Institute for Population Health
Institute for Population Health and Gilead Sciences

FOCUS grant: Detroit Learning Collaborative
Institute for Population Health partnered with Gilead Sciences in 2015 to implement routine HIV and Hepatitis C screening in the City of Detroit

- Three clinics: James Couzens, Northend, and Community Outreach
- SHAR Residential Treatment Center and Western Wayne Family Health Center

In 2015, we screened 33% of our target goal. We tested 3,215 out of 10,198 total patients seen. From the lessons learned we hired a Project Manager, expanded our partnership to 4 more clinics, and developed a new strategy to implement routine HIV and HCV screening in Detroit.
Lessons Learned: New Strategy

According to HRSA, Bureau of Primary Care Services (2014), HIV testing is required for FQHCs.

Four New FQHC Partnerships:
- Western Wayne Family Health Center
- SHAR Residential Treatment Center
- Covenant Community Care
- Health Center Detroit Foundation
- Advantage Health Centers (Health Care for the Homeless)
- Hamtramck Health Center

Hired Staff - Project Manager and Linkage to Care Coordinator
Lessons Learned: New Strategy

Location of Detroit Learning Collaborative Clinics and HIV Prevalence, 2012
Lessons Learned: New Strategy

- **Learning Collaboratives** to enrich the discussion about success and failures of HIV and HCV screening in their practice and information exchange
- Testing *integration* into normal clinic or *work flow*
- Electronic Medical Record *(EMR)* modification
- **Systemic Policy Change**
- Training, Feedback, and **Quality Improvement**
Grant Year 2016-2017

New Strategy:

Learning Collaborative Method
A learning collaborative is made of no more than 7-8 clinics or federally qualified health centers (or organizations).

Organizations commit to participating over the year long learning collaborative process.

Participating organizations are established based on continuums of care that compose geographic regions; in our case disease burden and underserved areas within the Detroit geographic region.

Group collectively aimed towards certain goals and are supported with technical support and resources.
**Quality Collaboratives in Health Care**

- Reduce disparity between actual & best practice
- Convene groups of practitioners from different organizations
- Meeting series to learn about best practice, quality methods and to share experiences making improvements
- Improve practice by testing & implementing changes quickly across organizations
Designed to close the gap between the establishment of evidence-based treatments and practices and their incorporation into frontline care

“Bridge the gap between knowledge and practice”

Model for Improvement

KNOWLEDGE =
CHANGE FRAMEWORK
KEY ELEMENTS

PRACTICE =
PDSAS / TESTS OF CHANGE
Keys to Successful Learning Collaboratives

• Robust participant training on HIV and Hepatitis C screening and linkage to care (*or topic of interest*)
• Deep facilitator knowledge of HIV and Hepatitis C screening and linkage to care (*or topic of interest*)
• Support from community and organizational leadership
• Frequent data collection and reporting
• Commitment to using the best practices by participating organizations
Things to Consider if you want to start a Learning Collaborative

1. Has your community created policies and procedures around routine HIV and Hepatitis C screening (*or topic of interest*)?

2. Have you provided systemic standards and training routine HIV and Hepatitis C screening (*or topic of interest*)?

3. Are providers generally familiar with the implementation of the core components of routine HIV and Hepatitis C screening (*or topic of interest*)?
Essential Learning Collaborative Components

• Pre-work (3 months): Expert Panel Meet, Develop Collaborative Goals, Create a Timeline, Select Participating Agencies, and Select Leadership Group

• Learning Sessions/Action Periods (7 months): Meet with learning collaborative, conference calls, site meetings, monthly metrics, quarterly metrics; all within the context of a PDSA (plan, do, study, act) cycle - shorthand for testing a change by developing a plan to test the change (Plan), carrying out the test (Do), observing and learning from the consequences (Study), and determining what modifications should be made to the test (Act)

• Outcomes (2 months): Evaluate to determine our impact, develop reports, and disseminate information
Pre-work (1 month)

• Determined if Learning Collaborative was feasible
• Hire staff
• Created Time Line
• Chose our partners
• Determine the resources needed to meet goals
• Determine metrics and data collection
Seven Learning Collaborative Meetings (11 months)

- **First** – FOCUS overview, Epidemiology HIV and HCV, grant objectives, introductions, operationalizing HIV and HCV testing in your clinic – **May 19th**
- **Second** - Monthly reports, gathering data, continuous quality improvements, Changes made to facilitate screening, and consent law – **June 22nd**
- **Third** – Continuous Quality Improvements, Quarterly reports, Linkage to Care – **August 4th**
- **Fourth** – PrEP, Policy Expert on Consent Law, Quarterly Reports, Linkage to Care – **October 27th**
- **Fifth** – Information Technology EMR Modification – **November 17th**
- **Sixth** – Toolkit and continuous quality improvements- **January 6th**
- **Seventh** – Re-engage Hepatitis C population (change of policy) and plan for the conference – **April 6th**
Institute for Population Health

IMPLEMENTING ROUTINE HIV AND HEPATITIS C SCREENING IN DETROIT TOOLKIT

Using the Learning Collaborative Method to Address HIV and Hepatitis in Detroit

The purpose of this toolkit is to get a better understanding of the HIV and Hepatitis C burden in Detroit and model the strategies and best practices used in Detroit to address HIV and Hepatitis C in other urban areas.

* The toolkit can be found on our Institute for Population Health website.
Participants of the Detroit Learning Collaborative

- Institute for Population Health
- Western Wayne Family Health Center
- SHAR Residential Treatment Center
- Covenant Community Care
- Health Center Detroit Foundation
- Advantage Health Centers (Health Care for the Homeless)
- Hamtramck Health Center
In 2010, President Obama released a set of strategic action steps to address the domestic HIV epidemic.

- Reduce New Infections
- Increase Access to Care and Improve Health Outcomes for People Living with HIV
- Reduce HIV-Related Health Disparities and Health Inequities
- Achieve a More Coordinated National Response to the HIV Epidemic

In 2015, United Nations Program on HIV/AIDS 90-90-90 initiative an ambitious treatment target to help end the AIDS epidemic

- 90% diagnosed, 90% on treatment, 90% virally suppressed
Detroit HIV - Statistics

- Estimated prevalence 5,620
- 74% are males
- 48% MSM (men who have sex with men)
- 10% PWID (people who inject drugs)
- Heterosexual (Males - 4%, Females - 15%)
- Largest age group 50-59
Detroit HIV – Linkage to Care

• The initiatives goal is to identify positive patients and link them into care as soon as possible.

• Being linked to care quickly improves prognosis and decreases transmission.

• Persons linked quickly to care are more likely to be in care during the years following diagnosis.

• 36% linked within 1 month of diagnosis and 71% linked 1-3 months after diagnosis.
Detroit HIV - Care and Viral Suppression

- Viral Suppressed PLWH have improved prognoses and reduced transmission risk.

- In recent years, viral suppression rates and the community viral suppression levels continue to rise.

- As of 2015, we have a 57% community viral suppression

- 75% of PLWH are in care
Hepatitis C - National Policy

• At-risk populations - One-Time HCV screening for Baby Boomers populations born between 1945-1965, patients who received blood or blood product transfusion prior to 1992, **underserved areas/populations**, homeless populations etc.

• Detroit Learning Collaborative adhering to the 2011 CDC recommendations:
  • Expand community-based programs that provide hepatitis C screening and testing services.
  • Expand programs to reduce the risk of Hepatitis C virus infection through injection-drug use.
  • Provide comprehensive Hepatitis C virus prevention programs.
  • Provide adequate resources to federally funded community health facilities for provision of comprehensive viral hepatitis services.
  • Provide resources and guidance to integrate comprehensive viral hepatitis services into settings that serve high-risk populations such as STD clinics, sites for HIV services and care, homeless shelters, and mobile health units.
Hepatitis C - National Policy

• In 2011, National Health and Nutrition Examination Survey (NHANES) data revealed that individuals infected with Hepatitis C are:
  • Less likely to be covered by private insurance compared with the overall population
  • Only half had any health insurance coverage

• The recent Affordable Care Act (ACA) Medicaid expansion program requires coverage for preventive services including Hepatitis C screening.

• One-time HCV screening for baby boomers and persons at high risk of infection are now covered at no cost to the individual.

• **Collaborative goal:** (Now is a critical time to scale-up HCV testing) Setting up the systems that support these new policy change and inclusions
Local Policy Efforts with Hepatitis C

- Screening at-risk populations is a cost effective use of health care dollars.
- In order to treat individuals we have to have a system that is set up to identify infected patients.
- Implementing the best practices of routine Hepatitis C screening at clinics ensures the catchment of positive patients which is a cost-benefit to the health care system.
Detroit Hepatitis C – Statistics

• Detroit Hepatitis C cases are going down, approximately 1000 cases

• However, data shows that there is a larger amount of infected individuals verses the number aware they are infected (diagnosed)

• Our initiative goal is to capture and test the undiagnosed population through routine screening.
A growing epidemic of prescription opioid abuse is linked to injection drug use, particularly heroin resulting in a rapid increase of HCV incidence in various areas of the United States.
Detroit Learning Collaborative

Goal:

- Close the Diagnosis Gap
- Ensure clinics use reflex RNA testing for HCV patients
Detroit Hepatitis C – Statistics and Disparity

• Early Diagnosis
• HCV RNA test type
• Understanding the statistics allowed the collaborative to understand our barriers in getting patients linked to care for treatment
Action!

Applying Best Practices
Learning Collaborative Model

Best Practice #1
Learning Collaborative - Michigan Consent Law

• Currently the Michigan HIV testing law is opt-in. Opt-in testing requires that the patient provide additional and separate written or verbal “informed consent” for the HIV test, and is a barrier to screening.

• Separate consent for HIV testing compromises the goal of routine screening. The providers shared at the learning collaborative that the opt-in consent deters patients from testing due to stigmatization.

• The collaborative became eager to learn about HIV consent laws in other states and learn strategies we could collectively work to change the Michigan HIV consent law and become an opt-out state.

• Opt-out testing, which is recommended by the CDC, indicates that the general consent is sufficient to notify patients that HIV testing may occur.
Learning Collaborative - Hepatitis C and Medicaid Coverage

- Data Collection and Quarterly report gave us an opportunity to take a closer look at our linkage to care from a 3 month snap shot.
- We discussed some of the barriers that are keeping us from following up with some of the HCV population.
- We realized that a lot of the Hepatitis C positive patients have Medicaid.
- Unfortunately Medicaid did not pay for Hepatitis C treatment or stage 0-2 of fibrosis.
- Medicaid only pays for stage 3-4 when the liver has reached cirrhosis. A lot of these patients and practitioners know their patients have Hepatitis C but have no way of treating them until they are really sick and have stage 3-4 fibrosis/cirrhosis.
- Waiting until the patient is sick has made a lot of our doctors feel as though their hands are tied, they diagnose patients but cannot treat them due to minimal health coverage and/or expensive medication.
- Policy Change as February 1, 2017 – Medicaid expanded to treat stage 2 fibrosis
Truvada is indicated in combination with safer sex practices for PrEP to reduce the risk of sexually acquired HIV-1 in adults at high risk.

Truvada taken once a day has been recommended as an HIV prevention therapy.

National PrEP campaigns
Testing integration into normal clinic or work flow and Systemic Policy Change

Best Practice #2
Testing integration into normal clinic or work flow and Systemic Policy Change

• Not dependent on dedicated testers and is fully integrated into regular patient flow.

• Multi-level, organization-wide commitment to implement routine HIV and/or HCV testing and linkage to care.

• **KEY:** Having an Administration Champion, engaging IT, working with the quality improvement staff, provider meetings, incorporating Project Manager into partnering facilities daily business
HIV Routine Screening Process Flow: Verbal Notification of HIV Test

- **EHR**: Determines eligible patients and prepopulates the lab order form; alerts staff
- **Registration / Waiting Area**: Pre-test info
- **Triage**: Opt out verbal notification followed by automated process
- **MD**: Notification and written documentation of decline
- **RN Blood Draw**
- **LAB**
Testing integration into normal clinic or work flow and Systemic Policy Change
Screening Friendly Environments
Each personnel has their role to play in the success of routine testing. Site visits in between each LC are essential to make people accountable to the tasks which were decided at the last LC. The provider meeting tour is the project director presenting the initiative at each of the partnering clinics at their provider meeting. Presenting data and the gap in care made the most impact at each provider meeting. Opportunity for all clinic staff to have an in-depth understanding of the initiative’s objectives and the best practices.
Cultural Competency

- Cultural competence requires that organizations have a defined set of values and principles, and demonstrate behaviors, attitudes, policies, and structures that enable them to work effectively cross-culturally.

- During our assessment of clinic flow clinic staff indicated the tremendous challenges in implementing HIV screening - clinic serviced a large Muslim population which required the initiative to be culturally competent.

- Required research - if there is even a suspicion of illicit sexual conduct or any HIV/AIDS infection, the affected person(s) is discriminated against and shunned by the family as well as by the community (Hasnain, 2005). To that end, HIV prevention, screening, and testing came with stigma from the community.

- There are clinics in predominantly Muslim areas that do HIV testing, however those clinics have been in the area for a very long time and have built trust with their patient population.

- We collectively decided that the grant funding would be better utilized at a clinic which would screen and test their patient population routinely without insurmountable cultural barriers.
Substance Use and Re-entry Clinics

- Drug use is an important risk factor for HIV and HCV among African Americans and Hispanics. Injection drug using is also associated with high rates of hospitalization for HIV disease as well as poor treatment outcomes.

- There are currently 2.2 million people in jail or prison in the U.S. According to the Bureau of Justice Statistics (BJS), about 1.5% of all inmates in state and federal prisons have HIV or AIDS (21,987 persons).

- This is 4 times the prevalence rate of HIV in the general population. As inmates are released back into their communities, they stand to impact the overall health and well-being of entire communities. As more inmates are susceptible to HIV infection in prisons, the communities into which they return are also placed at risk.

- Promoting the normalization and sustainability of routine testing at substance abuse and re-entry clinics is a priority for the Detroit LC.
Substance Use and Re-entry Clinics

- Our initiative has trained clinic nurses at SHAR with HIV test counselor certifications. *(The HIV test counselor certification is designed to prepare providers in a variety of settings to support individuals in conducting HIV testing, provide participants with the core elements necessary for delivering a positive test result, and teach participants how to understand delivering a reactive test result, linking a client to medical, and holding the initial partner services (PS) conversation (linkage-to-care)).*

- We implemented a policy that everyone who enrolls into SHAR Main will have an HIV test included in their routine test. They went from not testing anyone to testing all of their clients.

- The initiative also implemented HCV RNA test which were not being done before.

- Support from the initiative also provided SHAR with and EMR (paperless).
Electronic Medical Record (EMR) modification

Best Practice #3
“Good checklists, on the other hand are precise. They are efficient, to the point, and easy to use even in the most difficult situations. They do not try to spell out everything--a checklist cannot fly a plane. Instead, they provide reminders of only the most critical and important steps--the ones that even the highly skilled professional using them could miss. Good checklists are, above all, practical.”

— Atul Gawande, *The Checklist Manifesto: How to Get Things Right*
Electronic Medical Record (EMR) modification

- **2010-2011**
  - Movement away from dedicated testers
  - Provider ownership of HIV screening as a standard of care with or without prompts based on EMR capacity

- **2012-2013**
  - EMR prompts to determine HIV screening eligibility
  - Adjustments for jurisdictional legislation

- **2014-2015**
  - Smart EMR Algorithms allows for automation of multiple processes; eligibility, notification; lab order for various screens
  - Elimination of manual input
Electronic Medical Record (EMR) modification

Automated EMR Process for Routine HIV Testing

Eligibility
The electronic health record (EHR) determines the patients that are eligible for a test (no known positives, age range, recently tested etc.)

Notification
EHR prepopulates a lab order form and alerts staff to notify patient (patients may also be notified via consent for medical care - described below)

- Staff must click “declination” and either automatically, or via a second click, de-populate the lab order
- Patient declines
- Patient does NOT decline
- Staff does not need to take any additional step in the EHR
Guidelines for screening are based on CDC recommendations and Detroit’s prevalence areas:

HIV
- All patients, age 18 or older, once in their lives
- Patients who are between ages 13-17, if they have been sexually active or have snorted cocaine or injected drugs (IDU). These patients should be tested at least once, and possibly yearly if they remain active in these practices.
- All patients found to have a new STD, even if they have tested at an earlier date
- Yearly testing (or more frequently on case-by-case basis) if high risk sexual practices or IDU. High risk practice not well defined, but suggest more than one sexual partner per year, especially if inconsistent condom use.

Hepatitis C
- All patients born between 1945 and 1965
- Patients who received blood or blood product transfusion prior to 1992
- Gay males with HIV (yearly)
- Persons with history of injecting drugs (IDU), yearly while continuing to inject drugs.
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- Modify Micro MD – Smart EMR Algorithms March 2017
- Quest Diagnostics – negotiated lab prices for uninsured population
Health Center
Detroit
Foundation

• Goal: Paperless charts by January 2017!
• Practitioners have to stay later and input notes into EMR (Double work)
• Triage – Add tablet in the Triage Room
• Provider – Each provider will get a tablet to input notes during visit
• Prompts – EMR YOUR WAY Remind provider to screen for HIV and HCV
Western Wayne

- Goal: Morning huddle and Policy Driven Screening
- Now: Provider Driven
- Success EHS and MediQuire
- Automation of Eligibility Criteria
- Tracking of Outcomes
- Increase Testing – Provider report cards
- MediQuire cost $7,500 plus a small monthly fee
Advantage Health Centers

• Goal: Policy Driven Screening
• Now: Morning huddle and Provider Driven
• Success EHS
• Automation of Eligibility Criteria
• Tracking of Outcomes
• Increase Testing - Provider report cards
Covenant Community Care

• Goal: Policy Driven Screening
• Now: Provider Driven
• Infectious Disease doctor on staff helped write the eligible criteria policy
• EPIC – through Beaumont Health Systems challenge with automation of Eligibility Criteria
• Challenges - Screening Cost (grant dollars support testing)
SHAR Residential Treatment Center

• Goal: Paperless Charts
• Electronic Medical Records – behavioral health friendly and accredited
• Systemic Policy Change - Each new enrollee will be tested for HIV and HCV antibodies and RNA. Added to lab panel Quest Diagnostics, Lab interface with EMR
• Enrolling patient into Medicaid – Three month back payments
Linkage to Care

Best Practice #4
Linkage to Care

- Linkage HIV and HCV testing to care normally occurs within a month of confirmatory result if not sooner.
- The Care Coordinator determines the readiness of the client for care before locating care.
- This is a very important part of linkage to care, if a client has other issues that may prevent him/her from receiving treatment these issues should be addressed.
- The Detroit LC has identified several infectious disease physicians throughout the city that have experience with HIV and HVC client. This allows the care coordinator to give a warm hand-off to the referring doctor for identified clients.
Linkage to Care

- The care coordinator has been instrumental in helping staff at our partnering agencies to be certified in Counseling, Testing and Referral services through the State of Michigan.

- The training will give staff the skills need to face those barriers and challenges presented at the clinics.

- The HIV test counselor certification is designed to prepare providers in a variety of settings to support individuals in conducting HIV testing, provide participants with the core elements necessary for delivering a positive test result, and teach participants how to understand delivering a reactive test result, linking a client to medical, and holding the initial partner services (PS) conversation (linkage-to care).
Continuous Quality Improvement

Best Practice #5
Training, Feedback, and Quality Improvement

- Linkage to Care [https://preplocator.org/](https://preplocator.org/)
- Monthly Reports – Follow-Up
- Quarterly Report – missed opportunities
- HIV Counseling
- Conferences
- Building Relationships in the Community – Collective Impact
Continuous Quality Improvement

<table>
<thead>
<tr>
<th>Monthly Estimate</th>
<th>Monthly Data</th>
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<tbody>
<tr>
<td>Number of Primary Care Patients (Eligible patients)</td>
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<td>HIV Tests Performed</td>
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<td>Diagnosed Acute HIV Infections</td>
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<td>HIV Positive Patients (identified through testing) Attended First Appointment</td>
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<td>HCV RNA Tests Performed</td>
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<tr>
<td>HCV RNA Positive Patients (identified through testing) Attended First Appointment</td>
<td>Monthly Data</td>
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*The monthly data submission allowed us to track our efforts and determine where there was room for improvement.
Coding Culture

• Providers were using different procedure (CPT) and diagnosis codes (International Classification of Diseases, 10th revision, Clinical Modification, ICD-10) to document HIV and HCV screening.

• Recommended using CTP codes 86703 (HIV-1 and HIV-2, single result) and 87389 (HIV-1 antigen(s), with HIV-1 and HIV-2 antibodies, single result) for HIV screening and CPT code 86803 (Hepatitis C antibody) for Hepatitis C screening.

However, every clinic is set-up differently and uses their own policy based ICD-10 and CPT codes. Many of the codes vary due to insurance companies not reimbursing certain codes. We have found that each clinic’s billers have a lot of trial and error with billing Medicare, Medicaid, and various insurance companies. They have had to submit and resubmit codes to be paid for the providers services when insurance companies did not accept certain codes.
Cost Analysis

• Each clinic has uninsured populations and each clinic has had to pay for the uninsured patients.

• Some clinics have been able to write off the lab bills to bigger medical centers but some of the collaborative partners and IPH have had to pay a substantial amount of money for the lab fees of the uninsured population because of the initiatives’ testing goals.

• Gilead has been able to pay some of our uninsured billing.

• Since then we have built a relationship with MDHHS lab. We will be sending some of our HIV and HCV test to MDHHS lab for free testing going forward.
Partnerships: The Art Of Collaboration

- Detroit HIV community-at-large
- Gilead
- Michigan Department of Health and Human Services (MDHHS)
- Midwest AIDS Training and Education Center (MATEC)
- Quest Diagnostics
- Henry Ford
- Wayne State University
### Outcomes: Grant 2016-2017

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<tr>
<th>Site</th>
<th>April 2015-March 2016 (pre Learning Collaborative)</th>
<th>April 2016-March 2017 (post-Learning Collaborative)</th>
<th>Testing Percent Increase</th>
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<td>Detroit Learning Collaborative Total</td>
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Outcomes: Grant 2016-2017

- We have institutionalized the best practices of routine HIV and Hepatitis C at each one of the clinics
- Strengthen Detroit’s HIV and Hepatitis C network
- Learn and teach about the Learning Collaborative model
- United Nations’ goal of 90-90-90 with HIV
- Our nation’s HCV goal of adhering to the HCV cascade of care with each positive HCV patient.
Next Steps

Policy and Systems have been put in place clinics will continue with daily business with integrated testing...

Questions & Answers