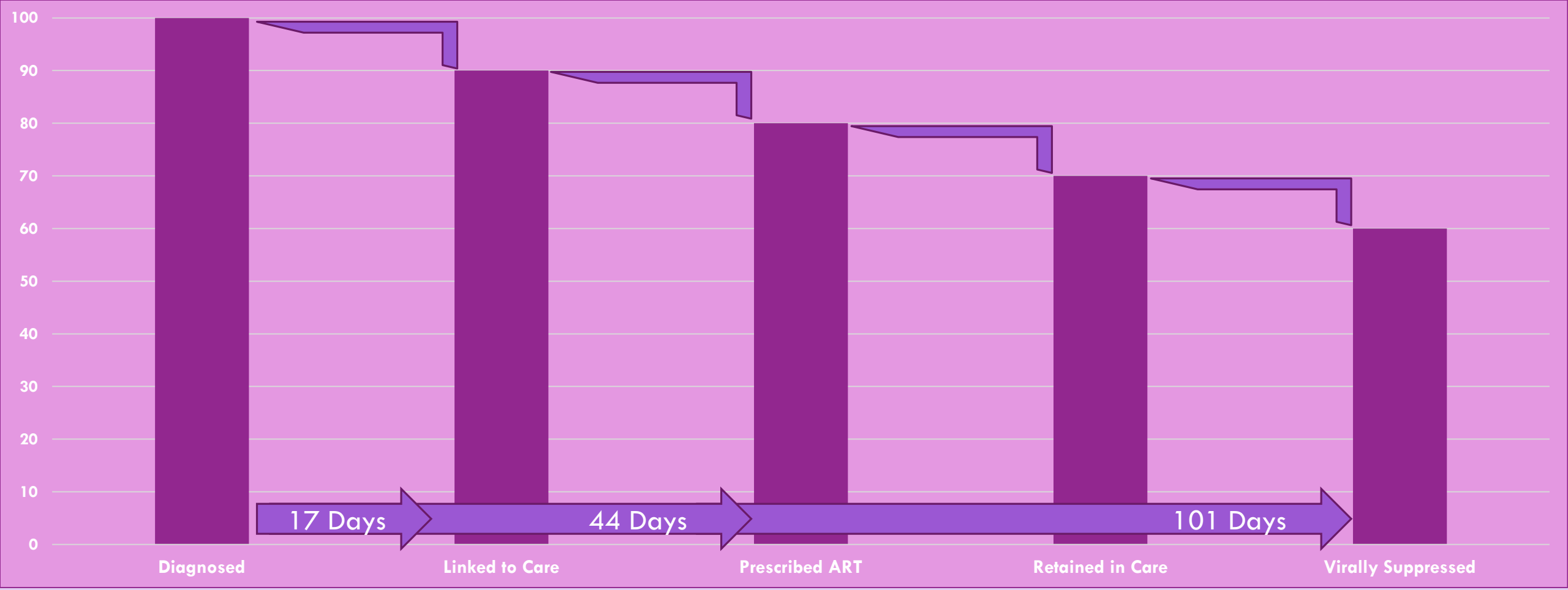
Rapid Treatment

at Callen-Lorde Community Health Center

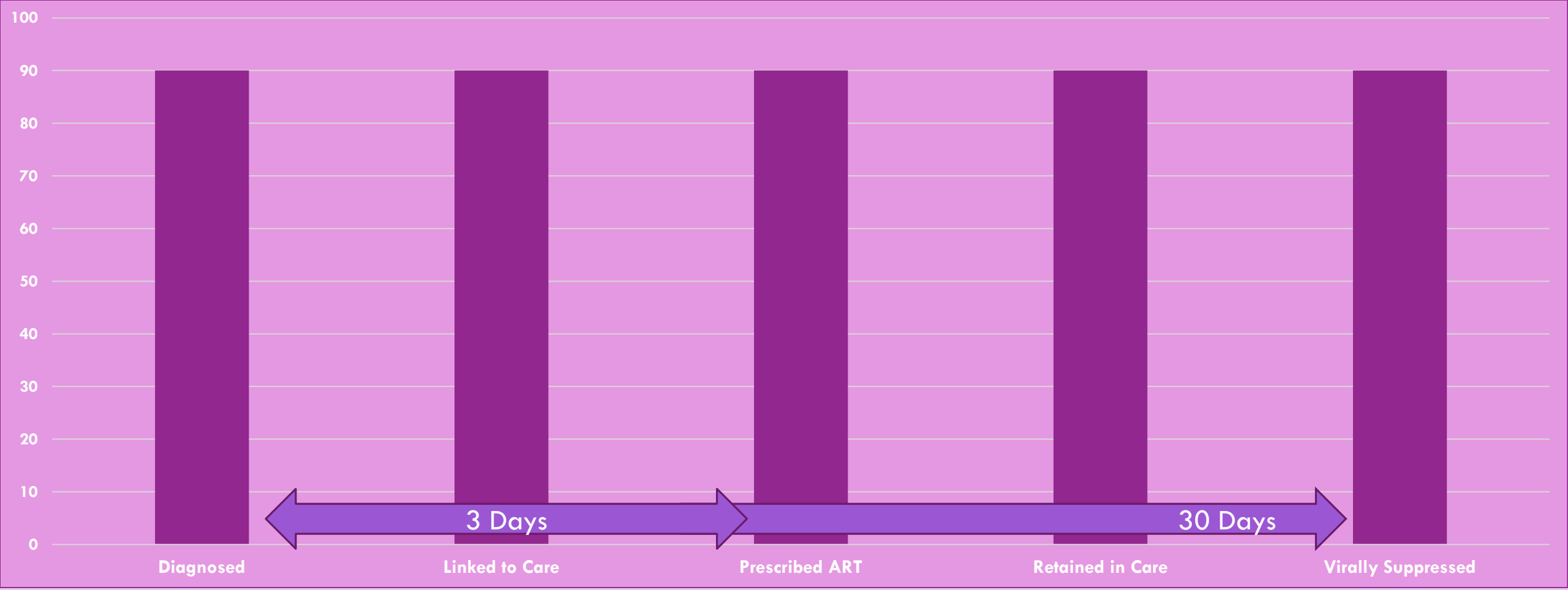
Katie Fisher, Retention & Adherence Program Specialist

Perri Hawley, Population Health Data Coordinator

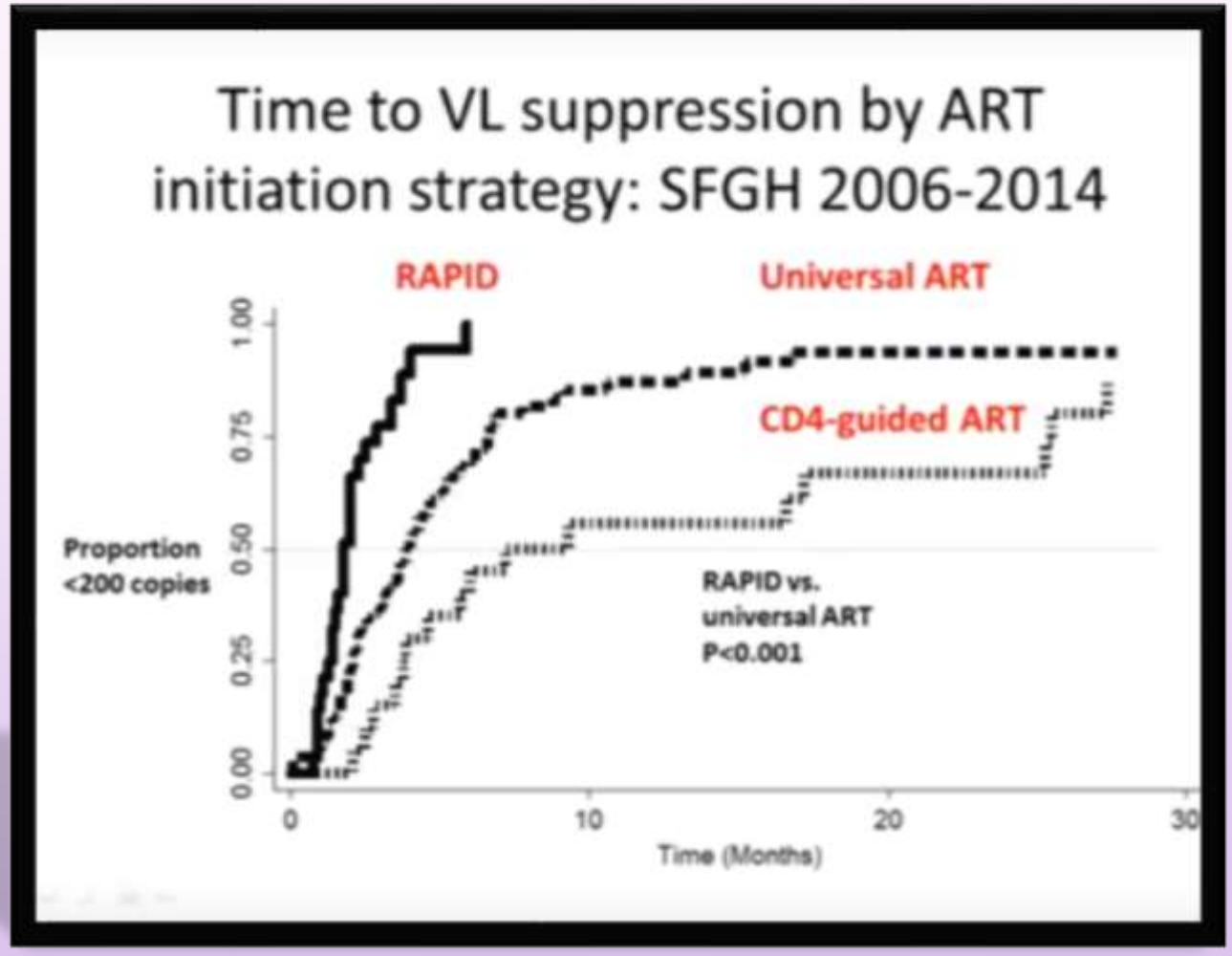


HIV Treatment Cascade – Usual Care

[for Calendar Year 2016]



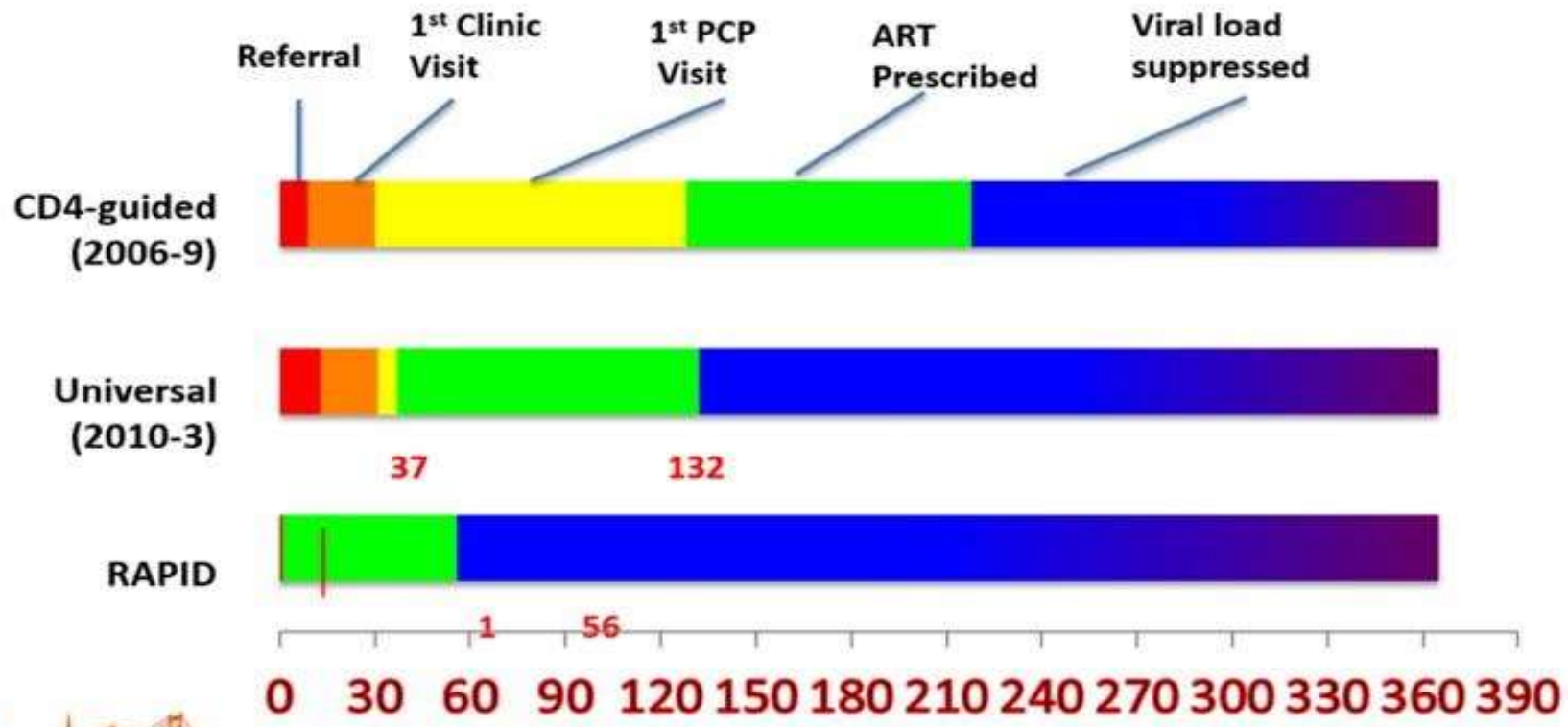
HIV Treatment Continuum – NYS/NYC "Ending the Epidemic" Targets



San Francisco General Hospital piloted a program called "RAPID" in which 39 patients received rapid treatment while 47 received Standard Care (aka Universal ART) & the results were noteworthy. It took only 56 days to reach virologic suppression (as opposed to 132 with Universal ART).

[Source: Asa Radix, "Test & Treat: Jan 2016 HIV Ops" Presentation]

RAPID Pilot Shortens Time to care, ART initiation, Virologic Suppression



POPULATION HEALTH DIVISION
SAN FRANCISCO DEPARTMENT OF PUBLIC HEALTH
CENTER FOR LEARNING & INNOVATION

Pilcher, IAS 2015

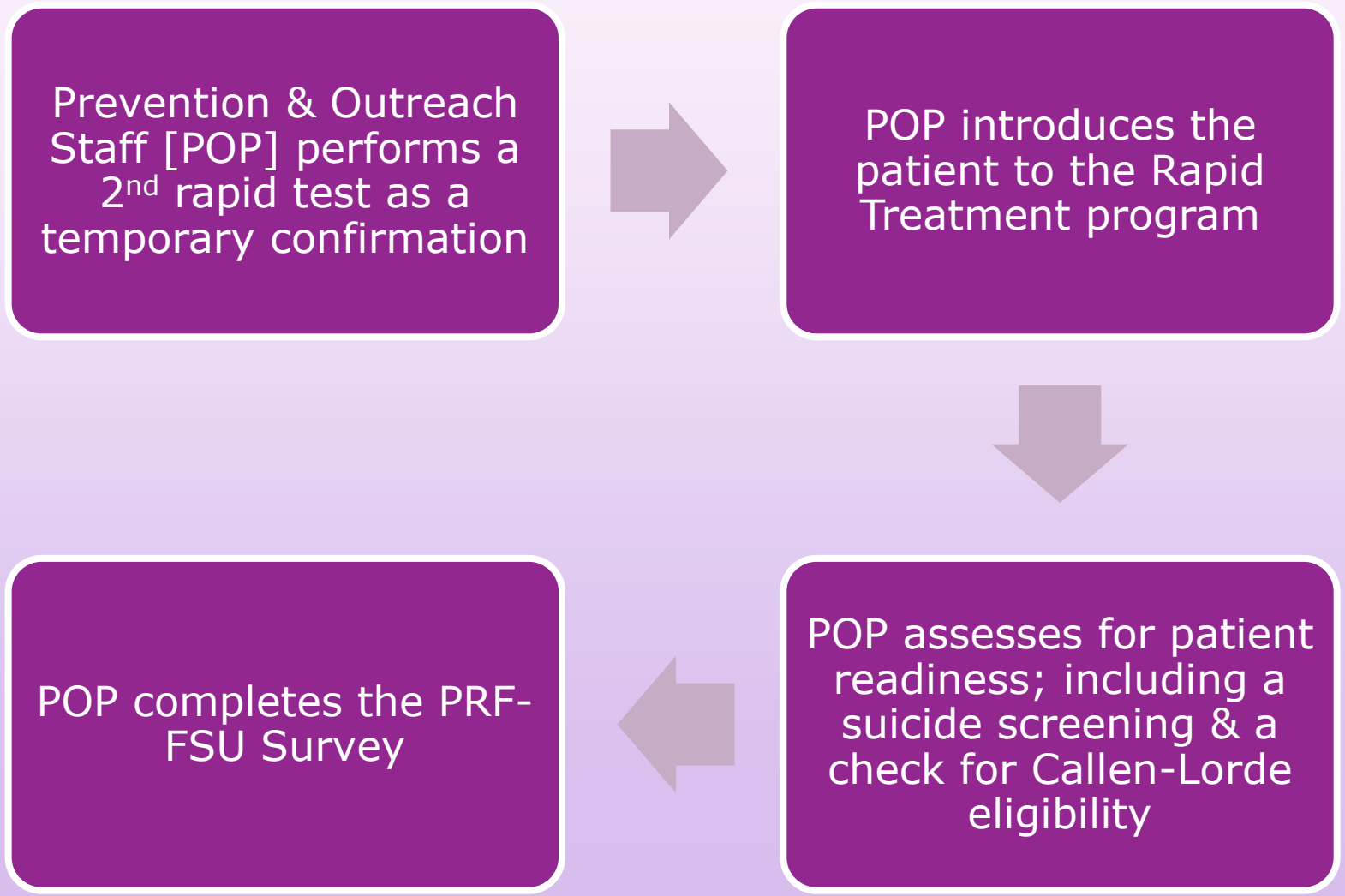
CPN
BUILDING THE CAPACITY OF THE NATION'S HIV PREVENTION WORKFORCE
Funded by Centers for Disease Control and Prevention

Rapid Treatment Comes to Callen-Lorde:

- As of January 2016, NYC DOH was discussing the possibility of rolling out Rapid Treatment at all STI Clinics across the city.
- Callen-Lorde launched NY's first pilot of Rapid Treatment in August of 2016, after being approached by ADAP/AIDS Institute.
- As of October 1st 2017, Callen-Lorde had initiated Rapid Treatment with 49 patients who have tested positive for the first time.

How Does Rapid Treatment Work at Callen-Lorde?

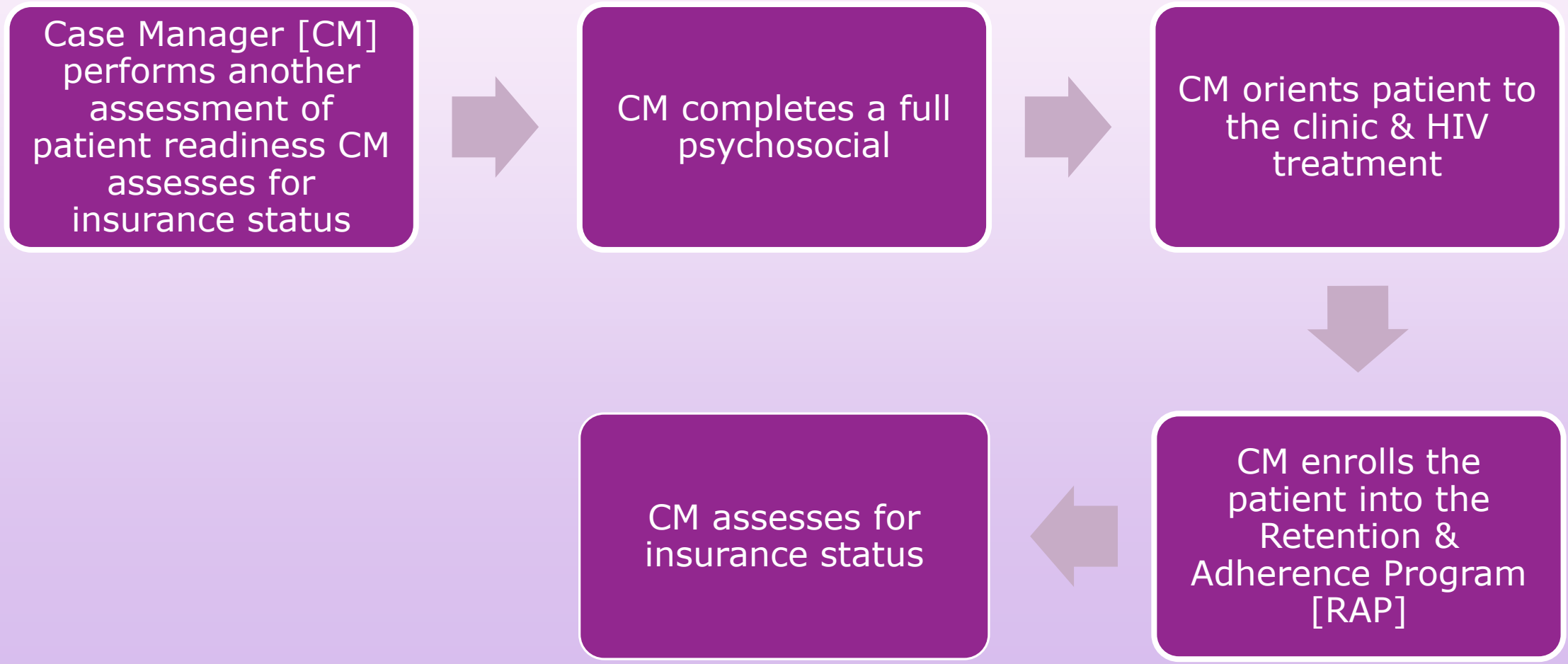
1. Prevention & Outreach Rapid Test = Reactive



What about False Positives?!

- The confirmatory blood test will be back within approximately 2 days
- So, in the case of a false positive, the patient is on unnecessary ARVs for approximately 2 days
- For reference, if the patient was on PEP and they weren't actually exposed to HIV, they would be on unnecessary ARVs for 30 days
- And this has yet to happen anywhere (including in San Francisco)

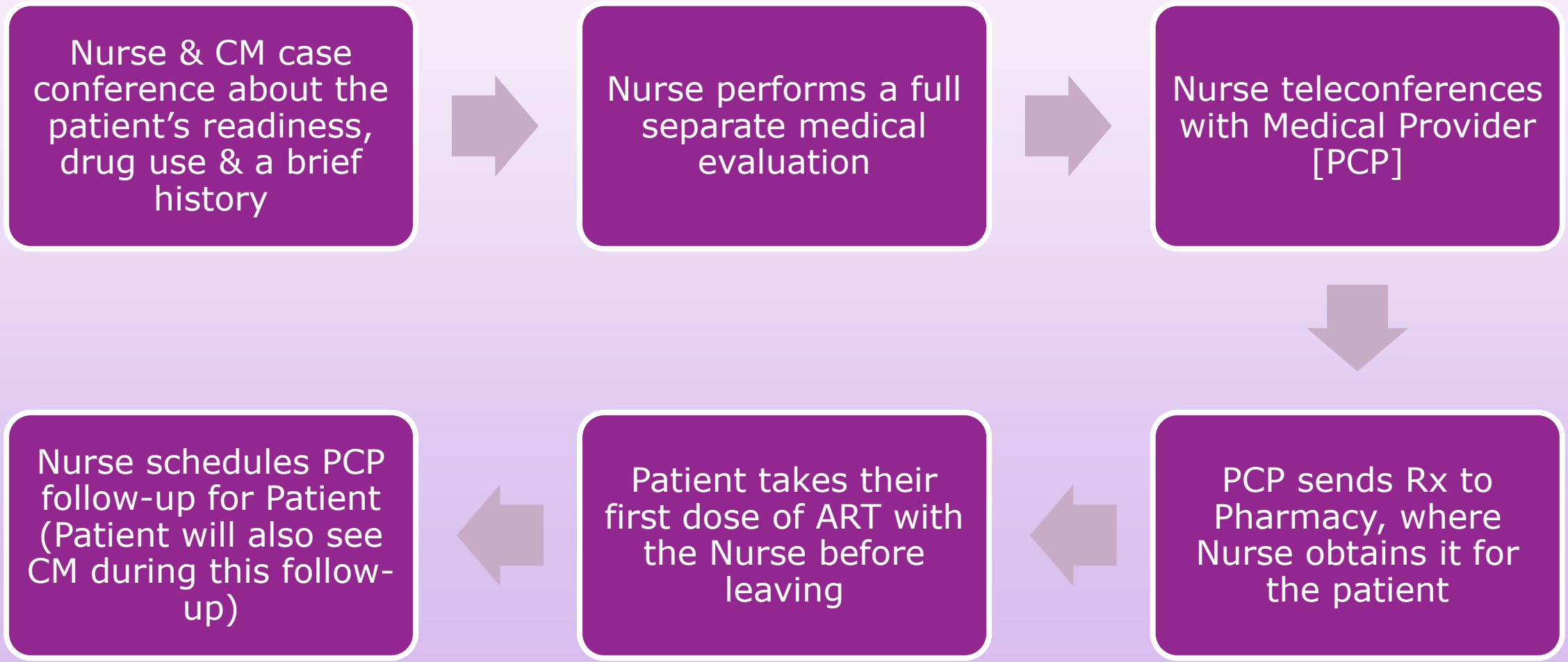
2. Case Management Appointment



What About Those Uninsured Folks?!

- Barriers
  - Medicaid takes 24 hours
    - Have to be a documented citizen & make below a certain amount of $
  - Standard ADAP takes 2 weeks to approved
  - This is all after patient and provider get documents together
- ADAP stepped up
  - Created a temporary Rapid Treatment Access Card system
    - Temporary ID immediately available via a 24/7 automated telephone system
  - Pays for labs, doctor's visits, medications – EVERYTHING standard ADAP pays for

3. Nursing Appointment



How do you pick the regimen?!

- Genotype takes 6 weeks

- High resistance barrier & low side-effects among the newest generation of drugs

4. Referrals


If needed, patient is sent for a Mental Health walk-in appointment
If needed, patient is sent to see a Facilitated Enroller for Medicaid coverage

5. Follow-Up

RAP CM calls the next day to assess for adherence, side effects & well-being

Within as early as a week, Patient returns for a complete HIV appointment with a PCP & a follow-up with CM

Within as early as a month, Patient returns for PCP follow-up [Genotype is back by this point, and patient has been on ART for a full month]

Follow-ups with PCP & RAP CM continue every 3 months for the next year

Is Rapid Tx Effective as HIV Care in a CHC Setting?

Known Positives
excluding Newly Diagnosed (NDs)

4098
Patients

87%
Viral Suppression

87%
Retention

ND – Usual Care
excluding Rapid Treatment

38
Patients

61%
Viral Suppression

74%
Retention

ND – Rapid Treatment

49
Patients

83%
Viral Suppression

90%
Retention

All Data is between 08/2016--09/2017

Viral Suppression =
Last HIV Viral Load < 200

Retention =
HIV Primary Care Appt w/in Last 6 Months

Average of **10 Days** to first **comprehensive** HIV Appt with a Prescribing Provider

Average of **36 Days** to Viral Suppression.

[101 for Usual Care]

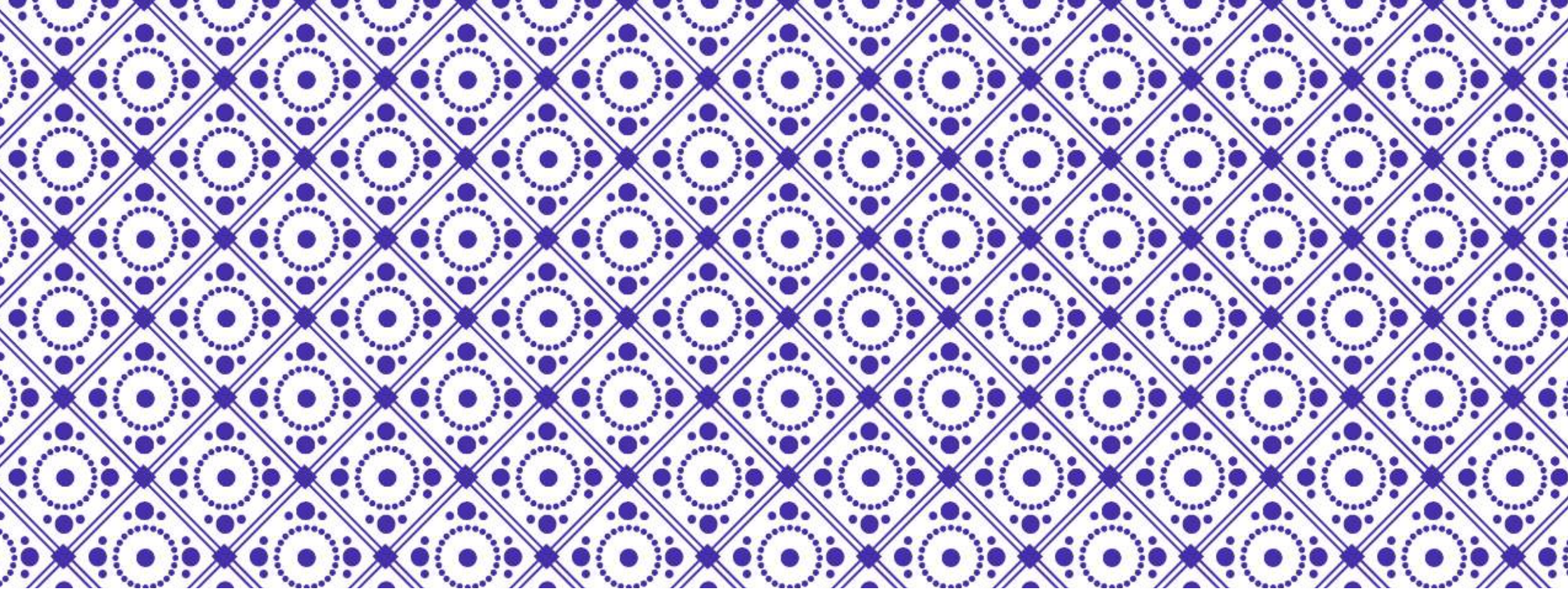
92% were Virally Suppressed at their Follow-up PCP Visit.

[2% for Usual Care]

Over 54% have utilized a Rapid Tx Access Card to pay for their first round of ART

0 false positives & **1** patient has needed to change initial ART regimen due to resistance

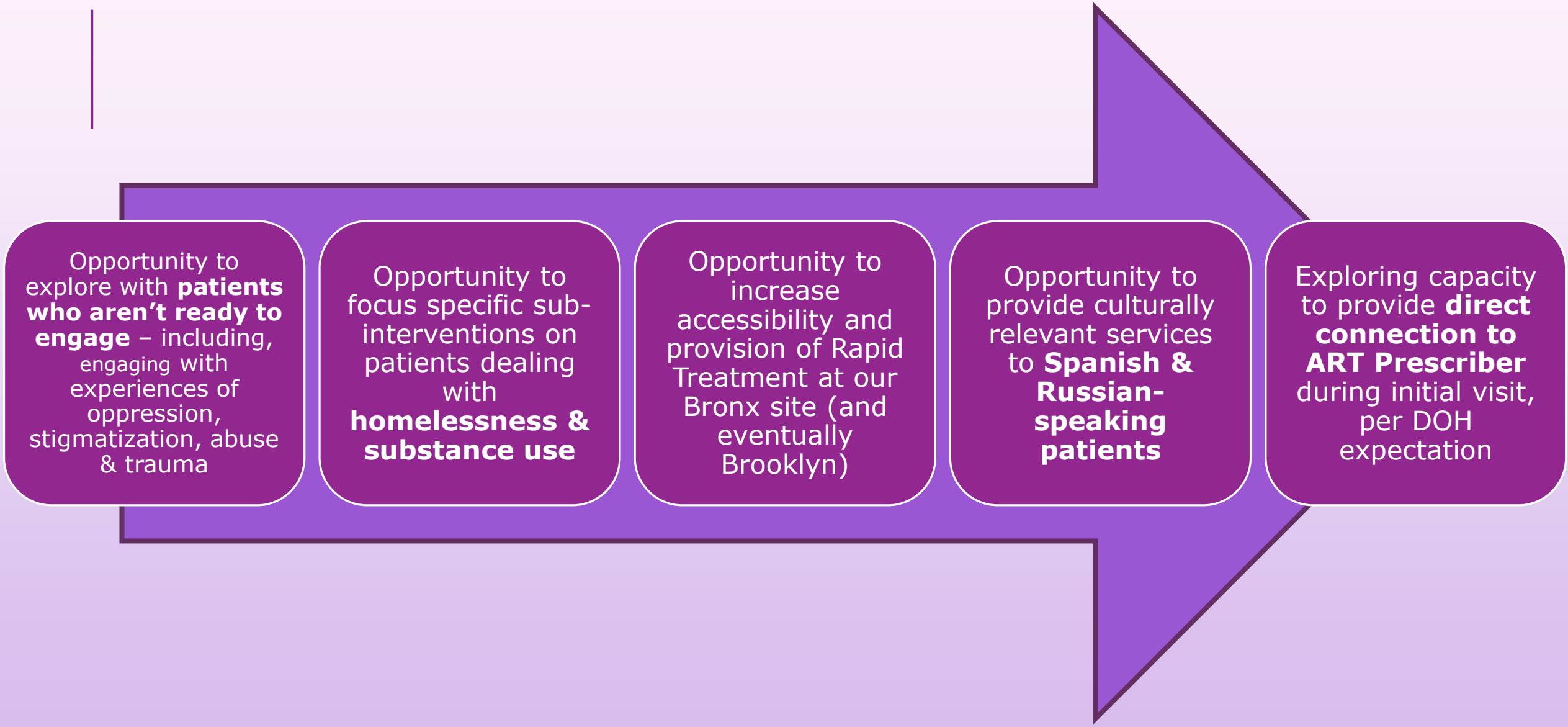
60% of all Newly Diagnosed patients have opted into Rapid Tx at time of diagnosis



What does this look like in real life?

- "E."
- Patient presented to initiate PrEP
  - Rapid Testing was Non-Reactive
  - Confirmatory Testing came back Reactive
- Clinic attempted outreach for 17 days to alert him to his HIV status
- Patient did not respond to outreach
  - Patient showed up un-announced at the front desk
  - PCA was able to connect patient to RAP Specialist because of outreach notes in the patient's chart
- Patient met with RAP Specialist that day & was initially resistant to starting on ART
  - RAP Specialist validated patient's concerns & connected their homeopathic and "natural" practices to potential ART as another tool in their wellness toolbox
- Patient ultimately decided to start Rapid Treatment THAT DAY
- Patient misses LV, Follow-up labs show (TCELLS & VIRAL LOAD) – RAP Specialist again begins outreach
  - Outreach goes on, un-responded to, for **30 days**
- Patient self-presented at front desk again, when he was out of ARVs
- Despite showing no outward "signs" that he was "adherent," patient had clearly committed to his care and treatment
- Patient has since been active in Medical and Case Management care and obtained Insurance, Housing, Mental Health services, and become Virally Suppressed

What’s Next for Rapid Treatment at Callen-Lorde?


Opportunity to explore with **patients who aren't ready to engage** – including, engaging with experiences of oppression, stigmatization, abuse & trauma
Opportunity to focus specific sub-interventions on patients dealing with **homelessness & substance use**
Opportunity to increase accessibility and provision of Rapid Treatment at our Bronx site (and eventually Brooklyn)
Opportunity to provide culturally relevant services to **Spanish & Russian-speaking patients**
Exploring capacity to provide **direct connection to ART Prescriber** during initial visit, per DOH expectation

Thank You!

Any Questions?

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A Nursing-led Quality Improvement Initiative in Promoting Routine HIV Testing in Two Urban Emergency Departments

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Lauren Collins, MSN, RN

Angie Lee, BSN, RN, CEN

Jocelyn Sese, MSN, RN, CEN

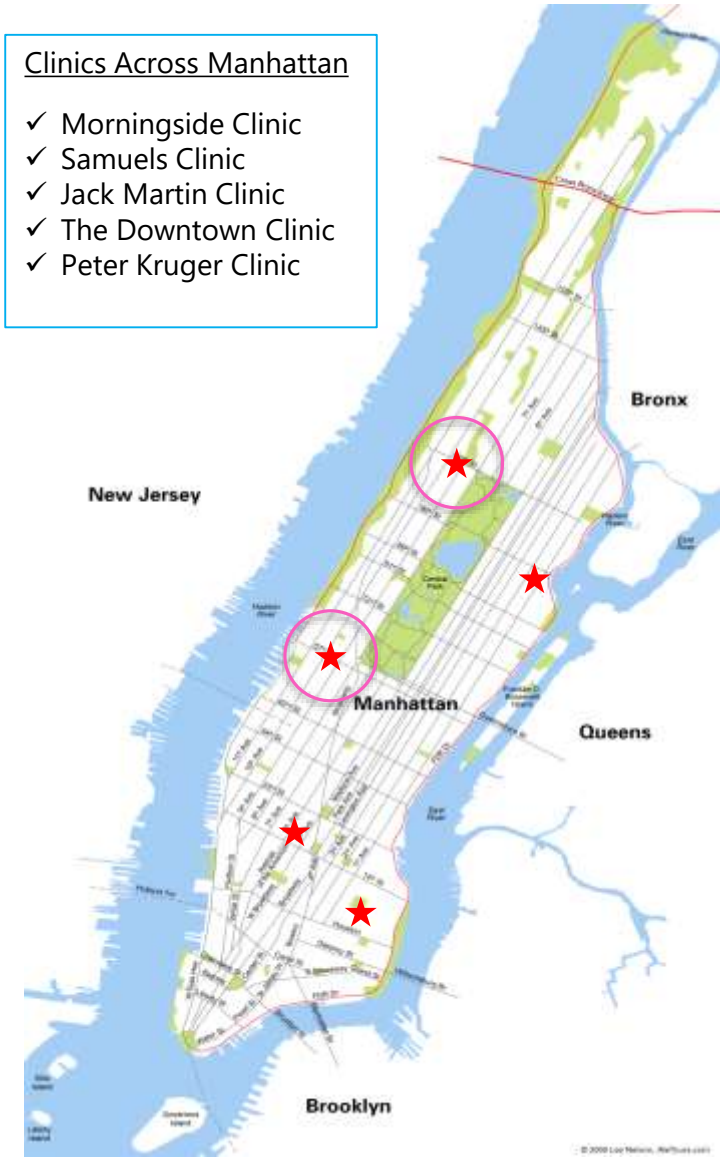
Dan Egan, MD

Mount Sinai

Institute for Advanced Medicine

Who We Are

- Five-site network of hospital and community-based clinics caring for more than 13,000 people with and at-risk for HIV/AIDS
- Co-located, comprehensive services to reduce barriers and increase a patient centered approach to care
- This QI Initiative took place at our Morningside and Samuels clinics attached in collaboration with the Mount Sinai St. Luke's and Mount Sinai West Hospitals (MSSL-MSW), specifically in the two Emergency Departments (EDs)



HIV Testing in the MSSL-MSW EDs

- Testing is offered to everyone over the age of 13

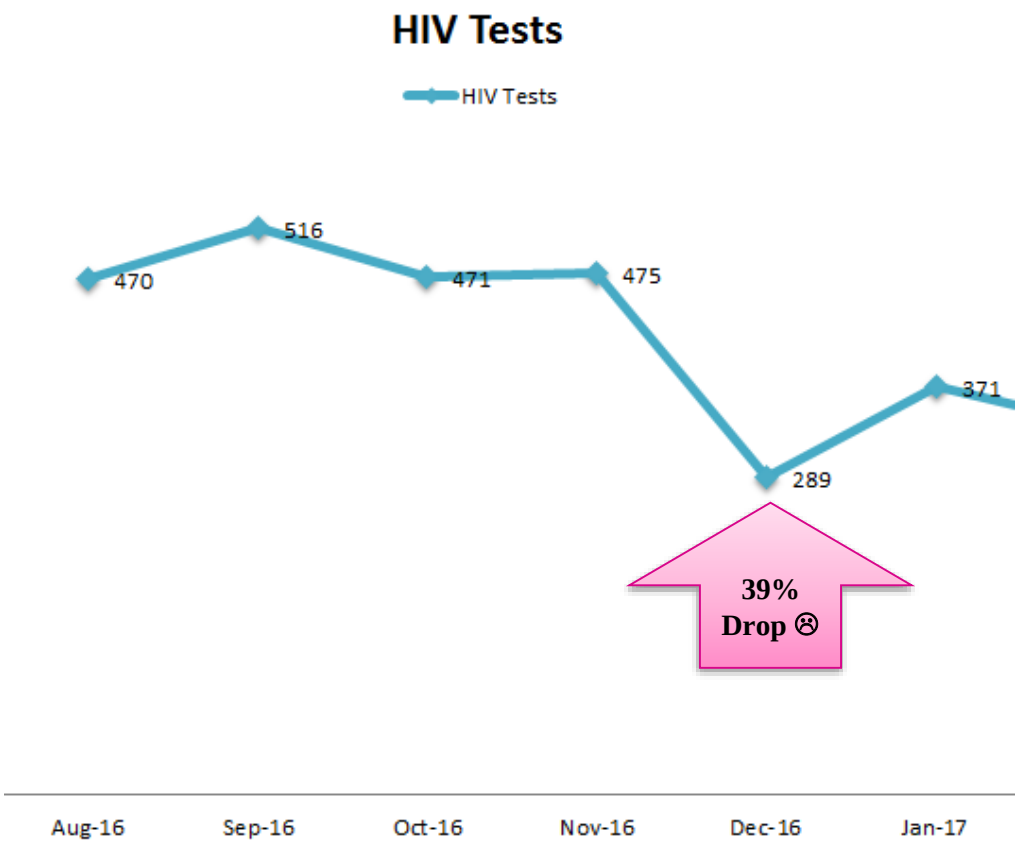
- Active Choice Model at Primary Nurse Assessment:

Initial Triage Acuity: Level III - Urgent
ID Band Intact: ID band intact
Would you like an HIV test?: Yes, verbal consent obtained
HCV Screening Criteria: Born 1945-1965
Would you like an HCV Test?: Yes
Language Verification: None Needed
Sepsis Alerts None: None
Thoughts of hurting yourself: No
Thoughts life not worth living: No
Thoughts of ending your life: No

- Point-of-care 3rd generation (oral swab) test ordered by nurse and administered by ED Tech

- ED orders 4th generation test with confirmatory reflex for:
  - Symptoms resembling Acute HIV infection
  - Patients seeking PEP services (or any recent exposures)
  - For any positive screening test

The Drop



Contributing Factors:

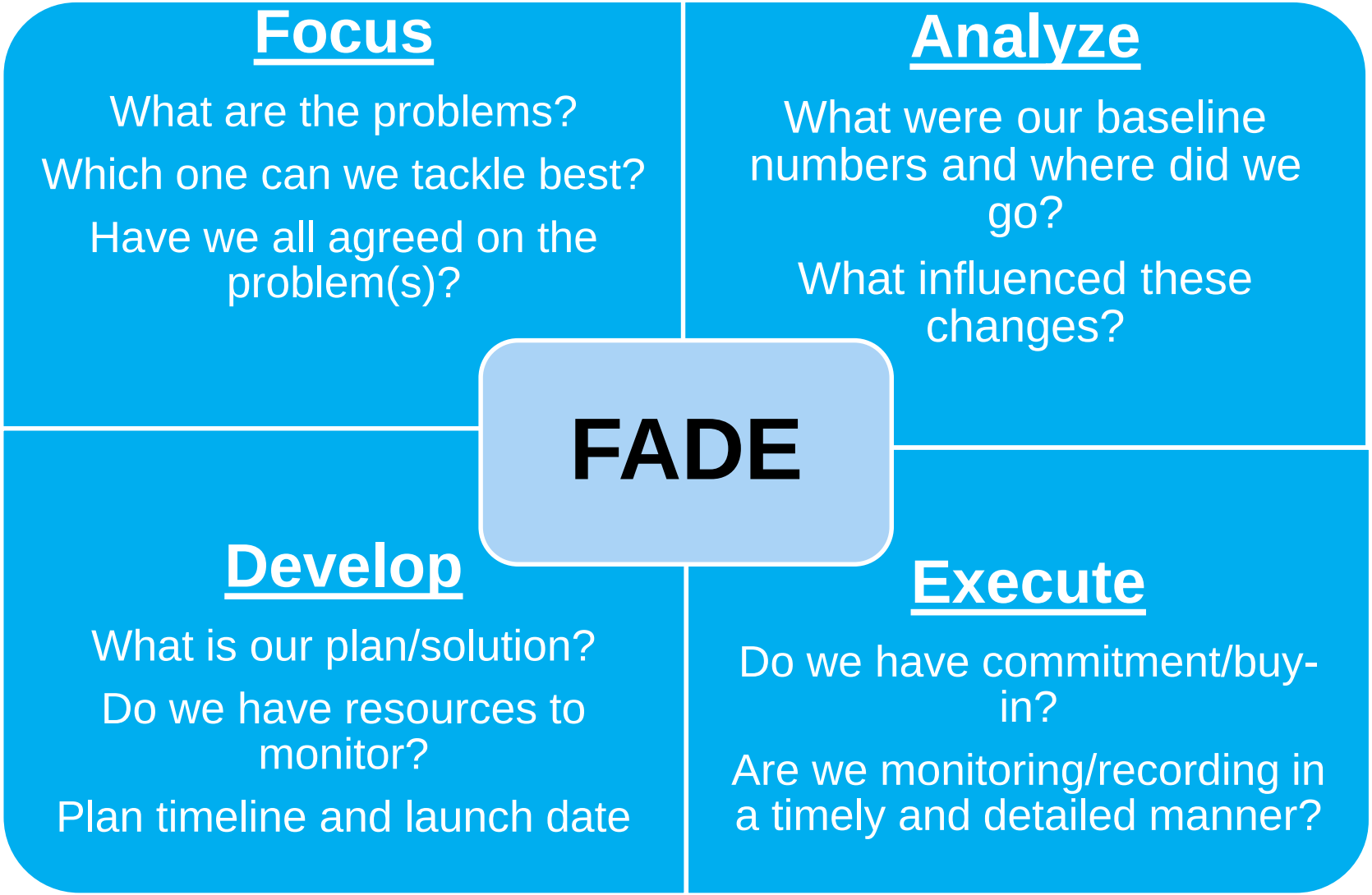
Split-Flow Model Adoption

- HIV screening migrated to a second tab (more clicks)
- The question moved from triage nursing to ALL nursing staff

Low Awareness of Monthly Testing Rates

- Nursing largely unaware of low testing months compared to stellar testing months
- No formalized feedback of testing rates between testing staff and ED staff

The Framework



The Framework

Focus

Declining acceptance rates

Declining testing rates (The Drop)

Low positivity

Split Flow Adoption

Analyze

Insecurity in the ask by nurses

Low awareness of testing rates

Lack of visibility of testing staff

FADE

Develop

Increased visibility of testing service (Case Studies, Success Stories)

Nursing Leadership-led directives

Cultivating buy-in

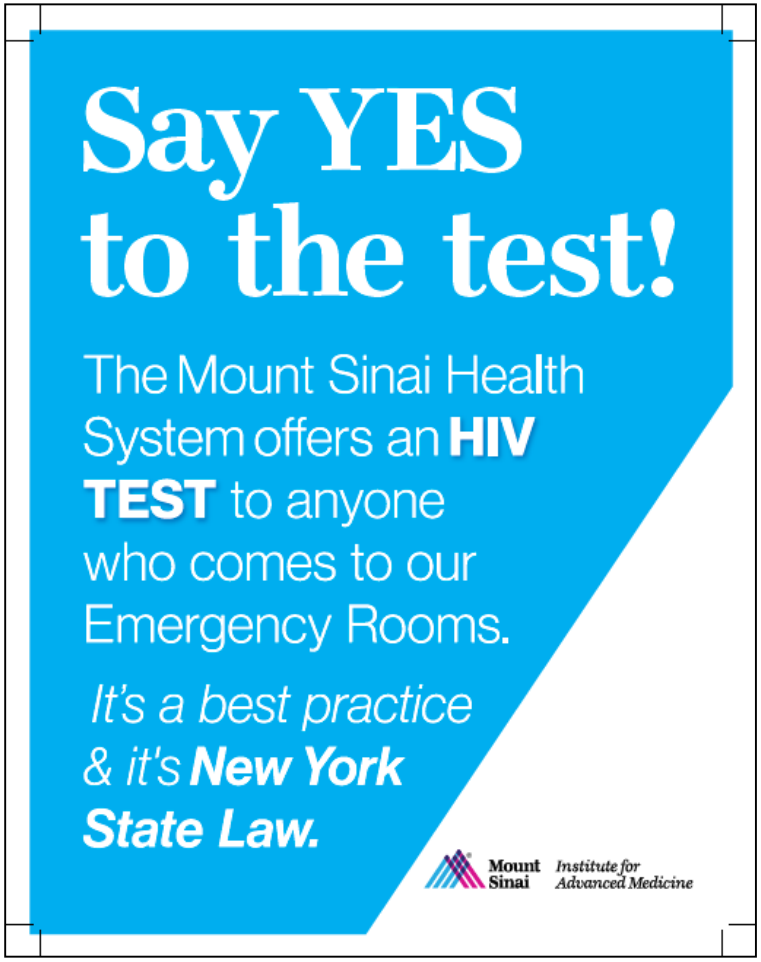
Execute

Initial months of 2017

Program staff follow directives and implement within a 3 month window

Data points prepared and time allotted for rigorous monitoring

Nursing-led Suggestions and Requests



-Increased visibility

- Signs normalizing the offer
- Program staff present at huddles
- More in-services to provide education and consolidate commitment

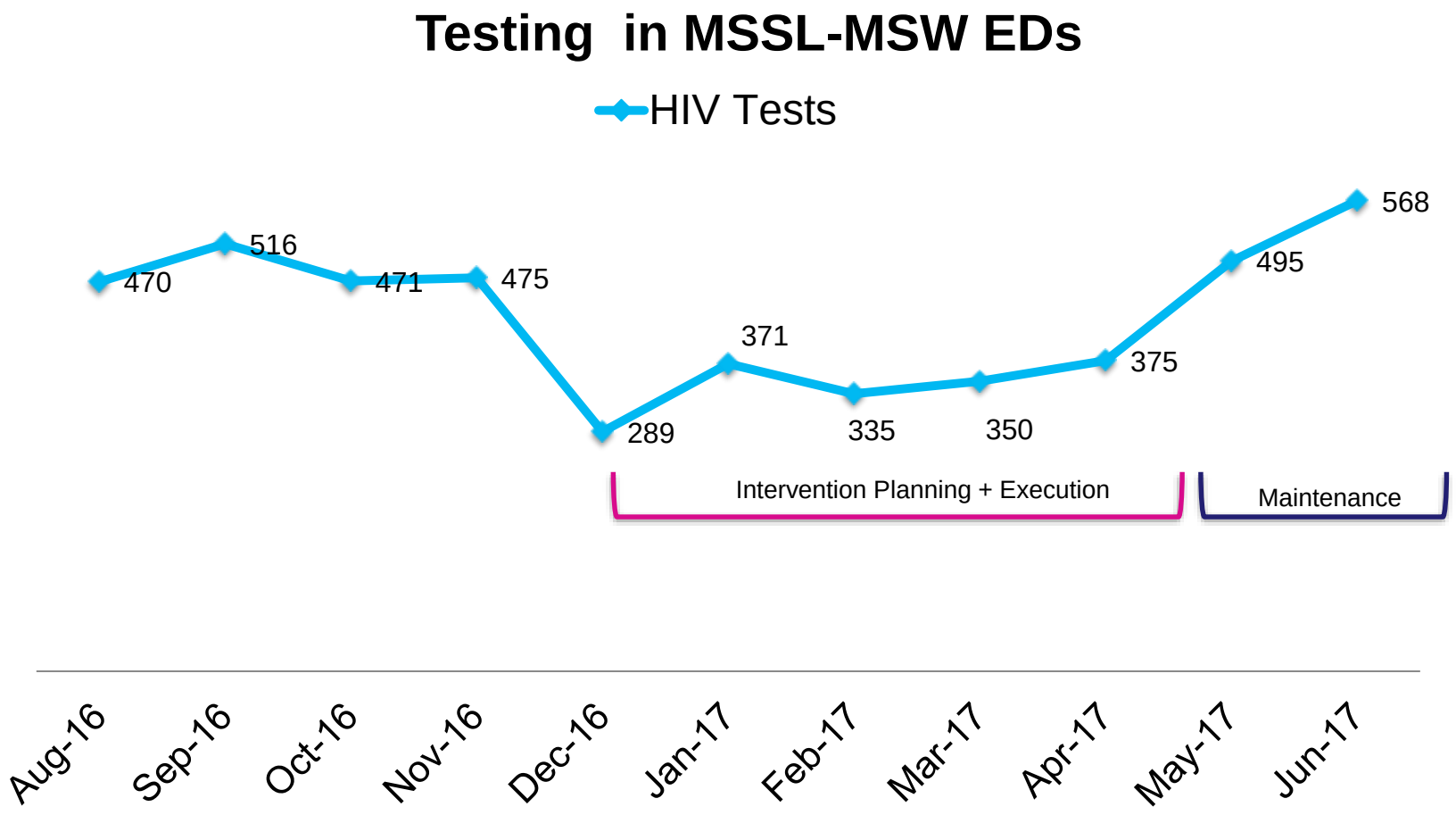
-Increase data monitoring and sharing

- Monthly e-mails tracking efforts (incorporating visual aids)
- Nurse-level acceptance and administration rates (and an increase in coaching)

-Formalized roles in leadership

- Who forwards program staff's e-mails to the teams?
- Who is our cheerleader on the ground?
- Who addresses low testing performance?

Results


Testing in MSSL-MSW EDs
HIV Tests
470
516
471
475
289
371
335
350
375
495
568
Intervention Planning + Execution
Maintenance
Aug-16
Sep-16
Oct-16
Nov-16
Dec-16
Jan-17
Feb-17
Mar-17
Apr-17
May-17
Jun-17

Case Study- “Hector”

- 27 year old, Hispanic Male
- Presented to the ED with a laceration on his face from a fall
- Accepted HIV testing at Primary Nurse Assessment
- Previous HIV test was 2 years ago with PCP he had through former employer’s insurance
  - Since then, has been uninsured
- Tested Positive at ED visit with a POC test
  - Immediate referral to Morningside was given
  - Program outreach conducted following business day
- Hector was linked to care two business days later
  - Baseline CD4 in 600’s
  - Started on ARV’s at 2nd visit
  - Undetectable by 3rd visit (One month later)
  - Still maintained in care

Takeaways/Next Steps

- Maintenance of the good results that is less reliant on program staff
  - Where are the areas where capacity needs to be built?
- The power of data!
- Higher-level data analyses
  - Demographics analysis (Who's accepting tests vs. who's not)
- Adapting for changes in HIV testing technologies
  - How can we maintain a robust service with lab-based testing?
- Adapting for changes in Electronic Medical Record
  - What will the EPIC era bring in terms of user view and ease of use?
  - How can this enhance the offering of testing- how could it possibly hinder?

Thanks

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Acknowledgements

Jennifer Irwin, MPA

Diane Tider, MPH

The MSSL/MSW ED Teams

MSSL/MSW Program Team

Say Yes to Gardening in the City

Heritage Health and Housing
Food and Nutrition Services Program

Heritage Health and Housing Project Background

Services Provided:

- Nutrition Education
- Meals – Breakfast, Lunch and Dinner
- Pantry
- Provide services five days /week with a pantry bag for the weekend

Improvement Goals

- To improve the pantry service at Heritage Health and Housing FNS program by providing additional kinds of food
- Adding fresh vegetables and herbs to the pantry bags

Project Aims

- Better contents in pantry bags
- Linkage to other community organizations and services
- ‘Spice up’ nutrition education sessions

How to Improve Pantry Bags

Conducted brainstorming session with nutrition staff

Results of brainstorming activity:

- A garden that would provide fresh vegetables and herbs
- Additional food from the Food Bank of NYC.
- Usage of the Farmers' market

Methods

Support

We needed resource support to get this project going since the program did not have funding for it.

Who helped us

- The CEO of Heritage Health and Housing
- Food Bank of New York City
- Snug Harbor Farm – Staten Island
- Department of Health – Health Bucks project

Methods, 2

The CEO of Heritage was very interested in this project and we were given the green light to go ahead with this project

<u>Space and funds for the Garden</u>

Heritage had back yard patio which was not in use and so we were allowed to utilize the space for the garden

Methods, 3

New York Restoration project (NYRP)-A not-for-profit organization that helps various communities to start community gardens.

- Provided us with labor – sent their workers to prepare the garden from scratch
- Provided starting material – soil, mulch and plants for the garden.
- CEO provided funding

Methods, 4

- The Food Bank of New York City helped by linking us with a farm (The Heritage Farm) in Staten Island

Training:

- Food Bank of NYC in collaboration with Snug Harbor of Staten Island provided a thirteen week training on gardening and farming
- Who was trained
  - Program Director and President of the Consumer Advisory Board (CAB)

Results: Stage 1 and 2

Summer of 2015

- The New York Restoration Project team came and prepared the land, tilled the soil and provided us with top soil for the beds.

Fall of 2015

- FNS program director and CAB president attended farm training

Results: Stage 3 Winter 2015

– Forming a garden team

- Consumers
- FNS program staff
- Staff of the NYRP team
- Decision – plants and herbs that keep sending out new leaves during the season.

(this way we will always have fresh vegetables and herbs for the pantry bags throughout the summer)

Results: Stage 4 Spring 2016

- NYRP and FNS program manager purchase organic seedlings for the garden: tomatoes, bell peppers, squash, thyme, mint, basil, celery, green beans and strawberries.
- May of 2016 - planting of seedlings

Education Sessions

- During the Spring and Summer of 2016, the Registered Dietitian and the Program Manager held education session on the nutrition value of the food and herbs distributed in the pantry bags

Managing the Garden

- Project consumers took turns visiting the garden to water and take care of the plants
- Nutrition staff visited the garden at the various stages and often included visits as part of the education sessions

The Garden

- During this session consumers asked related questions about the plants and were excited to see the fruits and vegetables emerge from the flowering of the plants

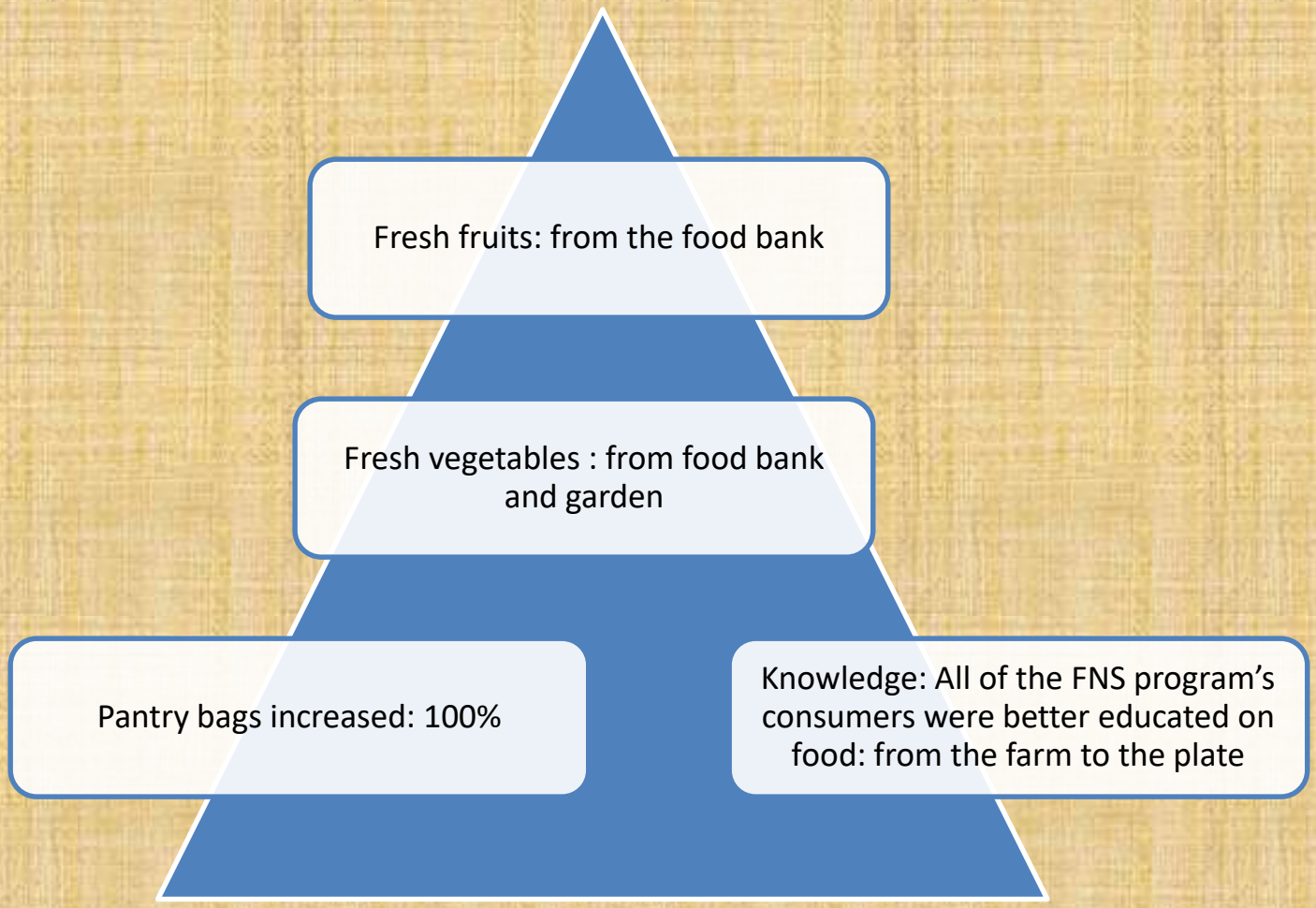
Results: Summer 2016

- Reaping
- Distribution
- Consumer response

Conclusion

- FNS consumers were very excited about growing their own vegetables and herbs
- The program is now in its second year of gardening and consumers have become more highly aware of what it mean for food to be from the “Farm to the Table.”

Conclusion


Fresh fruits: from the food bank
Fresh vegetables : from food bank and garden
Pantry bags increased: 100%
Knowledge: All of the FNS program's consumers were better educated on food: from the farm to the plate

Next Steps

Address Issues

- Loss of current space
- Linking with a community garden in the area
  - The Brotherhood SisterSol Foundation
  - Have more activities than at our previous garden
  - Identify more skilled staff

Moving Forward

- Looking forward to even better experiences with the community garden
- Closer to the program/organization
- Sharing of funding

Bon appetite

Sonia Grant
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Improving Tobacco Screening and Cessation Counseling across IAM

Amy Newton, MPH
HIV QI Manager
Institute for Advanced Medicine
Mount Sinai Health System

Mount Sinai

Organizational Background

- The Institute for Advanced Medicine (IAM) is comprised of five HIV practices across Manhattan:
  - Morningside Clinic at Mount Sinai St. Luke's Hospital in West Harlem
  - Samuels Clinic at Mount Sinai West Hospital in Columbus Circle
  - Jack Martin Clinic at Mount Sinai Hospital in East Harlem
  - Comprehensive Health Clinic in Chelsea
  - Peter Krueger Clinic at Mount Sinai Beth Israel in Union Square
- Represents the largest HIV primary care practice in New York and provides HIV primary care to over 10,000 people with HIV (PWH)
- The IAM's Quality Management (QM) Program establishes annual goals and uniform measures in order to standardize QI initiatives
- Each clinic develops and implements individualized QI projects tailored to their site

QI Project Background

- Tobacco screening and cessation counseling was selected as an annual quality goal in 2016
  - Smoking is a leading cause of premature mortality in people with HIV (PWH) demonstrating the importance of prioritizing routine tobacco screening and cessation efforts
  - Evidence supports the use of screening, counseling, and prescribing pharmacotherapy to increase the likelihood of successful tobacco cessation
- Each IAM clinic was tasked with setting measurable goals and implementing a QI project to increase tobacco screening and cessation counseling

QI Project Aim

Aim

- Increase tobacco screening and tobacco cessation counseling across the IAM

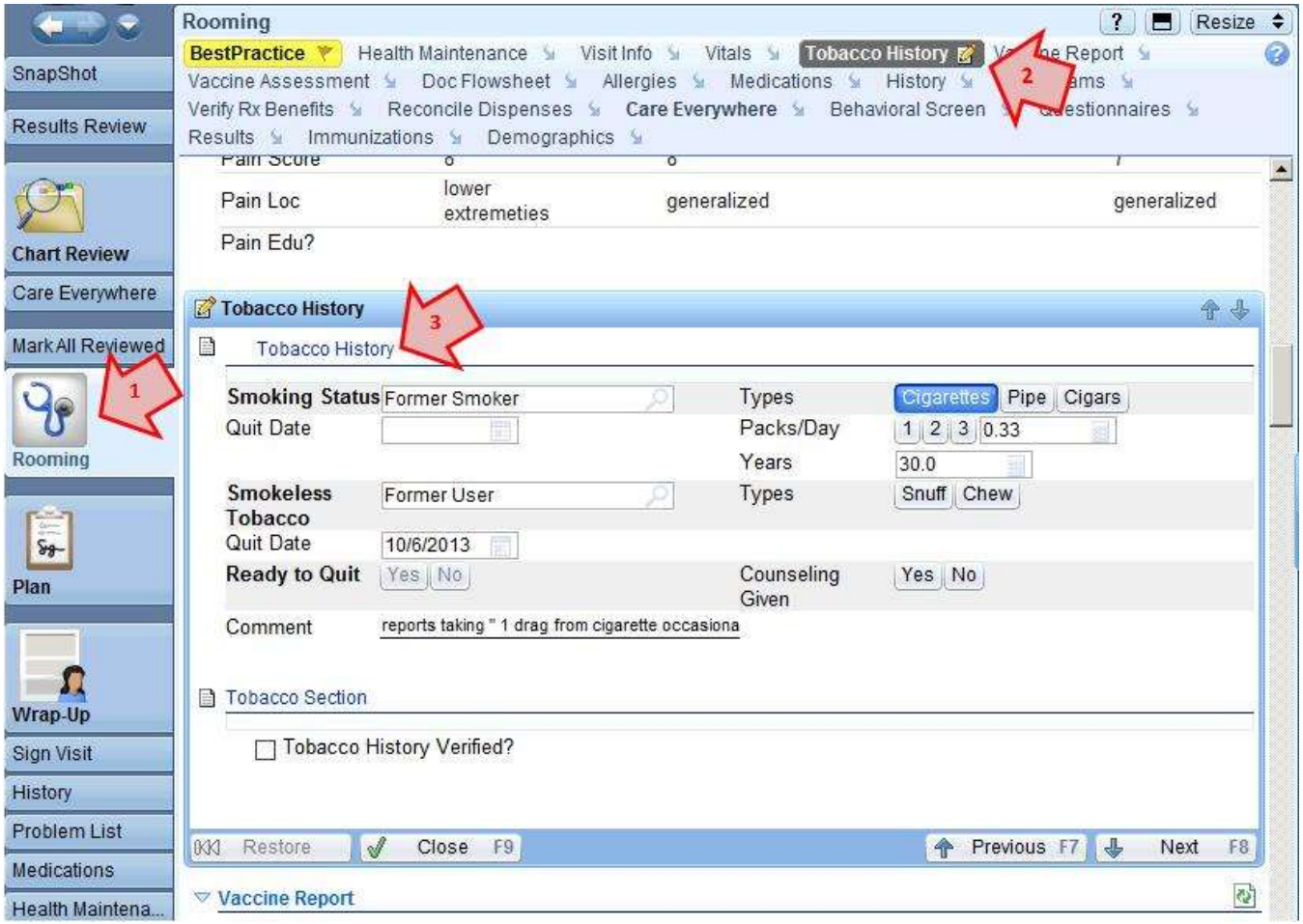
Goals

- Improve tobacco screening rates to 87% (2014 eHIVQUAL Mean) for all IAM clinics by the end of 2016
- Improve counseling rates for current smokers to 82% (2014 eHIVQUAL Mean) for all IAM clinics by the end of 2016

Methods

- Developed and implemented a process for routine tobacco screening and counseling adapted to each IAM clinic's flow and structure
  - Provider-driven or multidisciplinary with involvement from medical assistants, nursing, and medical providers
  - At a minimum, patients were expected to be screened and counseled annually
- Utilized a variety of trainings and resources
  - Training on proper EMR documentation
  - Smoking cessation trainings for IAM providers by subject matter expert, Mary O'Sullivan, MD
  - NYC Tobacco Quit Kit, NYC Quits screening tool, and the NYS Quit Line
- Collected data quarterly from the Epic EMR and reviewed at quarterly IAM QI Committee meetings and monthly clinic-level QI meetings

Method #1: Tobacco Use Fields in Epic for Meaningful Use



Method #2: NYC Quits Screening Tool

Do You Smoke?

If you do, fill this out and give it to your provider. It will help your provider better understand your health needs.

1. How many cigarettes do you smoke each day?

☐ 1 to 10 ☐ More than 10 ☐ I do not smoke every day

2. How soon after waking do you smoke your first cigarette?

☐ 30 minutes or less after waking

☐ More than 30 minutes after waking

☐ I do not smoke every day

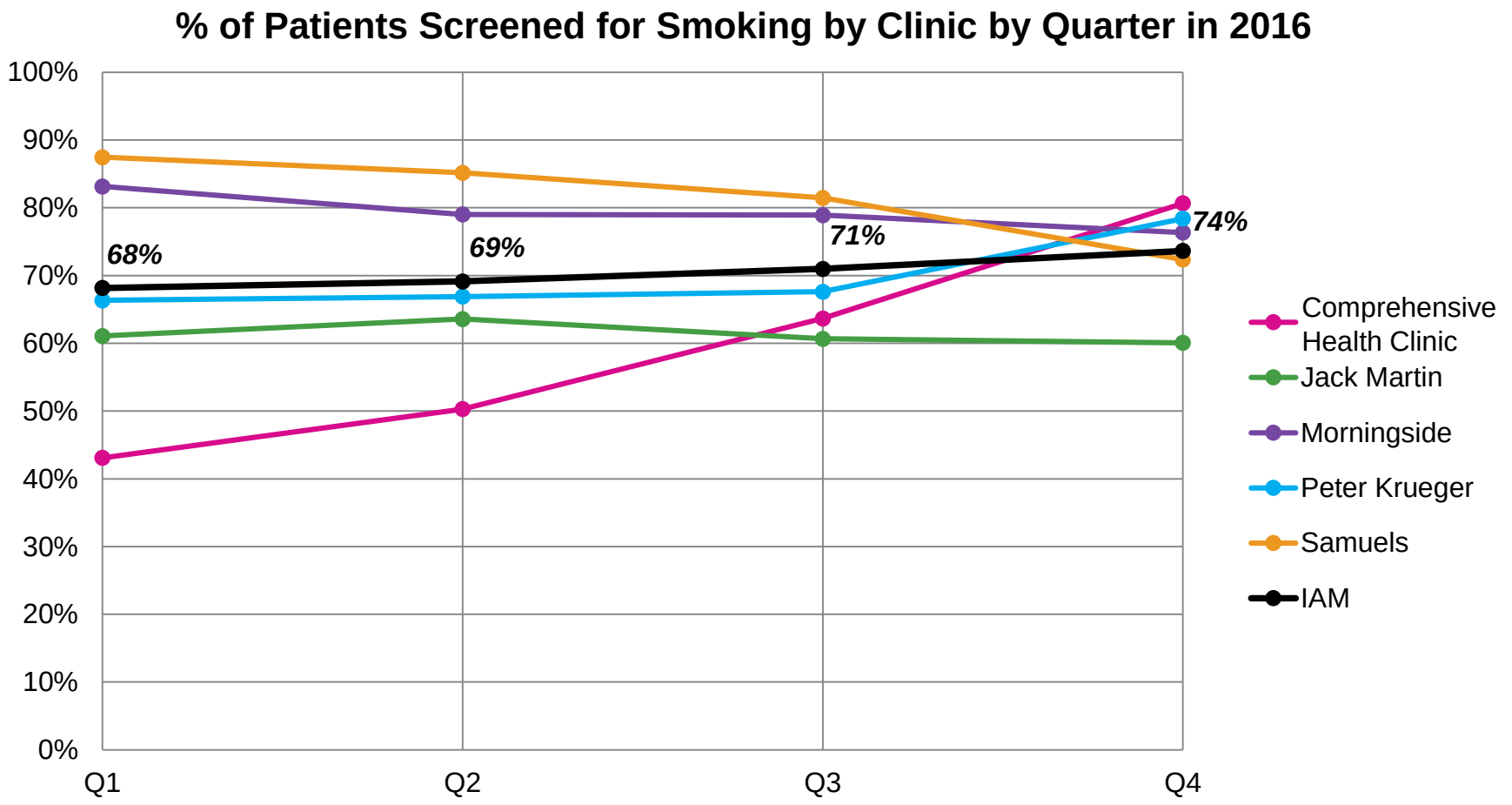
Note to Providers: Use the Tobacco Treatment Guide for prescribing recommendations.

Adapted from Heatherton TF; Kozlowski LT; Frecker RC; Rickert W; Robinson J. Measuring the Heaviness of Smoking: Using self-reported time to the first cigarette of the day and number of cigarettes smoked per day. *Br J Addict* 1989;84(7):791-799.

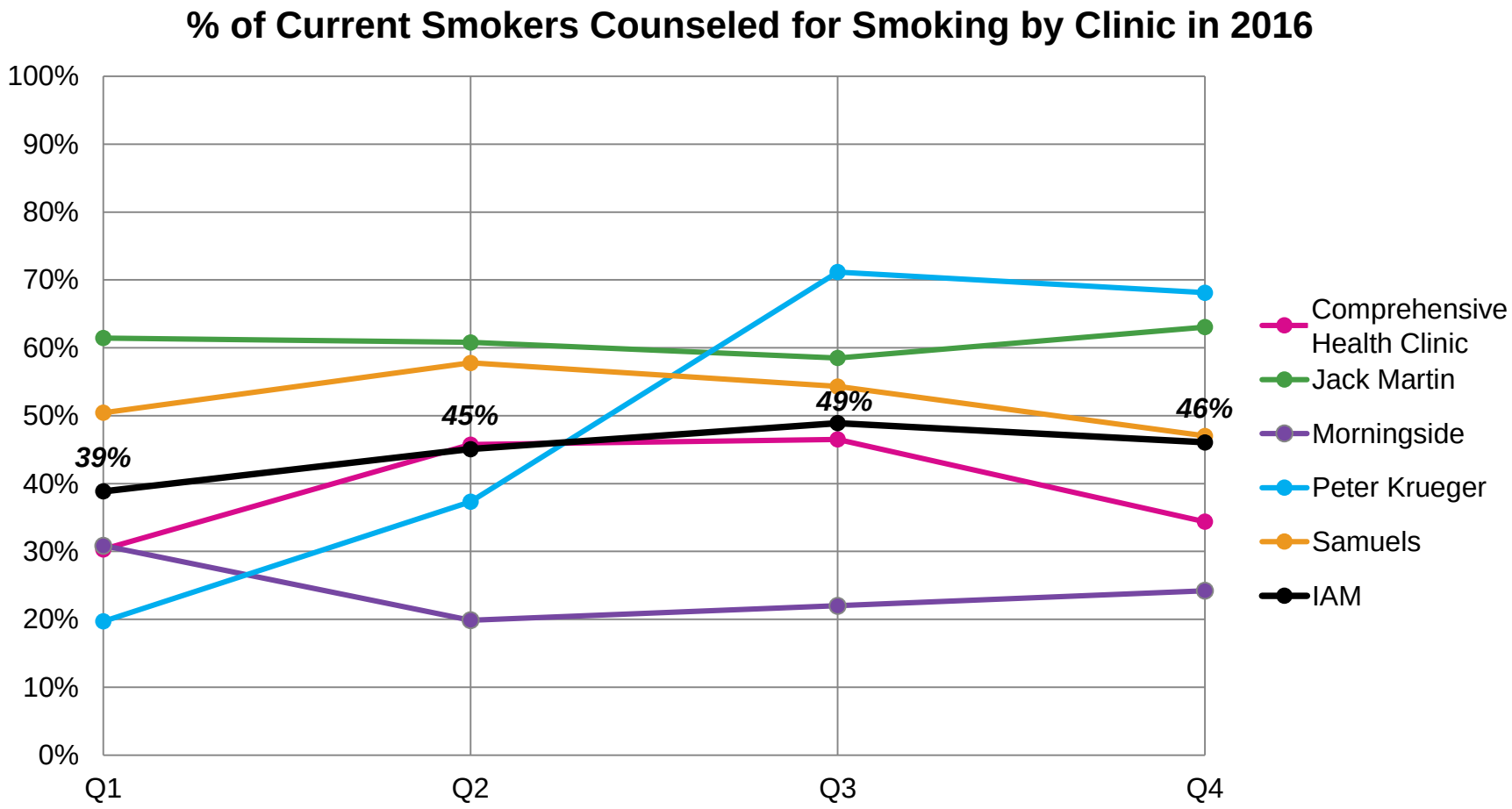
NYC Health

▼ Español al reverso

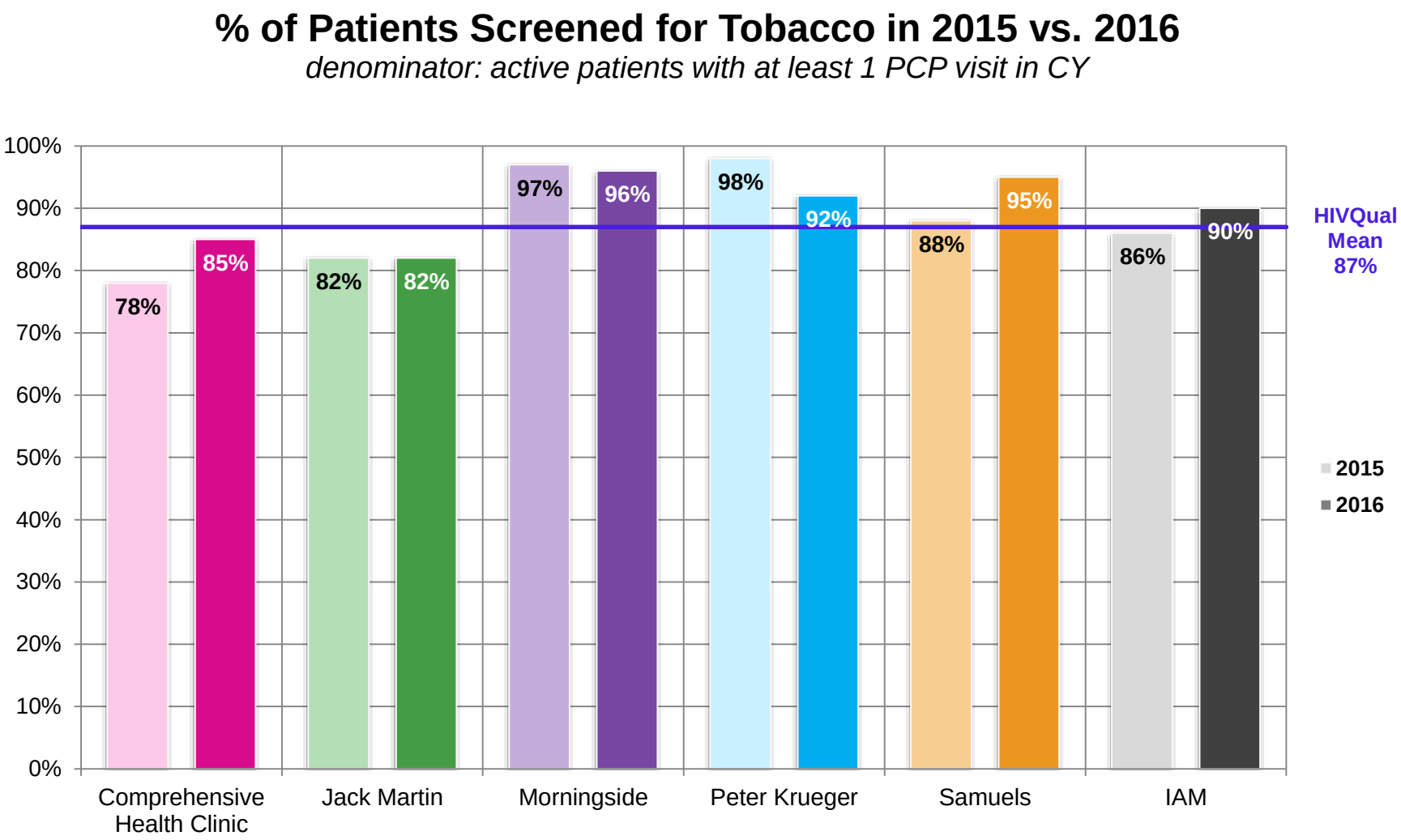
Tobacco Screening Results by Quarter



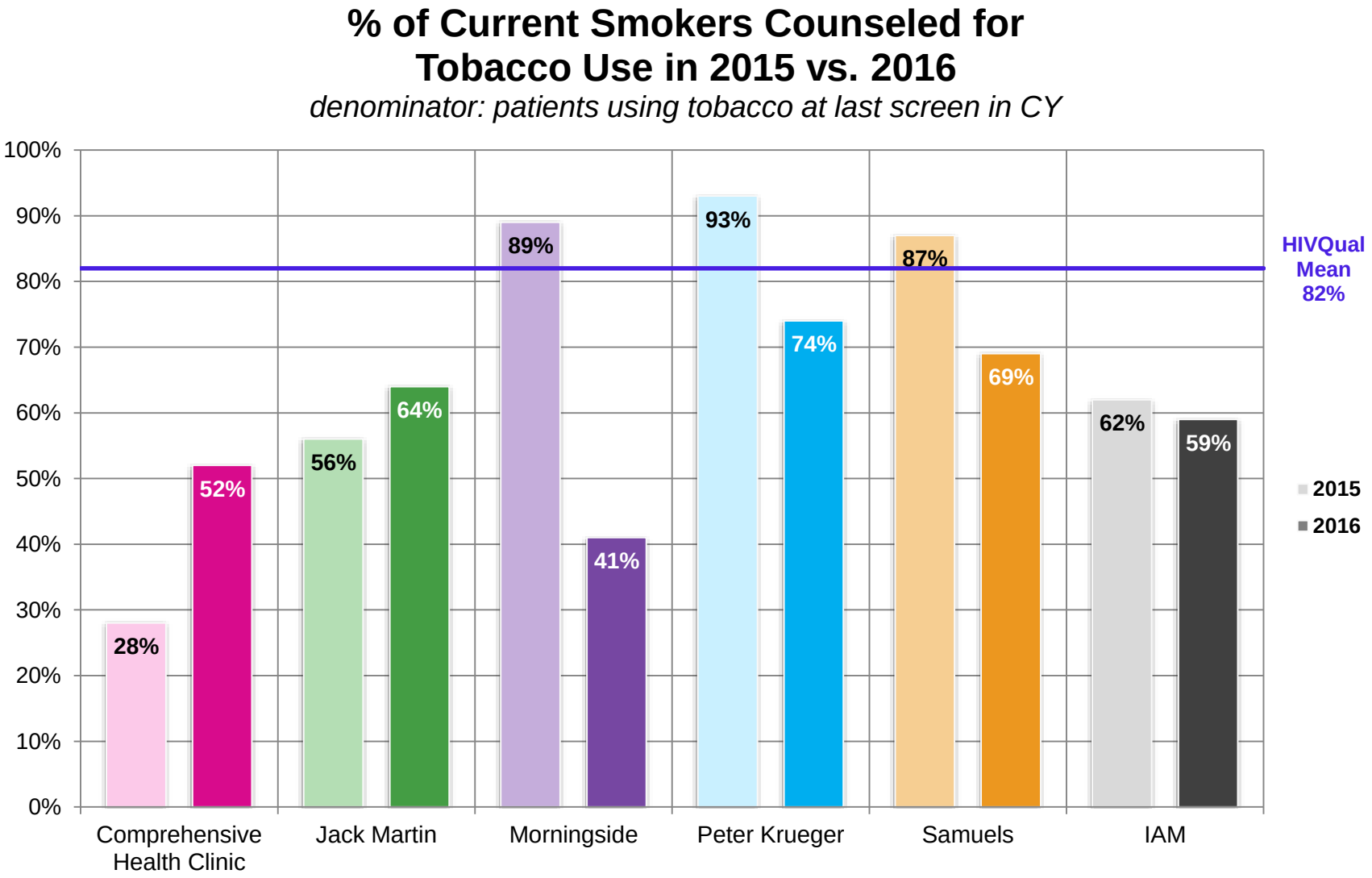
Tobacco Counseling Results by Quarter



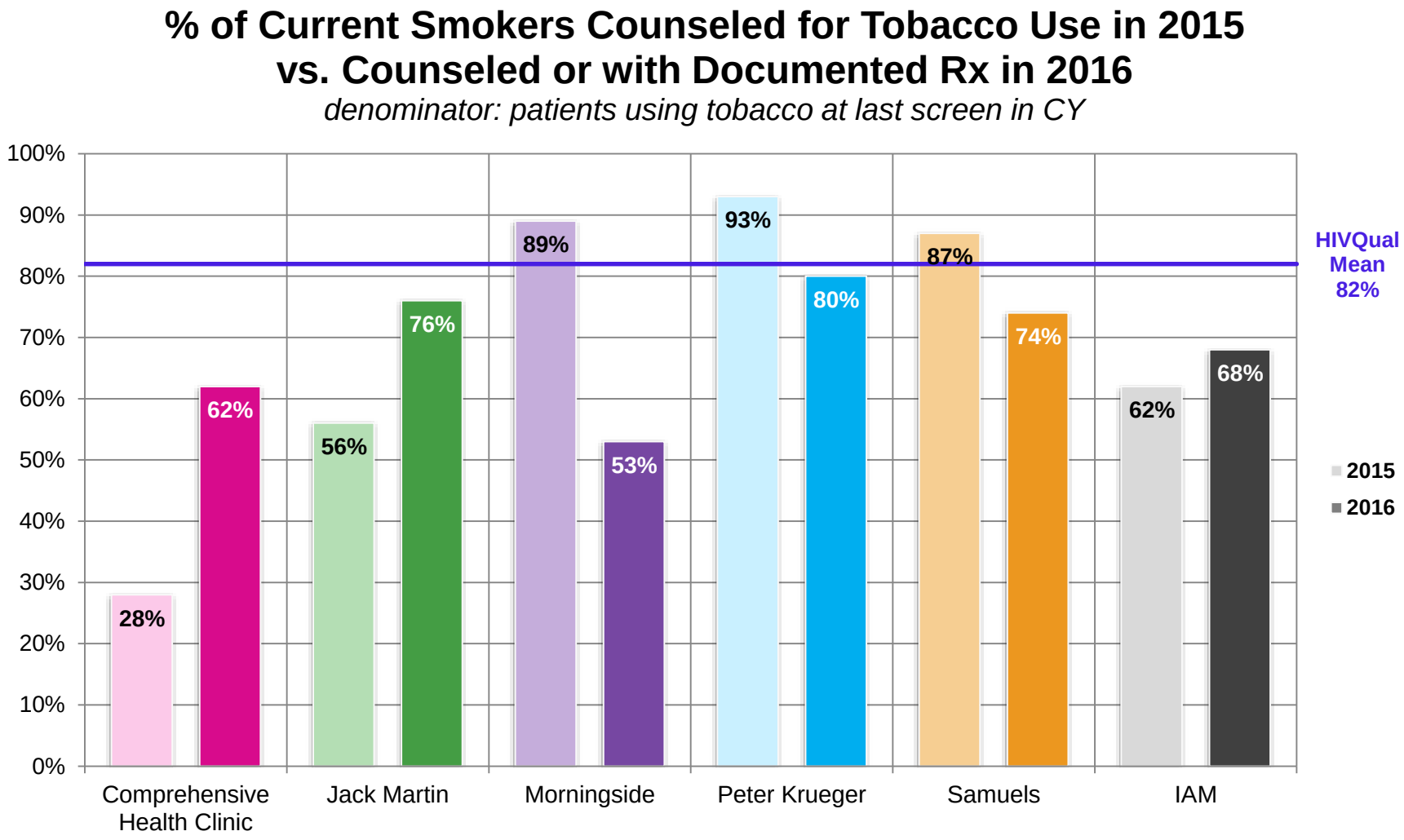
Overall Tobacco Screening Results in 2016



Overall Tobacco Counseling Results in 2016



Overall Tobacco Counseling & Prescription Results in 2016



Current Smokers' Reported Tobacco Use

	Current Smokers	Current Smokers with 2+ Screens in 2016	% of Current Smokers Screened 2+ Times in 2016	Patients with Lower Packs per Day (First to Last Screen)	% of Patients with Lower Packs per Day*
Comprehensive Health Clinic	490	366	75%	13	4%
Jack Martin	398	316	79%	24	8%
Morningside	556	437	79%	11	3%
Peter Krueger	384	322	84%	38	12%
Samuels	576	499	87%	23	5%
IAM Overall	2404	1940	81%	109	6%

Conclusions and Lessons Learned

- Overall, tobacco screening and counseling rates increased for IAM in 2016.
  - Screening reached 90% surpassing the HIVQUAL benchmark of 87%.
  - Counseling remains below the HIVQUAL benchmark of 75% at 68% using documented pharmacotherapy prescriptions as a proxy for counseling.
  - Additionally, 6% of patients reported a decrease in packs per day.

- Lessons learned include the continued need to improve documentation of counseling and share best practices of higher performing clinics, such as the provider-driven model, which resulted in the highest rate of counseling among patients identified as current smokers.

Next Steps

- Monitor tobacco measures quarterly
- Continue process improvement to improve documented provider counseling and pharmacotherapy rates
- Establish a follow up process for tracking reduction in tobacco use and quit attempts
- Determine meaningful way to document tobacco screening, counseling, and follow up in Epic

Acknowledgements

- Shruti Ramachandran, Director of Quality Management and Evaluation
- Rebecca Lindner, QI Analyst
- QI Leadership Teams across IAM clinics