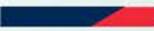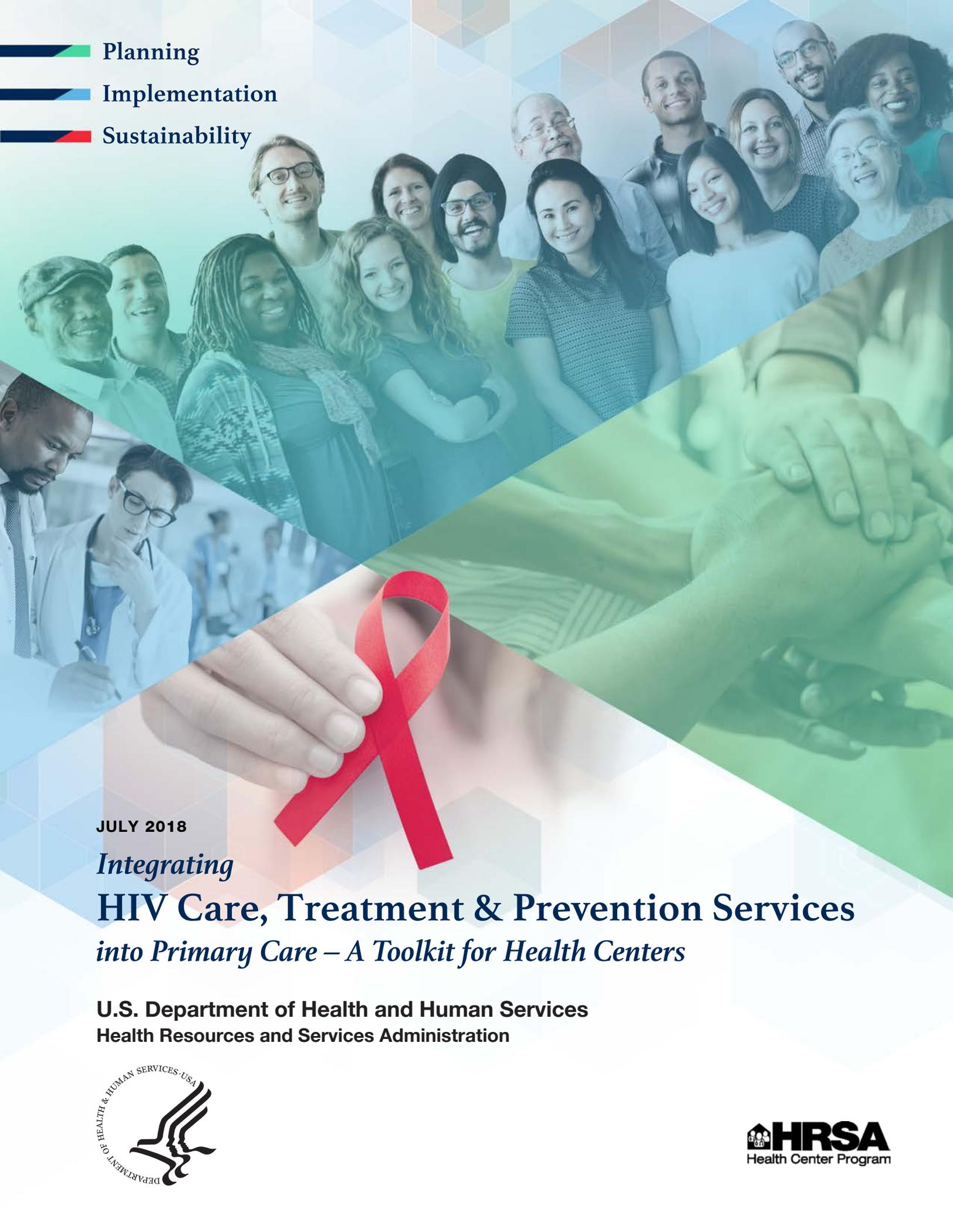**Planning**

Implementation

Sustainability

JULY 2018

Integrating

HIV Care, Treatment & Prevention Services

into Primary Care – A Toolkit for Health Centers

U.S. Department of Health and Human Services
Health Resources and Services Administration

HRSA
Health Center Program

Partnerships for Care (P4C): Health Departments and Health Centers Collaborating to Improve HIV Health Outcomes.

HRSA and the CDC Division of HIV/AIDS Prevention (DHAP) led a three-year, multi-agency project funded by the Secretary's Minority AIDS Initiative Fund and the Affordable Care Act called "Partnerships for Care (P4C): Health Departments and Health Centers Collaborating to Improve HIV Health Outcomes." HRSA-funded health centers worked in partnership with the CDC-funded state health departments in Massachusetts, New York, Maryland, and Florida to: (1) expand provision of HIV testing, prevention, care and treatment in health centers serving communities highly impacted by HIV; (2) build sustainable partnerships between health centers and their state health department; and (3) improve health outcomes among people living with HIV, especially racial/ethnic minorities. Other federal partners include the Office of HIV/AIDS and Infectious Disease Policy (OHAIDP) and the HRSA HIV/AIDS Bureau (HAB).

This toolkit is a compilation of resources, tools, and promising practices from the P4C project to support the integration of HIV services into primary care and build strong primary care-public health partnerships to expand the provision of HIV prevention and care services.

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Introduction

Partnerships for Care (P4C): Health Departments and Health Centers Collaborating to Improve HIV Health Outcomes was launched in FY 2015 as a three-year, multi-agency project funded by the Secretary's Minority AIDS Initiative Fund (SMAIF) and Health Center Program funding. Project leadership was provided by the Health Resources and Services Administration (HRSA) Bureau of Primary Health Care (BPHC) and the Centers for Disease Control and Prevention (CDC) Division of HIV/AIDS Prevention. The goals of the project were three-fold:

- To integrate HIV services into primary care at health centers through workforce and infrastructure development, service delivery, and quality improvement (QI);

- To build sustainable partnerships between HRSA-funded health centers and CDC-funded health departments located in high-HIV prevalence jurisdictions through improved use of surveillance and electronic health record (EHR) data, and coordination of care; and

- To improve health outcomes among people living with HIV, especially among racial and ethnic minorities.

P4C funded 22 health centers and four health departments in Florida, Massachusetts, Maryland, and New York. The P4C project was supported by the HIV Training, Technical Assistance and Collaboration Center (HIV TAC), established to coordinate, facilitate, and develop opportunities for training, technical assistance (TA), dissemination of promising practices and useful resources, and engagement.

ABOUT THIS TOOLKIT

A culminating product of the P4C project is this toolkit, which is designed for health centers and other safety net providers working to integrate HIV services into their primary care models—from those just considering integration, to those aiming to refine existing integration efforts. This toolkit is informed by the lessons learned, promising practices, and successful approaches used by P4C grantees to integrate HIV services into their primary care program. Specifically, the toolkit has the following purposes:

- Provide a clear roadmap for integrating HIV services into primary care provision;

- Identify best or promising practices for HIV management in primary care;

- Provide tools for building health centers' capacity in workforce development, infrastructure development, QI, quality assurance (QA), and other organizational issues; and

- Provide a comprehensive set of educational and instructional materials.

Organizations considering or in the process of integrating HIV services into existing primary care service provision often encounter challenges at the individual, organizational, and systems levels. From staff training to developing robust reporting documents, there are a variety of areas in which organizations often need additional support. The demonstrated successes of other organizations that have integrated HIV services into primary care are valuable resources for organizations embarking on a similar effort.

This toolkit reflects tools and resources developed by P4C grantees or by the P4C HIV TAC and its partners, as well as from a variety of sources, including those generated by federal and non-federal entities engaged in HIV service provision. The tools and resources were used to develop and implement integrated HIV and primary care services and have proven useful in enhancing structures, processes, and outcomes related to provision of integrated HIV and primary care.

HOW THE TOOLKIT IS ORGANIZED

The toolkit is organized into three modules based on the development stages of an integrated HIV and primary care program:

Planning	Implementing	Sustaining

The modules are autonomous and can be reviewed independently or sequentially depending on an organization's stage in integrating HIV and primary care. They contain hyperlinks to tools and resources either included in the appendices or publicly available via the internet.

✳ **Module I**

Planning
FOR HIV CARE INTEGRATION

Module 1

Planning for HIV Care Integration

Introducing HIV services into primary care can be a significant undertaking, particularly for busy health centers that are often operating with limited resources. Planning integration efforts and identifying potential challenges early will greatly help with implementing later steps.

Teams that provide effective HIV services must be knowledgeable about the target population, HIV-specific prevention and care practices, coding and billing strategies, data collection for reporting and decision-making, and partner organizations that can support integration activities. Much of this knowledge is obtained during the planning stages as well as throughout the implementation process. Organizations planning for this type of integration often have several overarching questions, for example:

What staff and resources will be required to integrate HIV services? How will these needs evolve over time? Who in the organization can assume new responsibilities?

What level of buy-in is needed from key internal and external stakeholders?

What practices or protocols need to be changed or implemented prior to providing HIV services to patients?

What are the best approaches for identifying potential partners for support and collaboration?

The tools in this module will help health centers during the initial stages of planning to integrate HIV services into primary care. These tools include trainings, document templates, and best-practice guidance to support subsequent implementation and sustainability efforts. The selected tools reflect those that Partnerships for Care (P4C) health centers and/or health departments found useful in their integration planning, including those that were developed as a result of their efforts.

This module, Planning for HIV Care Integration, features tools addressing the following areas:

Assessing and Enhancing Organizational Readiness

Building a Multidisciplinary Team

Developing Policies & Procedures

Enhancing Electronic Health Records

Establishing and Maintaining Partnerships, Linkages, Collaborations

Supporting Sustainability Planning

Health centers can use the tools included in this module either in sequential order or focus on the sections that are most useful to their stage in the planning process.

Assessing & Enhancing Organizational Readiness

Before embarking on a strategic plan to integrate HIV services, health centers need to assess their organizational readiness for the change and enhance, where possible, their degrees of readiness. A health center's degree of readiness will affect its ability to successfully implement new work streams or services. Reviewing early the organization's current practices, resources, and needs to identify gaps and opportunities has helped health centers efficiently plan HIV service integration. A strong organizational commitment, particularly from leadership and "on-the-ground" staff, will create an optimal environment in which changes can be adopted and implemented. **Bedford Stuyvesant Family Health Center (Brooklyn, NY)** reported success creating and maintaining leadership buy-in through regular updates to leadership on project progress (e.g., monthly reports), and by creating a space for leadership to contribute input and feedback and participate in major events and products (i.e., requesting leadership review of patient education materials or program marketing materials). The Chief Executive Officer (CEO) and Chief Medical Officer (CMO) at Bedford Stuyvesant were integral in the design and early implementation of integrated services at the health center.

Key areas to consider when assessing organizational readiness include:

SERVICE DELIVERY
HIV Testing and Linkage Services, HIV Treatment Capacity and HIV Prevention Capacity

WORKFORCE DEVELOPMENT
Care Team Staffing, Care Team Training Needs, and Referral Providers and Partners, Cultural Competency

INFRASTRUCTURE DEVELOPMENT
Data Management and Tracking Systems (e.g., EHR, financial management), Service Area/ Patient Needs, and Policies and Procedures

The (P4C) Health Center Readiness Assessment is a comprehensive needs assessment tool designed to assist the P4C health centers to gain a clear understanding of their readiness to integrate HIV services. The P4C HIV Training, Technical Assistance and Collaboration Center (HIV TAC) developed a survey-based tool to obtain input from a variety of key team members, and to create a holistic view of the organization's training and TA needs. The tool was informed by work conducted by the P4C health departments within their jurisdictions. This tool has assisted P4C health centers to identify existing services and workforce capacity relevant to planned HIV integration efforts. The assessment collects information on current practices, types of patients managed, training area needs, existing infrastructure supports related to HIV service delivery, and additional challenges and opportunities that may impact integration.

Integration Spotlight

Enhancing Readiness by Addressing Gaps

The readiness assessment for **North Shore Community Health Center (Salem, MA)** indicated the center had limited workforce capacity to deliver HIV care and treatment services. As the health center began building their HIV Care Team, they hired a Registered Nurse (RN) with expertise in HIV care and treatment. This RN has been an integral part of HIV patient care management at the health center; the health center reports a 300% increase in screening rates and 100% linkage to care for HIV-positive patients. The RN has also been key to building workforce capacity by encouraging staff participation in trainings and utilization of care and treatment resources.

On the basis of lessons learned from the P4C project, it is recommended that health centers assemble a multidisciplinary team (clinical and nonclinical staff) as well as leadership (e.g., the CEO or CMO) to complete the readiness assessment. Completing the assessment should take between two and three hours, depending on the depth of discussion. Following the assessment, a smaller group of clinical and

nonclinical members from the team should produce a written document that summarizes the discussion, including identifying existing resources and capacity needed to deliver integrated primary care and HIV services. The report should also include recommendations for how the health center will address the needs prior to implementation and/or use its resources to continue planning and begin implementation. The spotlight on page 9 provides an example of how **North Shore Community Health Center (Salem, MA)** used the results of its assessment to identify and fill gaps in HIV care and treatment and to implement an integrated service delivery model.

Although a readiness assessment can be completed within a relatively short time frame, some findings might require revisions in an organization's policies and procedures or new policy development before implementation. This policy development stage will take additional time, especially when board approval is needed for policy changes. Health centers should plan for time to develop proposed revisions in policies or new policy proposals well in advance of a board meeting at which the new policies will be presented for approval. Later in this module, guidance and tools used by P4C health centers are provided, including samples of policies and procedures developed to support integrated primary care and HIV service. This information will help expedite completion of the organization's planning phase.

A strong organizational commitment, particularly from leadership and "on-the-ground" staff, creates an optimal environment in which changes can be adopted and implemented.

Building a Multidisciplinary Team

Health centers are often models of excellence in providing care by multidisciplinary teams. More than two-thirds of health centers use the patient-centered medical home (PCMH) model which emphasizes proactive, multidisciplinary team-based care. Teams comprising providers and support staff in a variety of areas can create a "one-stop shop" for the services individuals receive. A team approach also allows for effective communication and coordination among providers and support staff, which can enhance care and improve outcomes. An important aspect of planning is determining which current team members may be able to assume new responsibilities as part of HIV service integration, as well as what existing processes can be leveraged to support HIV care. Additional training and/or new team hires may be necessary to meet organizational priorities and best serve the target population. Identifying and building this team early is key to ensuring sustainable services and the integration model. Planning for sustainability is important during this stage to allow full implementation of sustainability activities, and should not be left to later phases. Additional information about sustainability planning (e.g., building a team to ensure sustainability) is provided later in this module and in Module 3.

Two essential components of building a team for HIV service provision are 1) identifying "who" should be on the team, including those who may be nontraditional members, and 2) ensuring that the team has a communications structure and sufficient opportunities to discuss patients and the practice of the HIV services. Some organizations may need to shift from a traditional clinic model to a model based on a multidisciplinary care team. Health center staff on P4C HIV Care Teams included, for example:

- Primary care providers (PCP) (physicians, nurse practitioners/ advance practice nurses, physician assistants)
- Other medical providers (infectious disease physicians, nurses, medical assistants)
- Case managers/care coordinators
- Patient/community education specialists (treatment adherence counselors, community health workers, health educators, outreach specialists, HIV/STD prevention specialists)
- Behavioral health staff (social workers, substance use disorder treatment counselors, psychologists/clinical psychologists, psychiatrists)
- Dental staff (dentists, dental hygienists)
- Peer intervention staff (peer counselors, peer navigators, peer educators)
- Pharmacists
- Nutritionists

Integration Spotlight

Creating a "One-Stop Shop" for Individuals to Receive Integrated Services

Healthfirst Family Care Center/ Stanley Street Treatment and Resources (SSTAR) (Fall River, MA) developed a fully integrated, multidisciplinary team for HIV care coordination and treatment at their health center. Their HIV Care Team includes case managers, medical providers, and behavioral health clinicians who work together to provide coordinated, wrap-around services for their HIV-positive patients. The SSTAR HIV Care Team meets monthly to engage in professional education activities that have expanded the capacity of the team while enhancing the bonds between team members.

The HIV Care Team is led by a Provider Champion, a nurse practitioner with an HIV focus. She attends monthly provider meetings at the health center to promote routine HIV screening and use of pre-exposure prophylaxis (PrEP) with all the health center providers. Continued engagement of the Provider Champion has helped keep SSTAR's integrated primary care and HIV services visible to other providers in the health center.

Deciding who should be part of the multidisciplinary team should be informed by best practices from the literature, findings from the organizational assessment, and findings from a patient needs assessment to identify HIV service delivery needs. In many jurisdictions, HIV planning councils conduct needs assessments of people living with HIV (PLWH) living within their eligible metropolitan area. Health centers could also conduct a clinic-level assessment of patient needs.

For the P4C health centers, staff capacity, patient load, and organizational culture all contributed to decisions on HIV Care Team composition. For example, **Mattapan Community Health Center (Mattapan, MA** determined through their readiness and patient needs assessments that their HIV-positive patient load did not support a full-time provider to lead the HIV Care Team. They decided to share a provider with one of their partners, which allowed them to meet the staff capacity need without incurring the unnecessary cost of a full-time provider.

The use of peer intervention staff is a component of effective HIV prevention and service provision. Peers, individuals living with HIV, can often engage and navigate hard-to-reach communities that are often difficult for traditional staff to access. Often times, PLWH who have successfully been linked to and engaged in HIV care naturally become sources of information or guidance for family and community members. Identifying individuals, including patients, with a desire to support others at risk for or living with HIV, as well as the skills to influence their peers, can be a useful step in initiating a peer intervention effort. Peers can strengthen HIV services in a variety of ways, including (but not limited to): identifying outreach opportunities, promoting education and awareness, facilitating support resources, improving linkage to care and retention, and increasing the amount of contact time patients and clients have with intervention staff.[1,2] In addition to personal experience related to HIV, peer staff can benefit from (and may be required to complete) training prior to their engagement. Retention of peer staff may be challenging for health centers, particularly for those without specific funding allocations; however, health centers should consider a variety of incentive and compensation options when considering adding peer-based interventions. Many of the P4C health centers included peer staff on their HIV Care Teams as peer navigators, peer counselors, peer educators, and peer adherence support.

A key factor in implementing multidisciplinary care teams is finding time to effectively communicate on issues that impact both staff and patients. In the primary care setting where both patients and their medical issues are diverse, integrating a new service often adds complexity to an already complicated routine. One approach to achieve effective and efficient team coordination is the "team huddle." Huddles are a way of managing team meetings so that key information is shared among team members with the goal of improving patient care. By design, huddles are short in duration and can be structured for an organization's specific needs (e.g., held via telephone for multi-site organizations, utilize a conference form that describes follow-up items and next steps). Regularly scheduled huddles (e.g., daily, twice-weekly can strengthen a team's interaction by providing focused time to discuss patient needs, such as HIV testing, medication adherence support, behavioral health support, or other services). Huddles also provide time to introduce and engage new members as the team expands, and move the team efficiently toward overall objectives by ensuring the team members are aware and understand the issues at hand, including those that may change day-to-day (e.g., patient load, resource capacity). Huddles allow team members to communicate and coordinate with each other to improve workflow and, ultimately, improve patient care. Some organizations may hold case conferences, which serve very similar purposes.

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[1] Rapid Response Service. The role of peers in linkage, engagement, and retention in HIV care. Toronto, ON: Ontario HIV Treatment Network; April 2017.

[2] U.S. Department of Health and Human Services Health Resources and Services Administration HIV/AIDS Bureau. The Use of Peer Workers in Special Projects of National Significance Initiatives, 1993 – 2009; March 2010.

Below are several resources for use in building a multidisciplinary team focused on integrating HIV services into primary care.

Resources for Implementing Multidisciplinary Team-Based Care

P4C HIV TAC: Multidisciplinary Team-Based Care Resources

The P4C HIV TAC has developed resources on the characteristics and benefits of a team-based approach to care, as well as strategies on how organizations can shift from a traditional clinic model to a team-based one. Archived materials are available on:

Effective Team-Based Care

This webinar will help health center staff to develop or improve their team-based care. It identifies key aspects of team-based care, characteristics of effective clinical teams, and challenges in achieving clinical team effectiveness. It also provides examples of successful team-based care provision.

Share the Care

This webinar, a continuation of the Effective Team-Based Care webinar, highlights the Share the Care™ approach. With this approach, all team members share responsibility for and contribute to patient health. The webinar features P4C grantee presentations that illustrate how they have used a Share the Care™ activity to describe existing team roles and re-sponsibilities and how to adapt these to support team-based care. This webinar will help all members of the care team move toward effective team-based approaches.

Resources for Engaging Peers as Intervention Staff

The New York State Department of Health AIDS Institute's Library of Peer Certification Information and Resources

The New York State Department of Health AIDS Institute has created a library of peer certification information and resources focused on peer-based services that can enhance HIV-focused interventions and improve outcomes for engaged patients. Training and certifying peer intervention staff ensures that peers and their supervisors adhere to uniform standards and are aware of their responsibilities within a peer-delivered intervention.

The library provides resources on peer certification, including (but not limited to): FAQs to help get started, a list of core competencies for peer workers, study guides, and training webinars. The library is also available for supervisors or staff who are members of peer intervention efforts, such as outreach and intervention specialists, navigators, and community health workers.

Tools and Resources for Implementing Team Huddles and Case Conferences

American Medical Association's Practice Improvement Module: *Implementing a Daily Team Huddle*

The American Medical Association's (AMA) practice improvement strategies tools feature an educational module, Implementing a Daily Team Huddle. This module includes a comprehensive set of resources focusing on health centers or designed for primary care service delivery, including:

- An online module that provides step-by-step guidance on establishing the routine, developing relationships and designating roles, and evolving and improving huddles over time

- Case studies from a variety of health organizations that have implemented a huddle approach

- Downloadable tools including: a PowerPoint presentation of the educational module, huddle checklists and evaluation forms, a patient visit checklist, and a huddles best-practices document.

The AMA also offers email- and telephone-based implementation support for organizations as they develop and refine their own huddle approach.

University of California San Francisco (UCSF) Center for Excellence in Primary Care (CEPC): *Team "Huddles" Tools*

The UCSF CEPC provides downloadable tools and training videos on how team huddles can be implemented in health centers or other primary care organizations.

Healthy Huddles includes resources for use during every stage of huddle implementation, from planning meetings to addressing huddle follow-up items. Specific tools include:

- **Healthy Huddles Happen** – A PDF worksheet to introduce healthy huddles and how teams can identify the best ways to use huddle time.
- **Healthy Huddle Warm-Up Tool** – A PDF reporting tool to assist with "scrubbing" patient charts so that key information can be brought to a huddle.
- **Healthy Huddles Wrap Up** – A PDF tool to capture and prioritize issues (staffing, patient needs) brought up during a given week.
- **Spotlight on Huddles** – Huddle case studies from sites participating in the CEPC.

P4C HIV TAC: Team Huddles and Case Conferencing Resources

The P4C HIV TAC has developed resources on effective strategies to improve care and coordination through team huddles and case conferencing. Although these resources are not specific to HIV care, they provide useful information that can be easily adapted for HIV care multidisciplinary teams. Archived materials are available for sessions on:

Huddles in Team-Based Care

This webinar is designed for teams looking to implement team huddles, and describes the "who, what, where, when, why, and how?" of creating and maintaining a huddle approach. This resource also includes checklists, sample agendas, and templates for implementing huddles.

Effective Case Conferencing with Teams

This webinar describes in detail a case-conferencing approach that is guided by New York State Department of Health guidelines. This tool can help case-conference organizers and leads develop documents and protocols, as well as understand likely challenges and potential solutions.

Developing Policies & Procedures

Once multidisciplinary teams have been created, integrating HIV services into an existing primary care organization requires modifying current policies and procedures and/or developing new ones to address the expanded service offerings. These policies may include (but are not limited to): staff training, patient flow management, data collection reporting, team workflow and communication, cultural competence, reimbursement, and referral practices. While each provider organization has unique needs and processes, understanding key policies and procedures that directly support HIV services integration will help an organization identify where new guidance is needed and which team members should assume responsibility for new workflow requirements. Policies and procedures related to HIV and primary care integration can often be adapted from existing policies and procedures at a health center. Key policies and procedures based on best practices in HIV and primary care integration, and experience from the P4C project include:

- HIV testing and linkage to care
- Basic HIV care (i.e., managing HIV-positive patients initiating or receiving first line antiretroviral therapy (ART) with common health complaints, and in need of referral for more complex care)

- HIV prevention, including prevention for high-risk patients
- HIV-negative patients (e.g., PrEP, behavioral interventions)
- Medication management and adherence support
- Patient self-care plans
- Specialty care referrals
- Behavioral health services (including screening and treatment for mental and substance use disorders)
- Screening for sexually transmitted diseases (STDs), hepatitis, and tuberculosis (TB)
- Care coordination (across HIV Care Team, other health center service providers, and service delivery sites)
- Quality Improvement/Quality Assurance (QI/QA)
- Provider credentialing, privileging, continuing education, recruitment, and retention
- Data sharing with state and local health department and other service delivery partners

Integration Spotlight

The Importance of Policies and Procedures on Service Integration

Developing or modifying and uniformly implementing policies and procedures for routine HIV screening were reported by P4C health centers as key to increasing staff capacity and patient acceptance of HIV testing. **Care Resource (Miami, FL)** reported the following:

"Our policies and procedures on HIV in a health care setting defines for our practice the criteria by which medical patients should be routinely screened for HIV: timing and frequency of the screening, technology to use, patient age and risk factors.

Additionally, it describes critical components of the process such as patient consent and right to decline, confirmatory testing and treatment protocol. Having in place clearly written guidelines for medical providers and all support staff to be on the same page allowed our clients to seamlessly embrace HIV testing as part of their yearly checkup… This policy aims to help increase access to HIV testing and treatment, normalize patient and provider attitudes towards HIV screening, and ultimately help to destigmatize the screening, diagnosis, and treatment of HIV."

Developing policies and procedures for routine HIV testing is often a first step of HIV services integration. Guidelines exist on both the federal and state levels to assist providers in developing policies, practices, and procedures that ensure high-quality HIV testing services are developed.

Guidelines for HIV testing continue to evolve with changes in testing technology and methods for reaching persons who can benefit from these services. CDC's HIV Testing page provides the most updated CDC guidelines on HIV testing for providers, program managers, and laboratory personnel. CDC's HIV Guidelines and Recommendations website also provides guidelines and related implementation resources for prevention and care for PLWH, preventing new infections, HIV surveillance, and program management.

As part of the planning process, health centers should develop a written document outlining their HIV testing policies and procedures. Agency-specific HIV testing policies and procedures should include: policy, purpose, procedures (outlining the specific step-by-step sequence of activities or course of action to be followed for conducting routine HIV testing), responsible staff, documentation guidance, confidentiality procedures, training, and QA.

P4C health centers developed their routine HIV screening policies and procedures in different ways. **Betances Health Center (New York, NY)** developed integrated policies and procedures for routine HIV testing and linkage to care. Integrating HIV testing and linkage to care in one policy and procedure created a seamless process for health center staff to implement. **Care Resource (Miami, FL)** developed policies and procedures that integrated HIV and hepatitis C virus (HCV) screening. While the procedures are different for HIV and HCV testing, the same staff were responsible for conducting the training. Their integrated policy ensured that staff were aware of the similarities and differences in the policies. Both health centers incorporated federal guidance and state policies and procedures into their own and described how the elements of HIV testing, HCV screening, and linkage to care fit operationally into their organization's structure.

Following are several tools and resources to assist with developing policies and procedures for integrating HIV services into primary care.

Tools and Resources for Developing Effective HIV Policies and Procedures

Writing Effective Policies and Procedures for HIV Service Delivery in Primary Care Settings

The P4C HIV TAC has developed resources to support organizations as they plan for integrated HIV services. Several tools are available from the webinar, Writing Effective Policies and Procedures for HIV Service Delivery in Primary Care Settings. The materials describe the basic principles of policies and procedures; clarify the differences among policies, procedures, and standing orders; and provide tips on writing effective documents. These materials help administrators refine current policies and develop new policies that will effectively integrate HIV services into primary care.

Sample Policies and Procedures for Routine HIV Testing and Linkage to Care

BETANCES HEALTH CENTER (NEW YORK, NY)

Policy of HIV Routine Testing and Linkage to Care – Betances Approach to Routine HIV Testing

This document includes the health center's policy for and practice of routine HIV testing, including details on who should be targeted for testing, the purpose of testing, and the type of test to be used under different circumstances, as well as how to adhere to local and state public health policies.

CARE RESOURCE (MIAMI, FL)

HIV and HCV Screening in the Health Care Setting

This document includes policies and procedures for HIV testing and HCV testing, including detailed guidance on the target testing population, testing type, frequency of testing, requirements for securing patient consent, post-test procedures and counseling, and how treatment should proceed (as described in other clinical guidance documents).

Additional Resources for Developing Policies and Procedures for Routine HIV Testing

CDC has developed the following resources that may further support development of HIV-specific policies and procedures.

Implementing HIV Testing in Nonclinical Settings: A Guide for HIV Testing Providers (2016)

This guide supports the implementation of HIV testing services in nonclinical settings in the United States. The purpose of the guide is to familiarize providers with key programmatic issues and updates that impact HIV testing service delivery in nonclinical settings.

To Test or Not to Test? Considerations for Waived Testing (2014)

This document includes several sample items that will assist with developing policy and procedures such as: a training checklist, training evaluation, performance assessment, procedure content, and list of tips.

Sample Procedures for HIV Care Services

COMMUNITY CLINIC, INC. (GREENBELT, MD)

Procedures for HIV Care Services

This document includes procedures for care and treatment services for HIV-positive patients, including initial linkage to care, initial intake and provider visits, initial follow-up visit, initiation of or change in ART, routine referrals and services, preventive care screening, routine vaccinations, and follow-up visit schedule.

Additional Resources for Developing Policies and Procedures for HIV Care and Treatment Services

The following resources can be used by health centers to develop policies and procedures on HIV care and treatment.

Guidelines for the Use of Antiretroviral Agents in HIV-1-Infected Adults and Adolescents

Evidence-based guidelines for optimal use of antiretroviral agents for treating HIV infection in adults and adolescents in the United States were developed and are maintained by the Department of Health and Human Services Panel on Antiretroviral Guidelines for Adults and Adolescents.

Primary Care Guidelines for the Management of Persons Infected with HIV: 2013 Update by the HIV Medicine Association of the Infectious Diseases Society of America

Evidence-based guidelines for the management of persons infected with HIV were prepared by an expert panel of the HIV Medicine Association of the Infectious Diseases Society of America. These updated guidelines replace those published in 2009. The guidelines are intended for health care providers who care for HIV-infected patients.

Enhancing Electronic Health Records

EHRs can improve service provision by streamlining patient data, supporting clinical decision making, reducing replication errors, and supporting local and national surveillance data. Federal programs that provide financial incentives for the "meaningful use" of EHRs have led to its rapid adoption within the health care sector. EHRs help providers maintain a current and accurate view of patients' health, as well as provide effective care.

The introduction of HIV services into an existing primary care setting will benefit from and will likely require EHR modification. EHR modifications can help routinize HIV testing and care approaches by:[3]

- Determining which patients should be offered testing
- Prompting providers to offer and/or order testing
- Documenting testing results
- Supporting billing for HIV services
- Facilitating continuous quality improvement (CQI) efforts
- Data sharing with state and local health department and other service delivery partners

EHR modification may also be used as a tool to ensure alignment with local and national HIV reporting requirements that support surveillance. By developing or modifying EHRs that capture key information on HIV testing, follow-up, and linkage to care, health centers may increase the efficiency and accuracy of data reporting required by local mandate, as well as by funding entities and partner organizations.

Furthermore, organizations that include patient access to EHR data (i.e., through patient portals) may need to consider expanding those tools to include HIV-relevant information to support patient engagement. Examples of ways in which P4C health centers have used their EHR to support HIV integration include the following:

Community Clinic, Inc. (CCI) (Greenbelt, MD) created a HIV Routine Testing form within their EHR. The form was designed to satisfy Maryland's state law regarding HIV testing. Importantly, CCI has a standing order for rapid testing. One click box sends the order and associates the proper ICD-10 code automatically. The form contains a section where previous HIV test results auto-populate, so that medical assistants know the test has already been performed and they can skip the remainder of the form. When providers review the forms during a visit, they can view the test results, along with the date of testing. CCI's EHR form also includes click boxes to capture whether a test was offered, education was provided, and the test was accepted. The form also captures reasons why patients decline the test. Understanding the reasons patients decline tests will assist with QI and development of patient education materials.

Integration Spotlight

Enhancing EHR Systems to Improve HIV Services Integration

Prior to the P4C project, **Health Care Center for the Homeless/ Orange Blossom Family Health (Orlando, FL)** used an existing internal EHR dashboard for monitoring and QI efforts at their health center. For the P4C project, they created a specific dashboard to enable Care Team staff to quickly review performance metrics and progress related to HIV care and treatment (e.g., linkage to care rates, viral load suppression). These data were reviewed quarterly to determine whether health center performance goals were being met.

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[3]Sanchez TH, et al. A Novel Approach to Realizing Routine HIV Screening and Enhancing Linkage to Care in the United States: Protocol of the FOCUS Program and Early Results. *JMR Research Protocols.* 2014;3(3):e39.

Other health centers enhanced their EHR for care coordination and to track the quality of care indicators. **Mattapan Community Health Center (Mattapan, MA)** developed HIV service-specific templates in their EHR to capture data on HIV testing, linkage, and care services. A challenge they faced with improving patient data was the need to extract data from multiple data points in the EHR. To solve this, Mattapan developed a spreadsheet with 23 categories that tracked patient care and case management (e.g., date of birth, date of status update, CD4 count, viral load, prescribed ARTs, screening for STDs, partner screening for HIV) and used the spreadsheet to assist with mapping data points. These points are used to develop care coordination reports. Mattapan also used the reports to facilitate CQI efforts around documentation and to meet reporting requirements for the P4C program.
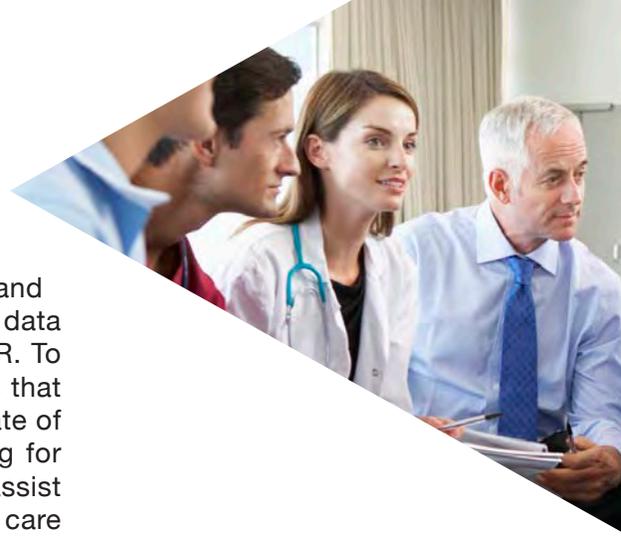
Following are several resources for enhancing EHR for integrating HIV services into primary care.

Resources for Enhancing EHR Systems to Improve Care and Data Management

P4C HIV TAC: Resources on EHR Use

The P4C HIV TAC developed a webinar series to facilitate training and discussion on implementing real-world EHR strategies for integrated HIV services provision. Each webinar session features expert presentations and a facilitated discussion among health center and health department participants.

Identifying Data and Reports Needed for Quality Improvement

This session focused on strategies to capture and provide data on outcomes and performance as needed for reporting and accountability efforts. The session included guidance on analyzing and addressing existing data gaps, supporting data validation efforts, identifying staffing needs, and managing unexpected challenges.

Leveraging Information Systems and Technology to Strengthen Care Coordination and Patient Engagement

This session featured a facilitated discussion on real-world practices implemented by participating health centers to leverage EHRs to improve their care coordination efforts.

Establishing and Maintaining Partnerships, Linkages, and Collaborations

The development and maintenance of interorganizational relationships are key components of health service provision. Community providers are increasingly underresourced while the needs of those they serve are often increasing. Fostering connections with other organizations makes possible knowledge exchange and resource sharing (and staff, as appropriate), optimizing policies and procedures, and ultimately a greater impact on patient and public health challenges. While some partnerships, linkages, and collaborations arise naturally, others may require focused efforts to identify the potential for a mutually beneficial relationship and determine how the relationship can be sustained over time.

The types of relationships differ by organizational need and other factors, and may involve:

- Networking: Mutual exchange of information

- Coordination: Mutual exchange of information and aligning activities to meet a common goal

- Cooperation: Mutual exchange of information, aligning activities to meet a common goal, and sharing resources in an effort to meet a common goal

- Collaboration: Mutual exchange of information, aligning activities to meet a common goal, sharing resources, and enhancing the capacity of all organizations involved in an effort to meet a common goal

Most health centers are already in partnership with entities such as local health departments, referral providers, and social service agencies, among others. These relationships are often dynamic and new opportunities may arise at any time. Organizations need to be aware of potential new partners with which to connect, as well as ensure that existing relationships remain beneficial and productive.

Integration Spotlight

Successes from Partnerships between Health Centers and Health Departments

Preliminary successes reported from P4C health center and health department partnerships include:

- Improved linkage to care, re-engagement in care, and retention in care for PLWH

- Implementation of case-conferencing to support care coordination

- Improved relationships between health centers and health departments fostered efforts to achieve a shared mission

- Development of electronic data sharing via web-based dashboards

- Development of relationships with P4C health centers for sharing lessons learned and best practices

A key component of the P4C model is the development of sustainable partnerships between state health departments and health centers located in high-HIV prevalence jurisdictions. The partnership developed between the health centers and health departments in the P4C project focused on the following goals:

- Integrating HIV surveillance data and health center patient data to improve health outcomes for PLWH;

- Expanding partner notification, linkage, retention, and re-engagement with care services for PLWH; and

- Providing training and TA activities for health centers (e.g., organizational assessments, ongoing TA, in-person and web-based training, tailored coaching, facility-level QI profiles, and resource sharing).

P4C health centers and health departments collaborated to implement the *Data to Care* public health strategy, which aims to use HIV surveillance data to identify PLWH not in care, link them to care, and support the HIV care continuum. Data to Care programs use laboratory reports from a health department's HIV surveillance program as markers of HIV care and analyze them to identify individuals who either never linked to care after diagnosis or who did not continue to receive care. The program then offers outreach to individuals on this list from health departments, providers, or both to assist re-engaging them into HIV care.

Based on their experience with the P4C project, the **New York State Department of Health (Albany, NY)** identified the following key components to implementation of a Data to Care program:

- **Defining who within a jurisdiction will be presumed out of care, and what data systems will be used to identify these individuals –** Jurisdictions will have differing levels of information on PLWH depending upon data systems available. Strict criteria should be used to ensure the definition captures individuals who are truly infected with HIV/AIDS.

- **Implementing system-level enhancements to identify individuals who are out of care, and document programmatic work –** Jurisdictions will have varying capacity to identify individuals who are presumed out of care and to document the programmatic follow up of these individuals. This may be dichotomized as surveillance and programmatic data. Building off existing system-level infrastructure for traditional partner services work is suggested, if available.

- **Developing a protocol for field staff to conduct outreach with individuals who are out of care –** The purpose of this protocol is to delineate steps to identify and locate PLWH who are presumed out of care within the jurisdiction. The protocol is specifically geared toward staff trained in disease investigation and partner services who are tasked with conducting re-linkage work. The protocol should include closure dispositions specific to this work, and outline any prioritization that might be necessary.

- **Providing specifically designed training and job aids for field staff beyond traditional partner services training –** No sanctioned training for partner services delivered Data to Care work currently exists; however, specialized training and job aids are needed to do this work. Training should build off existing partner services training, and focus on motivational interviewing (MI), and the trans-theoretical model of behavior change. Furthermore, defining core competencies to conduct this work is suggested to ensure staff are prepared to address the needs and challenges associated with re-engaging individuals along the HIV care continuum.

- **Developing a protocol for determining when and why to reassign previously worked cases –** Because Data to Care is an ongoing activity, decisions need to be made regarding when and why to reassign an individual who has already been assigned for re-linkage work. For example, how long will a jurisdiction wait to reassign an individual who re-links to care, but then falls out of care again? Or will you reassign someone who refuses any intervention? Will these individuals be excluded for a particular time frame, or forever?

- **Conducting ongoing program evaluation to ensure efficiency and success –** Ongoing evaluation is key to continued success. While it is important to contribute findings to the broader research community, it is equally important to share results within one's own jurisdiction. Examples from New York State include an infographic on reasons for being out of care among PLWH, Data to Care agency reports, and data briefs.

Each jurisdiction implemented its own approach to the strategy; however, common themes were identified as instrumental to success. Key contributors to the success of the partnerships included:

- Collaborative development of out-of-care definitions between the health department and health center;

- Development of comprehensive and bi-directional data sharing agreements to promote linkage, re-engagement, and retention in care;

- Close coordination between health center staff and health department linkage specialists/disease intervention specialists to identify and engage out-of-care PLWH and their partners; and

- Continuing open discussions about what is working and what is not working.

The following table includes the out-of-care definitions developed under the P4C project, by jurisdiction. All states developed definitions for surveillance initiated cases; Massachusetts and New York also developed definitions for health center initiated cases.

Table 1. Out-of-Care Definitions Developed by P4C Jurisdictions

State	Surveillance-Initiated Definitions	Time Frame for Out-of-Care Status
FL	Never or previously linked to care	≥ 12 months without labs (i.e., viral load and CD4 count)
MA	Previously linked to care	≥ 6 months without labs
MA	Never linked to care	≥ 3 months post-diagnosis with no labs
MD	Never or previously linked to care	≥ 13 months without labs (never linked diagnosed for 2-3 years)
NY	Previously linked to care – NYC	≥ 9 months without labs
NY	Previously linked to care – rest of state (ROS)	13-24 months without labs
NY	Never linked to care – NYC & ROS	≥ 3 months post-diagnosis without labs

State	Health Center-Initiated Definitions	Time Frame for Out-of-Care Status
MA	Previously linked to care	≥ 6 months without medical visit (after 12 months in care)
MA	Never linked to care	≥ 3 months post-diagnosis without medical visit
NY	Never linked to care – NYC & ROS	≥ 3 months post-diagnosis without medical visit
NY	Previously linked to care – NYC & ROS	≥ 9 months without medical visit

*Following are tools to use for establishing and maintaining partnerships, linkages,
and collaborations in support of integrating HIV services into primary care.*

Tool for Tracking Partners and Partnership Activities

Most organizations develop and maintain partnerships with multiple entities. Having a formal tracking system can help organize partner activities, keep records of key contacts and goals, document partner strengths and weaknesses, and identify potential gaps in needed partners.

The Partnership Toolkit

A Partnership Toolkit, produced by the P4C HIV TAC for **Bedford Stuyvesant Family Health Center (Brooklyn, NY)**, provides a comprehensive list of key considerations, steps, and Partnership-Focused Templates to help guide organizations' relationship building and tracking.

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Resource for Developing Partnerships between Health Centers and State and Local Health Departments

Partnerships between Federally Qualified Health Centers and Health Departments for Engaging in the Development of a Community-Based System of Care

In 2013, the National Alliance of State and Territorial AIDS Directors (NASTAD) developed an issue brief: Health Department – Community Health Center Collaboration – A Status Report and Action Steps for Capacity Building to report on the status of health department and health center collaborations, challenges of collaboration, and action steps for capacity building. The resource highlights three areas of focus for strengthening collaboration between health departments and health centers:
- Facilitating and promoting access to HIV/AIDS and viral hepatitis prevention and care services
- Improving coordination and continuity of care
- Enhancing the quality and effectiveness of both clinical and public health services

Supporting Sustainability Planning

The term "sustainability" has been increasingly associated with organizations planning to implement new programs and policies. For health centers, it often refers to the ability of the organization to continue programming beyond a specific funding period or in the event of a reduction or adjustment in resources (financial, staffing, etc.), while maintaining desired outcomes. In practice, sustainability goes far beyond just funding. It includes maintaining changes by engaging a variety of effective partners, mobilizing community members and resources, conducting ongoing training of new staff members, routinely implementing policies and procedures, and developing a comprehensive network of invested and engaged parties that are aligned with the overall objectives of the intervention. While funding is an obvious driver of some sustainability planning, true long-term sustainability requires buy-in and active understanding of and participation in the commitment to improving HIV outcomes in the health center and in the community. Ensuring that stakeholders within and outside of a health center are fully invested in the effort can provide the necessary support (e.g., advocacy, partnership, coordination) for a long-term or permanent intervention.

As with any new service provision, the integration of HIV services should start with sustainability in mind and a careful analysis of the resources (financial, human capital, time) of the effort. In addition to continuous efforts to secure necessary financial resources, sustainability planning may include a variety of strategies, among them: capacity building, ongoing needs assessments, partnerships and collaborations, and effective policy development. Lessons learned from the P4C project identified the following steps that health centers should consider during planning to enhance sustainability of their integrated HIV and primary care service model:

- **Invest in infrastructure to improve quality of care and become the "provider of choice" in the community –Codman Square Health Center (Boston, MA)** invested in an immunoassay system to increase their capacity to conduct in-house fourth generation HIV testing. This investment allowed Codman to provide same-day test results for HIV screening and PrEP eligibility. Through the health center's Same Day PrEP program, patients could come into the health center; complete appropriate lab work, a behavioral assessment, and a medical history; and receive a prescription for PrEP medication the same day. Enhancements to EHRs that improve care coordination and QI of integrated HIV and primary care services are another example of infrastructure development that supports sustainability.

- **Reorganize workforce to improve efficiencies –** Many of the P4C health centers reorganized staff on their HIV Care Teams to focus on care management and care coordination. Improved care coordination supports engagement and retention in care, which support sustainability of health outcomes, as well as increased billing and reimbursement. Identifying opportunities to use community health workers and certified allied health professionals to provide coordination services can support sustainability. Some states offer certification for community health workers, and certified allied health professionals in some states may be reimbursable.

Integration Spotlight

Key Components to Successful Sustainability Planning

Bedford Stuyvesant Family Health Center (Brooklyn, NY), identifies the following components as being key to their sustainability planning efforts.

- **Leadership Support –** Regular, consistent, and vocal commitment from health center leadership (e.g., CEO, CMO)

- **Strategic Partnerships –** Developed new and expanded existing partnerships by conducting activities that increase health center visibility (e.g., presentations, hosting events at health center)

- **Strategic Alignment –** Reviewed health center funding and critically assessed opportunities to better align work conducted under the P4C project with the health center's strategic plan

- **Expanded Provider Expertise –** Invested time and resources into expanding expertise of clinical providers engaged through the P4C project into service provision beyond HIV care and treatment.
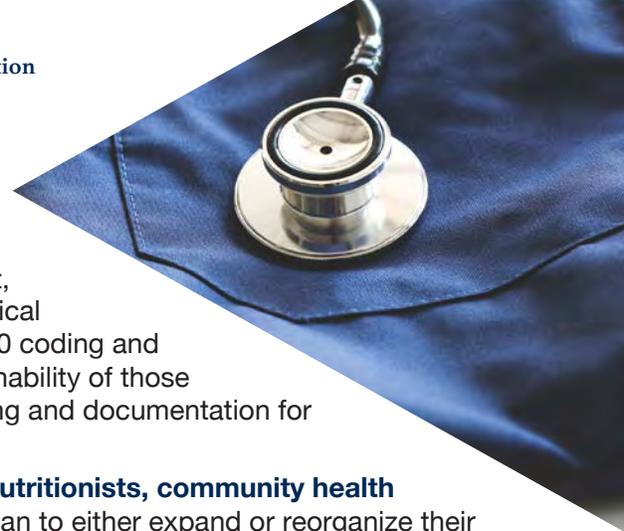
- **Maximize revenue through enhanced medical documentation and coding –** During the readiness assessment, many P4C health centers identified the need for training on medical documentation and coding. As organizations transition to ICD-10 coding and expand the types of services offered, it is essential to the sustainability of those services that providers are trained to implement enhanced coding and documentation for HIV screening, care, and treatment services.

- **Hire and use "billable" providers (i.e., clinical pharmacists, nutritionists, community health workers) for new or integrated services –** As health centers plan to either expand or reorganize their workforce to support integrated HIV and primary care services, including nontraditional billable providers on their multidisciplinary HIV Care Teams can support sustainability through increased revenue and improvement in clinical outcomes for patients with HIV. Health centers should research their state regulations and clinical licensure system to determine whether community health workers and certified allied health professionals are considered billable providers for specific services.

- **Expand partnerships with community-based organizations (CBOs) or hospital networks –** Planning for early engagement of CBOs or hospital networks can help increase patient engagement and retention in care, as well as enhance sustainability through sharing staff capacity and cost across agencies. **Damian Family Care Center (Queens, NY)** partnered with a CBO that provided services to young men who have sex with men (YMSM) of color to increase prevention services for high-risk HIV-negative patients. The health center provides medical and PrEP services, while the CBO provides engagement, retention, and adherence support for the YMSM receiving PrEP services. This partnership allows both organizations to provide sustainable services across two boroughs in New York.

Fundamentally, sustainability planning requires that health centers remain aware of the evolving challenges and opportunities related to program implementation and payment, as well as remain flexible to adapt to these changes in real time while maintaining program continuity.

Following are tools to support sustainability planning for health centers integrating HIV services into primary care.

Tool for Assessing Project Sustainability

Washington University of St. Louis Center for Public Health Systems Science

PROGRAM SUSTAINABILITY ASSESSMENT TOOL

The Program Sustainability Assessment Tool (PSAT) is a 40-item self-assessment that program staff and stakeholders can take to evaluate the sustainability capacity of a program.

The PSAT measures sustainability capacity across eight domains:

- Environmental support
- Funding stability
- Partnerships
- Organizational capacity
- Program evaluation
- Program adaptation
- Communications
- Strategic planning

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Tool for Sustainability Planning

High Impact Care and Prevention Project (HICAPP)
Sustaining Integrated Routine Testing Workplan

This workplan was developed based on input from the New York State Department of Health and partner P4C health centers. The workplan provides a structure for ensuring continuous support and improvement for routine testing in the health centers. It includes activities identified as being supportive of sustainability, the person responsible for completing the activity, and a timeframe for when the activity should be completed.

Module 2

Implementing
HIV CARE INTEGRATION

Module 2
Implementing HIV Care Integration

After a series of steps to address planning and readiness for HIV-service integration, health centers begin providing HIV services to their patients.

Some health centers may offer a full complement of services, from HIV testing through antiretroviral therapy (ART) treatment and monitoring, while others may offer a subset of steps in the HIV care continuum. During the implementation, health centers must keep in mind the decisions made during the planning stages to ensure that the work aligns with agreed-upon policies, procedures, and resource allocation. It may be tempting to expand activities during implementation, especially if early outcomes are favorable (e.g., significant patient interest in additional services); however, program sustainability and effectively implementing planned activities requires a careful and deliberate rollout of services that are in line with the original plan.

Health centers are positioned to support each stage of the HIV care continuum. They play a critical role in facilitating efficient progression through HIV diagnosis and receipt of treatment, both by providing direct services and by empowering people living with HIV (PLWH) to become active participants in their care through patient education.

The patient-centered medical home (PCMH) model has the potential to dramatically improve health care provision for PLWH. By receiving care that is comprehensive, patient-centered, and coordinated, with consistent and rapid access to services, PLWH are more likely to be rapidly linked to care, and ultimately achieve viral suppression. Even if a health center is not formally a PCMH, the resources in this toolkit can support many aspects of the PCMH model.

The tools in this module will help health centers as they begin to provide HIV services within their existing primary care model. These tools include trainings, document templates, and best-practice guidance to support implementation. The selected tools reflect those that P4C health centers and/or health departments found useful during their integration planning, including those that were developed as a result of their efforts.

This module, Implementing HIV Care Integration, features tools addressing the following areas:

- Supporting Routine HIV Testing with Linkage to Care
- Supporting Retention and Engagement in Care
- Supporting Initiation of ART
- Supporting Viral Suppression
- Supporting Prevention for Persons at High Risk

Health centers may use the tools included in this module either sequentially or focus on the sections that are most useful to their stage in the implementation process.

Supporting Routine HIV Testing with Linkage to Care

Only 20% of primary care providers (PCPs) routinely test for HIV[4]. Offering routine testing to all patients reduces late diagnosis as well as destigmatizes HIV testing by making it part of the overall standard of care. For many health centers, providing HIV testing is a first entry into HIV service integration. At this level, health centers provide screening and prevention services, provide counseling, support disclosure, promote linkage to care, and ultimately improve outcomes for patients.

Reviewing an organization's current practices, resources, and needs is an essential step for efficiently implementing HIV service integration. Every aspect of HIV diagnosis and linkage to care should be captured in the clinical workflow so each member of the multidisciplinary team knows what to do. In addition, organizations must be prepared to address complex multilevel barriers to HIV diagnosis and linkage to care on the patient, provider, and system levels. This requires that staff and providers understand key factors, including:

- Guidelines for populations that should be tested
- How to address stigma, avoidance, and discomfort
- How to enhance knowledge/ communication skills
- Opt-out testing and consent
- Types of available tests, lab orders, and reporting
- HIV testing technologies and algorithms

- Coding procedures for reimbursement
- Documentation and EHR systems
- Workflow diagrams
- Disclosure and delivery of results
- Post-test counseling and identifying community resources/partnerships

Providing patients with clear and concise information that explains why they should be tested can help improve patient-provider interactions and arm patients with tools to get more involved in their care. Educational needs differ by patient type. To have the greatest impact, efforts to reach target populations should be cultural- and audience-specific. To address the challenges they experienced when encouraging specific populations (e.g., teenagers, patients who speak a language other than English) to be tested for HIV, health centers developed tools that reflected the needs of their patients and effectively delivered educational material.

Linking patients to HIV-specific care following diagnosis is a critical drop-off point in the HIV care continuum, and thus an opportunity for health centers to leverage promising practices to improve outcomes. While they exist as distinct stages in the HIV care continuum, successful testing, diagnosis, and linkage to care practices can benefit from coordination. With coordination, transition between each component is efficient for both providers and patients. For example, implementing a testing effort without also considering how newly diagnosed persons will be linked to care may delay entry into treatment. Accordingly, many of the tools in this section address more than one component and have successfully helped health centers more rapidly implement cohesive service delivery.

Integration Spotlight

Reporting and Data Review

Mattapan Community Health Center (Mattapan, MA) developed a robust reporting and data review process for the HIV P4C team that outlines quality improvement (QI) initiatives and goals to increase internal HIV lifetime test-ing (i.e., at least one HIV test in a lifetime) rates and guideline-driven care for patients diagnosed with HIV and cared for in the health center. The HIV Care Team met weekly with the CMO to review HIV testing data and identify challenges to achieving testing targets and linkage to care.

The health center set a QI goal of achieving greater than 50% lifetime HIV testing at routine health center visits. This goal was achieved in less than a year by using the weekly reporting function to:

- Monitor HIV testing trends at the individual provider and health center levels over time.
- Create targeted intervention plans to improve HIV testing rates among specific providers and at the health centers (e.g., use of daily visit planner, provider specific training, etc.).
- Measure effectiveness of interventions.

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[4] Cohan, D., Gomez, E., Dowling, T., Zetola, N., Kaplan., Klausner, JD. (2009). HIV testing attitudes and practices among clinicians in the era of updated Centers for Disease Control and Prevention recommendation. *Journal of Acquired Immune Deficiency Syndromes,* 50(1), 114-116.

Tools for Implementing
Routine HIV Testing and Linkage to Care

Sample HIV Testing Algorithms and Workflows

Implementing workflow changes early in the process and ensuring consistent use by all staff can support the sustained changes needed to fully integrate HIV testing into service provision.

WHITTIER STREET HEALTH CENTER (BOSTON, MA)

HIV Testing Algorithm

This tool outlines the steps for HIV testing, both in a rapid-test setting and during a routine clinic visit.

THE COMMUNITY CLINIC, INC. (GREENBELT, MD)

Routine HIV Testing Workflow

This tool describes each step of the HIV testing by staff member (e.g., medical assistant, providers, phlebotomist). It also includes specific protocols for post-testing support for rapid and blood collection tests, including linkage to care.

COMMUNITY HEALTH CENTER OF BUFFALO, INC. (BUFFALO, NY)

HIV Testing Workflow

This tool assists with managing routine HIV testing by assessing initially if a patient is up to date on HIV testing. The workflow describes steps to take when a patient declines or accepts a test, as well as for post-test activities (for both negative and positive results).

WHITTIER STREET HEALTH CENTER (BOSTON, MA)

HIV In-Clinic Testing Workflow

This tool outlines the roles of the provider and the HIV care team for in-clinic HIV testing.

Resources for HIV
Testing in Clinical Settings

The CDC has a number of resources on HIV Testing in Clinical Settings. Resources of particular relevance to the P4C project, include:

- Implementation of Routine Testing in Health Care Settings: Issues for Community Health Centers
- Evaluation Toolkit: Patient and Provider Perspectives about Routine HIV Screening in Health Care Settings

The HIV Screening. Standard Care.™ program gives PCPs new tools to help ensure all patients are tested for HIV at least once in their life. Program tools include a resource toolkit, with posters, patient brochures, and guides for clinicians. The program also supports the HIV Screening. Standard Care.™ Resource Center which offers free medical and nursing education opportunities plus scientific articles for clinicians to learn evidence-based approaches to incorporating HIV screening in their practice. Serostatus Matters is a video-based educational program designed to help health care providers incorporate routine screening of HIV into their clinical practice. The program consists of four modules that discuss the importance of routine HIV screening, practical considerations for HIV screening implementation, and communicating test results with patients including counseling a newly diagnosed patient. It features a series of physician–patient vignettes that model these important behaviors. Serostatus Matters has received both CME and CNE accreditation from Tufts University.

Tool for Monitoring Routine HIV Testing

Community Clinic, Inc. (Greenbelt, MD):
HIV Testing Competency-Based Validation Form

With this tool, health centers can assess staff competency (both self- and observer-evaluated) on: identifying patients for testing, offering, and ordering an HIV test, conducting the test, documentation, and patient follow-up. This form captures whether the criteria were met and if any additional actions are needed.

Tools and Resources for Post-Test Services

Managing post-testing requires developing pathways for patients who test negative (e.g., ways to stay HIV-negative through prevention), as well as guiding next steps to provide services to those who test positive (e.g., additional testing needs, linkage to care resources).

Community Health Center of Buffalo, Inc. (Buffalo, NY):
Negative HIV Result Information Sheet

This resource can be given directly to patients who test negative for HIV. It explains what the result means and includes information on HIV prevention, when or if an individual should consider subsequent testing, and links to additional local resources.

Whittier Street Health Center (Boston, MA): LAB Fast Lane Algorithm

This simple resource prioritizes lab work for patients newly diagnosed with HIV via four quick steps that can help reduce stress for newly diagnosed patients due to long delays for further testing.

P4C HIV TAC: Tips on Delivering a Positive HIV Test Result

This one-page tool provides tips and recommendations for health center staff on delivering HIV testing results, with a focus on positive test results. The tool suggests information to provide, tips on managing patient and provider reactions to the test results, steps for follow-up, and special considerations when delivering results to pregnant women.

Tools for Supporting HIV Testing Patient Education

Community Clinic, Inc. (Greenbelt, MD): Routine HIV Testing Application (Android)

This app was developed to support routine HIV testing in the health center, and can be used to educate patients about HIV, the importance of HIV testing, and ways in which testing is conducted. The app features a short, approximately 2-minute animated video with narration in 10 languages: English, Spanish, French, Amharic, Arabic, Portuguese (Brazilian), Kinyarwanda, Burmese, Chinese (Mandarin), and Swahili. The app is currently developed for use on mobile devices using the Android operating system (e.g., tablets, mini tablets, smartphones). The app is not available in the Google play store. You may directly download it here.

Community Health Center for Buffalo, Inc. (Buffalo, NY): HIV Testing Education Materials

Teens, Parents, & HIV Testing

This one-page resource focuses on educating teenagers and parents/guardians about reasons for HIV testing, consent, privacy issues, and payment responsibilities. While the content was developed to reflect policies specific to New York, the format is easily adaptable for use in any state.

Why YOU Should Have Your HIV Test Today!

This factsheet highlights the reasons for HIV testing, as well as common routes of infection. In addition, this resource helps destigmatize routine HIV testing, and provides reassurance about treatment options, confidentiality, and the simple nature of the test.

Tools and Resources for Linking Patients to Care

Linkage to HIV services can take place within a health center or involve referrals to partner organizations. The following tools and resources have helped health centers understand potential barriers and develop strategies for rapid and effective linkage to care.

CDC: Anti-Retroviral Treatment and Access to Services (ARTAS) Intervention

ARTAS is an individual-level, multi-session, time-limited intervention to link individuals who have been recently diagnosed with HIV to medical care. ARTAS is based on the Strengths-based Case Management (SBCM) model, which is rooted in social cognitive theory (particularly self-efficacy) and humanistic psychology. SBCM is a case management model that encourages the patient to identify and use personal strengths; create goals for himself/herself; and establish an effective, working relationship with the linkage coordinator.

Mattapan Community Health Center (Mattapan, MA): Patient Access to HIV Care Workflow Map

This resource was developed to guide the workflow from HIV diagnosis through linkage and engagement in care, and describe to others in the health center how patients are navigated through the HIV services.

Supporting Retention and Engagement in Care

Several studies have demonstrated that optimal engagement and retention in HIV care correlates with favorable HIV-related health outcomes and reduced mortality. A positive patient-provider relationship is a key component of engagement and retention in care. Many of the P4C health centers used motivational interviewing (MI) to enhance the relationship. MI can be a powerful tool to develop trust and clear lines of communication between providers and patients. MI supports discussing specific goals with patients and motivating them to become active participants in the process by making positive decisions. For individuals managing HIV infection, MI can improve how patients progress through the HIV care continuum by motivating them to remain involved in their care and engage (or reengage) with providers.

Engagement and retention are not separate components, but rather parts of a coordinated process in patient-centered care. Care coordination and medical case management play a key role in patient-centered care, providing holistic, coordinated, and integrated services from multiple systems and providers. For example, this process may require the entire HIV team meet to review cases, visits, medical visits, missed appointments, labs, and medication adherence, and to develop methods to manage complex cases. The team also must ensure that the systems are in place to address the nonmedical psychosocial and community needs and potential barriers that patients may face.

The following components of these services are particularly beneficial in supporting engagement and retention:

- Medical care coordination (i.e., tracking appointments or communicating with providers)
- Benefits counseling
- Medication adherence support
- Housing advocacy
- Social services coordination
- Substance use risk reduction and treatment
- Mental health care
- Sexual health promotion
- Culture and language competency

A more difficult task for health centers is to develop a system for monitoring and measuring patient engagement and retention in care. Although engagement and retention quality indicators and standards usually measure health center visit constancy and/or missed visits, it is important to use a flexible approach that can be adapted to the changes in the individual's health status, clinic policies, or community context. This can be additionally complex in cases where patients select outside providers for their HIV care, but remain at the health center for primary care. In these instances, partnerships between the health center and outside agencies can strengthen the overall management by supporting referrals to care and increasing care coordination. The P4C health centers developed useful tools to document workflow, case management, and patient retention.

Integration Spotlight

Using Medical Case Management to Enhance Retention and Engagement

Lowell Community Health Center (Lowell, MA) implemented medical case management to provide support to newly HIV-diagnosed patients as they transition into HIV care and treatment. The medical case managers (MCMs) conduct initial needs assessments, schedule medical appointments, attend clinic visits, coordinate with pharmacy staff, and provide encouragement to newly diagnosed patients to attend appointments and adhere to medication. MCMs also facilitate support groups, conduct outreach and re-engagement services, provide patient education, and connect patients to supportive services.

The MCMs at Lowell play a significant and crucial role in engaging and retaining HIV-positive patients in care. Patients see their providers every three - four months, but come in and connect with their MCM on a regular basis to ensure all their needs are being met and to build relationships of trust.

Maintaining accurate and up-to-date patient records, and ensuring that the interdisciplinary team has access to those records, is a key component to effectively identifying patients in need of or lost to care, as well as prioritizing efforts for engagement. **Mattapan Community Health Center (Mattapan, MA)** successfully developed an interdisciplinary HIV medical care and case management tool that is updated in real time when patients are at medical visits, on the telephone, or engaged in case management or outreach. Information captured in the tool includes the following:

- Identifying information (e.g., name, medical record number, DOB, gender)
- Medical care plan description
- Case management plan description
- Medical release status
- Primary care provider (PCP) (i.e., usual PCP or PCP at P4C health center, if different)
- HIV testing information (e.g., date of HIV-positive testing status, confirmatory HIV test date)
- Linkage to care information (e.g., lost to care status or location of HIV care if linked to care)
- HIV infection status information (e.g., CD4 cell count and date, viral load and date)
- HIV care engagement information (e.g., number and date of non-HIV-related medical visits, HIV medical care at the health center/elsewhere within 90 days of diagnosis, screening for STDs within 90 days of diagnosis, prescribed ART)
- Partner services information (e.g., number of partners, information on partners' HIV status, whether interviewed by health department for partner services)

The HIV medical and case management tool is reviewed by the HIV program lead, clinical lead, program nurse practitioner, collaborating physician, outreach worker, and case manager at least monthly, if not weekly, to ensure care planning and continuity of care.

Whittier Street Health Center (Roxbury, MA) developed an easy-to-use engaging out-of-care PLWH workflow to quickly identify those who are not in care (either lost or never engaged), and refer them to medical case management. The workflow captures three primary avenues through which PLWH may interact with the health center: through self-referral at a primary care visit, self-referral to the medical case manager (MCM), or contact with an outreach worker.

Knowing the reason behind an individual's lack of engagement in care is helpful for health centers to ensure that reengagement resources are used efficiently. At times, a simple change of contact information may suggest that someone is out of care, due to difficulties reaching them. These patients are not truly lost and may be willing and able to continue engagement with their HIV care. **Community Health of South Florida, Inc. (CHI) (Miami, FL)** developed an Excel-based case conference log to track out-of-care patients, categorized by reason (e.g., lost, refusal of care, change of address, or death). The log contains basic information on each patient (name, date of birth, medical record number, telephone number, address, emergency contact name and telephone number, source of patient referral, additional comments, and new address or date of death, as appropriate). CHI found this tool useful for organizing and identifying why patients were out of care so that the appropriate reengagement strategies could be implemented.

Following are several tools and resources for supporting engagement and retention in care for PLWH.

Tools and Resources for Fostering Patient-Provider Relationships

P4C HIV TAC

Motivational Interviewing: A Recipe for Patient Engagement in HIV Treatment and Care

The P4C HIV TAC developed a webinar on motivational interviewing (MI) to encourage health professionals to apply MI principles to motivate PLWH to engage in care and behavior change. The webinar focuses on the application of MI to deliver person-centered HIV treatment and care, the fundamental principles of MI, the core MI communication skills and their role in the MI process, and the role of self-efficacy in behavior change, and engaging patients in HIV treatment and care.

Mountain Plains AIDS Education and Training Center (AETC):   All Motivational Interviewing All the Time — Pocket Guide for Health Coaches

This 2-page pocket guide details steps of the MI process and strategies – for both providers and patients – to build strong and effective relationships. The pocket guide is available for download.

Tool to Support Medical Case Management

Mattapan Community Health Center (Mattapan, MA): HIV Medical Care Case Management Tool

This tool was developed to track patient care and case management at the health center to enhance engagement and retention in care. The tool was also used to develop care coordination reports and facilitate CQI efforts around documentation.

Resource for Engaging Mobile Patients

P4C HIV TAC: Continuity of Care for Mobile Patients with HIV/AIDS

Creating a PCMH can be challenging but not impossible for patients with high mobility, such as migratory and seasonal agricultural workers or those experiencing housing instability. Self-management is an important skill for all PLWH to possess, but is even more vital for mobile patients. The webinar Continuity of Care for Mobile Patients with HIV/AIDS, developed by the P4C HIV TAC, describes:

- Key issues facing mobile PLWH.
- Practices that providers and case manager can use to promote self-management and engagement, including the "Five A's" approach (Assess, Advise, Agree, Assist, and Arrange).
- Case studies on a pregnant HIV-positive agricultural worker and an individual living with HIV and tuberculosis.

Tools for Addressing Prevention among PLWH

University of California San Francisco (UCSF): Positive Prevention Toolkit

One component of ongoing engagement with PLWH is the inclusion of prevention messages. The UCSF School of Nursing developed the **Positive Prevention Toolkit** to assist health care providers and counselors in delivering effective positive prevention messages during routine interactions with patients. Positive prevention focuses on reducing the risk of HIV transmission by PLWH and is distinct from prevention for high-risk negative patients. The toolkit includes a variety of resources on how to facilitate positive prevention training, such as:

- A detailed curriculum, including information on target audience and training length (ranging from 90 minutes to 4 weeks)
- Training and integration manuals and facilitation guides
- Factsheets on HIV prevention
- Personal narratives from PLWH

More information about the toolkit is available here.

CDC: Prevention IS Care Campaign

The Prevention IS Care campaign provides evidence-based tools – including educational brochures, in-practice tools, continuing medical programs, and additional resources such as exam room wall posters – to assist health care providers in motivating PLWH to live longer, healthier lives through retention in care, ART initiation and adherence, as well as avoiding co-infections.

CDC: Prevention with Partners of Persons with HIV Website

The Prevention with Partners of Persons with HIV website provides guidance on services directed at sexual partners and drug-use partners of PLWH. These resources were developed to support prevention, medical, and social services.

CDC: HIV Treatment Works Campaign

The HIV Treatment Works campaign includes resources that highlight how PLWH are staying healthy and overcoming obstacles to getting and staying in care. The campaign website features video personal stories from PLWH, as well as a number of informational materials, posters, infographics, and digital tools.

Supporting Initiation of ART

Starting patients on ART following HIV diagnosis is the first step toward achieving viral suppression with treatment. According to the U.S. Department of Health and Human Services' Guidelines for the Use of Antiretroviral Agents in HIV-1-Infected Adults and Adolescents, ART should be initiated as soon as possible and continued indefinitely for all PLWH, regardless of CD4 cell count. Because ART is administered for life, patient education is an important component of treatment initiation. Historically, patients diagnosed with HIV were referred to follow-up care for additional education and ART initiation. Current recommendations are for early treatment, in some cases at the time of diagnosis. Results from the RAPID (The Rapid ART Program Initiative for HIV Diagnoses) study at UCSF and San Francisco General Hospital, which offered same-day ART to newly diagnosed PLWH, led to a high rate of treatment uptake (90% for same-day treatment) and more rapid viral load suppression than standard practices (75% viral suppression within 3 months).[5]

By integrating HIV services into primary care, health centers have an opportunity to decrease the possibility of losing patients to follow-up by using coordinated care activities and expediting ART initiation.

[5] Pilcher, CD., Ospina-Norvell, C., Dasgupta, A., Jones, D., Hartogensis, W., Torres, S., Calderon, F., Demicco, E., Geng, E., Gandhi, M., Havlir, DV., Hatano, H. (2017). The Effects of Same-Day Observed Initiation of Antiretroviral Therapy of HIV Viral Load and treatment Outcomes in a US Public Health Setting. *Journal of Acquired Immune Deficiency Syndromes* 74(1), 44-51.

Following are several tools and resources that will assist with initiating ART in the primary care setting.

Tools and Resources for Initiating ART

San Francisco Department of Public Health

PROGRAM FOR RAPID ART INITIATION AND LINKAGE TO CARE

RAPID (The Rapid ART Program Initiative for HIV Diagnoses) is a clinical program being implemented throughout San Francisco that extends the concept of universal ART to include immediate linkage to HIV care and ART initiation at the time of HIV diagnosis. The potential benefits of RAPID are improving individual patient health by decreasing the time to virologic suppression and improving rates of early engagement and possibly long-term retention in care. Resources related to the program include a quick illustrated guide on why and how to implement the RAPID program, and a standard operating procedures document. The steps and concepts of the RAPID program can be adapted for health centers in other cities.

Supporting Viral Suppression

The major goal of clinical interventions for PLWH is long-term viral suppression. Suppressing HIV can preserve immune function, increase life expectancy, and significantly reduce transmission of HIV. Because ART treatments are highly effective, poor viral suppression is often due to low ART adherence or disengagement from care.

For health centers implementing HIV treatment, practices that support patient adherence and engagement with providers are key for achieving and sustaining suppression. As with HIV service integration in general, coordination among all those supporting PLWH can also improve viral suppression outcomes. Providing or referring patients to support services that address health issues (e.g., mental health, substance use disorders, medication access), as well as other factors (e.g., housing, transportation, employment) can significantly improve the likelihood of treatment adherence and, as a result, viral suppression. While not all health centers have the resources to implement a full complement of supportive services, employing a coordinated team approach that can refer patients as needed is still a meaningful intervention that can improve outcomes.

In many cases, P4C health centers have identified that a coordinated team approach, including the efforts of nonclinical patient engagement staff, can help many patients transition from receiving ART to achieving viral suppression. **Lowell Community Health Center (Lowell, MA)** incorporated MCMs to support PLWH in their care. MCMs serve as facilitators, supporters, advocates, and educators and form temporary yet impactful relationships with patients. The MCMs included a full-time registered nurse for complex care management, medical assistant/referral specialists, and other staff with varied skills (e.g., language, cultural competence, knowledge of housing and immigration). The overarching goals of the health center's program is to integrate case management into clinical services and help patients develop self-sufficiency with their HIV care management. MCMs are integrated into a larger interdisciplinary health center team, and the medical case management approach has improved care in a number of ways:

- **MCMs and peer support staff are respected as contributing team members.** They can facilitate a more complete view of the patient, as patients often reveal information to MCMs that they may not feel comfortable sharing with their providers.

- **MCMs bring community competency to the team** and can help other team members understand issues that patients face, as well as work toward appropriate solutions.

- **MCMs bring a wealth of knowledge** about available resources of which providers may be unaware.

- **CD4 and viral load results are integrated** into patient reassessment and individual support plan documentation.

- The health center formed **cooperative relationships** with other local agencies serving PLWH.

- **The medical case management program includes a shared EHR system** that facilitates communication among all team members for medical records and patient notes.

- **MCM and peer staff connect with patients outside of the health center** through outreach and home visits to support engagement and reengagement.

Integration Spotlight

Supporting Viral Suppression through Medication Adherence

Prior to the P4C project, medication adherence monitoring and support was limited at **Jordan Health (Rochester, NY)**. With the support of the P4C, Jordan fully integrated a formalized structure for monitoring medication adherence, which included hiring full-time medication adherence staff. Strategies utilized by Jordan included contacting the pharmacy to ensure patients picked up their medication, and calling patients to remind them if they had not; notifying PCPs of needed prescriptions for patients; developing a patient dashboard; conducting home visits; and instituting pre-visit planning.

Following implementation of the enhanced medication adherence support, Jordan reported an 80% viral load suppression rate. Furthermore, Jordan has been able to replicate effective strategies for viral suppression across both health center locations that conduct HIV care and treatment.

A significant challenge for Lowell's medical case management program was the high turnover of the MCMs and challenges with sustaining their roles. MCMs provide services that are typically nonbillable; thus, grant funding may be needed to financially support these key staff positions. Overcoming these barriers by investing in employee support and program sustainability practices can help to improve staff retention and the seamless continuation of intervention efforts.

Strict ART adherence is key to sustained HIV suppression, reduced risk of drug resistance, improved overall health, quality of life, and survival, as well as decreased risk of HIV transmission. Conversely, poor adherence is the major cause of therapeutic failure. A continuum of ART adherence support services is necessary to meet individual patient needs. All HIV care team members play integral roles in successful adherence programs. Effective adherence interventions vary in modality and duration, as well as by clinical setting, provider, and patient. P4C grantees employed a variety of strategies to improve adherence to ART, including using evidence-based treatment adherence interventions (i.e., interventions from the medication adherence chapter of the CDC Compendium of Evidence-Based Interventions and Best Practices for HIV Prevention), directly observed therapy during home visits, and coordination with pharmacies to ensure patients pick-up their ART in a timely manner.

Managing HIV-HCV co-infection is another critical component of treatment for the estimated 20% of PLWH who are also living with HCV infection. Treating HCV in PLWH is important because co-infection is associated with higher rates of liver disease and increased rates of liver-related death compared to PLWH who are not infected with HCV. Unlike HIV, HCV can be cured, and HCV can be treated while a patient is receiving ART. Treating HCV in PLWH requires careful consideration of the treatments being used and the potential for side effects, including drug interactions (that may increase or decrease effective drug doses), development of secondary conditions, and effects that may hinder HIV treatment adherence.

Managing mental health and substance use disorders can also be critical to keeping people in care, as well as achieving and maintaining viral suppression. Appropriate care ideally should be provided onsite, or through appropriate referrals and good care coordination.

Following are several tools for supporting viral suppression for integrating HIV services into primary care.

Tools for Supporting HIV Viral Suppression

Resources on Supporting Viral Suppression

P4C health centers, health departments, and federal partners used various resources to support their efforts around HIV medication adherence and viral suppression. The resources below focus on the importance of medication adherence, measuring adherence, and factors that contribute to adherence. Below, find the AETC National Coordinating Resource Center and CDC's Every Dose Every Day e-learning Toolkit.

AETC National Coordinating Resource Center

HIV/HCV Co-Infection: An AETC National Curriculum

This curriculum is an evidence-based online curriculum for health care providers and trainers of health care providers to increase their knowledge on HIV and HCV co-infection among people of color in the U.S. and its territories. Topics include prevention, screening, diagnosis and treatment recommendations as well as barriers and other cofactors that may impede optimal treatment outcomes for co-infected people of color.

CDC: Every Dose Every Day e-Learning Training Toolkit

The CDC developed the Every Dose Every Day™ e-Learning training toolkit for clinical and nonclinical HIV providers who serve PLWH. The toolkit features four evidence-based medication adherence strategies that can be delivered by a variety of HIV providers, including medical providers, licensed social workers, HIV case managers, health educators, and/or peers. Continuing education (CE) is available for nurses, physicians, pharmacists, and certified health education specialists for completion of the training modules for each strategy.

The four strategies are:

- HEART (CE# WB2257) - Individual/dyadic, social support and problem-solving intervention delivered before and in the first two months after initiating ART, includes a patient-identified support partner.
- SMART Couples (CE# WB2258) - Discordant couple-level intervention, addresses ART adherence and safer sex practices within the dyad by fostering active support between partners.
- Peer Support (CE# WB2259) - Individual- and group-level intervention, where HIV-positive people, currently adherent to ART, serve as peers and provide medication-related social support.
- Partnership for Health for Medication Adherence (CE# WB2260) - Individual-level, clinic-based, brief provider-administered intervention emphasizes the importance of the patient-provider relationship to promote adherence.

Supporting Prevention for Persons at High Risk

From a public health perspective, pre-exposure prophylaxis (PrEP) may be the single best HIV intervention currently available. Daily use of PrEP can dramatically reduce the risk of HIV infection through sexual contact (>90% reduction) and injection drug use (>70% reduction)[6]. Despite the widespread availability of barrier protection options, condom use among those at high risk for HIV remains suboptimal. PrEP therefore represents an important opportunity for prevention with greater real-world efficacy. Primary care settings often face challenges with providing PrEP, including lack of awareness, confusion about the role of primary care, limited support from organizational leadership, and the absence of a patient flow process. Despite these potential barriers, the combination of high drug efficacy and once-a-day dosing make PrEP an attractive and powerful tool for preventing new HIV infection among those at high risk. While PrEP administration alone does not address other STDs, HCV, and unintended pregnancy, it does provide an opportunity for health centers to provide preventive health care over a period of time.

Understanding how and when to use PrEP in clinical practice requires a fundamental awareness of which populations may benefit from prophylaxis, what steps are needed before PrEP can be prescribed, and how to monitor those receiving medication. The Partnerships for Care (P4C) HIV Training, Technical Assistance Center, and Collaboration (TAC) facilitated a webinar entitled Practical Strategies for Implementing PrEP in a Primary Care Setting, which provided grantees with detailed guidance on implementation steps. The webinar reviewed key information from the U.S. Public Health Service's clinical practice guideline, Pre-exposure Prophylaxis for the Prevention of HIV Infection in the United States – 2014;
and focused on the following components of a PrEP program:

- Eligibility for PrEP
- Evaluation for PrEP initiation
- Initial testing for PrEP initiation
- Process for PrEP initiation and follow-up
- Discontinuing PrEP
- Supporting PrEP access

The webinar also features case studies on potential PrEP candidates and their clinical management.

Integration Spotlight

Same-Day PrEP

Codman Square Health Center (Dorchester Center, MA) developed a program that supported real-time PrEP referrals including appropriate follow-up care. Codman Square's efforts included raising awareness of PrEP among all staff and employing a health navigator to assist PrEP patients. The health navigator is a key component of the team, providing support and linkage for additional resources (e.g., housing support, behavioral disorder treatment). Same-day PrEP was also facilitated by effective relationships with the pharmacy team, PrEP providers, marketing team (to increase awareness of the program), and referral providers.
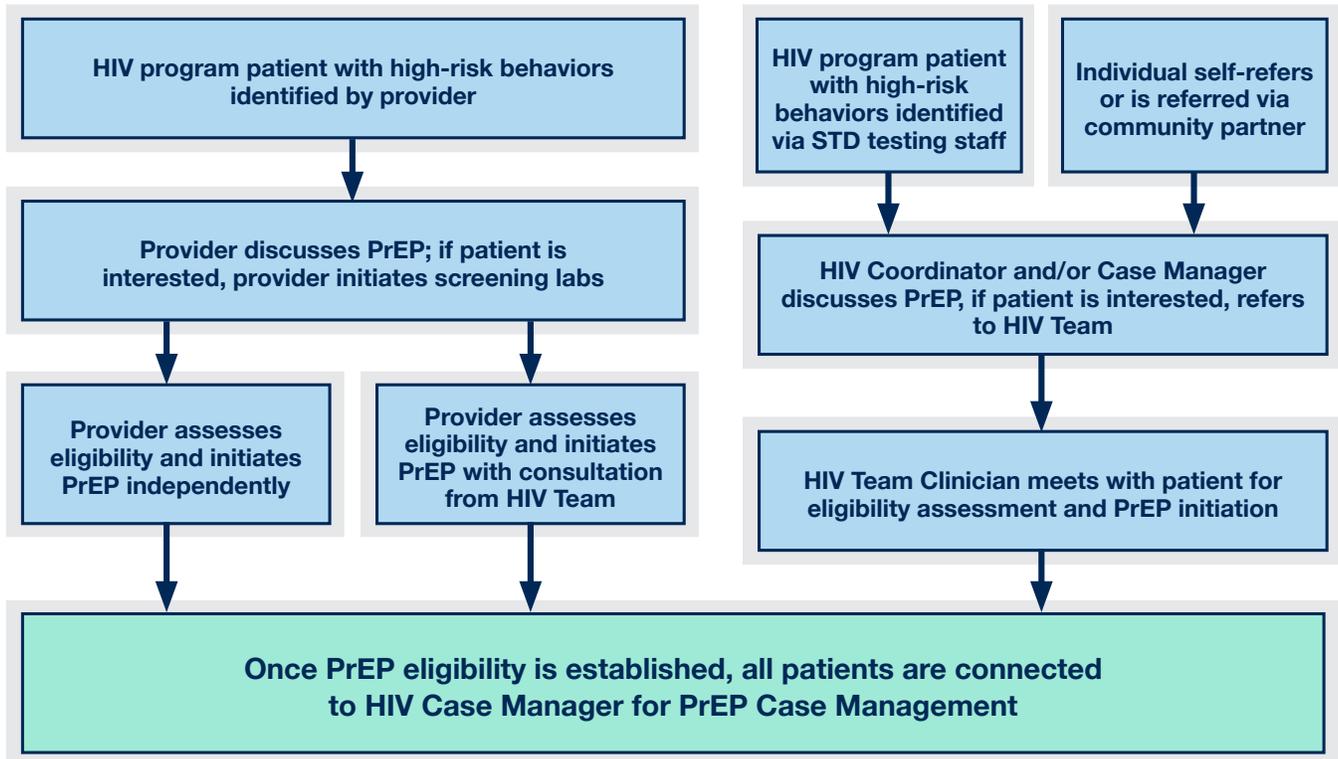
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[6] "Why take PrEP?" Accessed from https://www.cdc.gov/hiv/basics/prep.html

Mattapan Community Health Center (Mattapan, MA)
developed a PrEP Services Patient Entry to Care Workflow to
help staff determine patient eligibility for PrEP and the different staff
roles involved in the process. The workflow includes initial identification
by risk from either the provider or the patient, accommodating for the variety of
ways that discussions about PrEP may start in the primary care setting.

Mattapan Community Health Center PrEP Services Patient Entry to Care Workflow

HIV program patient with high-risk behaviors identified by provider

↓

Provider discusses PrEP; if patient is interested, provider initiates screening labs

↓

Provider assesses eligibility and initiates PrEP independently

Provider assesses eligibility and initiates PrEP with consultation from HIV Team

HIV program patient with high-risk behaviors identified via STD testing staff

Individual self-refers or is referred via community partner

↓

HIV Coordinator and/or Case Manager discusses PrEP, if patient is interested, refers to HIV Team

↓

HIV Team Clinician meets with patient for eligibility assessment and PrEP initiation

↓

Once PrEP eligibility is established, all patients are connected to HIV Case Manager for PrEP Case Management

While guidelines on who may be a candidate for PrEP are well described, understanding degrees of risk for HIV infection, and thus who may benefit the most from PrEP, can be difficult to determine. **Community Health Center of Buffalo (CHCB) (Buffalo, NY)** developed a simple tool to stratify risk and tailor outreach efforts by risk group. CHCB aimed for a 10% increase in patients actively taking PrEP, and this tool, Using HIV Risk Stratification to Guide PrEP Outreach and Prescribing, helped CHCB work toward their goal.

The risk stratification considers five main categories and assigns a "risk point" of one for each of the following criteria:

- Age 18-64
- Black (Hispanic or non-Hispanic) or Latino ethnicity
- History of injection drug use
- Sexual history (men who have sex with men (MSM), multiple partners, sex exchanged for money or goods)
- History of an STD or HIV exposure

The total number of risk points correspond to a scale of risk category and appropriate outreach actions.

Risk Category	Number of Points	Outreach Actions Taken
Low Risk	1	Patient offered testing as part of medical visit by medical support staff. Patient given brochure about PrEP by medical staff as part of routine care.
Fair Risk	2	Patient offered testing as part of medical visit by medical support staff. Patient given brochure about PrEP by medical staff as part of routine care. Patient offered HIV testing at least biannually.
Medium Risk	3	Patient offered HIV test, as part of visit, with HIV coordinator, if possible. HIV coordinator gives retesting counseling including PrEP information. Patient offered HIV testing biannually.
High Risk	4	Patient offered HIV test, as part of visit, with HIV coordinator, if possible. HIV coordinator gives retesting counseling including PrEP information. Patient offered HIV testing quarterly. HIV coordinator contacts patient quarterly to touch base, remind of testing. Push PrEP. Patients added to Elevated Risk listing. Mailing sent out about PrEP and HIV awareness events.
Very High Risk	5	Patient offered HIV test, as part of visit, with HIV coordinator, if possible. HIV coordinator gives retesting counseling including PrEP information. Patient offered HIV testing quarterly. HIV coordinator contacts patient quarterly to touch base, remind of testing. Push PrEP. Patients added to Elevated Risk listing. Mailing sent out about PrEP and HIV awareness events.

*Following are tools to support prevention for HIV negative individuals
in integrated HIV and primary care services.*

Tools for Integrating PrEP into Primary Care

Center for AIDS Research, University of Alabama at Birmingham

Preventing HIV Infection in the Primary Care Setting: The Role of Pre-Exposure Prophylaxis

This educational module, offered through Medscape, will assist health centers in the early stages of implementing PrEP into their practice. The module features a panel discussion of:

- The role of PrEP in HIV prevention efforts
- Key recommendations from the CDC's PrEP guidelines
- Strategies to integrate PrEP in the primary care setting, for patients at risk of HIV infection

An active Medscape account is required to access the module; it is free to register for an account.

Sexuality Information and Education Council of the United States

PrEP Education for Youth-Serving Primary Care Providers Toolkit

This toolkit is for organizations conducting PrEP education for youth populations (adolescents to 25 year-olds). It is a comprehensive resource designed specifically for PCPs looking to improve their skills at educating, counseling, and prescribing PrEP to youth. Included in the toolkit are descriptions and tools covering:

- **Clinical tools** (PrEP basics, policies for offering PrEP primary care, policies for sexual history-taking, background on adolescent development)
- **Billing for PrEP** (billing and coding, patient factsheet on getting access to PrEP, estimating PrEP cost under insurance)
- **HIV, stigma, and social determinants of health** (youth and social determinants, cultural competence, special populations)
- **Youth and HIV laws and policies** (policy considerations, list of state policies)
- **Additional resources** (PrEP and post-exposure prophylaxis (PEP) basics, practices for serving youth, creating a welcoming practice, patient tools)

Project Inform: Getting PrEPPED Infographic

Project Inform has developed a PrEP Flow Chart – a two-page resource that will help patients who are concerned about the costs of PrEP navigate the process. Health centers can use this tool during outreach to provide patients information on how to get started on PrEP and provide steps and resources to gain access to medication. Resources and guidance for patients includes patient and medication assistance programs, in-network pharmacy benefits, and opportunities for health coverage through Medicaid or insurance market places.

HRSA Technical Assistance Resource

Health Center Provision of HIV PrEP highlights information and resources for the provision of HIV PrEP in health centers including summary guidelines for PrEP and information on reimbursement for PrEP; it also links to resources for providers and consumers about this service.

P4C HIV TAC Resources

The P4C HIV TAC has developed resources to support organizations as they implement PrEP into their clinical practice. The following slide decks address various aspects of PrEP and describe real-world issues and solutions for integration efforts. These tools can help health centers by describing patient characteristics as they might present to a provider and describing the questions to ask to support clinical decision-making.

- Practical Strategies for Implementing PrEP in a Primary Care Setting identifies key steps in developing a PrEP program, including: patient identification, identification of the clinical setting for care, assembly of a multidisciplinary team, protocol development, education and outreach, treatment enrollment, adherence support, and on-treatment monitoring. The presentation features a case-based approach to describe how health centers can manage PrEP, from patient identification to long-term follow-up. A provider quick-reference guide was developed from the slide content.

- Implementing PrEP in Clinic describes the process by which a federally qualified health center developed a PrEP clinic within their primary care service delivery model. The presentation discusses the program timeline, clinic roles and workflow, strategies for enhancing patient adherence, electronic documentation, and challenges and solutions.

- PrEP Services and Approaches: Its More than Just Meds explores the four core elements of a comprehensive PrEP program: education, insurance/payment, medical, and pharmacy. It also discusses common facilitators and barriers to the success of a PrEP program.

Module 3

Sustaining
HIV CARE INTEGRATION

Module 3

Sustaining HIV Care Integration

Having adequate levels of financial support for continued HIV care integration – including when changes in resources, leadership, and/or policy occur – is necessary for ensuring that People Living with HIV (PLWH) have uninterrupted access to high-quality care.

Sustainability generally refers to consistent financial support for program continuity. However, there are many areas in addition to funding that can contribute to sustainability. Throughout the project, as part of their integration efforts, P4C health centers worked to develop strategies for sustainability beyond the P4C funding period. Many of these strategies are reflected in Modules 1 and 2 of this toolkit and emphasize the need for organizational alignment, dynamic and effective partnerships, and ongoing staff training. This module focuses on ways to maximize existing financial practices so that patient interactions and funding approaches are fully leveraged. Ideally, health centers should foster long-term relationships with other organizations to coordinate activities and share resources. They should also strategically seek funding from a variety of sources, minimizing the risk of a decline in resources if funding is discontinued.

The tools in this module include trainings, document templates, and best-practice guidance to support program/system sustainability. The following presents tools that P4C health centers and/or health departments either developed or found useful for supporting sustainability efforts, including those that were developed as a result of their efforts.

This module, Sustaining HIV Care Integration, features tools addressing the following areas:

Enhancing Billing for HIV Services

Supporting Diversification of Funding Streams

Enhancing Billing for HIV Services

Health centers that are integrating HIV services into existing primary care services need to ensure that appropriate medical coding and billing for reimbursement are used in their HIV practices. The mission of health centers is to provide primary care services. Health centers that are integrating HIV services into primary care services understand the complexity of billing and coding, and need to ensure appropriate billing and coding for reimbursement is used in their HIV practices. It will be necessary to train staff on HIV-specific items, including how to include these terms in electronic health records (EHRs) and information for billing.

The P4C HIV TAC partnered with HealthHIV to deliver a four-part webinar series about understanding and using billing and coding for HIV services. The webinars present definitions, key terms, and the appropriate application of codes for HIV services in the following areas:

Part 1 - Maximizing Third-Party Reimbursement through Enhanced Medical Documentation and Coding

- Current Procedural Terminology (CPT) codes and commonly used modifiers
- Office visit evaluation and management codes
- Coding for new patients versus established patients
- Differences between coding for preventive medicine visits versus preventive medicine counseling visit codes

Part 2 - Pathology and Laboratory HIV/AIDS CPT Codes

- CPT codes and Healthcare Common Procedure Coding Systems (HCPCS) codes and commonly used modifiers
- HCPCS codes necessary to report HIV pre-testing, HIV counseling (without pre-testing), HIV post-testing negative counseling, and HIV post-testing positive counseling

Part 3 - HIV Care Diagnoses Codes

- Identification and differentiation of ICD-10-CM (International Classification of Diseases 10th Revision, Clinical Modification) codes and guidelines that describe HIV/AIDS patient care
- Diagnostic code selection process
- Importance of proper coding sequencing

Part 4 - Wrap-Up – Coding Scenarios

- CPT, HCPCS, and ICD-10-CM codes
- Various coding scenarios that illustrate accurate reporting of the codes for HIV/AIDS medical care
- The importance of proper reimbursement documentation

In addition to this comprehensive description of HIV codes and examples of their use in clinical practice,

the following resources helped P4C health centers with training staff and developing procedures to accurately document and submit reimbursements for HIV care.

Tools and Resources for Enhancing Billing for HIV Services

National Association of State and Territorial AIDS Directors (NASTAD) Billing and Coding Resources for Health Centers and Health Departments

Financing HIV Prevention Services: Collaboration and Innovation between Public Health and Medicaid Agencies

This white paper, developed by NASTAD in collaboration with Health Management Associates, highlights examples of innovative Medicaid partnerships and financing arrangements for HIV prevention services from four jurisdictions.

Billing Coding Guide for HIV Prevention:
PrEP, Screening, and Linkage Services

This guide, developed by NASTAD in collaboration with a coding consultant and the HIV Medicine Association, assists health departments and their contracted providers navigate billing and reimbursement for HIV prevention services.

Supporting Diversification of Funding Streams

One approach to achieving greater financial stability is diversifying funding streams so that efforts are not dependent upon a single, and potentially one-time, source of money. Effective diversification requires health centers to stay abreast of available funding opportunities and mechanisms, to practice strong budgetary management techniques and processes, and to have expertise in maximizing fees and reimbursements. Often the responsibility for identifying available funding sources falls to grants or financial staff. Close communication and coordination between grants staff and clinical program managers can help identify opportunities. This should be an ongoing process (considered during planning and implementation), so that health centers can maximize existing opportunities to gain financial support.

Examples of approaches taken by P4C health centers to diversify funding for integrated HIV and primary care services included the following:

- **Application for Ryan White HIV/AIDS Program (RWHAP) funding –** The RWHAP provides a comprehensive system of care that includes primary medical care and essential support services for PLWH who are uninsured or underinsured. The majority of RWHAP funds support primary medical care and essential support services. Part C provides grant funding to organizations to support outpatient HIV early intervention services and ambulatory care. Part D provides grant funding to support family-centered, comprehensive care to women, infants, children, and youth living with HIV. Health centers may also want to consider applying for Part A or B funds for core medical or support services through their state or city/county health department.

- **Expansion of pharmacy services through the 340B Program –** The 340B Program expands access to affordable outpatient prescription drugs by requiring pharmaceutical manufacturers that enroll in the Medicaid Drug Rebate Program to offer their drugs to eligible safety net providers at a steep discount. Safety net providers eligible to participate in the 340B Program, including HRSA-funded health centers, provide health care services to underserved communities or to patients with medical conditions that are unduly expensive to treat, such as HIV. By saving money on the cost of outpatient drugs, the 340B Program enables health centers to allocate more resources toward expanding needed health services.

- **Development of cost-sharing arrangements with partner organizations for care and treatment services –** Here is an example of cost-sharing arrangements that P4C grantees participated in: sharing primary care providers' (PCP) time and costs with a partner agency, such as a hospital or RWHAP-funded clinic. This arrangement allows the health center to incur provider costs in proportion to their patient needs. Another example of a cost-sharing arrangement is to partner with an organization that conducts in-house processing for laboratory samples, specifically blood samples for 4th generation HIV testing. This type of arrangement allows the health center to enhance routine HIV testing procedures while realizing cost savings for lab processing.

- **Development of partnerships with community-based organizations and local health departments to pursue additional grant/cooperative agreement funding –** P4C health centers have partnered with community-based organizations (CBO) to increase patient engagement with specific high-risk populations, such as young men who have sex with men (YMSM). These types of partnerships allow the health center to pursue grant or cooperative agreement funding for non-reimbursable services for these populations. For example, a health center may partner with a CBO to pursue grant funding for expanding pre-exposure prophylaxis (PrEP) services for YMSM (see discussion on page 28 of partnership between Damian Family Health Center (Queens, NY) and CBO).

Below is a resource supporting diversification of funding streams.

Resources to Support Diversification of Funding Streams

HealthHIV: Fiscal Vault: Unlocking Innovative Fiscal Health Resources

HealthHIV's Fiscal Vault: Unlocking Innovative Fiscal Health Resources is an interactive portal designed to strengthen and sustain fiscal management of health care organizations. The resources cover topics related to health systems, grants management, and profit and sustainability.

Cross-cutting Elements for Integration

This toolkit contains resources that can support health centers at each of the three main stages of HIV service integration: Planning, Implementing, and Sustaining. There are a number of elements that span the stages of service integration, and are important to consider in each stage. These elements were identified by the P4C health centers and health departments as supportive of integration along the continuum. The selected tools may be appropriate for use at any point in the integration, and are presented in this section:

This module, Cross-cutting Elements for Integration, features tools addressing the following areas:

Enhancing Cultural Competence of Patient Services

Collection and Use of Data

Quality and Process Improvement

Technical Assistance and Training

Enhancing Cultural Competence of Patient Services

Culturally competent services are an essential component to providing care for people living with HIV (PLWH), in part because many populations that are disproportionately affected by HIV are also marginalized and/or stigmatized by the health care system and society. Culturally competent patient services can increase the effectiveness of engagement efforts, more efficiently build trust between PLWH and the health center, promote patient advocacy and engagement in their care, and ultimately support successful progression along the HIV care continuum. The diversity of individuals seeking care from health centers spans race, ethnicity, gender, sexual orientation, nationality, and primary language. Effective engagement and service provision require an understanding of the specific needs and challenges facing various populations, as well as the implementation of concrete actions to support appropriate patient interactions.

A key aspect of integrating HIV services is ensuring that patients, particularly PLWH, feel welcomed and accepted. HIV-related stigma can be defined as "a process of devaluation of people either living with or associated with HIV and AIDS[7]." Stigma can pose a major barrier to addressing the HIV epidemic. HIV stigma can prevent individuals from seeking information about HIV, reduce the likelihood of testing, and delay successful progression along the HIV continuum of care. Stigma and discrimination can be overcome through education and training. This can be lengthy and ongoing because the sources of stigma must be recognized and the associated perspectives need to shift. Establishing organizational policies that promote and maintain a stigma-free environment is useful for supporting both providers and patients.

The P4C health centers identified staff training and organizational technical assistance (TA) that addressed a number of cultural competency topics and were integral to successfully delivering integrated HIV and primary care services.

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[7] National AIDS Control Organization, National Consultation on HIV estimates/surveillance India 2004: Policy and Programme Implications.

Key topics included:

- Addressing stigma and discrimination for PLWH and lesbian, gay, bisexual and transgender (LGBT) patients
- Addressing cultural competency for LGBT populations
  - Providing an inclusive and affirmative health care environment
  - Meeting the health care needs of LGBT patients
  - Clinical considerations for transgender health
  - Reaching young men who have sex with men (YMSM) and engaging them in care
  - Effective communication with LGBT patients
- Engaging immigrant and refugee populations in HIV services
- Engaging agricultural workers in integrated HIV and primary care services
- Engaging older populations (50+ years old) in HIV care and treatment services
- Establishing and maintaining culturally competent environments for racial and ethnic minorities: African Americans, Hispanic/Latino, Caribbean, and Asian Americans
- Using the Culturally and Linguistically Appropriate Services (CLAS) Standards to Enhance Cultural Competence in Integrated Care

Following are several resources for enhancing cultural competence among those providing services to patients.

Resources to Support Culturally and Linguistically Appropriate Service Provision

HHS
Think Cultural Health

The HHS Office of Minority Health maintains the Think Cultural Health website, which features information, continuing education opportunities, resources, and more for health and health care professionals to learn about culturally and linguistically appropriate services, or CLAS. The National CLAS Standards define ways in which organizations can improve their quality of services to reduce health disparities and achieve health equity. The National CLAS Standards include 15 action steps for organizations to implement to provide appropriate care and services. The Blueprint for Advancing and Sustaining CLAS Policy and Practice provides guidance and additional resources for implementing each standard. Another resource available on the website is the Guide to Providing Effective Communication and Language Assistance Services, which supports both administrators and providers with tools to implement policies that support effective patient care for diverse populations.

Georgetown University National Center for Cultural Competence

The National Center for Cultural Competence at Georgetown University provides information on how to adopt cultural and linguistic competence into organizational policies and practices. The center's website contains key definitions, guiding values and principles, and other components of a cultural competence conceptual framework. The website houses multiple resources, including assessment instruments, checklists, guides and planning tools, and distance learning modules.

P4C HIV TAC: Resources for Cultural Competency in Integrated HIV and Primary Care

The P4C HIV TAC has developed a number of resources to guide organizations and providers that deliver integrated HIV and primary care toward cultural competence.

Engaging and Linking YMSM into Health Care

YMSM experience some of the highest incidence rates of HIV, suicide, homelessness, and substance use disorders. This webinar, conducted with the National LGBT Health Education Center, discusses how health centers, health departments, and their partners can strategically and effectively work to better engage and link YMSM into health care.

Engaging Immigrant and Refugee Populations in HIV Services

This webinar presents strategies for addressing the barriers to HIV care experienced by immigrant and refugee PLWH or those at risk of HIV infection. Resources for organizations providing quality health care to migrant and other mobile underserved populations are also discussed.

Engaging and Retaining Older Patients in HIV Care and Treatment

The CDC reports that, thanks to better treatments, persons age 50 or older make up 45% of Americans living with HIV. However, adults in this age category face unique health challenges and may be less aware of their risk. This webinar discusses the stigma that older adults living with HIV experience, clinical considerations for retention in care and treatment adherence (e.g., adverse drug reaction), and effective strategies for engaging and retaining older adults in HIV care.

[Ten Things: Creating Inclusive Health Care Environments for LGBT People](#)

This webinar, conducted in conjunction with the National LGBT Health Education Center, focuses on 10 key practices for creating LGBT-inclusive and affirming health care organizations. Approaches discussed include shaping policies and processes, collecting data, and engaging the community.

[Using the CLAS Standards to Enhance Cultural Competence in Integrated Care](#)

This webinar provides an overview of the National CLAS Standards, how they are intended to be used, and strategies for how health centers can use the standards to enhance care for racial, ethnic, gender, sexual, and linguistic minority PLWH.

Tools and Resources to Address Stigma

Health Policy Project Resources for Achieving a Stigma-Free Health Facility

The Health Policy Project developed two tools to help organizations identify, understand, and ultimately reduce or eliminate stigma in the health care setting. The Facilitator's Training Guide for a Stigma-Free Health Facility: Training Menus, Facilitation Tips, & Participatory Training Modules (PDF) contains a variety of tools to inform training and practices aimed at addressing stigma among health center staff. Achieving a Stigma Free Health Facility and HIV Services: Resources for Administrators (PDF) is aimed at organizational leaders, presents the root causes of stigma; and provides resources for developing policies and procedures.

National LGBT Health Education Center: Resources for Addressing Stigma

The National LGBT Health Education Center provides educational programs, resources, and consultation to health care organizations with the goal of optimizing quality, cost-effective health care for lesbian, gay, bisexual, and transgender people.

They have a number of resources focused on addressing stigma:

- Structural Stigma and the Health of Lesbian, Gay, and Bisexual Populations is a webinar that focuses on current research on the far-reaching health consequences of structural stigma for LGBT people, and examines future directions for structural stigma research, including exploring how providers at health centers and other health care organizations can mitigate the effects of structural stigma with their LGBT patients.

- HIV Prevention in the South: Reducing Stigma, Increasing Access is a publication that presents four strategic elements for preventing the further spread of HIV among vulnerable populations in the South, and suggests a more hopeful future for reducing the HIV epidemic.

- Understanding Bisexuality: Challenging Stigma, Reducing Disparities, and Caring for Patients is a webinar that explores what it means to be bisexual, provides strategies for providers to best prepare to meet the needs of their bisexual patients, highlights disparities faced by bisexual people, and challenges negative messages and stigma that surround the bisexual community.

Collection and Use of Data

Data collection is an integral part of any health care organization, both to ensure accurate and timely capture of patient information and to support data-driven efforts (e.g., quality improvement (QI), reporting to local authorities, program evaluations, policies and procedures development). Given the widespread use of electronic health records (EHRs), most health centers have a wealth of data on each patient, and there are potentially endless ways to modify existing systems to capture and manage patient data. Developing processes to ensure that patient data support all aspects of care for PLWH (e.g., screening, treatment, linkage to services, follow-up appointment scheduling, regular monitoring) should be key during planning and is important for initial implementation, as well as to sustain efforts in HIV service integration.

Given the need for long-term engagement of PLWH with their HIV providers, it is important for health centers to have data-based systems in place that directly support continued programming. Data collection and use of that data will depend on health center type (e.g., stand-alone center, member of a larger system) and should be tailored so that the broader needs for information can be met without the need for major revisions over time. For example, collecting information on sexual health and behavior is an important component of HIV service provision and informs patient assessment and care beyond just HIV testing and management. Standardizing sexual history data collection for all health center patients can improve overall care. Making data collection an organizational standard rather than only a component of HIV services could also support strategies to reduce stigma and support sustainability.

The National LGBT Health Education Center and the National Association of Community Health Centers developed a toolkit and companion webinar to guide implementation of routine sexual health history taking. Taking Routine Histories of Sexual Health: A System-Wide Approach for Health Centers was used by many P4C health centers. This toolkit explains how sexual history information can improve patient care beyond HIV and STD screening. It provides a step-by-step guide to sexual history taking and counseling, key terminology and considerations for interacting with special populations (e.g., men who have sex with men (MSM), transgender women), staff and resource requirements, and descriptions of how to routinize this approach. The toolkit also includes detailed samples of EHR risk assessment forms and links to additional information.

P4C health centers and health departments employed a variety of organizational- and systems-level approaches to data collection to facilitate long-term patient tracking and management. These approaches helped to support program sustainability beyond the end of the P4C funding period.

Quality and Process Improvement

Understanding the actions needed to promote and maintain improvements in health outcomes is a key component of sustainability. Quality and process improvements make possible systematic improvements that support better care for PLWH. Quality and process improvements can also enhance data collection and reporting to outside agencies (e.g., funders), organizational efficiency, resource utilization, and collaborations. These improvements should be strategic, attainable, and directly reflect the unique dynamic of a health center and their target populations.

Mattapan Community Health Center (Mattapan, MA) identified several key lessons learned for QI processes that included:

- QI planning is vital for identifying health center-, program-, and provider-level needs, and to assess the effectiveness of interventions.
- Creating HIV program goals to be part of overall health center QI initiatives encourages committee buy-in and health center investment in the program.
- Developing robust data reports by utilizing data analytics software facilitates QI activities.
- Data validation across platforms must be continuous as EHRs and health center goals change; data must be maintained and cleaned to ensure the reporting reflects the care.

QI initiatives and approaches are discussed throughout the earlier sections of the toolkit. Following are several resources for enhancing QI.

Resources to Enhance Quality Improvement

TARGET Center
QI Resources

The TARGET Center hosts a number of resources on clinical quality management and related topics. Ryan White HIV/AIDS Program (RWHAP) has a long history of clinical quality management and related resources. Many of the resources are targeted to RWHAP programs, they can be adapted for non-RWHAP grantees that provide HIV services. Resources of broad relevance include:

- The HIVQUAL Workbook, a step-by-step, self-learning guide that gives HIV providers a clear road map for making QI a reality in ambulatory care settings.
- Measuring Clinical Performance: A Guide for HIV Health Care Providers, a downloadable PDF file that details a step-by-step performance measurement process.

Technical Assistance and Training

P4C health centers participated in numerous TA and training activities to integrate HIV services into primary care. Many of the webinars included in this toolkit were initially delivered as trainings for the P4C grantees. Training and TA topics fell into one of three categories:

- **Workforce Development:** Basic HIV disease, cultural competency, multidisciplinary care, retaining PLWH in care
- **Infrastructure Development:** Billing and coding, EHR enhancements, partnership development, policy and procedures development, sustainability
- **Service Delivery:** HIV care and treatment, medication adherence, pre-exposure prophylaxis (PrEP), routine HIV testing, sexual health

The HIV/AIDS Bureau established a revised performance measure portfolio in November 2013 that focuses on critical areas of HIV care and treatment, and aligns with milestones along the HIV care continuum. The measures are for RWHAP recipients, but can be adapted for non-RWHAP grantees. For additional information, visit HRSA's HIV/AIDS Bureau Website.

A number of the health centers expressed interest in HIV certification for their clinical providers. Obtaining HIV certification is a way to maintain current expertise, demonstrate frontline experience, and evolve with changes in HIV technology, including new treatments and shifts in the nation's health care system. The American Academy of HIV Medicine offers professional certifications for physicians, nurse practitioners, physician assistants, and pharmacists in three main areas: HIV Specialist™ for frontline clinicians, HIV Expert™ for nonpracticing clinicians, and the HIV Pharmacist™ for those specializing in HIV medication. The HealthHIV HIV Primary Care Training and Certificate Program™ is a continuing medical education approved, professional development course designed to help primary care clinicians develop new skills and professional competencies to optimize the quality of care they provide to patients infected with HIV.

Another resource is the National HIV Curriculum, a free educational web site from the AIDS Education & Training Center Program National Coordinating Resource Center and the University of Washington. The National HIV Curriculum provides ongoing, up-to-date information needed to meet the core competency knowledge for HIV prevention, screening, diagnosis, and ongoing treatment and care to health care providers in the United States. Free CME and CNE credits are offered throughout the site.

Many health centers face difficulties in accessing specialty care and best practices such as those often found at large urban and academic institutions. Connecting providers and other staff with experts from around the country is a cost-effective approach to workforce development and to reducing health disparities in lower-access areas. **North Shore Community Health Center (Salem, MA)** used two such programs to support staff training and patient care:

The Medical Alumni Volunteer Expert Network (Maven) Project serves community health centers by connecting them with physician volunteers. Volunteers work to reduce disparities related to clinician shortages and overburdened health centers using telemedicine.

The Project ECHO (Extension for Community Healthcare Outcomes) model empowers clinicians to improve their level of care through collaborative education and care management. Project ECHO aims to increase the capacity of providers, particularly those in rural communities, without the burden of in-person training or hiring additional staff.

CONCLUSION

This toolkit has offered a "roadmap" through the stages (planning, implementing, and sustaining) of developing an integrated HIV and primary care program. It is intended to provide ideas and resources for health centers and other safety net providers considering or in the process of integrating HIV services into existing primary care. The material in this toolkit has been informed by the lessons learned, promising practices, and successful approaches used by P4C health centers, health departments, and their partners to integrate HIV services into their primary care programs.

HRSA
Health Center Program

Appendix A

Module 1 Tools
Planning for HIV Care Integration

1. **The Partnerships for Care (P4C) Health Center Readiness Assessment**

2. **Betances Health Center (New York, NY): Policy of HIV Routine Testing and Linkage to Care – Betances Approach to Routine HIV Testing**

3. **Care Resources (Miami, FL): HIV and HCV Screening in the Health Care Setting – Policies & Procedures**

4. **Community Clinic, Inc. (Greenbelt, MD): Procedures for HIV Care Services**

5. **The Partnership Toolkit**

6. **Partnership-Focused Templates**

7. **HICAPP Sustaining Integrated Routine Testing Workplan**

The Partnerships for Care (P4C) Health Center Readiness Assessment

Partnerships for Care (P4C) Health Center Readiness Assessment

Date _____

Community Health Center _____

State Health Department_____

Completed by _____Title_____

HIV Care Team Status

Question	Yes	No	Comments/Questions
Has your health center established a multi-disciplinary **HIV Care Team**(s)?			
Are all **HIV Care Team** positions filled?			

Question	Vacant Positions
If all positions are not filled, what positions remain vacant?	

Service Delivery (HIV Testing & Services)

Question	Yes	No	Comments/Questions
Does your health center provide routine HIV testing, (i.e., offer HIV testing to all patients aged 15 to 65) as part of routine medical care?			

Question	Rapid/ Oral	Rapid/Finger Stick	4th Generation	Other
What HIV testing technologies are used? Check all that apply.				

Question	Yes	No
Does your health center provide linkage to care for newly diagnosed positive patients?		

Question	On-site	Referral
If you provide linkage, please indicate whether linkage is provided on-site and/or by referral.		

Question	Types of Patients
If linkage is provided by referral, which types of patients are referred?	

Service Delivery (Medical Treatment and Prevention)

Please indicate which members of your HIV Care Team are able to manage and provide care for each type of patient.

Type of Patient	All Care Team Staff	Most Care Team Staff	Other Non-Care Team Staff	Other Non-Care Team Staff
HIV-positive patients who have not yet started on Anti-Retroviral Therapy (ART) or are on 1st line ART therapy				
HIV-positive patients who are on 2nd or 3rd line ART therapy				
HIV-positive patients with common complaints				
HIV-positive patients with opportunistic infections or advanced HIV disease				
HIV-positive patients in need of prevention-of-mother-to-child-transmission (PMTCT) services				

Please indicate for each type of service whether your health center provides the service directly, by formal written referral, by informal referral, or not at all.

Type of Service	Directly	Formal Written Referral	Informal Referral	Not offered
Mental health treatment				
Substance abuse treatment				
Oral health				
Enabling services (transportation, translation, eligibility, housing, case management)				
Patient navigation/care coordination services for HIV-positive patients				
HIV medication adherence education and counseling for PLWH				
Any behavioral or structural interventions to reduce the risk of HIV transmission for PLWH				
Care and treatment for sexually transmitted infections				
Care and treatment for Hepatitis B virus				
Hepatitis C treatment and screening guidelines				
Care and treatment for TB				

HRSA Health Center Program

Workforce Development

Please indicate which health center staff would benefit from training in each of the identified areas (Check all that apply).

Workforce Development Area	Some or all members of HIV Care Team	Other medical/ clinical staff	Some or all leadership	Some or all general health center staff	Some or all board members	No one
Routine HIV Screening						
Prevention and care for PLWH						
HIV care and treatment						
Health information technology infrastructure						
Utilizing HIV surveillance data to improve care outcomes						
Best practices for multi-disciplinary, team-based care						
Sexual health and risk behavior assessment						
Hepatitis C screening and co-infection						
Establishing HIV care plans for patient self-management						
Referrals for management of HIV complex care and co-morbidities						
Managing occupational exposure						
Managing patients using clinical consultation						
Retaining PLWH in care						
Using patient data to support quality improvement						
HIV service delivery in primary care settings						
Basic HIV Epidemiology						
Addressing stigma and discrimination in HIV service delivery						
Establishing/maintaining culturally competent LGBT/ PLWH health care environments						
HIPAA and patient protection and confidentiality						
Other training needed: _____						

Question	Yes	No	Comments/Questions
Have you identified at least one resource for clinical consultation on HIV/AIDS patient management and Continuous Quality Improvement (CQI) in HIV service delivery?			

Infrastructure Development

Question	Yes	No	Comments/Questions
Does your health center currently use electronic health records (EHR)?			

Question	EHR Used
If yes, what EHR are you currently using?	

Question	Yes	No	Comments/Questions
Does your health center have financial management systems to support budgeting, accounting, coding, and billing across different funding streams?			

What systems or approaches do you use to support patient tracking and referrals? (Check all that apply)

Patient Tracking and Referral Systems	Yes	No	Comments
EHR			
A separate electronic system			
Written policies and procedures			
Verbally established policies and procedures			
Other			

Question	Yes	No	Comments/Questions
Has your health center developed a service area or patient needs assessment to ensure identification of service delivery needs for PLWH and those at high risk of HIV infection?			
Does your health center currently participate in HIV planning groups (e.g., Ryan White Part A planning council, CDC prevention planning group)?			
Does your health center have policies or procedures that ensure coordination of care between the HIV Care Team and other health center service providers?			

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Please indicate whether your health center has established policies and procedures in place for the provision of the following HIV services, either written, communicated verbally, or informally. If no policies and procedures are established for the provision of a service, check none.

HIV Services	Written	Verbal	Informal	None
Testing				
Linkage to Care				
Basic HIV Care				
Medication Management				
Adherence Support				
Patient Self-Care Plans				
Formal Referrals for Specialty Care				
Enabling Services				

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Betances Health Center (New York, NY): Policy of HIV Routine Testing and Linkage to Care – *Betances' Approach to Routine HIV Testing*

Page 1 of 3

Policy of HIV Routine Testing and Linkage to Care
Betances' Approach to Routine HIV Testing

Policy & Purpose

It is the policy of Betances Health Center (BHC) to offer routine HIV Testing as a part of health care to all patients 13 and older. In addition, all prenatal patients at BHC are to receive HIV testing as part of routine prenatal care. It is our goal for each patient of BHC to have at least one documented HIV test in their lifetime. Patients who are considered "high risk" will have yearly HIV screening. "High Risk" is defined at BHC as injection-drug users and their sex partners, persons who exchange sex for money or drugs, sex partners of HIV-infected persons, and MSM or heterosexual persons who themselves or whose partners have had more than one sex partner since the most recent HIV test.

Purpose of offering HIV testing is to increase early diagnosis and treatment of HIV, link HIV-positive patients to primary care, as well as offer preventive interventions for those who qualify. BHC will use 4th generation laboratory technology, conventional testing when medical care visits occur, and rapid testing when appropriate such as circumstances when patient refuses venipuncture, and for urgent source testing in case of exposure incidents (e.g. before PEP).

BHC will adhere to HIV Testing policies & procedures as defined by the New York State Department of Health/New York City Department of Health & Mental Hygiene.

Staff Roles

Medical Director: The Medical Director will provide administrative oversight of the HIV Routine testing. S/He will facilitate multi-disciplinary collaboration and conduct regular meetings with providers to review outcomes. They will also review goals and statistical reports prepared by HIV Program Lead.

HIV Specialist: Will be responsible for updating HIV testing protocols and technologies and communicate to all BHC Staff any updates.

Medical Providers: Responsible for offering HIV testing as outlined in "Scope of Services."

HIV Program Lead: Responsible for reporting statistical requirements.

Behavioral Health Staff: Will be called if any crisis intervention is needed for patients who tested positive.

Case Manager: HIV Testing Case managers will be responsible for the oversight of the Rapid Testing, training and development of staff, coordination of testing staff, conduct HIV counseling and testing, data entry tasks related to HIV testing, including assistance in the area of communications, inter-office and customer relations, quality assurance, inter-agency collaboration efforts, and program statistical analysis.

Project Interfacing

HIV Testing efforts are well integrated into all aspects of service delivery within BHC. Each medical provider of BHC who screens patients for HIV will share positive test results with the HIV specialist when they internally refer patients to them for HIV management. Behavioral Health Staff will be called upon to provide needed mental health and case management services.

Scope of Services

HIV Testing Administration Procedure

1. Medical provider will offer HIV testing at each primary care visit
    a. If patient agrees, HIV 4th Generation screening will be ordered
        i. Provider will inform patient to return within 2 weeks to discuss lab results
    b. If patient declines, provider will document reason of refusal in designated data field into electronic medical records (EMR)
2. Medical Assistant (MA) will fulfill lab orders as directed by medical provider
    a. Labs will be directed to authorized laboratories for testing
    b. Following lab drawn, MA will provide patient with appointment 2 weeks from date of service
3. Medical providers will review laboratory results
    a. Providers will document results into EMR
    b. Providers will discuss lab results with patient
    c. Positive lab results will result in an internal referral to the HIV Specialist for management

Lab Results Procedure

HIV test results will follow HIPPA documentation protocols and should be readily available to all health-care providers involved in the patient's clinical management.

1. Positive HIV result
    a. Provide psychological counseling
        i. Connect Behavioral Staff for crisis intervention if needed
    b. Engage patient in discussion regarding treatment options
    c. Provide safe-sex counseling
    d. Discuss partner notification (See "Partner Notification Counseling")
2. Negative HIV result
    a. Provide safe-sex counseling
    b. Encourage continued routine testing
        i. If engaging in high risk behavior, offer PrEP for patients who qualify

Partner Notification Counseling

When HIV infection is diagnosed, medical providers will encourage patients to disclose their HIV status to their spouses, current sex partners, and previous sex partners and recommend that these partners be tested for HIV infection. BHC will follow NYSDOH partner notification protocols.

Documentation and Confidentiality

All HIV testing records must be documented within the EMR. All reports, information, or data related to HIV testing are confidential.

Quality Assurance

HIV Program Lead will create a monthly data report broken down by provider and provided to HIV Medical Lead for their review and discussion at monthly provider meetings. During these meetings, topics such as challenges, successes, and improvements will be addressed.

Outreach

BHC promotes HIV testing at all points of care. Brochure, posters, and health educational materials are readily available throughout BHC. Videos promoting HIV testing and PrEP are also on display in the waiting area. Ongoing events promoting testing are scheduled in and outside BHC.

Other outreach targets are considered, such as:

- Community Based Organizations
- Community Coalitions and Self-help Organizations
- Professional Organization Networks
- Social Media
- Informal Street Networks
- Pharmacies
- Consulates

Training

As part of continuing educational opportunities for our staff at BHC, we provide trainings on the following topics:

- EMR Documentation of HIV Services
- Pre and Post Exposure Prophylaxis
- LGBT Competency
- Motivational Interviewing

ADMINISTRATIVE MANUAL
POLICIES AND PROCEDURES
MEDICAL CARE SERVICES   POLICY NO. 8020.008

SUBJECT: HIV and HCV Screening in Health Care Setting

POLICY: Care Resource intends to implement the state of Florida HIV testing policy in a health care setting. HIV tests are to be one routinely unless a patient explicitly refuses to take the HIV test. Equally, Care Resource intends to implement the US Preventive Services Task Force (USPSTF) recommendations on Hepatitis C (HCV). HCV screening should be voluntary and undertaken only with the patient's knowledge and understanding that HCV testing is planned. Health care setting refers to a setting devoted to the diagnosis and care of persons or the provision of medical services.

PROCEDURE:

A) HIV Screening and Treatment

   a. Medical providers will perform once a year routine HIV testing with 4th Generation HIV antigen/antibody tests in patients age 13-64 or beyond as part of routine primary care. If the patient cannot afford the 4th generation HIV test, a rapid HIV antibody test (OraQuick) will be used. The patient will be notified prior to testing. Once a year screening for HIV risk will be performed for all patients age 13-64 after they have had at least 1 negative HIV test. If a patient has HIV/STD risk, the HIV test will be performed.
   b. For individuals at high risk for HIV acquisition, HIV testing may be done more than once a year. HIV screening will be performed in all individuals who seek treatment for STDs and an STD screen will be performed for each new complaint of an STD.
   c. The person to be tested for HIV shall be notified orally or in writing that the test is planned and that he or she has the right to decline the test. If the person to be tested declines the test, such decision shall be documented in the medical record.
   d. A person who has signed a general consent form for medical care is not required to sign or otherwise provide a separate consent for an HIV test during the period in which the general consent form is in effect.
   e. Informed consent must be obtained from a legal guardian or other person authorized by law if the person a) is not competent, is incapacitated, or is otherwise unable to make an informed judgment; or b) has not reached the age of majority.

POLICY NO. 7029.001

   f. If a patient has a reactive HIV antibody test on a rapid HIV test, a confirmatory test will be performed and confirmed positive patients will be referred to the linkage department for linkage to HIV care. Each person confirmed HIV positive will also be reported to the local Department of Health for partner notification services.

   g. In the case of an HIV positive individual, Care Resource will follow the treatment guidelines adopted by the Department of Health and Human Service Guidelines. See Policy on Clinical Guidelines.

B) HCV Screening and Treatment

Providers need to understand that HCV screening should be voluntary and undertaken only with the patient's knowledge and understanding that HCV testing is planned. Patients should be informed orally or in writing that HCV testing will be performed unless they decline (opt-out screening). Before HCV screening is performed, patients should receive an explanation of HCV infection, how it can (and cannot) be acquired, the meaning of positive and negative test results, and the benefits and harms of treatment. Patients should also be offered the opportunity to ask questions and to decline testing.

   a. Medical providers will follow the USPSTF recommendation that 1-time HCV testing be performed for anyone at increased risk for HCV infection, including:
      1) Persons born from 1945 through 1965
      2) Persons who have ever injected illegal drugs, including those who injected only once many years ago
      3) Recipients of clotting factor concentrates made before 1987
      4) Recipients of blood transfusions or solid organ transplants before July 1992
      5) Patients who have ever received long-term hemodialysis treatment
      6) Persons with known exposures to HCV, such as health care workers after needle sticks involving HCV-positive blood and recipients of blood or organs from a donor who later tested HCV-positive
      7) All persons with HIV infection
      8) Patients with signs or symptoms of liver disease (e.g., abnormal liver enzyme tests)
      9) Children born to HCV-positive mothers (to avoid detecting maternal antibody, these children should not be tested before age 18 months)

   b. HCV Screening Intervals
      1) Persons with continued risk for HCV infection (injection drug users) should be screened periodically. How often screening should occur in persons who continue to be at risk for new HCV infection is based on the clinician's best judgment.
      2) For anyone not at risk for HCV screening is voluntary and not recommended.

Several blood tests are performed to test for HCV infection, including:

   a. Screening tests for antibody to HCV (anti-HCV): enzyme immunoassay (EIA) and enhanced chemiluminescence immunoassay (CIA) which if positive will reflex to either a qualitative or quantitative test.

   b. Qualitative tests to detect presence or absence of virus (HCV RNA polymerase chain reaction [PCR]).

   c. Quantitative tests to detect amount (titer) of virus (HCV RNA PCR).

d. Counseling Patients with HCV

1) Patients should be informed about the low but present risk for transmission with sex partners.

2) Sharing personal items that might have blood on them, such as toothbrushes or razors, can pose a risk to others.

3) Cuts and sores on the skin should be covered to keep from spreading infectious blood or secretions.

4) Donating blood, organs, tissue, or semen can spread HCV to others.

5) HCV is not spread by sneezing, hugging, holding hands, coughing, sharing eating utensils or drinking glasses, or through food or water.

6) Patients may benefit from a support group.

7) HCV-positive persons should be advised to avoid alcohol because it can accelerate cirrhosis and end-stage liver disease.

8) Viral hepatitis patients should also check with a health professional before taking any new prescription pills, over-the counter drugs (such as non-aspirin pain relievers), or supplements, as these can potentially damage the liver.

e. HCV Treatment

The purpose of antiviral treatment regimens is to prevent long-term health complications of chronic HCV infection (such as cirrhosis, liver failure, and hepatocellular carcinoma). Providers are to follow the guidelines from the American Association for the Study of Liver Diseases (AASLD) for the treatment of HCV. Care Resource providers can choose to provide HCV treatment or refer to outside providers.

C) Emergency Procedures

If an employee or a program participant has a significant exposure to blood or body fluids through needle stick, instruments, or sharps, the following procedures must be followed:

POLICY NO. 7029.001

1) The incident must be reported immediately to the Program Manager who will in turn communicate the incident to the physician of record.

2) All employees and/or program participants who incur an exposure incident will be offered post exposure confidential medical evaluation and follow-up as prescribed by OSHA standards.

3) Any employee exposed to blood borne pathogens will be referred for medical care using current workers compensation procedures. Referral should be made within 24 hours of the incident so that preventive treatment can be initiated. Specific follow-up actions shall include, at a minimum, documentation of the route of exposure and circumstances under which the exposure occurred.

4) If the source is unknown, or if known and staff refuses testing, the employee will follow the guidelines for prophylaxis for exposure to a source individual that has not been tested or is unknown in accordance with the most current recommendation of the U.S. Health Department.

CCI Health & Wellness Services
PROCEDURE
HIV Care Services

1. HIV-positive patient is referred to the HIV Nurse Care Coordinator

   - Internal referrals through EMR
   - External referrals will be directed to nurse care coordinator
   - Nurse contacts the patient (within 48 hrs) to schedule initial appointment.

2. After initial contact, new HIV-positive patients will be seen in the practice:

   - Within 48 hours for a nurse care coordinator appointment
   - Within 1 week after nurse visit for a provider appointment

3. Nurse Care Coordinator Visit #1: Initial HIV Intake Visit

   - Medical Assistant rooms patient as a "HIV Initial Intake-Nurse"
   - History of present illness
   - Assessment of urgent medical issues
   - Perform a care coordination-needs assessment (EHR Needs Assessment Form)
   - Release of Information (ROI) for medical records
   - Depression Screening PHQ-9 and SBIRT
   - Documentation of medication list (including past & present antiretroviral therapy-ART) and allergies
   - Assessment of general HIV knowledge base
   - Provide initial general HIV education
   - Introduction/Referral to Community Health Worker
   - Provide initial visit folder (contains educational materials, services, contact numbers, support programs)

4. HIV Provider Visit #1: Initial HIV Provider Visit

   - Medical assistant (MA) follows Adult Visit workflow and labels the adult visit "HIV Initial Provider Visit"
     - Adds these forms (in addition to standard forms): HIV History of Present Illness (HPI), HIV Decision Point, Sexual History, TB Testing Form, Patient Instructions, and Education Forms.
   - Provider reviews:
     - HPI
     - Past medical/surgical history

-    o   Medication history/allergies
-    o   Social/family history
-    o   Previous medical records
- Provider performs:
    - o   Sexual history
    - o   Review of systems
    - o   Physical examination
    - o   Review of available laboratory and other results
- Referral/Introduction to Behavioral Health Consultant for initial assessment and a baseline Mini Mental Status Exam (MMSE)
- Initial set of laboratory tests will be ordered at this visit according to the <u>HHS Guidelines for the Use of Antiretroviral Agents in HIV-1 Infected Adults and Adolescents.</u>

5. <u>Provider Visit #2/RN Visit #2: Two Week Lab Follow-up Visit</u>

   a. <u>HIV Provider Visit #2</u>

   - MA follows Adult Visit workflow and labels the adult visit "HIV Provider f/u Visit"
   - Provide general HIV education
   - Review laboratory results
   - Discuss antiretroviral therapy (ART)
       - o   Assessment of readiness
       - o   Patient lifestyle considerations
   - Perform brief physical examination
   - Assess need for referrals
   - Order vaccines if indicated
   - Prescribe preventive medications if indicated
   - Counsel on risk reduction strategies

   a. <u>Nurse Care Coordinator Visit #2</u>

   - Provide general HIV education
   - Assess readiness for ART
   - Provide medication education
   - Establish medication initiation/support plan
   - Address barriers to medication adherence
   - Counsel on risk reduction strategies

6. Starting ART or switching regimens

- Medication counseling with provider and nurse care coordinator
- Consultation with a clinical pharmacist if needed
- Case conference if needed
- Laboratory testing after regimen initiation:
  - -2 weeks- viral load, comprehensive metabolic panel, CBC
  - -6 weeks- viral load
  - -12 weeks- routine 3-4 month laboratory testing
- Follow-up appointment 2, 8 and 12 weeks after initiation of ART

7. Routine referrals/services

- Dental-every 6 months
- Ophthalmology- CD4 <50 or diabetic (annually)
- Nutritionist- annually
- Gynecology- cervical cancer screen every 6 months in first year, then annually if normal

8. Preventive Care Screening

- Smoking cessation
- Depression
- Substance abuse
- Sexual health and risk reduction counseling
- Routine age-appropriate health maintenance

9. Routine vaccinations when CD4 is ≥200 for 3 months (Attachment B):

- Exception is influenza, should be administered for all CD4 counts

10. Follow-up visit schedule

- Every 3-4 months
- If patient has been on a stable ART regimen, viral load is undetectable and CD4 ≥200 for > 2 years, consideration may be given to every 6 months visits

HHS Guidelines for the Use of Antiretroviral Agents in HIV-1 Infected Adults and Adolescents 2015
Primary Care Guidelines for the Management of Persons Infected With HIV: 2013 Update by the HIV Medicine Association of the Infectious Disease Society of America

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Partnership Toolkit

The contents of this toolkit will be resources to modify and track partnerships pursued by a health center. This toolkit was created to support P4C activities but can be modified as needed in the future for the Access Health Project. The resources included in this toolkit are meant to be modified based on the nature of partnership, the needs of health center staff, and based on experience building these partnerships.

General Guidelines for Successful Partnerships

The following are general principles to create and sustain successful partnerships and could be used as a code of contact for all staff engaging in creating and sustaining partnerships.

Adopted from: *Centers for Disease Control and Prevention (CDC), Division of Partnerships and Strategic Alliances, National Center for Health Marketing. (2011). What Makes a Partnership Successful: General Guidelines. CDC Partnership Tool Kit, Washington, D.C.*

Mutual Understanding: Partners need to understand each other's needs, respective resources, language, and goals to effectively communicate and to partner.

Securing Trust: No partnership can be successful without trust. Recognizing that trust takes time to build and keeping commitments and promises is one of the measures. Openness and honesty are critical elements and include information about plans, available resources, and resource requirements. A frank discussion about "what I need to get out of this relationship for my organization" is relevant in building an ongoing relationship.

Clarity of Goals: Clear discussion of and agreement about the shared mission and goals is essential and can be fostered by beginning with clearly defined short-term and longer term achievable results statements that are used to work backwards to an action plan that defines the roles and responsibilities of the partners.

Finding Champions: Sponsorship by committed leaders with the power to achieve results from the initiatives is crucial. The framework this takes in terms of organizational structure for governance may vary.

Sharing Data: Making good use of data in all stages and tasks—assessment, planning, implementation, and evaluation—will help to determine reasonable goals and to mobilize support. Frank discussions about sharing data, data security, access, and reporting will also need to be part of the dialogue for successful partnerships.

Recognizing Contributions: On-going recognition of partner contributions is essential. Acknowledgment of incremental progress and accomplishments will help assure recognition of all contributions to success.

Ensuring Mutual Benefit: An effective partnership will work to achieve benefits for each partner while also working toward the common goal.

Insuring Productivity: The efficiency of meetings will help to assure a sound decision making process including opportunities for input and to assure that all are actively engaged in the process. Ground rules for meeting procedures and frequency as well as ongoing communication will help to clarify decisions and resulting actions such as task designation, timetables, responsibilities, and follow up. Time for social interaction and networking are also important elements to consider as well as respect for participants and the need to start and end on time. Location and time of meetings should be convenient for all and use of phone meetings an alternative for convenience.

Process for Pursuing Partnerships:

1) Identify partners and identify who the champion will be at the organization. As defined above, champions are individuals that can foster change at the organization.

2) Request a meeting with the champion and any other staff they would like to invite to learn more about your health center, your patient needs, and to determine potential opportunities for collaboration and referral. Begin to form a personal relationship.

3) Gather your data on the population you serve and their needs, to further define the need and establish buy-in. Define your specific goals and objectives related to your funding and what you are seeking in the partner. Invite your partner to prepare information about their organization, services, and goals to also share at the meeting.

4) Arrange or host meeting. If the entire health center staff is not available to attend the meeting, consider inviting the partner back to present at a staff meeting at the health center.

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Framework for Pursuing Partnerships
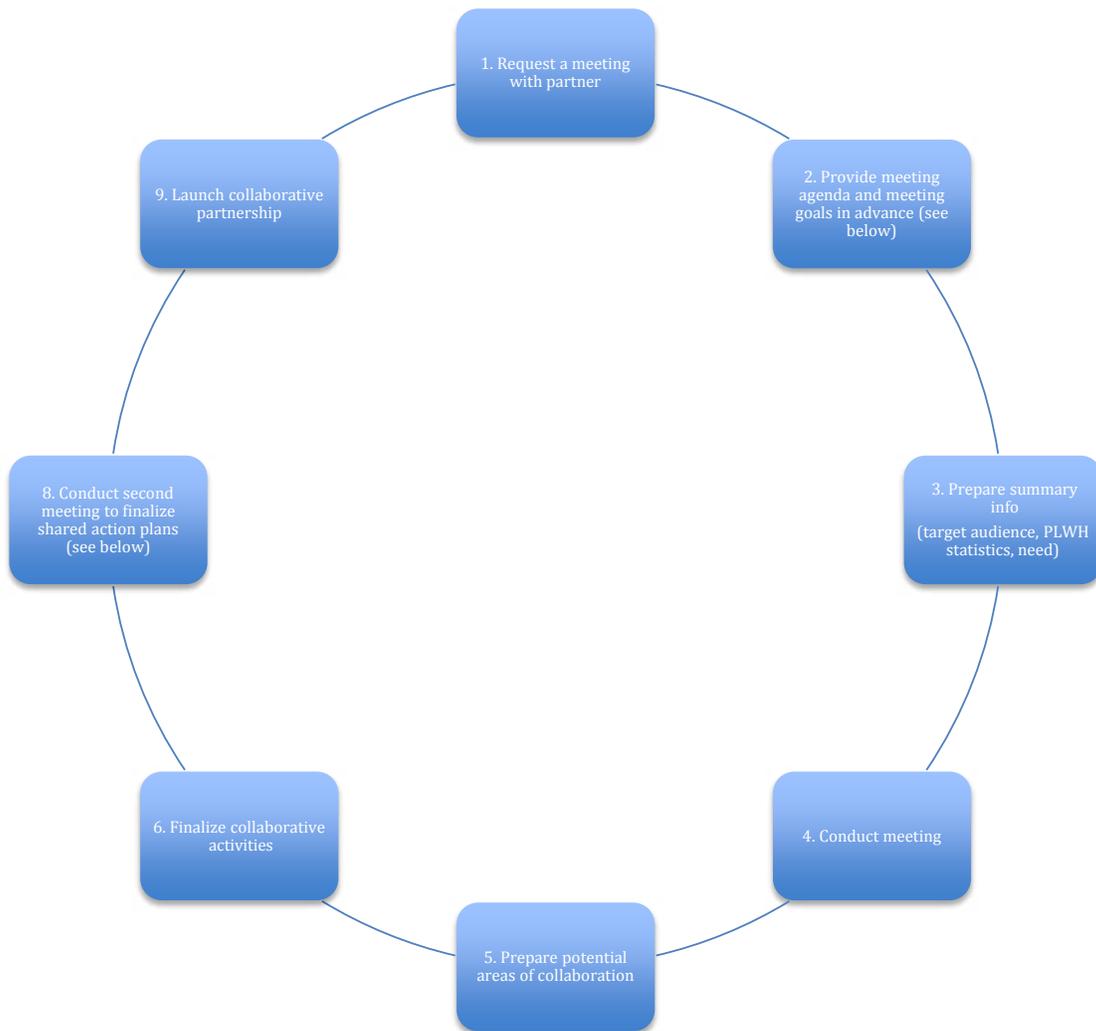
- 1. Request a meeting with partner
- 2. Provide meeting agenda and meeting goals in advance (see below)
- 3. Prepare summary info (target audience, PLWH statistics, need)
- 4. Conduct meeting
- 5. Prepare potential areas of collaboration
- 6. Finalize collaborative activities
- 8. Conduct second meeting to finalize shared action plans (see below)
- 9. Launch collaborative partnership

Initial Meeting: Agenda
Location
Date

Introductions and Purpose of Meeting	- Review purpose of meeting - Introductions	5 minutes
Information Sharing	- Services provided - History - Primary care patients served - Services provided - HIV-positive patients served and statistics along the care continuum - Goals of partnership - Target populations	10 minutes
Partner Organization Information Sharing	- Services provided - History - Patients served - Services provided - Goals of partnership - Target populations	10 minutes
Collaborative Opportunities	- Identification of overlapping populations and services - Identification of unique services that each organization provides that could benefit the other organization	15 minutes
Wrap-up and Next Steps	- Send summary of meeting and potential areas of collaboration - Send communication about next steps (if this is a partnership to pursue then a follow-up meeting will be scheduled)	5 minutes
	Total Time	*45 minutes*

Participants from health center: Partnership for Care team
Consider hosting the initial meeting at the partnership location in order for the P4C staff to visibly see the environment and space of the potential partner.

Initial Meeting Follow-up Items:

- Send a meeting thank you via email, phone, or note. This provides the opportunity to reiterate action items/next steps and distribute any follow-up information or materials.

- Determine if second meeting or phone conference is needed to review shared action plan. This may be a great opportunity to visit the partner's location or invite them to the health center. Prepare for the meeting by capturing potential ways discussed to work together that would be mutually beneficial.

- Define a shared action plan. Outline specific tasks and objectives for partnership with a timeframe; be clear about roles and responsibilities.

- Communicate progress and share successes. Through regular communication identify any changes to action plan and ensure the partner's needs are met.

Follow-up Meeting: Agenda **Location** **Date**		
Introductions and Purpose of Meeting	- Review purpose of meeting - Introductions	5 minutes
Review Shared Action Plan	- Review draft action plan and modify as needed based on partner feedback - Finalize action plan and determine launch date	20 minutes
Determine Resources	- Discuss if any formal MOU or additional resources will be needed to make this action plan a reality - Determine plan for data sharing to track and monitor progress towards objectives	15 minutes
Wrap-up and Next Steps	- Determine if regular meetings will be scheduled and determine date to launch partnership	5 minutes
	Total Time	*45 minutes*

Participants: Health center CFO and CEO invited, Partnership for Care team

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Partnership Tracking Form					
Agency Name	Agency Type	Address	Contact Name	Contact Title	Contact Phone
1					
2					
3					
4					
5					
6					
7					
8					
9					
10					
11					
12					
13					
14					
15					
16					
17					
18					
19					
20					
21					
22					
23					

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	Partnership Tracking Form					
	Purpose of Partnership	Strengths (Expertise)	Weaknesses	Contact Made	Status	Notes
1						
2						
3						
4						
5						
6						
7						
8						
9						
10						
11						
12						
13						
14						
15						
16						
17						
18						
19						
20						
21						
22						
23						

High Impact Care and Prevention Project (HICAPP) Sustaining Integrated Routine Testing Work Plan 2016 - 2017

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Goal: To ensure continuous support and improvement for integrated routine testing for all patients.

Training and Orientation

Activity/next step	Who?	Start date Completion	Comments
Staff for the POC			
Patient Engagement - Motivational interviewing			
New staff training			
QI process to review data			
Engagement of entire health center			
Follow-Up: Develop a QM Accountability Diagram that includes key stakeholders and Health Center's QM Committee/ structure			

Funding and Budget Administration

Activity/next step	Who?	Start date Completion	Comments
Budget for rest of tests			
Administration/oversight of tests			
Insurance payment for tests			
Advertisement/outreach to community			
Payment of staff/services			
$ for time spent in patient visit			
Future RFP to support sustainability			

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Care Coordination

Activity/next step	Who?	Start date Completion	Comments
Timely, support services/ system			
Patient education regarding program			
Reducing time that the provider spends with patient; build reference points			

Policies/Procedures/Administration

Activity/next step	Who?	Start date Completion	Comments
Written policies and protocols (include protocols for opt-out)			
Oversight implications			
Senior management buy-in			
Make it easier for providers			
Engagement of entire health center			

Measurement Systems

Activity/next step	Who?	Start date Completion	Comments
Electronic medical record -to capture if test needed/offered			
Data system to track			
Number of test offered/ number of eligible			
Number of preferred & acceptance/ number of tests offered			
Reporting monthly -develop charts			

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QI Process

Activity/next step	Who?	Start date Completion	Comments
Measurements and reports			
QI process to review			
Advocacy/promote testing			
Request staff meetings to reinforce efforts			
Patient involvement – input			
Add routine testing to agency-wide QM plans (baseline, goals, interventions, results, next steps)			
Add sustainability to QM plans			

Management/Organizational Capacity

Activity/next step	Who?	Start date Completion	Comments
Outreach to community – community education			
Regular staff meetings to reinforce efforts			
Engagement of entire health center and leadership articulates vision			
Building a relationship with the lab and all external entities i.e. hospitals			
Publications/advertising to community			

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Champions
Who are the internal champions? How do they fit in?
- Clinical providers
- Health center staff in the room at P4C NY Learning Collaborative
- QI staff
- Different levels of advocacy

Who are the external champions?
- Supportive laws for routine HIV testing
- CDC guidance
- Department of Health – county, city, and state Departments of Health
- Local hospitals
- Agency to agency partnerships for complex patients

Challenges
- Cost vs. Non-cost activities
- Determining the minimal level of sustainability
- Reporting data:
  - Understanding directions/guidance
    - Definition of medical visit
  - Amount of staff
  - Involvement of informatics staff
  - Health report – time of submission (due same time as another competing deadline on health reporting)
  - Long time span between when guidance is given and when the report was due for submission.

Module 2 Tools

Implementing HIV Care Integration

1. Whittier Street Health Center (Boston, MA): HIV Testing Algorithm
2. Community Clinic, Inc. (Greenbelt, MD): Routine HIV Testing Workflow
3. Community Health Center of Buffalo, Inc. (Buffalo, NY): HIV Testing Workflow
4. Whittier Street Health Center (Boston, MA): HIV In-Clinic Testing Workflow
5. Community Clinic, Inc. (Greenbelt, MD): HIV Testing Competency-Based Validation Form
6. Community Health Center of Buffalo, Inc. (Buffalo, NY): Negative HIV Result Information Sheet
7. Whittier Street Health Center (Boston, MA): LAB Fast Lane Algorithm
8. HIV TAC & Partners: Tips on Delivering a Positive HIV Test Result
9. Community Health Center of Buffalo, Inc. (Buffalo, NY): Teens, Parents & HIV Testing – Information Sheet
10. Community Health Center of Buffalo, Inc. (Buffalo, NY): Why YOU Should Have Your HIV Test Today! – Fact Sheet
11. Mattapan Community Health Center (Mattapan, MA): Patient Access to HIV Care Workflow Map
12. Whittier Street Health Center (Roxbury, MA): Out-of-Care PLWH Workflow
13. Mattapan Community Health Center: HIV Medical Care Case Management Tool
14. Quick Reference Guide for Pre-Exposure Prohylaxis (PrEP) for HIV Infection

HIV TESTING ALGORITHM

RAPID TESTING ROOM

↓

Pre-test counseling

(If not registered at WSHC collect data to back track)

→ **Negative (-) result**

→ **Positive (+) result**

Negative (-) result

↓

Prevention Counseling

↓

Return in 3-6mo time re-testing

Positive (+) result

↓

Generate lab slip for confirmatory testing (HIV 1/2 antigen/antibody). Utilize "Fast Lane". Verify INS.

→ **Negative (-) result**

→ **Positive (+) result**

Negative (-) result

↓

Give result to patient via phone/in person & repeat testing in 3-6months.

Positive (+) result

↓

Flag HIV RN/HIV team to deliver results & Link to care /Medication

---

CLINIC TESTING

↓

Exam Room

↓

In Physical do HIV Testing (ages 15-65yrs)

↓

Order HIV testing & Flag HIV RN that testing was done.

→ **Negative (-) result**

→ **Positive (+) result**

Negative (-) result

↓

Give result to patient via phone & repeat testing in 3-6months.

Positive (+) result

↓

Flag HIV RN/HIV team to deliver results & Link to care /Medication

---

CCI Health & Wellness Services
Workflow

Routine HIV Testing

In accordance with USPSTF guidelines, all patients between the ages of 15-65 shall be tested for HIV once in their lifetime through CCI.

Adult/Adolescent Medical Visit

Medical Assistant:

1. Follows Adult/Adolescent visit workflow.
2. Selects the Adult Screenings Form.
3. Checks HIV test result box. If there is no documented result, then proceed with form.
4. Introduces the HIV Routine Testing program by reading routine testing statement (on the form) to the patient.
5. Provides HIV education to the patient:
    a. Electronically- Gives the patient the electronic device and initiates the HIV routine testing video in the patient's preferred language.
    b. Print- Gives patient HIV video script for pre-test counseling in the patient's preferred language.
    c. Verbally- If patient has low literacy or materials are not available in the patient's preferred language, education will be delivered verbally or via interpreter using a script.
    d. Once the routine testing video is complete; the MA selects *HIV Testing Offered: "Yes"* and *HIV Education Provided: "*Yes", and leaves the room with the device.

Patient does not decline testing

Medical Assistant:

1. Selects the "HIV Rapid Test Order" standing order from the HIV Testing form.
2. Routes the office visit to the provider.
3. Initiates the HIV rapid test following the manufacturing procedure.

Provider**:**
1. During visit provider reviews routine screening form and is available for questions.

Patient <u>declines</u> the test

<u>Medical Assistant</u>:

1. Selects *HIV Testing Declined "Yes",* documents the reason for decline on the HIV Testing form.
2. Routes office visit to the provider.

<u>Provider</u>:

3. Provider reviews HIV Testing form, discusses declination with the patient and answers questions.

If the patient has questions before a testing decision can be made:

<u>Medical Assistant</u>:

1. Routes the visit to the provider and informs the provider verbally that the patient has questions.

<u>Provider</u>:
1. Answers questions about HIV routine testing during the office visit.
2. If patient does not decline testing at this time; provider selects the HIV Rapid Test Order and notifies MA that patient will be tested.
3. If patient declines; provider selects *HIV Testing Declined "Yes",* notes the reason and proceeds with visit.

<u>Performing the HIV Rapid Test</u>

<u>Medical Assistant</u>:

1. Assures test control performed according to manufacturer procedure and up to date in Testing Quality Control Log (performs Quality Control, if indicated).
2. Confirms HIV rapid test order in patient's record.
3. Performs test in the room with the patient, labels the specimen and places it in the lab for processing.

<u>Performing Venipuncture HIV Testing</u>

<u>Provider</u>:

1. Places order for HIV Testing (HIV ½ Ab/Ag, 4th Generation)

Phlebotomist/Medical Assistant:

1. Performs venipuncture.
2. MA checks outgoing labs report once weekly to assure results are received.

Negative Rapid Test Result

Medical Assistant:

1. If the result of the HIV Rapid test is not ready by the time the provider finishes the visit, the patient can be directed to wait in the reception area to be called back to a patient room once the result is available.
2. Documents test result on the HIV Testing form in the patient's record and routes to provider for review and signature.
3. Delivers result and documents on the HIV Testing Form in the patient's record and checks "Results given to patient" box and signs "Performed by" box.
4. Provides *"It's Routine"* HIV testing brochure.
5. If the provider signs the visit before the result is documented:
     i. "Append" the office visit.
     ii. Select visit type: Office Visit.
     iii. Complete HIV Testing form.
     iv. Route to provider to review and sign.
6. If the patient has questions about the result, route question via phone note to the Team RN or provider.

Provider:

1. If the result of the HIV Rapid Test is ready before the provider finishes the visit the provider delivers the results to the patient; checks "Results given to patient" box on HIV Testing Form and signs "Reviewed by" section of the form.
2. Provides recommendations for repeat testing according to established Centers for Disease Control and Prevention Guidelines.
3. Provide *"It's Routine"* HIV testing brochure.

Positive HIV Test Results-Rapid

See "Positive HIV Test Workflow" (Attachment B)

Medical Assistant:

1. Documents the result on the HIV Testing form and routes the result to the provider.
2. Notifies provider verbally of positive result.
3. If the patient is in the waiting area, the MA calls the patient back to an available room and notifies the provider that the patient is ready.
4. Routes visit with result to HIV Care Program for state mandated reporting and tracking.

Provider:

1. Informs patient of results while in the patient room and documents checks "Results given to patient" box on HIV Testing Form and signs "Reviewed by" section of the form and documents in the patient's record.
2. Orders "HIV ½ Ab/Ag 4th Generation" venipuncture test.
3. Patient leaves clinic with an appointment to return for results (MA makes appointment).

Invalid Results

Medical Assistant:
1. If the result of the HIV rapid test is invalid the test should be repeated according to manufacturer procedure.
2. If the test is invalid a second time
   i. Notify provider of invalid result
   ii. Complete incident report according to CCI established procedure
   iii. Inform HIV care team of repeated invalid result for manufacturer notification.

Provider:
1. Informs patient of invalid result
2. Orders "HIV ½ Ab/Ag 4th Generation" venipuncture test

<u>Program Monitoring</u>

1. Data for the following variables will be reviewed by the HIV Care Program monthly: number of HIV tests offered, declined and performed. Progress will be reported to individual practice locations.
2. Below average locations will be further evaluated to assess issues with workflow, identify patient declination reasons, address staff concerns and develop plans to increase testing numbers.
3. Monthly reports will be generated via the EMR identifying patients with positive HIV tests and patients with codes for "HIV" ICD-10, B20. Results will be reconciled with the HIV Care Program master list of CCI patients with an HIV diagnosis.
   a. If a patient does not appear on the master list, the patient's chart will be reviewed in the EMR to assure HIV care is being provided.
   b. Follow-up with the patient's listed PCP will be performed via flag in EMR.
4. Annually, HIV incidence and prevalence will be assessed and stratified by race, gender, ethnicity, preferred language and age to identify special populations within CCI targeted testing beyond national guidelines.

Attachment B: Positive HIV Test Results Workflow

Attachment B

CCI Health & Wellness Services
Workflow

Positive HIV Test Result

HIV Positive Test Result-RAPID TEST

Provider (and clinical support personnel):

In the room with patient the provider informs patient that their HIV rapid test result was positive and provides post-test education:

1. Explains <u>preliminary positive</u> result;
   a. *(explanation of results, next steps & process of confirmatory testing, treatment options if confirmed positive, informs/referral CCI HIV program)*
2. Orders confirmatory "HIV ½ Ab/Ag 4th Generation" by venipuncture to be performed at the visit.
3. Assesses need for mental health, clinical and/or support services with a warm-hand off, if possible.
4. Provides informational packet
   a. (Post-Test Education, *Community Resource Guide)*
5. Instructs staff and patient to schedule a follow-up appointment in 1 week to receive results.
6. Routes results to RNCC/Team RN for coordination and monitoring of follow-up.

Medical Assistant/RNCC/Team Nurse:

1. Calls patient the following day to assess how patient is doing.
   a. Assists with linkage to behavioral health or other resource as needed.
2. Contacts patient one day prior to confirm appointment for confirmatory test result.
3. MA/RNCC/Team RN notifies HIV Care Program if they are unable to reach patient or   patient does not return for results after 3 call attempts over a 48 hour period.
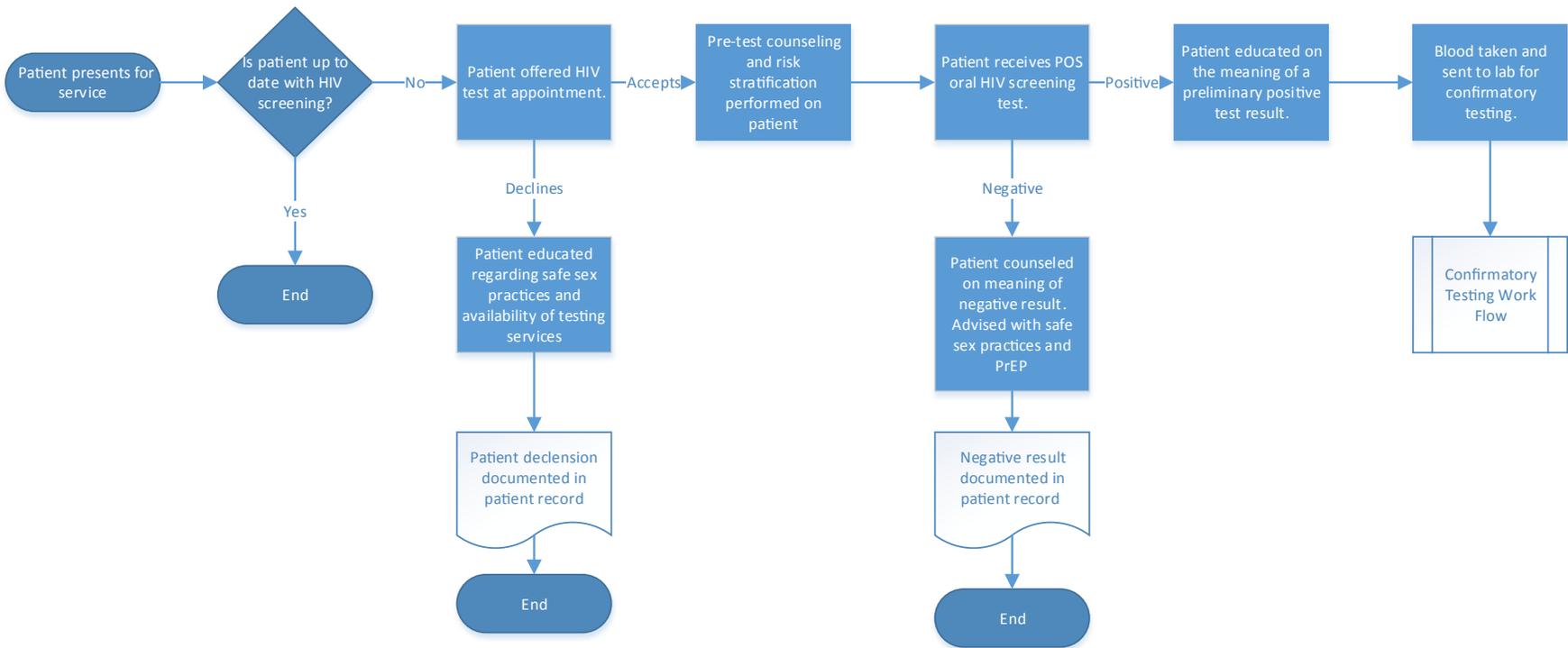
HIV Positive Test Result-VENIPUNCTURE

Provider:

In the room with patient the provider informs patient that their HIV venipuncture test result was positive and provides post-test education:

1. Explain positive result.
   a. *(script will include-explanation of results, next steps & treatment options)*
2. Assesses for need of mental health, clinical and/or support services with a warm-hand off, if possible.
3. Provides informational packet.
   a. *(HIV post-test education, Community Resources Guide)*
4. Routes results to RNCC/Team RN for coordination and monitoring of follow-up.
5. Routes results and visit to HIV Care Program to set up initial visit or to provide linkage to care with a community provider and facilitates warm hand-off in person or via phone, if possible.
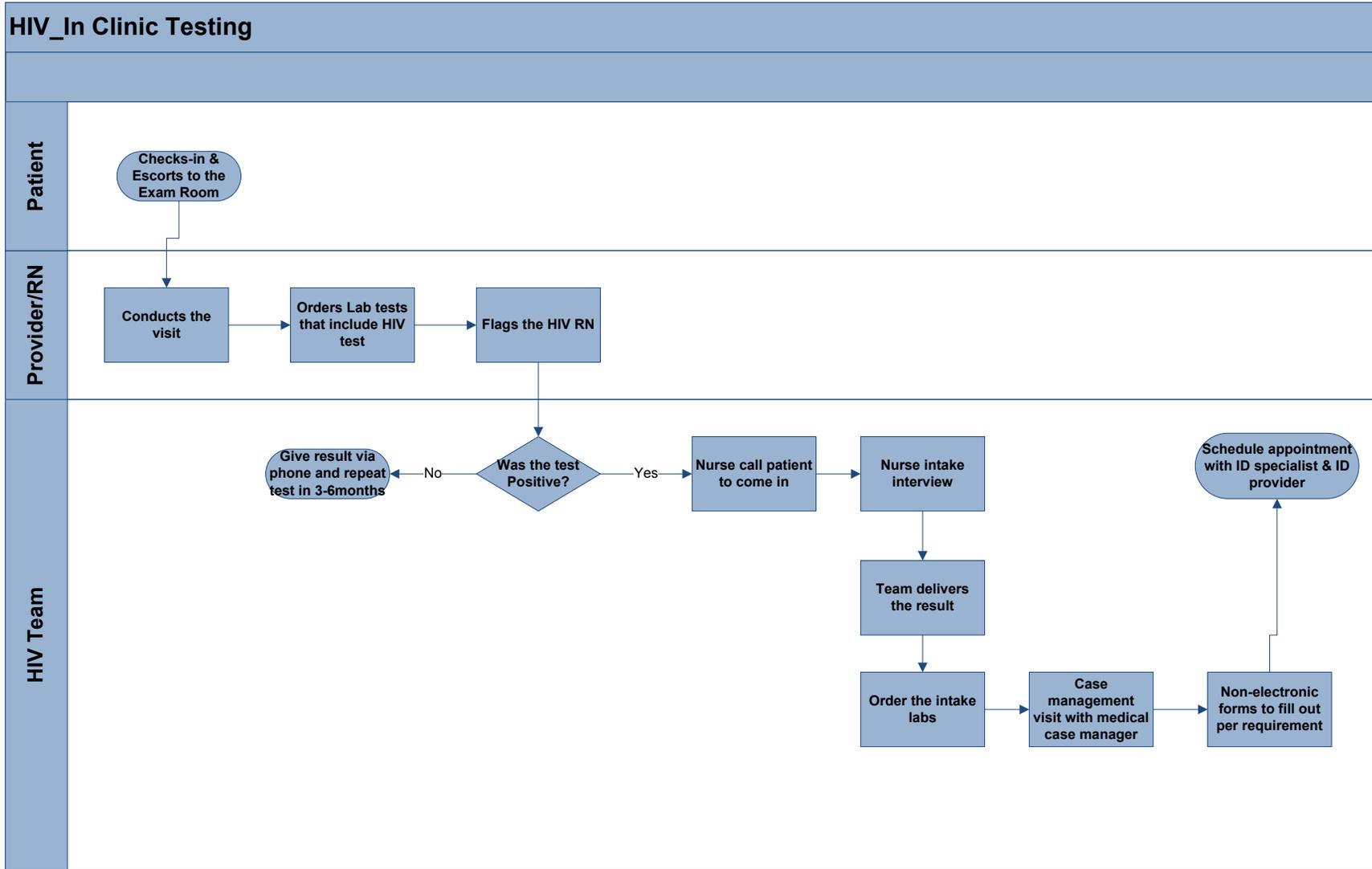
CCI HIV Care Program:

1. Contacts patient same day as the visit after results have been delivered.
   a. Discusses care options (CCI, local health department, community providers)
   b. Sets up an appointment with the HIV Care Team RN to meet the patient for initial visit if patient will be receiving care at CCI.
   c. Makes referral to another HIV provider if care will not be provided at CCI and assists patient with scheduling the appointment.
2. Reports HIV positive case to the local health department and discusses linkage to care and partner notification needs.

Integrating HIV Care, Treatment & Prevention Services into Primary Care: A Toolkit for Health Centers

Patient presents for service

Is patient up to date with HIV screening?

—No—

Yes

End

Patient offered HIV test at appointment.

—Accepts—

Declines

Patient educated regarding safe sex practices and availability of testing services

Patient declension documented in patient record

End

Pre-test counseling and risk stratification performed on patient

Patient receives POS oral HIV screening test.

—Positive—

Negative

Patient counseled on meaning of negative result. Advised with safe sex practices and PrEP

Negative result documented in patient record

End

Patient educated on the meaning of a preliminary positive test result.

Blood taken and sent to lab for confirmatory testing.

Confirmatory Testing Work Flow

HIV_In Clinic Testing

Patient
- Checks-in & Escorts to the Exam Room

Provider/RN
- Conducts the visit
- Orders Lab tests that include HIV test
- Flags the HIV RN

HIV Team
- Was the test Positive?
  - No → Give result via phone and repeat test in 3-6months
  - Yes → Nurse call patient to come in → Nurse intake interview → Team delivers the result → Order the intake labs → Case management visit with medical case manager → Non-electronic forms to fill out per requirement → Schedule appointment with ID specialist & ID provider

The Community Clinic, Inc. (Greenbelt, MD): HIV Testing Competency-Based Validation Form   Page 1 of 3

CCI Health and Wellness Services

ALERE DETERMINE™ HIV – 1/2 Ag/Ab COMBO COMPETENCY BASED VALIDATION FORM

Name:_____   Position:_____   Date:_____ ❑Initial / ❑ Annual Assessment

Performance Criteria	Self - Assessment				Observation Date	Observer Evaluation		Action Plan/Comments	Observer's Signature
	Have you done this before		Do you meet criteria			Was criteria met			
	NO	YES	NO	YES		NO	YES		
Initiating Routine HIV Test Performance Evaluation									
Rooms and confirms correct patient using two (2) identifiers.									
Locates patient chart in EMR. Selects **New Document**, "*Adult-*" or "*Pediatric Visit*"..									
Confirms document type, provider, location and documents chief complaint and transition of care in "*Update Chart*" form.									
Identifies appropriate candidates for routine HIV Screening using the Alere Determine ™ HIV – 1 /2 Ag/Ab Combo CLIA-waived test. Inclusion criteria include all patients between 15 – 65 years of age.									
Opens "*Adult Screening*" form and locates "*HIV Testing*" tab.									
Looks for presence of HIV test result cell in "*HIV Testing*" tab. If no documented result, initiates testing protocol.									

ALERE DETERMINE™ HIV – 1/2 Ag/Ab COMBO COMPETENCY BASED VALIDATION FORM

Name:_____   Position:_____   Date:_____ ❑Initial / ❑ Annual Assessment

Performance Criteria	Self - Assessment				Observation Date	Observer Evaluation		Action Plan/Comments	Observer's Signature
	Have you done this before		Do you meet criteria			Was criteria met			
	NO	YES	NO	YES		NO	YES		
Testing Protocol Performance Evaluation									
Appropriately reads HIV Testing script, **"According to national recommendations everyone between the ages of 15-65 should be tested at least once for HIV. Some people may need to be tested more than once. This test will be done during your visit."**									
Chooses *HIV Testing Offered:* "Yes" Starts the educational HIV video on a Tablet and hands to the patient.									
Uses written HIV education script **or** verbalizes process when Tablet not available in preferred language.									
Once video is complete selects *HIV Education Provided*: "Yes".									
If patient does not decline testing, selects *HIV Testing Accepted:* "Yes". Selects HIV Rapid Test order to generate the standing order. Proceeds to Fingerstick and Sampling Protocol.									

The Community Clinic, Inc. (Greenbelt, MD): HIV Testing Competency-Based Validation Form   Page 2 of 3

CCI Health and Wellness Services

ALERE DETERMINE™ HIV – 1/2 Ag/Ab COMBO COMPETENCY BASED VALIDATION FORM

Name: _____   Position: _____   Date: _____ ❑Initial / ❑ Annual Assessment

Performance Criteria	Self - Assessment				Observation Date	Observer Evaluation		Action Plan/Comments	Observer's Signature
	Have you done this before		Do you meet criteria			Was criteria met			
	NO	YES	NO	YES		NO	YES		
Fingerstick and Sampling Protocol Evaluation									
Washes hands thoroughly and prepares a clean workstation.									
Assembles sterile lancet capable of producing 50 µL of blood, alcohol wipe, gloves, gauze, band aid, disposable capillary tube, disposable workstation, a timer, and Chase Buffer.									
Bends the Alere Determine™ HIV - 1 /2 Ag/Ab Combo test strip along the perforation, tears one strip from the right and removes the cover. Verbalizes understanding that assay should be initiated within 2 hours after cover removed.									
Places the strip inside the disposable workstation being careful not to touch the sample pad with fingers.									
Labels workstation with patient's name and DOB									

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3

ALERE DETERMINE™ HIV – 1/2 Ag/Ab COMBO COMPETENCY BASED VALIDATION FORM

Name: _____   Position: _____   Date: _____ ❑Initial / ❑ Annual Assessment

Performance Criteria	Self - Assessment				Observation Date	Observer Evaluation		Action Plan/Comments	Observer's Signature
	Have you done this before		Do you meet criteria			Was criteria met			
	NO	YES	NO	YES		NO	YES		
Fingerstick and Sampling Performance Evaluation									
Performs techniques to optimize blood flow if needed, including warming the hand by washing in warm water, lowering the hand below the heart level or massaging the finger with a downward motion before performing the fingerstick.									
Cleans the patient's finger with an alcohol wipe, allowing to dry thoroughly.									
Using a sterile lancet, punctures the skin just off the center of the finger pad and wipes the first drop with sterile gauze.									
Expresses blood by gently squeezing at the base of the finger tip just above the first joint. Does not milk the fingertip.									

The Community Clinic, Inc. (Greenbelt, MD): HIV Testing Competency-Based Validation Form   Page 3 of 3

CCI Health and Wellness Services

ALERE DETERMINE™ HIV – 1/2 Ag/Ab COMBO COMPETENCY BASED VALIDATION FORM

Name: _____   Position: _____   Date: _____ ❏Initial / ❏ Annual Assessment

Performance Criteria	Self - Assessment				Observation Date	Observer Evaluation		Action Plan/Comments	Observer's Signature
	Have you done this before		Do you meet criteria			Was criteria met			
	NO	YES	NO	YES		NO	YES		
Fingerstick and Sampling Performance Evaluation									
Collects second drop of blood in the capillary tube, holding horizontally and slightly downward while touching the tip to the blood sample. Maintains position until the flow has reached the fill line without squeezing the bulb.									
Touches the tip of the capillary tube containing the blood sample to the sample pad and expels all contents by gently squeezing the bulb preventing leakage or bubbles from forming.									
Once full blood specimen on the pad, using a timer, waits one minute to deliver **one drop** of the Chase Buffer solution to the sample pad, then sets timer for 20 minutes.									
Places labeled workstation and timer in lab for processing.									
Reads test result at **20 minutes but no longer than 30 minutes** after the addition of the Chase Buffer.									

5

CCI Health and Wellness Services

ALERE DETERMINE™ HIV – 1/2 Ag/Ab COMBO COMPETENCY BASED VALIDATION FORM

Name: _____   Position: _____   Date: _____ ❏Initial / ❏ Annual Assessment

Performance Criteria	Self - Assessment				Observation Date	Observer Evaluation		Action Plan/Comments	Observer's Signature
	Have you done this before		Do you meet criteria			Was criteria met			
	NO	YES	NO	YES		NO	YES		
Documentation and Follow-Up Evaluation									
Can verbalize correct reading of test results.									
Notifies patient of negative test results and provides "It's Routine" HIV post-test brochure.									
Documents result correctly in EHR and routes to provider									
Properly disposes test strip and workstation.									
Verbalizes workflow for positive results; including verbal provider notification and documentation.									
Documents rapid HIV test use on HIV inventory CCI tracking sheet.									
Verbalizes Quality Control testing procedures and schedule.									
Declinations									
If patient declines testing, selects *HIV Testing Accepted:* "No". Documents reason for declination.									

<u>YOUR HIV TEST IS NON-REACTIVE.</u>

-A negative result almost always means you are not infected with HIV, the virus that causes AIDS. There is the possibility of recent infection if you took part in risky behaviors in the 3 months before the test.

-Protect yourself and be retested in 3 months if you have taken part in high risk behaviors in the 3 months before the test.

-High risk behaviors are: having unprotected sex and/or sharing needles for drugs, tattoos or piercings with someone whose HIV status you don't know.

<u>PROTECT YOURSELF!</u> ☺

-Have your HIV test every year with your annual check-up - more often if have risky behaviors.

- Don't have sex or share needles with a person who has HIV or whose HIV status you don't know.

-If you do have sex, use a latex male or female condom because they work very well to prevent HIV infection if you use them the right way, every time you have sex.

-If you shoot drugs, use new needles and equipment every time you shoot up and don't share needles, syringes or works.

-Never buy needles on the street, even if they look new. You can buy new needles at many drugstores if you are over 18 and syringe exchange programs provide clean needles for free. Don't share needles for piercing or tattoos of any kind.

You can go online to see more free HIV prevention resources!

Sterile Syringe Access, Syringe Exchange Programs: provide sterile injection equipment and many services to drug users free of charge.

Expanded Syringe Access Program: allows you to buy syringes without a prescription from participating pharmacies.

Early Treatment of STDs: having an STD makes it easier to give HIV to others and easier to become infected with HIV if you are exposed to it.

LAB "FAST LANE" ALGORITHM

The "Fast Lane" is a system that allows newly diagnosed HIV patients to be given priority in getting their labs drawn. Below is the algorithm that should be followed for labs draws. In order to prevent additional emotional stressors, all newly diagnosed HIV patients should have labs drawn via the "Fast Lane".
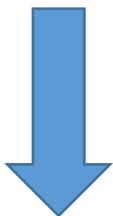
Newly diagnosed HIV positive patient

↓

Print lab slip (Hard copy of lab slip is required)

↓
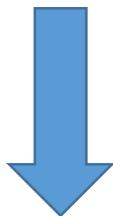
Call testing room @ X3062, 15 min before bringing patient to lab

↓

Transport patient to lab. Enter lab via Urgent Care's back entrance.

Delivering HIV Test Results

Background. Getting an HIV positive test result is a life-changing experience; therefore, the importance of HIV testing remains critical as a public health intervention in reducing the transmission of HIV infection and improving health outcomes. When delivering a positive result, the provider should be sensitive to the needs of the individual, while providing current, accurate, and culturally competent information on living with HIV. Discussing treatment options early avoids a missed opportunity to link and engage newly diagnosed patients to care and establishes the foundation for retention and minimizes the chance of future transmission. Likewise, an HIV negative result can also be life-changing, affording the health care provider an opportunity to educate the individual on understanding his/her own risk for HIV infection, HIV prevention counseling, and access to medical interventions such as pre-exposure prophylaxis (PrEP).

Setting the Stage to Deliver an HIV Test Result
- Conduct delivery of an HIV test result, positive or negative, in-person if at all possible.
- Provide a confidential, private setting to deliver results.
- Be present, anticipating, and minimizing any possible distractions.
- Make time, and be flexible, based on the patient's reactions and needs.
- Know, and have available, referral services for immediate linkage to medical care, mental health care and social services as needed.

Delivering an HIV Negative Result
- Explain exactly what the test result means in clear, simple terms.
  - HIV antibodies and/or antigen, depending on what tests were performed, were not detected.
  - Explain the window period specific to the test performed.
  - Offer re-testing to close window periods.
- Provide support, education and counseling.
  - Identify behaviors that elevate risk for HIV acquisition.
  - Recognize methods and enhance skills for reducing risk.
  - Evaluate options for PrEP or nPEP services.
  - Refer to medical care, substance use treatment, mental health services, or other social services if needed.
  - Set a foundation for retention in care and ongoing HIV testing/risk reduction.

Delivering an HIV Positive Result
- Explain exactly what the test result(s) means in clear, simple terms.
  - HIV antibodies and/or antigen were detected. If test was a confirmatory test, explain this means the patient has active HIV infection.
  - If test was a preliminary test, explain the meaning of a preliminary result and necessary follow-up confirmatory testing needed.
- Provide support, education and counseling.
  - Help the patient understand the diagnosis.
  - Provide short-term therapeutic interventions/counseling to help patient cope with the diagnosis.
  - Provide education on current treatment for HIV and how HIV is a chronic, manageable condition if patient receives consistent care and treatment.
  - Discuss partner notification/importance of disclosure of status to sexual and/or needle-sharing partners.
  - Assess immediate safety concerns for the patient and make an agreement for support services during the initial phase of dealing with a new diagnosis.

April 2016

- ◦ Discuss importance of preventing further transmission of HIV and specifically how the patient can minimize their risk of transmission.
- ◦ Refer to medical care, substance use treatment, mental health services, or other social services if needed.
- ◦ Provide education on the importance of immediate and consistent care/treatment, setting up a foundation for long-term retention in care.

Tips for Conveying a Positive Result
- Be specific about what the test results mean (rapid/laboratory testing/confirmatory testing).
- Allow time for the patient to react to what they have just heard before providing information/education/further care.
- Remain present, calm and nonjudgmental. You may be surprised by a reaction or what comes up around behaviors leading to the HIV infection.
- Offer immediate reassurance that having HIV does not mean AIDS, or a death sentence.
- Show empathy, warmth, and caring.
- Perceived loss of health is a bereavement and comes with all the components of denial, anger, bargaining, depression, and acceptance.
- Try not to show surprise to potential outbursts or make value-based statements like, "There is no need to be so upset, you will be fine."
- Stress the importance of immediate and lifelong engagement in HIV and primary care.
- Ask what specific questions, concerns and fears the patient has right now. Address them in as simple terms as possible. Let them know as time goes on they will have more questions and you/your organization will be there to help answer them.
- Refer them to other services and organizations for needs patient may have that are outside the scope of your organization.
- Assess plans after leaving the clinic and available support networks.

Be Prepared for Common Questions
- Prognosis, health and life expectancy
- Access to care and treatment
- Care and treatment options
- Impacts on lifestyle
- Identification of source
- Legal questions, including disclosure, employment, HIV criminalization laws, health care coverage
- Family/ability to have children
- Safety of existing family/children
- How/what/when to tell partners and others
- Intimacy/protecting partner(s)
- Rejection/isolation

Follow-up Plan
- Plan for immediate follow-up (potentially even later that day or next day)
- Plan for linkage to HIV care/treatment
- Other immediate services, including legal, emergency financial services, food access, case management, and domestic violence services

Special Considerations for Pregnant Women
- Discuss PMTCT (Prevention of Mother to Child Transmission) basics
- Counsel on staying healthy and PMTCT during pregnancy
- Counsel on safe delivery of the baby
- Counsel on infant feeding
- Create concrete plans for her own and baby's care
- Provide appropriate referrals

TEENS, PARENTS & HIV TESTING☺

☺ **Why offer testing to teens?** The American Academy of Pediatrics recommends routine HIV testing for adolescents. NYS Law requires the *offer* of an HIV test to all people ages 13 and up. 18% of all new HIV cases in NY occurred among 13-24 year olds.
- Adolescence is a time of experimentation and self-exploration.
- Teens face many pressures around sexual behavior and substance use.
- Teens may not always be able to talk with their parents about all their behaviors.
- It's important for teens to have a trusted health care provider to address their concerns and questions about their changing bodies and health.

☺ **As the parent, don't I have to consent to my child's HIV test?** NYS Law allows people to consent to an HIV test at any age, so teenagers can consent to their own test. If your health care provider has specific concerns about your child's ability to understand the nature and consequences of the HIV test, the provider will talk with you about HIV testing.

☺ **As the parent, will I be told the result of my child's HIV test?**   Minors can consent for the test, but not for complex medical care, unless married, pregnant, or parenting. If the HIV test is positive, your health care provider will work with your child to develop a plan for involving you in HIV medical care decisions.

☺ **As the parent, will I be able to find out what my child told the doctor?** Information your teen shares with the provider is confidential. It is important to respect the relationship between your teen and the health care provider.

☺ **Medical appointments with teenagers** include time for the provider to meet with your child individually. This is important to establish a good provider-patient relationship. It also helps your child learn how to take responsibility for his or her own health.

☺ **Will insurance bill me for my child's HIV test?** Yes. If your insurance covers the HIV test, we will submit a bill for payment. Parents are responsible for any required co-pays. If you are concerned about payment, we can tell you how to access free HIV testing.
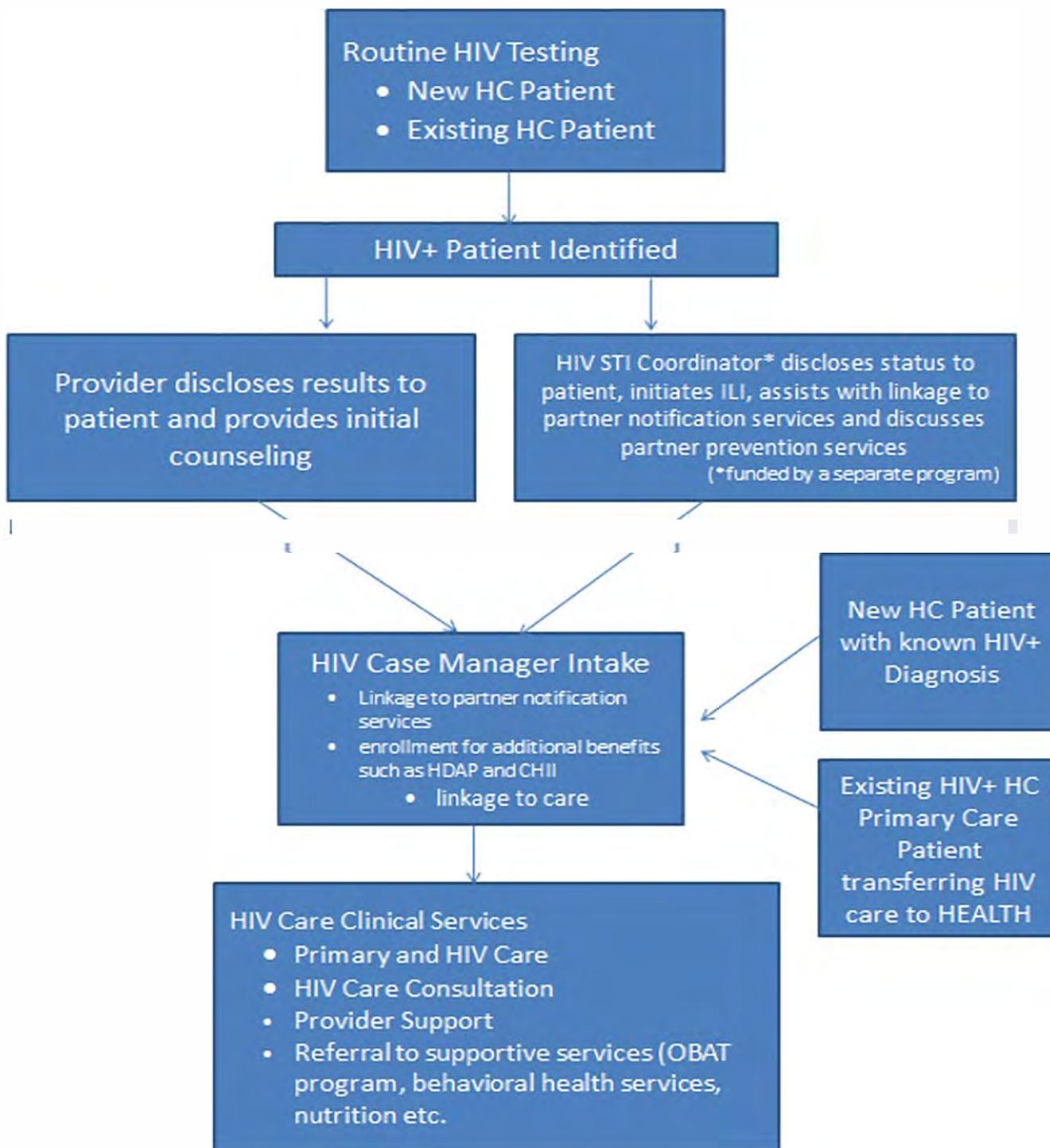
☺ <u>WHY *YOU* SHOULD HAVE YOUR HIV TEST TODAY!</u>

☺ **The only way to know if a person is infected with HIV is to be tested!** A person can look and feel fine and have HIV.

☺ **HIV testing is as normal** as test ng your cholesterol or blood sugar. You are tested yearly along with all your other annual tests, or every 3 months if you are high risk. If we provide your primary health care, you should have a record of your HIV status in your chart.

☺ **There are treatments for HIV/AIDS** that can help a person stay healthy.

☺ **People with HIV/AIDS can use safe practices** to protect others from becoming infected.

☺ **Safe practices also protect people with HIV/AIDS** from being infected with different strains of HIV.

☺ **HIV test results** and related informat on are kept **private/confidential.**

☺ **The oral test is easy, fast and painless.**

☺ **If you are having other blood work done**, an HIV blood test can be done at the same t me.

☺ **We offer the test to everyone!**

☺ **HIV is the virus that causes AIDS.** It can be spread by: unprotected vaginal, anal, or oral sex with someone who has HIV; sharing needles for tattoos, piercings or IV drug use with someone who has HIV; mothers who have HIV can give it to their baby during pregnancy, delivery, or breastfeeding.

KNOW YOUR STATUS! GET TESTED TODAY!
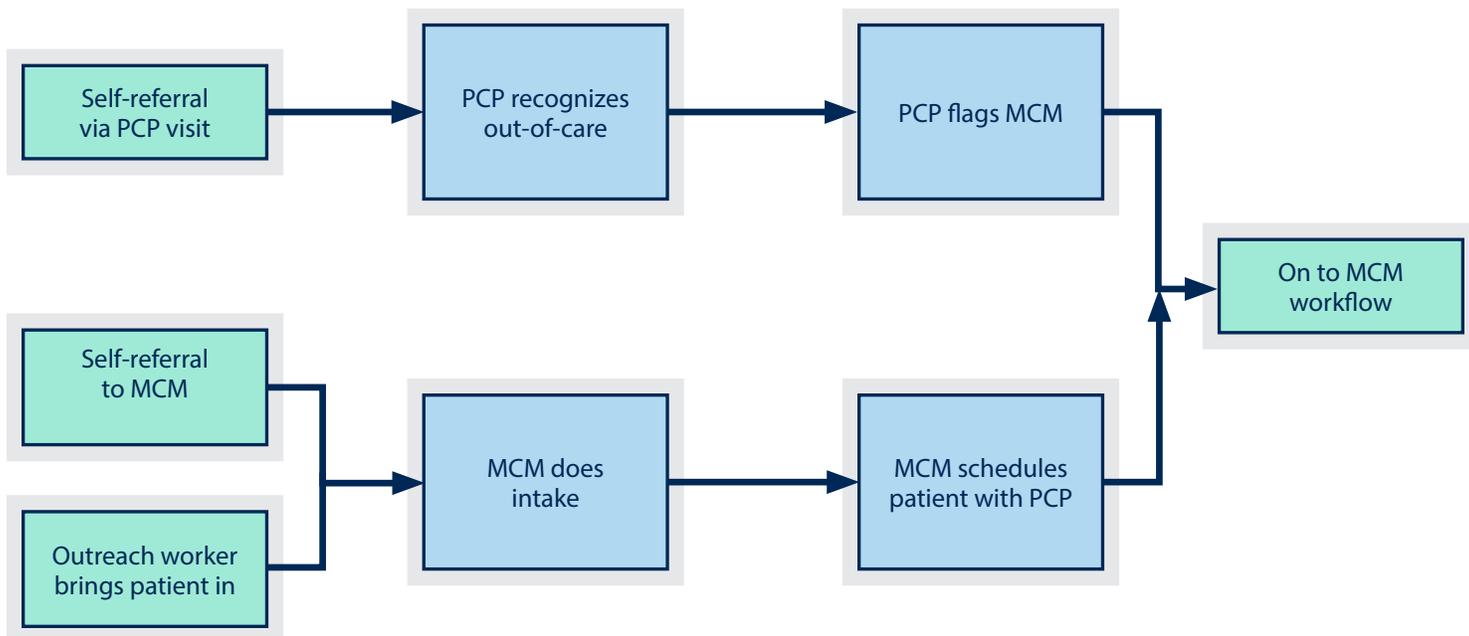
LET'S END HIV!

Patient Access to HIV Care at the Health Center

Routine HIV Testing
- New HC Patient
- Existing HC Patient

HIV+ Patient Identified

Provider discloses results to patient and provides initial counseling

HIV STI Coordinator* discloses status to patient, initiates ILI, assists with linkage to partner notification services and discusses partner prevention services
(*funded by a separate program)

New HC Patient with known HIV+ Diagnosis

HIV Case Manager Intake
- Linkage to partner notification services
- enrollment for additional benefits such as HDAP and CHII
  - linkage to care

Existing HIV+ HC Primary Care Patient transferring HIV care to HEALTH

HIV Care Clinical Services
- Primary and HIV Care
- HIV Care Consultation
- Provider Support
- Referral to supportive services (OBAT program, behavioral health services, nutrition etc.

Engaging HIV+ Out-of-Care Workflow

Self-referral via PCP visit → PCP recognizes out-of-care → PCP flags MCM

Self-referral to MCM → MCM does intake

Outreach worker brings patient in → MCM does intake → MCM schedules patient with PCP → On to MCM workflow

Mattapan Community Health Center (Mattapan, MA): HIV Medical Care Case Management Tool — Page 1 of 2

NAME	John Doe	Josie Doe
Care Plan	10/12015 identified as positive through routine screening, risk factors MSM, started Odefsy on 1/1/2015. Achieved viral suppression after 1 month of treatment, excellent adherence, no SE's. LGSIL on anal PAP, referred for HRA. Continues to see MNHP for depression and anxiety. Next medical visit 5/1/2016.	HIV diagnosis in Trinidad, was on meds for a while, does not recall regimen and does not have records. Stopped before she came to US last year. History of pneumonia and thrush. Confirmed at HC on 1/1/2015 with 9200 copies/mL and CD4 165/7%. Started on Tivicay and Descovy 4/1/2015. Refuses prophylactic medications, monitoring closely for infection or complication with visits Q4 weeks or PRN.
Case Management	Refuses HDAP and CHII, does not want to engage in AAC support group. CM available as needed for further assistance.	HDAP certified 4/1/2015, expected recert due 10/1/2015. Collaborating with AAC housing advocate to obtain housing assistance.
MRN	9999999	8888888
DOB	1/1/1969	12/12/1992
Gender	Male	Female
Medical Release	Yes	Yes
Date of Positive Test	10/1/2015 through routine screening	1/1/2015 first visit to clinic but preexisting dx at outside facility, approximately 2006
Confirmatory Test Date	10/5/2015	1/1/2015
Usual PCP	Dr. Pepper MD	Nurse Smith NP
Lost to Care HIV	no	no
Linked to Care (where getting care)	Local Comm. Health Center	Local Comm. Health Center
CD4 Cell Count (cells/mm3)	10/5/2015 = 900/55% 4/1/2017 = 1118/57%	1/1/2015 = 165/7%
Viral Load (copies/mL - include date)	10/5/15 = 35 copies/mL 12/1/2015 = <20 copies 4/1/2016 = <20 copies	1/1/2015 = 9200 copies/mL
# non-HIV-related medical visits (include date)	none	none
PCP	Smith NP	Smith NP
Received HIV medical care at MCHC/elsewhere within 90 days (y/n)	yes	no
Provided HIV risk reduction screening/counseling within 90 days (y/n)	yes	yes

NAME	John Doe (contd.)	Josie Doe (contd.)
Screened for GC Chlamydia, and Syphillis within 90 days (y/n)	yes	yes
Prescribed ART (y/n)	yes	yes
Interviewed by health department for partner services (y/n)	no	no
# Partners	1	3
# Partners not known to have HIV	0	1
# Partners tested at MCHC	0	0
# Partners with new HIV+	0	0
# Partners who are HIV+ and received care within 90 days of diagnosis	0	0

- **Who is a PrEP Provider?**
  - ◦ Providers who manage primary care, HIV care, STD care, or drug treatment

- **Who should be prescribed PrEP?**
  - ◦ Populations indicated for once-daily PrEP (tenofovir disoproxil fumarate/emtricitabine [Truvada]) include: sexually active MSM, heterosexually active women and men, people who inject drugs

- **How should patients be evaluated for PrEP initiation?** – Conduct several assessments:
  - ◦ Brief sexual history (gender of sexual partners, consistency of condom use, number and HIV status of sexual partners, recent STD history)
  - ◦ Brief drug history (injection drug use, drug treatment)
  - ◦ Recent potential HIV exposure
  - ◦ Possible contraindications (recent signs/symptoms of acute viral illness, kidney or bone disease, used of medications toxic to the kidney)

- **What initial testing should be done?**
  - ◦ Initial laboratory testing (HIV, creatinine, hepatitis B if unvaccinated, pregnancy, STD)
  - ◦ If an initial HIV test is positive, PrEP will need to be deferred pending additional testing

- **What should be done when first prescribing PrEP?**
  - ◦ Prescribe up to a 90-day supply of medication
  - ◦ Educate patients on dosing, potential side effects, and side effect management
  - ◦ Provide education and support on drug adherence, as well as safer sex and injection practices
  - ◦ Assist with insurance and/or medication assistance programs
  - ◦ Schedule a follow-up visit for within 3 months

- **What should be done at follow-up appointments?**
  - ◦ Perform the following tests: HIV (every 3 months), creatinine (at 3 months, then every 6 months), pregnancy (every 3 months), STDs (every 6 months for asymptomatic patients)
  - ◦ Assess adherence and risk/protective behaviors at each visit
  - ◦ Provide another PrEP prescription (up to a 90-day supply) and schedule another follow-up appointment

- **What should be done if PrEP is discontinued?**
  - ◦ If a patient tests positive for HIV (seroconversion), offer them a treatment regimen and document any HIV resistance results
  - ◦ In discontinuation of HIV-negative patients, HIV and creatinine results should be documents, alternative HIV prevention strategies should be recommended, and in the case of a hepatitis B flare, consult an expert as appropriate

- **How can health centers support access to PrEP?**
  - ◦ For insured patients, seek co-pay assistance from Gilead or the Patient Access Network Foundation
  - ◦ For low-income or uninsured patients, seek support from Gilead's Medication Assistance Program for no-cost drugs. Also available through Gilead are free HIV and hepatitis B testing, free HIV resistance testing for patients who seroconvert on PrEP, and free condoms.

Adapted from *Pre-Exposure Prophylaxis (PrEP) for HIV Infection*, developed by Jeffrey Klausner, MD, MPH for the Partnerships for Care HIV Training, Technical Assistance, and Collaboration Center (9/30/2015)

CONTRIBUTORS

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FLORIDA

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Sulzbacher Center (Jacksonville, FL)

MARYLAND

Community Clinic, Inc. (Greenbelt, MD)

Family Health Centers of Baltimore (Baltimore, MD)

Healthcare for the Homeless, Inc. (Baltimore, MD)

Maryland Department of Health and Mental Hygiene (Baltimore, MD)

Park West Health Systems, Inc. (Baltimore, MD)

MASSACHUSETTS

Codman Square Health Center (Boston, MA)

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Lowell Community Health Center (Lowell, MA)

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NEW YORK

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Betances Health Center (New York, NY)

Community Health Center of Buffalo, Inc. (Buffalo, NY)

Cornerstone Family Healthcare (Cornwall, NY)

Damian Family Care Centers, Inc. (Jamaica, NY)

Jordan Health (Rochester, NY)

Appendix D
ACRONYM LIST for HRSA P4C TOOLKIT

Term	Definition
ADAP	AIDS Drug Assistance Program
AETC	AIDS Education and Training Center
AMA	American Medical Association
ART	Antiretroviral Therapy
BPHC	Bureau of Primary Health Care
CBO	Community-based organization
CCI	Community Clinic, Inc.
CDC	Centers for Disease Control and Prevention
CHCB	Community Health Center of Buffalo
CHI	Community Health of South Florida, Inc.
CLAS	Culturally and Linguistically Appropriate Services
CPT	Current Procedural Terminology
CQI	Continuous quality improvement
DRVS	Data-Reporting and Visualization System
ECHO	Extension for Community Healthcare Outcomes
EHR	Electronic health records
FQHC	Federally Qualified Health Center
HCPCS	Healthcare Common Procedure Coding Systems
HCV	Hepatitis C Virus

HHS	Department of Health and Human Services
HICAPP	Health Insurance Counseling & Advocacy Program
HIV TAC	HIV Training, Technical Assistance, and Collaboration Center
HRSA	Health Resources and Services Administration
ICD-10-CM	International Classification of Diseases 10th Revision Clinical Modification
LGBT	Lesbian, Gay, Bisexual and Transgender
LHD	Local health departments
MCM	Medical case manager
NASTAD	National Association of State and Territorial AIDS Directors
P4C	Partnerships for Care
PCMH	Patient-Centered Medical Home
PLWH	Persons living with HIV
PrEP	Pre-exposure prophylaxis
PSAT	Program Sustainability Assessment Tool
QI	Quality improvement
RAPID	Rapid ART Program Initiative for HIV Diagnoses
RN	Registered nurse
RWHAP	Ryan White HIV/AIDS Program
SMAIF	Secretary's Minority AIDS Initiative Fund
SSTAR	Stanley Street Treatment and Resources
TA	Technical assistance
UCSF	University of California San Francisco
UCSF-CEPC	University of California San Francisco Center for Excellence in Primary Care
UCSF-CHI	University of California San Francisco Center for HIV Information
YMSM	Young men who have sex with men

HRSA
Health Center Program

Integrating HIV Care, Treatment & Prevention Services into Primary Care:
A Toolkit for Health Centers