The Future of HIV Care and the Changing Role of FQHCs
Agenda

- Webinar overview
- 2014 UDS measure on HIV Dx and care
- Routine HIV screening and linkage to care
- Resources and referrals for the metro area and statewide
2014 Oregon HIV Data

- 1,623 HIV patients in FQHCs, 1,383 are at Multnomah County

- 14,876 HIV visits in FQHCs, 14,200 visits are at Multnomah County

- First HIV Dx at FQHC = 148
  - 101 of these are at Multnomah County
Number of HIV Patients

- **Tot Oregon**: 1334, 1549, 1623
- **PDX**: 1252, 1362, 1409
- **Balance of State**: 82, 187, 214

Legend:
- 2012
- 2013
- 2014
Number of HIV Visits

<table>
<thead>
<tr>
<th></th>
<th>2012</th>
<th>2013</th>
<th>2014</th>
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<tbody>
<tr>
<td>Tot Oregon</td>
<td>17574</td>
<td>16859</td>
<td>14876</td>
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<tr>
<td>PDX</td>
<td>17377</td>
<td>16370</td>
<td>14337</td>
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<tr>
<td>Balance of State</td>
<td>197</td>
<td>489</td>
<td>539</td>
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HIV LINKAGE TO CARE (LINE 20)

PERFORMANCE MEASURE: The performance measure is “Percentage of newly diagnosed HIV patients who had a medical visit for HIV care within 90 days of first-ever HIV diagnosis.” This is calculated as follows:

- **Numerator**: Number of patients in the denominator who had a medical visit for HIV care within 90 days of first-ever HIV diagnosis
- **Denominator**: Number of patients first diagnosed with HIV between October 1, of the prior year through September 30, of the current measurement year

Section L: HIV Linkage to Care (Line 20)
Patients who were diagnosed for the first time ever with HIV between October 1, 2013, and September 30, 2014 are reported on Line 20.
## Quality Measures HIV 1st Time Diagnosis & Treatment

<table>
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<th>T6A, R2, C(b)</th>
<th>T6B, R20, C(a)</th>
<th>T6B, R20, C(b)</th>
<th>T6B, R20, C(c)</th>
<th>% in Compliance</th>
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<tr>
<td>2014</td>
<td>1st HIV Dx: @ FHQC</td>
<td># Patients 1st Dx w/HIV</td>
<td>Charts Sampled or EHR Total</td>
<td># Pts Seen within 90 Days</td>
<td>% in Compliance</td>
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<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>100%</td>
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<tr>
<td>CCC</td>
<td>6</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0%</td>
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<td>0</td>
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</tr>
<tr>
<td>C. River</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
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</tr>
<tr>
<td>CHC</td>
<td>0</td>
<td>5</td>
<td>5</td>
<td>4</td>
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<td>0</td>
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<td>8</td>
<td>8</td>
<td>6</td>
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<tr>
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<tr>
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<td>101</td>
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<tr>
<td>NHC</td>
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<td>6</td>
<td>6</td>
<td>4</td>
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<td>Ol</td>
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<td>3</td>
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<td>0</td>
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<td>Siskiyou</td>
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<td>2</td>
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<td>Umpqua</td>
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<td>0</td>
<td>0%</td>
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<td>YVFWC</td>
<td>9</td>
<td>4</td>
<td>4</td>
<td>4</td>
<td>100%</td>
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<tr>
<td>OR</td>
<td>148</td>
<td>158</td>
<td>158</td>
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<td>#N/A</td>
<td>#N/A</td>
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</table>
Discussion of UDS Measure

- How does your organization currently screen and document for HIV?
- Workflows for tracking: Do you track the # of newly diagnosed patients?
- Do you have a practice that you currently referral to?
- Closing the referral – what’s your current process?
Routine HIV Screening & Linkage to Care

Melissa D. Murphy, MD
Medical Director, Oregon AETC
Infectious Disease Staff Physician, Portland VAMC
Associate Professor of Clinical Medicine, OHSU

Presentation prepared by:
Melissa D. Murphy, MD
Dayna Morrison, MPH
1.18 million people with HIV/AIDS in the United States

~ 50,000 new HIV infections each year in the past decade

(almost ½ of these are acquired from people who didn’t know they were infected)
4,685 Oregonians living with HIV as of 10/1/2014

50% in Multnomah County
Living Oregon HIV/AIDS Cases

Living resident cases of HIV infection in Oregon (8/8/11)
with last viral load ≥ 10,000 copies/mL
Late Diagnosis of HIV in Oregon

- Only 41% of Oregon adults have ever been tested for HIV

- During 2008 – 2012, 39% of Oregonians newly diagnosed with HIV infection had severe enough immune suppression to meet AIDS criteria within 12 months of diagnosis

- These individuals likely had been infected for ≥7 years

- These individuals reported missed opportunities for testing, often because they didn’t recognize or report their HIV risks.
Natural History of Untreated HIV Infection
CD4 Cell Count at First Presentation for HIV Care
NA-ACCORD, 1997-2007

Patients with CD4 count ≥ 350 at Presentation

<table>
<thead>
<tr>
<th>Year</th>
<th>% with CD4 Count ≥ 350</th>
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<tbody>
<tr>
<td>1997</td>
<td>38%</td>
</tr>
<tr>
<td>1998</td>
<td>39%</td>
</tr>
<tr>
<td>1999</td>
<td>38%</td>
</tr>
<tr>
<td>2000</td>
<td>40%</td>
</tr>
<tr>
<td>2001</td>
<td>41%</td>
</tr>
<tr>
<td>2002</td>
<td>43%</td>
</tr>
<tr>
<td>2003</td>
<td>42%</td>
</tr>
<tr>
<td>2004</td>
<td>44%</td>
</tr>
<tr>
<td>2005</td>
<td>45%</td>
</tr>
<tr>
<td>2006</td>
<td>45%</td>
</tr>
<tr>
<td>2007</td>
<td>46%</td>
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N = 44,491

Routine HIV Testing in Health Care Settings

Definitions

- **Diagnostic testing.** Performing an HIV test for persons with clinical signs or symptoms consistent with HIV infection.

- **Targeted Testing.** Performing an HIV test for subpopulations of persons at higher risk, typically defined on the basis of behavior, clinical, or demographic characteristics.

- **Screening.** Performing an HIV test for all persons in a defined population.

- **Informed Consent.** A process of communication between patient and provider through which an informed patient can choose whether to undergo HIV testing or decline to do so.

- **Opt-out Screening.** Performing HIV screening after notifying the patient that 1) the test will be performed and 2) the patient may elect to decline or defer testing. Assent is inferred unless the patient declines testing.

- **HIV-Prevention Counseling.** An interactive process of assessing risk, recognizing specific behaviors that increase the risk for acquiring or transmitting HIV, and developing a plan to take specific steps to reduce risks.

Revised Recommendations for HIV Testing of Adults, Adolescents, and Pregnant Women in Health-Care Settings
Indications for Routine HIV Screening

- HIV screening is recommended for all patients aged 13 – 64 in all health-care settings
- Persons at high risk for HIV infection should be screened for HIV at least annually

In April 2013, the U.S. Preventive Services Task Force (USPSTF) updated its 2005 recommendations for HIV screening as follows:

• The USPSTF recommends that clinicians screen adolescents and adults aged 15 to 65 years for HIV infection. Younger adolescents and older adults who are at increased risk should also be screened. (Grade A recommendation)

• The USPSTF recommends that clinicians screen all pregnant women for HIV, including those who present in labor who are untested and whose HIV status is unknown. (Grade A recommendation)
Rationale for Routine HIV Screening

- Early HIV diagnosis and treatment improve health outcomes
- Routine HIV screening is cost-effective even in health care settings with low HIV prevalence
- More patients accept HIV testing when it is offered routinely, without a risk assessment
- Patients aware of their HIV infection substantially reduce behaviors that put them at risk of transmitting HIV

Ann Intern Med. 2009; 150:125-131
Correlation of Baseline CD4 Count and Outcome after Starting Antiretroviral Therapy

Study Background
- N = 12,574 HIV-infected adults starting antiretroviral therapy

Per Person Survival Gains with Various Interventions for Chronic Diseases in US

Figure Reproduced with permission from University of Chicago Press
Early Testing & Treatment Save Money

• HIV patients with the lowest CD4 counts cost the most to care for
  • Early testing and treatment thus reduces overall costs!

• The costs of ART are offset by lower inpatient and outpatient costs for those treated at higher CD4 counts
It is VHA policy that HIV testing be a part of routine medical care; that providers routinely provide HIV testing to all Veterans if they consent (verbal consent is sufficient; written consent is not required.)

Choose one:
- Click HERE to order the HIV test - if the patient gives Verbal Consent...
- HIV Test done outside of this VA facility...
- Patient has been offered HIV testing and has declined. I have explained that HIV testing is recommended for all adults, even if all risk factors are absent.
- Life expectancy less than 6 months.

Click HERE to view/print the HIV Testing educational materials
MyHeathVeet Survey: Acceptance of Routine Screening

Valdiserri, Nazi, McInnes, Ross, Kinsinger J Community Health. 2010 Feb 10.
CD4 Count at Diagnosis vs HIV Test Rate
VA Greater Los Angeles HCS

Program Implementation

New Diagnoses (x100)  Tests  % CD4 <200
HIV Testing Methodologies

Rapid Test

Optional

Reactive
Preliminary
Positive

EIA
CIA

Supplemental

HIV-1 Western blot
*or*
HIV-1 IFA
*or*
HIV-1 RNA

Positive

EIA = Enzyme Immunoassay
CIA= Chemiluminescent Immunoassay

HIV Infected

Client considered infected with HIV

ELISA

1. Add patients serum to microtiter well coated with HIV Ag
2. Wash
3. Add anti-human Ab linked to an assayable enzyme like peroxidase.
4. 0.4% false positive
Rapid Testing: Saliva Test: *OraSure*

- ELISA test
- Can be read in 20 minutes
- The amount of IgG in saliva is well above the 0.5mg/L level necessary for detection of HIV antibodies
- Shelf life extended to 24 months in 2010

Sensitivity: 99.3%
Specificity: 99.8%
Western Blot

- Detects antibody against viral peptides that have been separated by electrophoresis and blotted.
- ELISA + Western together give .005% false positive
Laboratory Studies with Acute HIV

- Positive HIV-1 RNA Assay and Negative HIV Antibody Test
Recommendations to facilitate routine HIV screening

- Provide HIV Testing educational materials to patients

- Consider opt-out testing
  - Specific informed consent no longer mandated in Oregon

- Include HIV Testing Clinical Reminder in your electronic health record system

- Build HIV screening notification and opt out options into clinical materials and general consents for care

- Advise patients regarding the possibility of false positives and the need for confirmatory testing prior to screening

- Make a plan for giving positive test results and referral to an HIV proficient provider

CD Summary: Screen Your Patients for HIV, Oregon Public Health Division, Oregon Health Authority. February 13, 2015 Vol. 64, No. 2
Goals of Routine HIV Screening

- Improve Survival & Quality of Life
- Prevent New HIV Infections

1. HIV Screening
2. HIV Diagnosis
3. Link to Care
Linkage to Care

Increase linkage to care w/in 3 months of Dx from 65% to 85%

Increase HIV serostatus awareness from 79% to 90%

Increase RW clients in continuous care from 73% to 80%

Increase proportion of HIV Dx’d persons with undetectable VL by 20%

Slide courtesy of Michael J. Mugavero
HIV Treatment Cascade


Slide courtesy of Michael J. Mugavero
HIV Testing & Linkage to Care

✓ Undiagnosed HIV infection: Hidden threat
  ➢ Transmission rates 3-7x higher in undiagnosed
  ➢ 20% undiagnosed → 49% of new infections

✓ HIV testing influence on linkage to care
  ➢ Rapport, information quality & counseling provided
  ➢ Active vs. passive referral for services
  ➢ Delayed linkage w/ testing in community settings

HIV Care Continuum in Oregon

Source: Oregon Health Authority, HIV and Linkage to Care.  
Barriers

FINANCIAL
• Lack of insurance or underinsurance
• Competing subsistence needs: food, housing

STRUCTURAL/ADMINISTRATIVE
• Unavailable or inconveniently located services
• Long appointment wait times
• Language barriers

PERSONAL
• Stigma of HIV, sexual identity, drug use
• Lack of trust in medical system
• Difficulty accepting diagnosis
• Comorbid mental illness or substance abuse

Summary & Conclusions

- Linkage to care is a shared responsibility of diagnosing site, HIV clinic and public health
- Linkage success = first visit within 3 months
- ~1 in 5 do not successfully link to care
- Partner with testing sites and public health to implement/improve linkage programs
- Case management, active linkage assistance, and follow-up to ensure linkage are crucial
- Provider and clinic role:
  - Intervention for no-show new patient appointments
  - Orient new patients to timeline of HIV care and clinic
AIDS Education and Training Center
The AIDS Education and Training Center (AETC) Program is the training arm of the Ryan White HIV/AIDS Program. The AETC Program is a national network of leading HIV experts who provide locally based, tailored education, clinical consultation and technical assistance to healthcare professionals and healthcare organizations to integrate high quality, comprehensive care for those living with or affected by HIV.
AETC Training Modalities

- Didactic presentations
- Interactive presentations
- Communities of practice
- Self-study
- Clinical preceptorships
- Clinical consultations
- Coaching for organizational capacity building
Changes beginning July 1, 2015

• **New Region: Frontier**

• **Restructuring of funding**
  - Based on HIV prevalence

• **Target Population**
  - Health care providers (physicians, physician assistants, nurses, advanced-practice nurses, pharmacists, dentists) **and** allied health professionals (case managers, social workers, & others who assist with adherence)

• **40% of the Budget Allocated to Practice Transformation**
  - Work with FQHCs in Oregon that meet specific criteria*
  - Year one requires a needs assessment of where FQHCs are on the HIV Continuum and where the clinic wants to be in four years.
  - FQHCs work with the OR AETC to design & implement a training curriculum
  - AETCs work with clinics to evaluate the process
Continuum for HIV Diagnosis and Clinical Care

- **Tier 1**: HIV Screening & Diagnosis
- **Tier 2**: Basic HIV Clinical Care
- **Tier 3**: Intermediate HIV Clinical Care
- **Tier 4**: Advanced HIV Clinical Care
- **Tier 5**: Expert HIV Provider and Educator

Knowledge Experience
Questions?

Clinical Consultations
Melissa D. Murphy, MD
Oregon AIDS Education Center, Medical Director
Portland VA Research Foundation
melissa@reg.org

Get Involved/Get More Training
Dayna Morrison, MPH
Oregon AIDS Education Center, Program Manager
Portland VA Research Foundation
dayna@reg.org
971.200.5266

www.nwatetc.org
Ryan White HIV/AIDS Programs

- Largest federal program focused exclusively on HIV/AIDS care
- Federal grant funds fill gaps in care for low income individuals living with HIV disease.
- Payment of last resort
- Specific service categories defined by HRSA/HIV AIDS Bureau
Continuum of Care or Cascade

Implementation Cascade for the Continuum of Care

- Testing
- Diagnosis
- HIV Care
- Treatment
- Linkage
- Engagement/Retention
- Virologic Suppression
- HIV
Resources: Delivering a Positive Result


  This online training can be completed within a few hours and provides example scenarios for delivering test results.
Linkage to Care

- **Definition** = Initiation of HIV care
- **Standard metric**: Completed visit with an HIV medical provider ≤ 90 days after HIV diagnosis
- **US National HIV/AIDS Strategy goal**
  - 85% linkage within 3 months

*HRSA HIV/AIDS Bureau, Centers for Disease Control, Institute of Medicine*
HIV Case Management

HIV Case Managers serve every county in Oregon.
Case managers help clients:

- find an HIV specialist
- enroll in insurance
- provide patient education
- medication adherence counseling
- risk reduction support
- monitor health outcomes and
- assist clients in accessing support services necessary to obtain and retain medical care
HIV Case Management Services, State of Oregon, 2015

Legend
- The Alliance
- EOCIL
- Linn County Department of Health
- Crook County Health Department
- Deschutes County Health Department
- Hood River County Health Department
- Jefferson County Health Department
- Polk County Health Department
- Tillamook County Health Office
- Transitional Grant Area
Support Services

Services vary by county:
- Housing & Utility assistance
- Nutritional Support
- Mental Health Treatment
- Substance Use Treatment
- Transportation
- Dental care
- Psychosocial support
- Other emergency assistance

Refer clients to an HIV case manager to help access this support!
CAREAssist
(AIDS Drug Assistance Program)

The CAREAssist Program (AIDS Drug Assistance Program) can help with:

- Health insurance premium payments
- Prescription drug co-payments
- Medical service co-payments and deductibles
- Enrollment services
- Short term medications and medical service assistance for uninsured clients

Other services include adherence support, tobacco cessation resources, dental insurance

Refer clients to an HIV case manager to help access this support too!
Contact Information

- Annick Benson-Scott
  HIV/TB Community Services Manager
  Oregon Health Authority
  971-673-0142
  annick.benson@state.or.us

- Margy Robinson
  HIV Care Services Manager
  Multnomah Co Health Department
  503-988-8800
  margy.robinson@multco.us
HIV Case Manager Contacts

Oregon HIV/STD Hotline (services statewide)
http://www.oregonaidshotline.com/sub.php

HIV Case Management Contacts:
http://public.health.oregon.gov/DiseasesConditions/HIVSTDViralHepatitis/HIVCareTreatment/Pages/cmcontacts.aspx