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

Referral 1st Clinic Visit 1st PCP Visit ART Prescribed Viral load suppressed

CD4-guided (2006-9)

Universal (2010-3)

RAPID

Pilcher, IAS 2015
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

Prevention & Outreach Staff [POP] performs a 2\textsuperscript{nd} rapid test as a temporary confirmation

POP introduces the patient to the Rapid Treatment program

POP completes the PRF-FSU Survey

POP assesses for patient readiness; including a suicide screening & a check for Callen-Lorde eligibility
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

Case Manager [CM] performs another assessment of patient readiness CM assesses for insurance status

CM completes a full psychosocial

CM orients patient to the clinic & HIV treatment

CM assesses for insurance status

CM enrolls the patient into the Retention & Adherence Program [RAP]
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

Nurse & CM case conference about the patient’s readiness, drug use & a brief history

Nurse performs a full separate medical evaluation

Nurse teleconferences with Medical Provider [PCP]

Nurse schedules PCP follow-up for Patient (Patient will also see CM during this follow-up)

Patient takes their first dose of ART with the Nurse before leaving

PCP sends Rx to Pharmacy, where Nurse obtains it for the patient
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

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

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]
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?
Contact Us:

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

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Esther Fleharty, BA
Lauren Collins, MSN, RN
Angie Lee, BSN, RN, CEN
Jocelyn Sese, MSN, RN, CEN
Dan Egan, MD
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

Focus
What are the problems?
Which one can we tackle best?
Have we all agreed on the problem(s)?

Analyze
What were our baseline numbers and where did we go?
What influenced these changes?

Develop
What is our plan/solution?
Do we have resources to monitor?
Plan timeline and launch date

Execute
Do we have commitment/buy-in?
Are we monitoring/recording in a timely and detailed manner?

FADE
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

**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

FADE
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

Intervention Planning + Execution

Maintenance
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

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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.

Space and funds for the Garden

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

- Pantry bags increased: 100%
- Fresh fruits: from the food bank
- Fresh vegetables: from food bank and garden
- 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
  o The Brotherhood SisterSol Foundation
  o Have more activities than at our previous garden
  o 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
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.
Tobacco Screening Results by Quarter

% of Patients Screened for Smoking by Clinic by Quarter in 2016

- Comprehensive Health Clinic
- Jack Martin
- Morningside
- Peter Krueger
- Samuels
- IAM

Q1: 68%
Q2: 69%
Q3: 71%
Q4: 74%
Overall Tobacco Screening Results in 2016

% of Patients Screened for Tobacco in 2015 vs. 2016

denominator: active patients with at least 1 PCP visit in CY

<table>
<thead>
<tr>
<th>Clinic</th>
<th>2015</th>
<th>2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>Comprehensive Health Clinic</td>
<td>78%</td>
<td>85%</td>
</tr>
<tr>
<td>Jack Martin</td>
<td>82%</td>
<td>82%</td>
</tr>
<tr>
<td>Morningside</td>
<td>97%</td>
<td>96%</td>
</tr>
<tr>
<td>Peter Krueger</td>
<td>98%</td>
<td>92%</td>
</tr>
<tr>
<td>Samuels</td>
<td>88%</td>
<td>95%</td>
</tr>
<tr>
<td>IAM</td>
<td>86%</td>
<td>90%</td>
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</tbody>
</table>

HIVQual Mean 87%
Overall Tobacco Counseling Results in 2016

% of Current Smokers Counseled for Tobacco Use in 2015 vs. 2016
denominator: patients using tobacco at last screen in CY

Comprehensive Health Clinic 52% 56% 89% 93% 87%
Jack Martin 28% 69% 74% 69% 59%
Morningside 56% 64% 89% 93% 87%
Peter Krueger 41% 62% 69% 69% 59%
Samuels 62% 69% 74% 69% 59%
IAM 59% 62% 69% 69% 59%

HIVQual Mean 82%
Overall Tobacco Counseling & Prescription Results in 2016

% of Current Smokers Counseled for Tobacco Use in 2015 vs. Counseled or with Documented Rx in 2016
denominator: patients using tobacco at last screen in CY

HIVQual Mean 82%

- 2015
- 2016
# Current Smokers’ Reported Tobacco Use

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

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