Urban Health Plan, Inc.

HIV Focus Team

Integrating Routine HIV Testing in Primary Care:
A Learning Collaborative

United States Conference on AIDS
November 12, 2011
Agenda

- Background of Urban Health Plan
- HIV Focus Grant
- Quality Improvement
- HIV Testing Project
- How to Conduct a PDSA (Plan, Do, Study Act) Rapid Test Cycle
• Federally Qualified Health Center
• 4 Health Centers; 5 School Based Health Programs; 2 Homeless Shelters
• Additional Site Scheduled to Open December 2011
• Adolescent Health and Wellness Center to Open Winter 2012
• Additional 54,000 sq. ft. facility to open in 2012/2013
• 450 FTE staff and 88 FTE providers
• Live with EHR – February 2006 / Dental August 2010

Annual number of patient encounters: 250,000

Best Served in Another Language – 51%
Language - Spanish
Achievements

Named a top performing Health Center by HRSA

Level III PCMH by NCQA (Medical Home)

HIMSS Nicholas E. Davies Award of Excellence (CHO)

2011-Gilead Sciences Inc. awards UHP a grant to integrate routine testing & increase HIV Test Offer and HIV Testing Rate
EHR Functionality

- All disciplines and specialties within UHP are connected
- Bidirectional Interfaces to improve workflow
- Clinical Decision Support / Order Sets
- Performance Improvement teams
- Iris Recognition
- Improved Patient Scheduling and Patient Cycle Time
- UHP Employee Health and Wellness Program
- Efficiencies – Referrals, Calls Center, Case Management
- DOH - CIR, Syndromic surveillance
UHP's Board approved the strategic plan
- Project Management Team included executives who conducted needs assessments and rigorous evaluation
- Selected Project Manager with clinical and administrative skills
- Clinical Systems Administrator position created
- Development of strategic partnerships with application vendors to add value inside the organization and for their partners
- Use technology as a means to accelerate change and to advance organizational goals
Technology

- Virtualization
- High Availability
- Fault Tolerance
- Storage Area Network (SAN)
- Training and testing environments
- Reports servers
- Real-time measurement of system response time/automatic alerts to IT Department
Value

- Increased number of patients, visits, billable visits and the ratio of visits to total staff
- Developed a P4P program
- Annual savings by reducing the Medical Records storage
- UHP has implemented video conferencing
- Revolutionized patient satisfaction process
- Improved clinical reporting
- Patient Centered Medical Home
- Enhanced oversight
Institute for the Advancement of Community Health (IACH)

- Created in 2005 to assure infrastructure for continuous Performance Improvement
- Advisory Committee gathers an Expert Panel to conduct Pre Work
- Mastermind Train the Trainer Curriculum is used to Train Team Leaders and Teams to begin PI Team work
- Team Data Graphs are generated from the EHR centrally through MIS and provided to the teams monthly for review
- Learning Sessions are conducted every few months
- On going Team Coaching
- Spread of Improvements is approved by Senior Leaders and process is standardized
- All employees are trained in Performance Improvement during new employee and annual orientation
- Performance Improvement is built into every job description
- The IACH has been retained to conduct Performance Improvement Training and/or PI Project Facilitation for external organizations
Initially, Used MS Access Data Base for Tracking of Team Progress
- Modification of encounter forms was also used as an Interim Solution
- Upon implementation of EMR, created templates and structured data fields to capture QI measures
- Conduct dual reporting: data base and ECW until electronic data is accurate
- Monthly Graphs are generated by the registry coordinator and reviewed by each PI Team
Lessons Learned

- Data Validation
  - Create required fields (data)
  - Training providers and support staff on documentation
  - Oversight of process
  - Ran concurrent reports from Access and eCW
  - Run only from eCW when reports match (validated)

- Dashboard Creation
  - Requires teamwork and collaboration
  - Clearly defining numerator and denominator
  - Setting the goals from the Strategic Plan
Evolved Use of Data

- Staff has become more sophisticated in their use of data
- Importance of Operational Definitions
- Understand continuum and use of data
  - Data Collection
  - Data Analysis
  - Performance Improvement
  - Performance Monitoring
Initiatives Using EHR

- Provider Pay for Performance Program
- Focused Performance Improvement Projects
- Ability to target at risk populations vs. shotgun approach
- EHR adoption for Employee Health Services
- Transfer of daily information to NYCDOHMH
- All leading to meaningful use of the EHR
  - Patient Engagement
  - Quality improvement
  - Management of Population’s Health
  - Interoperability
HIV FOCUS Goals

- Goal 1: Make routine screening a standard of care
  - Effective July 30, 2010, NYS HIV testing law requires medical providers to routinely offer HIV tests as per CDC 2006 recommendations

- Goal 1: Reduce the number of undiagnosed individuals and those diagnosed late and link them to care
  - 12,658 to 30,582 undiagnosed individuals in NYC
  - 25% individuals in NYC diagnosed late

- Goal 3: Normalize the HIV testing process
HIV FOCUS Cities

2008 Rate of adults/adolescents living with an HIV diagnosis per 100,000 population:
- 249+
- 135 to 248
- 84 to 134
- 54 to 83
- 0 to 53
- Data Not Shown*
- Data Not Available**
- No Counties in this Jurisdiction***

Source: www.AIDSVu.org
HIV FOCUS is working to:

- **Routinize** Screening in Community Health Centers and Primary Care Settings
- **Integrate** HIV Screenings into Other Health Screenings
- **Normalize/De-Stigmatize** Screening in Impoverished Communities through Routine Offers
HIV Diagnosis Rate, Prevalence, and Death Rates, by NYC Neighborhood 2009
NYC Remains the Epicenter of HIV/AIDS in the US

- In 2009 there were 3,669 new diagnosis of HIV/AIDS
- Of all new HIV diagnosis in NYC, almost 25% are concurrent with AIDS
- Approximately 40% of New Yorkers reported that they never tested for HIV (Asian 58%, White 51%, Black 28%, Hispanic 28%, other 23%)

Source: NYC DOHMH, September 2010
NYCDOHMH Epi Query
Gender

- 76% of all **new HIV** diagnosis are among **MEN**

- 43% of new HIV diagnosis are among **MSM**
  - Among NYC’s MSM Population, HIV prevalence among **Black MSM** is as high as 40%
  - Among young MSM ages **13-19**, the number of new HIV diagnosis increased by 68%!

- 24% of all new HIV diagnosis are among **Women**

- **95%** of all new HIV Diagnosis among women are among **Black & Hispanic Women**

(DOHMH Epi Field Services  Semi-Annual Report October 2009)
In 2009

- New Yorkers age 20-40 accounted for approximately 71% of new HIV Diagnosis

- New Yorkers age 45 and older accounted for 55% of all PLWHA

- 39% of new HIV diagnosis among New Yorkers >50 was concurrent with AIDS compared to 12% among youth age 13-29

Source: NYCDOHMH October 2010
Race and Ethnicity

- 80% of all new HIV diagnosis are among **Blacks and Hispanics**

- Blacks and Hispanics consistently account for the highest number of **concurrent diagnosis-83% in 2009**

- Of all AIDS deaths in 2009, **88%** were among Blacks and Hispanics

Source: NYCDOHMH October 2010
Risk Stratification among New Yorkers newly diagnosed with HIV, 2009

- 43% MSM
- 22% Heterosexual contact
  - Females 75% of individuals reporting heterosexual risk compared to 25% males
  - IDU accounted for only 5% those newly diagnosed with HIV
- Risk Unknown for over 29%!

Source: New York City Department of Health and Mental Hygiene. HIV/AIDS Surveillance Report
HIV Testing is no longer about risk

- The best possible patient care includes HIV testing.
- Awareness of HIV status results in changes in risk behavior.
- Earlier detection and linkage to care can result in better outcomes.
- Public health benefit: reduced HIV transmission.
- Routine HIV testing reduces stigma and increases acceptance by patients.
- Time is NOW to Offer Routine HIV Testing to Everyone---Without Exception.

By routinizing HIV Screening in our Health Centers, we are helping to change the course of the HIV epidemic.
New HIV Diagnosis
New York City 2001-2009

Source: NYCDOHMH HIV Epidemiology and Field Services Program Semiannual Report, October 2009
Urban Health Plan, Inc.
Quality Improvement Infrastructure
History and Overview of the Models
Overview of Federally Qualified Community Health Centers

- Community controlled
- Comprehensive Primary Care
- Approximately 1200 + organizations
- Over 8,000 sites: rural & urban
- Over 20 million people served

Data from National Association of Community Health Centers, 2009
Health Disparities

- Diabetes
- Cardiovascular Disease
- Immunization
- Infant Mortality
- HIV
- Cancer
An ambitious goal... and a plan to reach it.

100% access 0% disparities

Series of Health Disparity Collaboratives for health centers across the country
BPHC Strategic Goal and Objectives

Moving Toward 100% Access/Eliminating health disparities

- Workforce to Meet the Need
- Strengthening the Safety Net
- New Access through Community Development Expansion and Partnerships
- Excellence in Practice
Glycemic Control

- A 1.0% reduction in HbA1c:
  - 17% reduction in mortality
  - 18% reduction in MI
  - 15% reduction in stroke
  - 35% reduction in cardiovascular endpoints
  - 18% reduction in cataract extraction
- Cost: $98.2 billion/year in the U.S.A.

Source: GHC
Contact: David K. McCulloch, MD, FRCP
Email: McCulloch.d@GHC.org
Urban Health Plan, Inc.
Participation in BPHC Asthma II Collaborative

- Prevalence of Asthma in our community
- Inability to jumpstart our own Asthma Program
- Exciting Venture for Staff
- Federal Initiative
- Desire to improve health outcomes
Collaborative Model

➤ Model for Improvement

➤ Chronic Care Model

➤ Learning Model
Model for Improvement

- What are we trying to accomplish?
- How will we know that a change is an improvement?
- What change can we make that will result in improvement?

- Provides a framework for developing, testing and implementing changes that lead to improvement.

- The model has its basis in scientific method.

- It attempts to temper the desire to take immediate action with the wisdom of careful study.

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To Be Considered a PDSA Cycle

✓ The test or observation was **planned** (including a plan for collecting data).

✓ The plan was **attempted**.

✓ Time was set aside to **analyze** the data and study the results.

✓ **Action** was rationally based on what was learned.
Repeated Use of the Cycle

Changes That Result in Improvement

Hunches Theories Ideas

DATA

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“The model of care is a population-based model that relies on knowing which patients have the illness, assuring that they receive evidence-based care and actively aiding them to participate in their own care.”
Six Components of the Care Model

1. Organization of Healthcare
2. Clinical Information Systems
3. Decision Support
4. Delivery System Design
5. Self Management
6. Community Resources
The Care Model - A Systems Approach

The diagram illustrates the relationships between community, health system, health care organization, and patient interactions, focusing on self-management support, delivery system design, decision support, and clinical information systems. The goal is to achieve productive interactions that lead to informed, activated patient/client/family and prepared, proactive practice team, resulting in functional and clinical outcomes.

Adapted from: Improving Chronic Illness Care, a national program of the Robert Wood Johnson Foundation
www.improvingchroniccare.org
Overall Aim: Implement the Care Model

Strategies for Each Component of the Care Model
Learning Model
(adapted from the IHI breakthrough series)

Select Topic
- Expert Panel

Participants apply and are selected
- Pre-work
  - Time for setting aims, allocating resources, preparing baseline data leading to the first 2 day meeting.

Planning Group
- Identify Change Concepts

Action period 1:
- LS 1: Adapt and test the ideas for improved system of care

Action period 2:
- LS 2: Further develop the system of care at the pilot site and spread the system to other sites &/or practitioners

LS 3
- National Congress and Spread

Supports
- E-mail
- Conference Calls
- Assessments
- Success Reports
- Site Visits
- List Serv
URBAN’S DREAM
of
Planned Excellence
TRAIN THE TRAINER PROGRAM
“MASTERMINDS”

- Focus on Five Managers
- Train them on the Collaborative Model
- Work with a team each
- Work with Team Leader so that they can then become Masterminds
- 10 Masterminds within one year
- Within 3 to 5 years, fully integrated into organization
Completed Performance Improvement Teams now implemented as permanent improvements to care:

Asthma, Depression, and HIV
Performance Improvement Teams in Progress...

- Pediatric Preventive Care
- Prevention of TYPE II Diabetes (Obesity) in Children
- Cancer Screening and Follow-up
- Cycle Time (patient wait time)
- Materials Management
- School Based Health Clinic
- Women, Infants and Children
- HIV FOCUS
HIV Focus Project Overview

- Grant from Gilead to conduct a multi site Learning Collaborative to implement the new NYS HIV Testing Legislation

- The Objective of the grant is to integrate HIV testing into routine care (rather than have a counselor driven model) and to increase HIV Testing rates

- Gilead is looking to UHP to develop a successful replicable model that can be used for other CHC’s
Forming an Expert Panel

- Senior Leaders: CEO and CMO
- Chief Technology Officer
- Clinical Systems Administrator (EMR)
- Director of Nursing
- Section Head of Adult Medicine/ID Specialist
- Director of the Institute for the Advancement of Community Health (internal Quality Institute)
Work Performed by the Expert Panel

- Study the new HIV Testing Legislation
- Consult with an Outside Expert
- Training Provided by Outside Expert
- Develop Team Structure
- Hire an HIV Testing Coordinator
- Develop protocols (flow charts)
- Draft policies and procedures
- Create fields in Electronic Health Record (EMR) to capture and report on HIV Measures (test new fields)
Implement a Testing Team to PDSA the process comprised of:
- Provider Champion
- Medical Assistant
- Site Director or Dept Coordinator

- Share Baseline Data with the Team
- Creates Healthy Team Competition
- Conduct Weekly Team Meeting with Provider Level Feedback on offer and testing rates
**HIV Focus Team Structure**

- **Institute for the Advancement of Community Health**
  - **Program Coordinator**
    - **Satellite Health Center Teams**
      - **Plaza Del Sol Health Center Team**
        - Team Members:
          - Site Director
          - Associate Med Director
          - Providers
          - Nurse
          - Medical Assistants
      - **Bella Vista Health Center Team**
        - Team Members:
          - Site Director
          - Associate Med Director
          - Providers
          - Nurse
          - Medical Assistants
      - **Plaza Del Castillo Health Center Team**
        - Team Members:
          - Site Director
          --Providers
          - Nurse
          - Medical Assistants
    - **Main Site Health Center Teams**
      - **Walk in Clinic**
      - **Adult Medicine**
      - **Prenatal**
      - **GYN**
      - **Adolescent Clinic**
      - **School Health**
        - Team Members:
          - Dept Coordinator
          - Providers
          - Nurse
          - Medical Assistants
      - **Adolescent Health Center Team**
        - Team Members:
          - Site Director
          - Provider
          - Nurse
          - Medical Assistants
      - **Walk in Clinic Team**
        - Team Members:
          - Dept Coordinator
          - Providers
          - Nurse
          - Medical Assistants
      - **Prenatal Team**
        - Team Members:
          - Dept Coordinator
          - Providers
          - Nurse
          - Medical Assistants

- **Ex: Pert Panel/Advisors**
- **IT Support**

**Senior Leaders**
- *Clinical Systems Administrator*
- *Director of Nursing*
- *Clinical Director of HIV Services/ID Specialist*
- *Others as determined*

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*The diagram illustrates the structure and team members for the HIV Focus Team, including satellite and main site health center teams.*
Utilizing the Care Model and a multisite Team Collaborative approach, UHP will implement the new NYS HIV testing legislation assuring that all patients ages 13-64 are offered HIV testing. UHP will integrate and standardize this process into routine primary care, and data reporting mechanisms, across all UHP health center sites.
Population of Focus

- All patients ages 13-64 seen in primary care at any UHP health center site
Measures

- 90% of patients ages 13-64 offered HIV Testing
- 40% of patients ages 13-64 will have an HIV Test
- 70% of patients tested will receive their HIV Test Results
- 95% of patients with a positive HIV test result will be provided with a HIV primary care appt
Health Care Organization

- Senior Leaders Provide Resources
- Grant Funds from Gilead Sciences
- Forming an Expert Panel
- HIV Testing Coordinator
- Time set aside for monthly meetings
- MIS Support
**Changes Tested (PDSA) with Testing Team**

- **Decision Support**: Adult Providers, Adolescent Providers and Medical Assistants are trained on the new HIV Testing Legislation, updated protocols and EMR.

- **Delivery System Design**: Adult Providers and Medical Assistants routinely offer testing to adults ages 18-64. Monthly meetings are held with test providers to review protocol and progress (weekly data reports).

- **CIS**: Structured data fields are added to the EMR to capture offer of testing, order of HIV test, refusal, patient receive negative test results and weekly data reports are run from the New EMR structured fields and shared with the all teams.

- **Self Management**: The seven points of information are used to educate the patients so they will understand why it is important to have an HIV Test.
Community Resources

- NYS DOH
- NYC DOHMH
- Bronx Knows Initiative
## HIV Testing-Baseline Rates by Site

(DOS: 5/1/10 - 4/30/11)

<table>
<thead>
<tr>
<th>Site/Department</th>
<th>Eligible Patients (ages 13-64 seen for Primary Care)</th>
<th>Patients Tested for HIV (blood work/rapid test)</th>
<th>% Tested</th>
</tr>
</thead>
<tbody>
<tr>
<td>El Nuevo San Juan</td>
<td>13391</td>
<td>1796</td>
<td>13.4%</td>
</tr>
<tr>
<td>Prenatal</td>
<td>351</td>
<td>317</td>
<td>90.3%</td>
</tr>
<tr>
<td>Adolescent Clinic</td>
<td>1305</td>
<td>99</td>
<td>7.6%</td>
</tr>
<tr>
<td>Adult Medicine</td>
<td>3855</td>
<td>342</td>
<td>8.9%</td>
</tr>
<tr>
<td>Gynecology</td>
<td>1344</td>
<td>382</td>
<td>28.4%</td>
</tr>
<tr>
<td>Plaza Del Castillo</td>
<td>1188</td>
<td>172</td>
<td>14.5%</td>
</tr>
<tr>
<td>Bella Vista</td>
<td>1708</td>
<td>718</td>
<td>42.0%</td>
</tr>
<tr>
<td>Plaza Del Sol</td>
<td>4579</td>
<td>139</td>
<td>3.0%</td>
</tr>
</tbody>
</table>
Review of Policies, Protocols, EMR Templates
Pt. registers for visit.

MA will check the practice Alerts to see if the patient was ever offered an HIV test.

If pt. has not been tested or offered testing, The MA (medical assistants) verbally offers HIV testing to all patients 13-64 during the prepping session.

MA documents in EMR (Lab Reports): “HIV TEST OFFERED/7 Key points of information provided” as a lab and assigns to provider.

Does Pt. Want HIV testing?

Yes: MA educates Pt. by pointing to 7 points of information.

Provider sees documentation of “HIV test offered” in EMR Template and verbally confirms with the patient the “HIV testing offered”.

Provider explains HIV testing is voluntary and Pt. can withdraw acceptance of offer, at any time.

Does Pt. Agree to an HIV test?

Yes: Provider clicks “HIV ½ Antibodies Test Offered and Accepted” lab test is ordered.

A laboratory requisition form is generated by provider.

No: Provider will document “HIV test Refusal” in the Preventive Medicine section. Click Refused Test then drop down “HIV Testing” and choose the reason for refusal.

During the discharge process the MA or Provider will give patient the Lab Req form and inform the patient that they can receive results on their next PCP visit or walk-in and request HIV test results.

STOP
MA will check the practice alerts to see if the patient was ever offered an HIV test.
MA will Click Lab Reports and Order “HIV Test Offered & 7 points of information provided”
MA will then click on the HIV Test Offered in the Lab Window “Received, open, and assign to a Provider”.

![Lab Results Screen](image)
If patient was offered HIV testing during triage, it will show in template as “HIV Test Offered & 7 points of information provided to patient”. This will alert providers to explain HIV testing is voluntary and assess to see if patient is interested in taking an HIV Test.
If patient has accepted HIV testing during the exam, provider clicks “HIV 1/2 Antibody, HIV Test Offered and accepted” located in the lab reports.
If patient has accepted HIV testing during the exam, it will show in template as **HIV ½ antibodies offered and accepted**.
If Patients **Refuses** HIV Testing the provider will click “**Preventive Medicine Section**” Click Refused test HIV Testing and choose a response that best fits the patients reason for refusal.
HIV Negative Test Result Protocol

Adult and Adolescent

Start

Patient registers to see Provider or RN for HIV Testing results.

Provider or RN will review HIV Lab test results and gives Patient Negative results.

- Provider documents in EMR under the exam section as "STD / Infectious Disease-HIV Test Reviewed".
- RN Documents under HPI “Post Test” Template.

Does Pt. ask for a Copy of HIV Test results?

Yes

- Provider will document in the EMR under the examination section as STD/Infectious Disease – “Copy of Neg. HIV test results given to patient.”
- RN will document in HPI section “HIV Post Test” template “Copy of Neg. HIV test results given to patient”.

No

Patient is discharged by MA per protocol.

Stop

Stop

Patient is discharged as per UHP protocol.

Stop

Urban Health Plan, Inc.
Provider will document in EMR under the Examination Section as “STD / Infectious Disease”
Provider will choose “HIV and Copy of Negative HIV test results given to patient”
RN will document in the Nursing template reason “HIV Post Test Notification” and under the HPI Section as “HIV Post Test”. Complete the following Post test tabs:
* Risk Level
* Results
* Counseling for all results
* Copy of test results given to patient
HIV positive results for all sites are centralized and goes through critical values process.

Diagnostic dept. receives positive HIV test results and informs the rendering provider and the HIV Testing Coordinator.

The HIV Testing Coordinator will check with diagnostics dept. daily to see if any HIV positive critical values have come in.

The HIV Testing Coordinator will speak to the provider and agree upon a date to have pt. return for follow-up. The diagnostic dept. will send out a recall letter as per provider request.

HIV Testing Coordinator acts as consultant to providers to arrange support services, and information regarding outside Primary care services if patient refuses UHP services.

Pt. responds to recall and registers to see a Provider

Provider reviews positive HIV lab results in EMR “lab section”.

Provider informs Pt. of positive HIV test results, explains the meaning of the test, assures Pt is stable, and documents in examination section that the result are positive. In the event of no CM, provider must complete HIV Post Template.

Case Manager will complete the HIV Post test Positive template which includes:
- Introduction to UHP PCU Clinic
- Discussion of Partner Notification options.
- Education re: condom use and offer of condoms to the pt. to protect sexual partners.
- Referrals for supportive services
- Appointment for HIV Primary Care Services.

**Completion of the DOH 4189 Form**

Case Manager will schedule appointment to UHP PCU and electronically stamp referral in EMR and give pt. a copy.

Provider generates an internal medical referral for UHP PCU clinic.

Does Pt. agree to UHP Primary Care Services?

- **Yes**
  - Provider generates an internal medical referral and assigns to Referrals Dept.

- **No**
  - Case manager may assist provider in scheduling HIV PC appointment for pt. of their choice that same day and this will be documented in EMR so referrals dept. is aware. A List of Outside facilities will be provided to CM.
  - Case Manager must complete DOH 4189 provider form and hand deliver to HIV Testing Coordinator within 21 days of test results becoming available.

HIV Testing Coordinator collects the 4189 form and gives to Director of Nursing assuring all Protocols for positive patients are followed.

Stop.
**Post Test Positive Protocol Adolescent**

**Start**

HIV positive results for all sites are centralized and goes through critical values process.

Diagnostic dept. receives positive HIV test results and informs the rendering provider and the HIV Testing Coordinator.

The HIV Testing Coordinator will check with diagnostics dept. daily to see if any HIV positive critical values have come in.

The HIV Testing Coordinator will speak to the provider and agree upon a date to have pt. return to clinic. The Provider will contact adolescent patient by phone.

HIV Testing Coordinator acts as consultant to providers to arrange support services, and information regarding outside Primary care services.

Pt. responds to recall and registers to see a Provider

Provider reviews positive HIV lab results in EMR “lab section”.

Provider informs Pt. of positive HIV test results, assess support system and explains the meaning of the test, assures Pt is stable, and documents in examination section that the result are positive.

Case Manager or Social Worker will complete the HIV Post test Positive template which includes:
- Assess Adolescent support system.
- Discussion of Partner Notification options.
- Education re: condom use and offer of condoms to the pt. to protect sexual partners.
- Referrals for supportive services
- Appointment for HIV Primary Care Services.

**Completion of the DOH 4189 Form**

Provider generates an external medical referral and assign it to REFERALS Dept.

Case Manager or Social Worker will schedule offsite appt. for pt. and this will be documented in EMR so Referrals dept. is aware. Patients will be given a copy of the information be discharge.

HIV Testing Coordinator will assist in this process assuring that the patient receives the appt. in a confidential manner, and that the appt. date and time is documented in EMR.

Social Worker or Case Manager must complete DOH 4189 form and hand deliver form to HIV testing Coordinator within 21 days of test result becoming available.

HIV Testing Coordinator collects the 4189 form and gives to Director of Nursing assuring all Protocols for positive patients are followed.

Social Worker or Case Manager must complete DOH 4189 form and hand deliver form to HIV testing Coordinator within 21 days of test result becoming available.

HIV Testing Coordinator collects the 4189 form and gives to Director of Nursing assuring all Protocols for positive patients are followed.

**Stop**
Case Manager or Social Worker will complete the HIV Post test Positive template which includes:
HIV Refusal Responses and Rates

- Not Sexually Active/Never Sexually Active
- Perceived Cost
- Did not Expect an HIV Test Today
- Self Reported Previous HIV Testing
- Not Perceived to be at Risk
- Miscellaneous
- Recently Tested
- Doesn't Want It

Urban Health Plan, Inc.
HIV Positive Patients UHP

- Total HIV Positive Patients
  - 39 Confirmed

- Total lost of contact HIV Positive
  - 1
  - Male
  - 66 yrs. old
TOTAL NEWLY DIAGNOSED = 9

- Age Range (17-43): 17
- With PCP Appt: 9
- Females: 5
- Males: 4
- Kept Appt: 9

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TOTAL PREVIOUSLY DIAGNOSED HIV POSITIVE = 29

Age Range (20-55) 29
Females- 15
Males- 14
Kept Appt- 25
Did not Keep the Appt- 4
With PCP Appt 29

Urban Health Plan, Inc.
HIV Comprehensive Primary Care

- 140 HIV positive patients
- Two ID Specialists/MD
- 1 HIV Specialist RPA-C
- Case manager
- Nutritionist
- Social Worker (as needed)
- Specialty Care including mental health services
- Monthly Graphs on HIV Primary Care Key Clinical Indicators for continuous quality improvement
Example: Individual Provider Results

[Graph showing offer rates for each week from Week 1 to Week 9. The rates are as follows:
- Week 1: 50.0%
- Week 2: 82.5%
- Week 3: 78.8%
- Week 4: 100.0%
- Week 5: 100.0%
- Week 6: 95.8%
- Week 7: 100.0%
- Week 8: 95.7%
- Week 9: 95.2%]

The graph indicates an upward trend in offer rates, with a significant increase from Week 1 to Week 4, followed by a plateau from Week 4 to Week 8, and a slight decline in Week 9.
HIV Screening Rates
10-20-11 to 10-26-11
HIV Test PDSA: Organization Wide

- **Offered**
  - Week 1: 6.1%
  - Week 2: 6.6%
  - Week 3: 7.8%
  - Week 4: 7.8%
  - Week 5: 5.1%
  - Week 6: 11.3%
  - Week 7: 11.5%
  - Week 8: 14.5%
  - Week 9: 27.4%
  - Week 10: 50.4%
  - Week 11: 58.9%
  - Week 12: 61.8%
  - Week 13: 69.9%
  - Week 14: 75.2%
  - Week 15: 78.4%
  - Week 16: 78.4%
  - Week 17: 77.9%
  - Week 18: 77.4%
  - Week 19: 77.4%
  - Week 20: 78.8%
  - Week 21: 77.6%
  - Week 22: 79.0%

- **Tested**
  - Week 1: 14.5%
  - Week 2: 19.0%
  - Week 3: 20.0%
  - Week 4: 21.0%
  - Week 5: 11.5%
  - Week 6: 11.3%
  - Week 7: 5.1%
  - Week 8: 39.3%
  - Week 9: 45.1%
  - Week 10: 42.3%
  - Week 11: 43.1%
  - Week 12: 45.9%
  - Week 13: 45.9%
  - Week 14: 44.9%
  - Week 15: 44.1%
  - Week 16: 43.4%
  - Week 17: 45.2%
  - Week 18: 48.9%
  - Week 19: 44.8%
  - Week 20: 47.7%
  - Week 21: 47.7%
  - Week 22: 46.7%
HIV Test PDSA: ENSJ GYN Department

Offered

Tested

Week1: 85.7%
Week2: 85.4%
Week3: 78.9%
Week4: 99.0%
Week5: 100.0%
Week6: 90.7%
Week7: 87.8%
Week8: 79.8%
Week9: 73.3%
Week10: 61.0%
Week11: 79.8%
Week12: 79.2%
Week13: 80.0%
Week14: 77.8%
Week15: 71.7%
Week16: 76.4%
Week17: 73.3%
Week18: 77.0%
Week19: 77.5%
Week20: 81.9%
Week21: 80.3%
Week22: 75.9%
HIV Test PDSA: ENSJ Adult Medicine Department

- **Offered**
  - Week 1: 68.8%
  - Week 2: 74.4%
  - Week 3: 83.9%
  - Week 4: 94.2%
  - Week 5: 100.0%

- **Tested**
  - Week 1: 85.7%
  - Week 2: 81.5%
  - Week 3: 89.4%
  - Week 4: 92.3%
  - Week 5: 96.4%

Percentage of patients offered and tested for HIV during 22 weeks, with a peak of nearly 96.4% tested in the second week.
HIV Test PDSA: Bella Vista Health Center
HIV Test PDSA: Plaza Del Sol Health Center
HIV Test PDSA: Plaza Del Castillo Health Center
HIV Test PDSA: ENSJ Walk-In Clinic
HIV Test PDSA: ENSJ Adolescent Clinic

- **Offered**
- **Tested**
Openly discuss challenges in implementing routine testing
- Minimize clicks and new screens in EMR
- Reinforce where those fields are in the EMR
- Provide accurate feedback data
- Provide training on giving a positive test result
- Provide support for positive patients (LMSW, Case manager, HIV Testing Coordinator)
The HIV Focus team presented a coherent, well-organized approach to introduce the protocol to providers and staff on a gradual basis. It was very helpful to see weekly data of individual departments’ (and providers’) offer and testing rates, in order to chart progress and identify areas for improvement.
MEDICAL ASSISTANT FEEDBACK:

I believe that having providers order the HIV for pts and having them go to the lab directly is a faster process that having the pt go to the HIV counselor and have them go through a whole process to get tested and getting their results.

Pt’s themselves have stated that its much faster and easier for them to have the provider order it for them. Having the 7 key facts to help explain to the pts what HIV is and what their rights are was extremely helpful and beneficial to the pts. I believe that having it done this way is a better way of having all pts tested rather than having to refer them to a counselor where many pts sometimes don’t want to wait after having to had wait to see their provider.

- (MA, GYN Team)

Having the providers order the HIV test for patients will be more suitable not only for providers but for the patients as well. Patients tend to leave without seeing the HIV counselor to get tested because they refuse to keep waiting. I believe by having the providers order it; the process will be much quicker.

-(MA, GYN Team)
Provider Best Practices

Physicians Assistant-Walk-in Department ENSJ
“When I see Patients I inform them, that we are offering all patients an HIV test. I also let them know that it is important to get tested once a year when you get a physical just so you know your status and since you are getting tested for things today why not add the HIV test.” Provider states that she does her best in convincing her patients to get test because she knows how important it is.

Physician Assistant-Satellite Health Center
“Provider offers HIV testing to all her patients that are sexually active or engage in injection drug use. The provider states that she would inform her patient that it is important to get tested and know your HIV status especially if you are having unsafe sex. The provider also states that many of her patients who refuse would like to be tested on a future date and would make a note to remind herself to offer the test to the patient.
Expert panel formed to support project planning:
- Test and tweak proposed flow
- Develop internal protocols and policies
- Identified provider champions and accompanying HIV FOCUS clinic teams
- Provider champions (PC) given opportunity to review and modify protocols

NYSDOH expert on HIV testing legislation engaged to provide training, review, and advise on clinic flow/compliance

EMR templates updated to support proposed flow

Weekly learning collaborative meetings convened May 2011
Using PDSA cycles, PC and their teams test the new process with their patients;
  - Intensified reach weekly
  - Progress charted, reported and discussed at weekly meetings; modifications to process made as needed

Teams permitted to spread process to other selected providers with cumulative goal of all providers coming on board

Communication/Dissemination
  - 2 accepted abstracts (USCA & CHCANYS)
  - Through research grant, plan to work with Albert Einstein School of Medicine to evaluate
  - New York City Research Improvement and Networking Group-NYC RING storyboard and abstract
Lessons Learned-HIV Focus

- Benefit of pre-work by expert panel
- Piloting the process prior to full scale implementation proved to be invaluable
- Providers will always question the data; be prepared to assure data accuracy or program will not progress
- Providers need to be part of the planning and development process
Challenges

- Initially too many different screens and clicks in EMR required for routine screening
- EMR fields for HIV test ordered, HIV test refusal, and reason for refusal moved around several times during PDSA testing.
- Some Medical Assistants not comfortable asking patients about HIV testing (new role)
- Discomfort among some providers in giving a positive result
- Overhaul of the counselor model
Next Steps

- Complete Spread to Adolescents and Prenatal
- Integrate HIV Testing Training within the Learning Center
- Align Routine Testing with Provider Pay for Performance
- Develop Incentive Program for Medical Assistants aligned with Routine HIV Test offer
- Continue Provider Training: Giving a Positive Result, Use Case Studies etc.
- Analyze Provider Differences in Test Acceptance Rates and Spread Lessons Learned
- Determine Innovative Ways to Increase Patients Receipt of Negative Results
- Continue to Monitor and Improve Offer and Testing rates
- Finalize Policies and Procedures
- Add Routine Testing Measures to Clinical Dashboard
Review:
Implementing a Learning Collaborative

- Choose a Topic
- Form an Expert Panel
- Determine Team, Population of Focus and Measures
- Obtain Baseline Data on Measures-Assure Accuracy
- Have Senior Leaders Kick Off the Team
- Assure Weekly Team Meetings
- Share Data Weekly
- Monitor and Celebrate Progress!
- Spread when Success is Sustained
- Obtain Final Approval of Policies
- Document Final Change Package (Next Slide)
Community Resources and Policies
- NYS DOH
- NYC DOHMH
- Bronx Knows Initiative

Health System Organization of Health Care
- Strong Senior Leader Support
- Form an Expert Panel & Consult with External Expert
- Obtain Grant to Support the Project
- Resources: Provider attend Team meetings and Learning Sessions
- MIS Support-Creating Reports to generate HIV Test Measures Data

Self-Management Support
- Seven Key Points of Information
- Provider Engages Pt in Self Management-Important of Testing

Delivery System Design
- Medical Assistant Provides the seven key facts of information & offers HIV Testing as part of routine visit for patients 13-64 years of age
- Provider confirms patient wants the HIV Test & orders the HIV test if patient agrees
- Recall patient with positive result.
- Provider (with Social Worker & CM support) provides positive result to patient.
- Patient returns for HIV negative result at next scheduled visit
- Policies and Procedures are written and approved

Decision Support
- Training provided by expert on the new NYS HIV Testing Legislation
- Training provided by expert on how to give a positive HIV Test Result
- Case managers in training on HIV 101
- Decision Alert in the EHR reminds Medical Assistant that HIV testing has not been offered
- After HIV Test offer, Decision Support Alert is suppressed

Clinical Information Systems
- Data captured via electronic health record
- MIS generated weekly graphs for providers on HIV Offer and Testing rates
Conducting a PDSA
- Model for improvement developed by the Institute for Healthcare Improvement
- Trial and learning model to discover what is an effective and efficient way to change a process
- Based on three questions:
  - What are we trying to accomplish?
  - How will we know that a change is an improvement?
  - What change can we make that will result in an improvement?
- Cycles are short and quick
- Tested on a small population
Always written in future tense
- Be very specific
- State the problem or objective (why are you testing a change)
- Plan for the change
  - What are we testing?
  - Who are we testing the change on?
  - When are we testing?
  - Where are we testing?
  - How are we going to test the change?
D - DO

- Always written in past tense
- Carry out the plan and indicate who did what, when, where and how
- Collect the data and document it
- What was actually tested?
- Was the test carried out as planned?
- What happened?
- Did anything unexpected happen?
- What were your observations
- What problems (if any) did you encounter?
A complete analysis of the data

What did you learn or find from the data you collected?

Compare your data to your prediction. Was your prediction correct? If not, why not?

What effect did the change have on the process, patients and staff?

State whether the problem stated in the plan was solved
Always written in future tense
What is the next logical step based on the P,D & S?
What changes (if any) should be made before the next cycle?
What will the next test be?
Resolve any problems
Re-evaluate successes in a few weeks or months
The ACT from cycle 1 becomes the PLAN for cycle 2
This system of care truly works.
You must be willing to be creative in terms of financial and human resource strategies.
Team work and morale improve:
“Coming together is a beginning. Keeping together is progress. Working together is success.“
Passion + Commitment + Structure = Excellence in Practice
Leadership is the KEY
Where We Are

- National Recognition
- Institute for the Advancement of Community Health
- Learning Center
- Department of Health Education
- Development of Telephone/Case Managers
- Transformation of our Organization
How We Made It Happen

ORGANIZATIONAL COMMITMENT.....

- Committed Board and Senior Leadership
- Organizational Alignment
- Commitment of Time and Resources

FINANCIAL AND HUMAN RESOURCE STRATEGY....

- Secured funding for Consultant
- HRSA support for Registry Coordinator
- Fundraising Strategy that worked
- Student Internships
- Improve use of Medical Assistants
- Strategic Community Partnerships
- Hired Quality Management Coordinator

Urban Health Plan, Inc.
MESSAGE

YOU CAN help eliminate health care disparities.

YOU ARE making a real difference in the lives of our communities.
Energy and Persistence Conquer All Things

-Benjamin Franklin
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