. And there's a lot of people from

Haiti, from Africa, Somalia, even Asians as well, that come to our center. And our mission is to promote wellness and prevention and address health disparities and social inequalities for all these people that we serve.

And we're highly skilled in innovative approaches to addressing health disparities and health equity. We have strong community partnership, engagement, education, and outreach, and empowerment. We have actually a very, very strong outreach because we're located in a place that has a lot of housing developments. And most of them, due to stigmas, want to come to health care center. So we do a lot of outreaching to those developments for not just HIV services, but even for other health issues, and then bring them back into the center to access health care services.

So just to give you guys the context of where we are located, this is our community. Like I said, we serve 28,000 people, mainly minorities, residents of Roxbury, Dorchester, Mattapan, and the surrounding areas. If you know Boston very well, we're located just right in the middle of almost everything.

This area has high concentration of low income households with over 30% of children in poverty. It has low educational attainment compared to the Boston average. It also has high prevalence of chronic diseases and STIs, also with the highest rate of crime in the city, according to the Boston Police Department.

Most of the people around here actually come to Whittier Street-- we're talking about all the way from Roxbury, Hyde Park, Mattapan, to East Boston-- even though there are some other health centers located in those areas as well. But we still have a lot of people coming from all those areas to our center.

So the HIV department at Whittier Street was established in 1994. And we've been doing HIV testing and providing HIV services since that time. And then recently, in 2004, we redesigned our care continuum just to position ourselves.

As you all know, you've seen the whole statistics about men having sex with men have been the highest in terms of incidence. So we wanted to restructure ourselves in such a way that we can be able to also tap into those populations, and also to African-American which is affecting of almost 40% of the population that we also serve.

So in doing that, we established collaborations with three grassroots organizations that are also within this area, namely Multicultural AIDS Coalition, Hispanic Black Gay Coalition, and Justice Research Institute. And because they also serve minorities and they also serve a lot of the MSM populations. So we collaborated with them to bring in referrals.

Because we're a clinic, we have medical care services. So when they see some of the people-- for example, MAC, that doesn't offer primary care, for example. We worked out with them in such a way that they can refer people for us. Some of their clients also work with Fenway too.

So they refer people to us for PREP, for linkage to care, for treatment and stuff like that. And of course, the [INAUDIBLE] is led by me.

So in 2014, so talking about our HIV testing in Whittier Street. In 2014, Whittier Street was funded by the CDC to implement routine HIV testing into primary care. We partnered with Mass League and other CBAs to create workflows. So we talked to the providers to actually be able to get all the information to map out the workflows that will help us in carrying out our testing. Mass League actually did a lot of work. And we've been doing actually continuing to obtain some of the information.

In our discussion a couple of days ago with our project officer, we talked about some modifications that we'll do actually in terms of those who do not qualify, some of our [INAUDIBLE] included in the workflow. So it's an ongoing process, you know, looking at the workflows and then doing some tweaking just to make sure every aspect of what we do is actually captured in the workflow in such a way that anybody who picks up the workflow will know what to do. And we also share these workflows with the providers. And it makes it easier for everybody to know what to do without getting lost.

We are funded... the Ryan White program has actually helped us to link all our HIV positive clients into care and then retain them in care. So I can tell that almost 90% of people that actually test positive in our center are immediately linked to medical case management, and some of those to care support services.

I don't know if you guys can see this very clearly, but the handouts are there, like Victor said. So you can actually download the handout and you can see clearly. So this is the HIV testing here at Whittier Street. So we're working them into two.

We still do rapid testing right now and we're working with Mass Department of Public Health to implement the phlebotomy, the blood draw testing. Our team members who are going for training in phlebotomy. So we're getting trained next month. And then we will do practice before getting into the blood testing.

So on the left hand side, this is rapid testing. For rapid testing, we have outreach workers who also go into the communities, into halfway houses, high risk populations, high risk areas, shelters and stuff like that, to do outreach and also do testing. We have a hotline that anybody can call. It's on our flyer. Anybody can call and then come into the center for testing.

And we also use this rapid testing for non-medical appointments. People can actually come in maybe for dental or for eye care, and then they request for HIV testing. We have actually come in for family care and they'll be able to call the line and then come for testing.

So when that happens, they come in. We have a testing room, confidential testing room. They come into the room. We say pre-test counseling-- I know it's not required, but it's just we kind

of sit them down and just give them a little bit of what to expect, what's going to happen. And then the test is actually done.

So we do four generation testing with Alere combo antigen test. And if the result comes out as negative, we do prevention counseling. And depending on, like Dr. Wendle was saying, depending on the risk, depending on the kind of lifestyle client or patient is assessed to, we can tell them to come back in three to six months.

And then if the result comes out as positive-- remember, this is rapid testing-- we generate a lab slip. And I'll talk about the fast lane a little bit later in the next two slides. So the nurse comes in, and then we generate a lab slip, through the final claim, that will take the patient to the lab.

And in that instance, we also get some other information from the client. Because at this point in time, most likely, the patient, we've registered him as a patient of Whittier Street. So getting some other documentation for insurance, registering the client into the system, and letting them know.

So they have the High-Risk Nurse now take that patient to the lab through the fast lane protocol for the test. And then they will let them know to come back in a few days for the results. The High-Risk Nurse will call them back when the result is out.

And so when the result comes out, the lab will flag the High-Risk Nurse to tell them the result is ready. And then, depending on what it is, if the result is positive, the nurse will call the patient and tell them to come back into the health center without telling them what the result is.

We try to centralize giving out results just to make it easier for the provider to get on with their job, and then so we also know that we're passing on the right information to the client. Also, I will describe later we pass on the HIV positive result to the patient in such a way that the patient has the support. And then we also link that client immediately to care.

So for the clinic testing on the right hand side. So when someone comes in for a routine physical they come into the exam room for physical. So it's like an opt out procedure also. Ages 15 to 65, the patient is asked, we do the HIV testing. We do the HIV testing unless the patient declines and they don't want to do it. So they order HIV. And then they flag the High-Risk Nurse that HIV has been ordered for this client. So in that way, they can keep track of the results. So the High-Risk Nurse will keep track of the results.

So when the result comes in as well, too, so the nurse keeps track of this. And then if it's positive, again, now the whole team will be called in. And then they will call in the client to come in to get the results. If the result is negative, if something happens, we'll assess the risk and then tell the client to come back in three to six months.

So this is just what I just said in detail. So the patient checks in. This is in-clinic testing. So the patient checks in and is escorted to the waiting room. While with the provider, the provider does a visit and all the lab tests that include HIV test and then flags the nurse. And then, depending on what the result is, if the result is negative, they give it to clients over the phone.

But if it's positive, again, the patient is called in by the nurse. And then the nurse will give an intake interview and then call in the team. The team actually comprises medical case managers, the provider, the peer support staff, and the client himself in the room. And then they deliver the results.

So the peer support staff gives their own perspective. And then the medical case manager and the High-Risk Nurse are there to link the client immediately to care. And then they're able to see if the provider is the person you'll be working with. And then appointments are made immediately with the patient for the provider for the next available visits.

And then the High-Risk Nurse also orders intake lab. So we also work with the lab to have a [INAUDIBLE] lab that should be ordered immediately, that of course include things like CD4 counts, viral load, and the whole labs. And then the patient also will meet with medical case management to start their own intake processes just to make sure they also take care of other psychosocial needs. And then fill up with whatever else they need to retain them in care and then keep monitoring their visits with the providers as well too.

So this is the fast lane lab I was talking about. Just to make it less stressful for the patients who test positive, we're just trying to-- the lab can be very busy and very confusing for somebody in that state of mind. So telling them to go to the lab by themself and just sit there and then wait to be called in, we find is actually not very comfortable for the patient. So we tried to create what we call the fast lane lab.

So when somebody comes in who is newly diagnosed as positive, the High-Risk Nurse will actually print a lab slip hard copy. We do have an electronic system [INAUDIBLE] but also print a hard copy. So this is something we actually spoke to the lab and then established this workflow. We call them 15 minutes before bringing in the patient. So the High-Risk Nurse will call the lab the exact number and then now physically take the patient to the lab to the urgent care.

So by the time they get into the lab, the lab already has whatever [INAUDIBLE] for the patient. And then they just go ahead and take their blood. And then the patient can leave and come back in a couple of days' time to keep in touch with the [INAUDIBLE] nurse, just letting them know that they should expect a call to get the results.

So Whittier's approach to greater coordination, integration, and innovation is one, through capacity building to better serve the target population, care coordination, and clinical-community linkages. Basically, we're big on training. We believe that the best way to actually serve your client very well is to train the staff members very well. So we've done a lot of training in the last year, an enormous amount of training.

We've also gone ahead to also establish an LGBTQ clinic that I also lead just to make sure that we're not missing out on anybody. Because our goal is just to serve anybody who comes into the center. So we want to make sure that we have the capacity and the competence to serve everybody that walks into our clinic. Also, we have patients in the medical home. We have ID specialists. We have behavioral health or some sort of substance abuse. We have pharmacists onboard and high-risk nurse, and case managers.

We'll have two meetings to discuss the care coordination cases every month. the whole clinical HIV team meets. We look at all our cases, review all our cases to see what a few things like visits, medical visits, missed appointments. We'll look at the labs, see who is actually adhering to medications, see whose lab is up to date. managing the CD4 counts and see what needs to be done. Look at some people who have complicated cases and then see if we should make referrals to add a special list.

But it's all done monthly I serve the High-Risk Nurse. Medical case managers, the providers, the physicians. In the case of post-doc members, we'll meet and review all the cases on a monthly basis. And then we'll talk about Health Ambassadors and Peer Advocates who work in the communities. We'll go into the communities that we know are the hardest hit areas and then try to bring all these people back into the center and then into care. Oh, even to establish care in the first place.

So for successes, we'll have fully integrated HIV routine HIV testing into care. We'll conduct several of our trainings for providers and support staff with assistance of MayaTech, PCDC corporation and other CBAs. We've eliminated HIV clinics that foster stigma. We should have just a set number of [INAUDIBLE] like we'll call them the HIV team or HIV clinics.

We find that that's really stigmatizing so basically the whole goal is routine testing, so we'll try and make it in such a way that everybody who comes in, the providers should just to routine HIV testing.

I talked about establishing an integrated core team that reviews cases on a monthly basis. So we'll have a High-Risk Nurse Case manager that manages high-risk clients and coordinate referrals between the ID specialists and the providers. The ID specialists they actually serve as a consultant to the provider. They review complicated cases, and then they can ask casual questions.

So she comes from Boston Medical Center and she comes like every other week to our clinic to review and see complicated cases before they are now passed on to the other providers to see them routinely. We'll also establish an LGBTQ program as I mentioned before.

Challenges, we have a few challenges here and there. Attrition is one of them. In the last year, we've trained, tentatively, two nurse practitioners who, for some reason, moved on. Surely, there's nothing you can do about that, you know.

So what I'll do is just hire some new ones and also do some customized trainings just making sure that we update most of our providers and make them comfortable enough to see and prescribe for our HIV-positive clients. There have been 3 cases of false positive tests in the past. That was actually one of the reasons why we tell them to make sure that we change some of our systems and protocols and make sure that every result is actually verified and given centrally by the High Risk Nurse.

So by the time we actually give our results now, we have to make sure that we run them through the lab again and confirm the viral load before we can confirm that the result is actually positive before we can give it out to the client. Some of this EMR will have right now. They're looking to move into [INAUDIBLE]. In the next few months, we're moving to EPIC.

So I hope you have the ability to capture gender identity and expression. Right now it doesn't capture those data, so we struggle with keeping track, I mean, our Ryan White program actually captures this data, but the EMR doesn't. So we have to use two systems to keep track of some information.

Retaining homeless individuals is actually very difficult to have a lot of homeless patients in our caseload. So most of the time, we rely on our hardest workers that work in collaboration with the medical case managers to track most of these patients when they're out of care and we know where they are. Most of the time they are on the streets, especially when the weather is nice often [INAUDIBLE] among them, so they would rather use drugs then to take their medications.

So those are some of the people that actually give us a hard time retaining them in care. But there are just quite a few of them. Every now and then when we have those numbers, the medical case managers that work to retain them in care I work collaboratively with the outreach workers to track those people.

We've also been working with the Department of Public Health. There's one who called it the out-of-care landless program. We have the phlebotomist, the High-Risk Nurse. So we make a list of people that are out of care and that we couldn't find ourselves. And then the DOH helps us track the hired epidemiologist that actually have more information than we do about these clients, and they track them and then bring them. In the last month they brought in one of our patients

that was out of care and then who successfully linked them back to care again, so that's one good thing with that. That's one group collaboration that we have with the DP here that's actually working effectively right now. And, of course, we'll have our competing priorities. Yeah, I think that's about it. OK.

VICTOR RAMIREZ: And this is Dr. Ubiem's contact information. At this moment, we'd like to open up to more questions and more comments from the participants. I think the staff, Dr.

Wendel, and Ms. Burnside from the Denver Prevention Training Center. They are back online. We did have three questions that came up during your presentation, Dr. Ubiem.

CYRIL UBIEM: OK.

VICTOR RAMIREZ: The first one, "do you have any success in offering partner services to those who test positive?"

CYRIL UBIEM: That is something we are working on right now. I wouldn't say a lot of success, but some of them have been able to come in for testing.

VICTOR RAMIREZ: OK. Second question, "given the demographics presented earlier, does your health center have special programs targeting women of color other than during pregnancy?"

CYRIL UBIEM: Yes. So we have the men's health program. We also have the women's health program. So the women's health program has extensive programs for women from all kinds of services to do, from gardening, to wellness, to everything, to groups and stuff. So yes, we offer extensive women's health program that actually has a lot of programs for women [INAUDIBLE].

VICTOR RAMIREZ: OK. And "have you seen a lot of false positive results with the Alere assay?"

CYRIL UBIEM: Yes. I wouldn't say a lot, but it's certainly maybe about 4 to 5 in the past since the start of the project and that is something I've discussed with the Alere as well. And that is why we have decided not to give out any more results until they're fully confirmed that it's positive through a blood test. So any positive results from Alere right now has to be confirmed by the blood test before we actually give out the results.

VICTOR RAMIREZ: All right. Dr. Wendel?

KAREN WENDEL: Hi, I'm sorry to interrupt. Dr. Ubiem, those positive results, were they with the P24 component? Or was the antibody component falsely positive?

CYRIL UBIEM: With the P24 component.

KAREN WENDEL: So I just have a general comment for our listeners. There's been considerable concern about the P24 component. There was a meta analysis that was published looking at studies that had used the Alere, and certainly these were primarily sites in Africa. And it wasn't entirely clear if it was the same manufacturer kind of site producing the test, as is the case in the United States. However, the positive predictive value coming out of that study was 0 for a P24 antigen. And so I think that it is particularly notable that we should be very cautious in providing that result as a true positive just as Dr. Ubiem has suggested that that component is not performing to the same level as the lab-based fourth generation.

VICTOR RAMIREZ: All right, and a follow up to the Alere. We used the Alere for a month and had 9 false positives in one month with a mix of Ab and Antigen, just an FYI from the same participant. We do have another question. "Are newly diagnosed patients transferred to an HIV specialist or co-managed with a primary care provider or both?"

CYRIL UBIEM: For us it's both. So what we're trying to do is, at the beginning, if somebody is diagnosed initially, put them up with an ID specialist, first of all, to review the case. And then after the initial review with the ID specialist, we now transfer them to the primary care. The ID specialist just counts like a consultant. There are able to start the patient with initial treatment and then do the whole [INAUDIBLE] again.

The primary care providers who will not just be the HIV prescriber, but also manage the primary care, their physician. They will pick up there and start managing that patient. And then, of course, they work with the medical case manager to make sure that they work on that [INAUDIBLE] and then what's monitoring their viral load and CD4 count making sure they go to the lab and then deal with other psychosocial issues that they have. So the outside is both.

VICTOR RAMIREZ: All right. Thank you, Dr. Ubiem. We have a comment from one of our CDC participants. And it's a long one, so please hold on. "It seems very clear that the nuances of how a condition framed HIV testing and how testing is perceived by patients to be routinely integrated into standard clinic practice can have a significant impact on whether or not patients agree to testing.

A script like, are you interested in being tested for HIV today, might actually have a negative impact on testing acceptance because a patient can feel as if they were being singled out. However, a script like, today we will be screening for hypertension, diabetes, and HIV, unless you decline. Do you have any questions? Might show that screening is being provided to all patients. I was wondering if you agreed and had any additional simple tips for approaching patients about testing that might increase testing acceptance," and I guess it's for both of you.

CYRIL UBIEM: I mean, OK, I completely agree with CDC person who said that because that's exactly how our providers do it. They will talk about every other lab request for that day and then include HIV as well and then ask them if they specifically want to take out any one. And from our own experience, we actually have never heard of any patient who says, no, I don't an HIV test. That has been our experience for a long time.

Most people now actually don't mind. They want to know. Even the hotline that we have gets a lot of calls. We actually have some people that are trained to do the testing, so we'll get a lot of calls every day for people asking for HIV tests apart from people that are actually coming in for a routine primary care visit that includes a sort of HIV test. So I agree completely with the comment.

KAREN WENDEL: I very much appreciate the CDC making that comment because I think it's important to push that kind of a script idea for providers to kind of help them. The way you can

put it is that in your age group, we screen everyone for HIV. And we'll be doing that today unless you decline. It's sort of the way that we might generally want to go about it.

Certainly the message can sometimes change if you're in an STD clinic or a TB clinic. It's sort of the same message. Everybody that's being treated in this clinic for tuberculosis is tested for HIV. We'll be performing that test unless you decline. So I think those types of messages can be specific, like to a public health clinic, or can be extremely general in a community health setting.

VICTOR RAMIREZ: All right, thank you. And we have a follow up on the question that we asked during our first Q&A session. And this is coming from the health department perspective. "I wanted to clarify my question from earlier about how health departments can promote routine screening. I meant, how can we work with clinics in a private sector to increase their routine screening?"

KAREN WENDEL: You know, I think that one of the ways that it can be done-- certainly some of it can just be done through providing provider education, either through health network type of broadcasts, news, items. It certainly can be done through talks. You know, almost every health care center will have routine meetings for education, and that can be provided that way.

And then you can even go to each with a health care provider and sort of help bring that message directly to the clinics. And that, of course, would be the most time intensive. But identifying a champion in the clinic delivering that message and then checking back with them and seeing their progress, so I think those are three ways that it can be done in a broad stroke.

VICTOR RAMIREZ: All right, thank you. At this point, I'd like to move on because we're actually way over our time. I know that there's a lot of questions and comments that participates may have, though we have one more polling question. Maybe go ahead and put that up.

NARRATOR: So the polling question reads, "what percent of patients at your health center are routinely tested for HIV?" Is it 100%, 75% to 99%, 50% to 74%, 25% to 49%, or less than 25%? Please take a moment to answer the poll.

OK, so it looks like 25% are in the 75% to 99% category. Now you have 25% that are in the 50% to 74% category. You have 40% that are in the 25% to 49%. And we have 10% in the less than 25%.

VICTOR RAMIREZ: Just a reminder to all our participants today, I mean, we do want to hear from you. You can send us your additional questions or comments that you have via email at P4CHIVTAC@MayaTech.com or P4CHIVtac@MayaTech.com. Any questions or comments either for the Denver Prevention Training Center, email it over to them. Or if you have any questions or comments for Dr. Ubiem, of course, his contact information was also included in the slide deck. We will forward it to him.

Dr. Wendel or Ms. Burnside, Dr. Ubiem, any last comments before we sign up for today?

KAREN WENDEL: I just want to think everyone who's been involved I think it's been really helpful to hear from Dr. Ubiem and also the input from the CDC to make this a really complete educational experience. So thank you.

VICTOR RAMIREZ: I'd like to add to that. Just thank you very much to both of the Denver Prevention Training Center and to Dr. Ubiem and the Whittier Street Health Center. Just as an FYI, you can now register for Session 2 of our Community of Practice. Session 2 will be talking about HIV screening technology, so we are very much looking forward to seeing everybody in our second session.

And, again, throughout the month the health centers as you participate in your, either, weekly or bi-weekly conference calls with your MayaTech liaison, either Shelly Kowalczyk or Chelsea White. As you participate and contact them, they will be inquiring if you would be willing to participate as a grantee presenter, both for this community of practice and for the other ones that are coming up. So please don't be shy. Like Dr. Ubiem and Whittier Street Health Centers showed us today, it's very important to get that health center perspective. I think that there's a lot of information that health centers throughout the country can learn from each other.

You might be going through some of the same challenges. You might be having the same successes. So that's what we're looking for. So we would really like to hear from you and have health centers participate in these communities in practice. OK, Steve?

STEVE LUCKABAUGH: Thank you, Victor. All right, thank you for participating in today's webinar. We hope that you are able to find the information provided useful as you continue your P4C project and ask that you take a few minutes to complete the feedback survey that you will receive when you close out of this webinar. You will also receive it via email.

Today's webinar was recorded in the audio and video versions of the entire webinar as well as the slides and handouts from today's webinar will be made available on the P4C website within the next few weeks. Copies of our prior P4C webinars are currently available on the website on the P4C resource materials page at P4CHIVTAC.com. You will need to log in to access the materials. If you need login credentials, send an email to P4CHIVTAC@MayaTech.com.

Thank you, again, for participating in today's webinar. And thank you to our presenters for their excellent presentations. If you have any additional questions for the P4C project or for our presenters, please email us at P4CHIVTAC@MayaTech.com. Take care, everybody. And we'll see you next time.