Path to Desegregation: Integrating HIV Management in Primary Care

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Director
Center for Key Populations
Community Health Center, Inc.
August 24, 2016

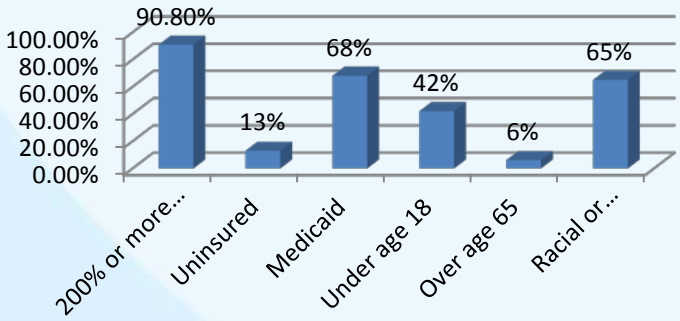
Community Health Center, Inc. Where health care is a right, *not a privilege*, since 1972.

Community Health Center Inc. Profile:

- Founding Year - 1972
- Primary Care Hubs – 13
- No. of Service Locations - 216
- Licensed /Total SBHC locations – 51
- Mobile dental in 200 locations
- Organization Staff - 800

CHC Patient Profile:

- #consider CHC their health care home: 130,000
- Health care visits: more than 429,000



Three Foundational Pillars:

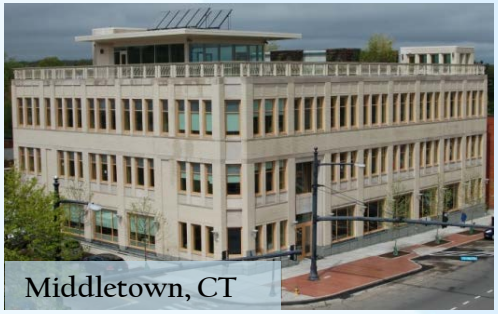
Clinical Excellence
Research & Development
Training the Next Generation

CHC's New Regional Structure

Innovations:

- Center for Key Populations
- Weitzman Institute
- Project ECHO for vulnerable populations
- National NCA on clinical workforce development
- Post graduate residency training for NPs and postdoctoral psychologists
- Formal research program
- Transformative quality improvement program
- E-consult specialty services

Buildings in transformation


Middletown, CT

New Britain, CT

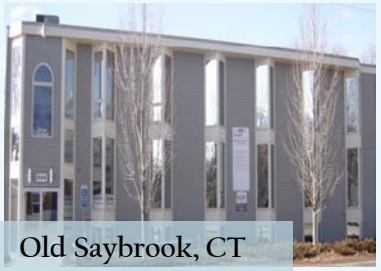

Meriden, CT


Norwalk, CT


New London, CT

Waterbury, CT

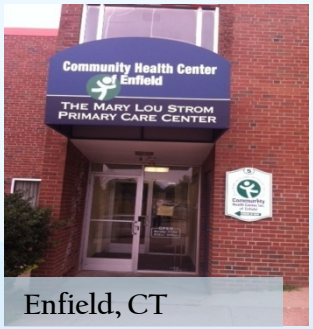

Groton, CT


Old Saybrook, CT

Danbury, CT


Bristol, CT

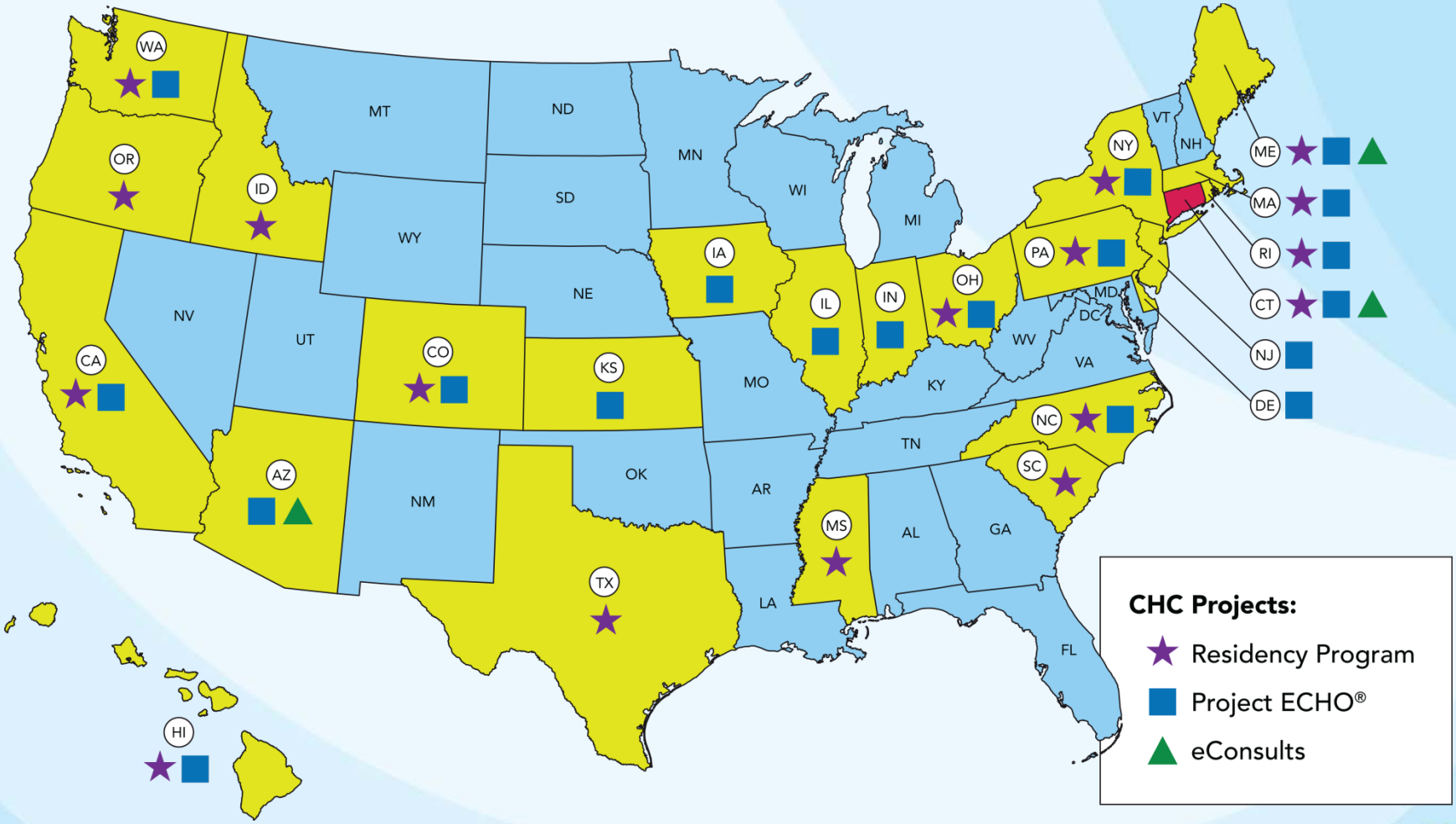

Clinton, CT



Enfield, CT

Stamford, CT

CHC's Educational, Technical & Innovation Projects



CHC Model Of Care

Patient-Centered Medical Home (Level 3 NCQA)

- Comprehensive, integrated primary medical, dental and behavioral health care
- Integrated specialty care (HIV, HCV, Substance use, Pain, e-consults)
- Wherever You Are Healthcare for the Homeless
- Access to ancillary services: Nutrition, Podiatry, Chiropractic care, CDE, OB
- Advanced access scheduling, expanded hours, 24/7 coverage, and Saturdays
- Quick Care Clinics

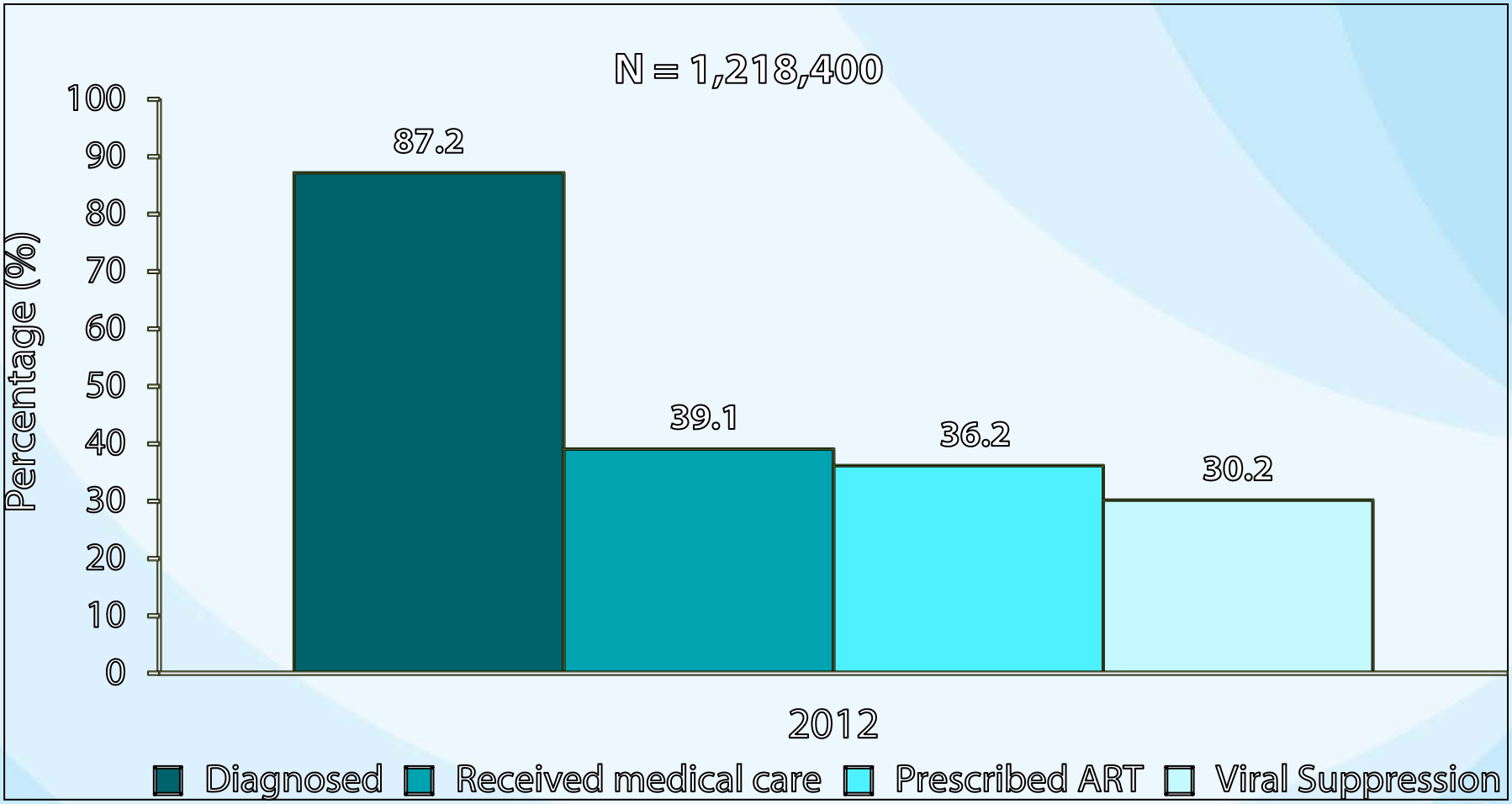
Planned Care and Chronic Care Model

- Team-based approach: clinical pods consisting of medical provider, RN, MA, BH
- HIV Case manager, Outreach coordinator, PrEP Navigator

Data Driven

- Outcome focused: clinical dashboards, QI clinical microsystems

Persons Living with Diagnosed or Undiagnosed HIV Infection
HIV Care Continuum Outcomes, 2012 — United States and Puerto Rico

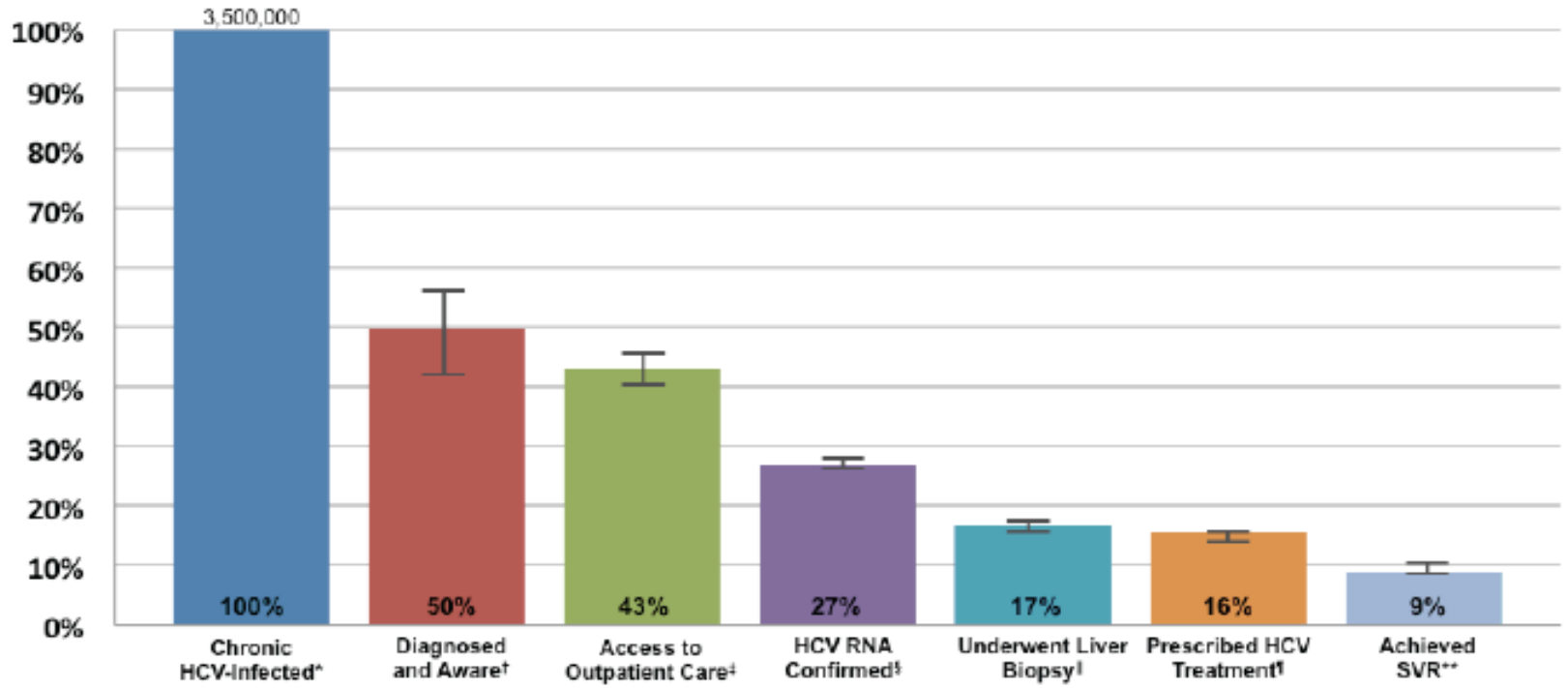


National HIV Surveillance System,: Estimated number of persons aged ≥13 years living with diagnosed or undiagnosed HIV infection (prevalence) in the United States at the end of 2012. The estimated number of persons with diagnosed HIV infection was calculated as part of the overall prevalence estimate.

Medical Monitoring Project: Estimated number of persons aged ≥18 years who received HIV medical care during January to April of 2012, were prescribed ART, or whose most recent VL in the previous year was undetectable or <200 copies/mL—United States and Puerto Rico.

Hepatitis C Treatment Cascade

Figure 2. Treatment Cascade for People with Chronic HCV Infection, Prevalence Estimates with 95% CI



Yehia BR, Schranz AJ, Umscheid CA, Lo Re V III (2014) The Treatment Cascade for Chronic Hepatitis C Virus Infection in the United States: A Systematic Review and Meta-Analysis. PLoS ONE 9(7): e101554. doi:10.1371/journal.pone.0101554

Opioid Epidemic in the United States

- 4.7 million people age 12+ illicitly used opioid pain relievers or heroin in 2014.
- 2.5 million had an opioid use disorder.
- Opioid overdose death rate: 9.0 per 100,000
- # Received Opioid Substitution Therapy (2013)
  - 330,308 – Methadone
  - 48,148 – Buprenorphine

The NSDUH Report, SAMHSA, 2015.
Behavioral Health Barometer: United States, 2014. HHS Publication No. SMA–15–4895, SAMHSA, 2015
SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey of Substance Abuse Treatment Services, 2009-2013


CENTER FOR KEY POPULATIONS

Center for Key Populations: Mission

- To ensure that key populations in the communities we serve have a central and cohesive focus.
- To ensure that the integration of their care is fully realized through the integral collaboration and utilization of the vast and rich resources available at CHC, including
  - World-class clinical care
  - Quality improvement
  - Training and education of the next generation to care for these populations, and
  - Research and publication to help study, improve and transform the care they receive.

Center for Key Populations

- Ensures access to integrated, quality specialty care for 5 key groups with highest burden of, and risk for, HIV who experience barriers to comprehensive, respectful and safe care.
  - Men who have sex with men
  - Transgender people
  - People who inject drugs
  - (Recently) incarcerated
  - Sex workers
- Services:
  - HIV screening, prevention, and treatment
  - HCV screening, prevention and treatment
  - STI screening, prevention and treatment
  - Buprenorphine maintenance therapy for opioid use disorder
  - Homeless care services
  - LGBTQ health

Center for Key Populations Organizational Chart

CHC Senior Leadership
CHC Board of Directors
Mark Masselli, CEO
Margaret Flinter, VP
Veena Channamsetty, CMO
Mary Blankson, CNO
Gary Reid, BOD Chair

Center for Key Populations
Kasey Harding – Wheeler
Marwan Haddad, MD, MPH

Key Populations Team
Patricia Mik, RN
Lizbeth Vazquez, MA
Omar Perez, MA
Lizbeth Vazquez, MA
Maria Lorenzo, MCM
Stephanie Moses, Data
Douglas Janssen, Outreach
Idiana Velez, PrEP

- Wherever You Are (Homeless) Program
- HIV Program (Ryan White Part C)
- HCV Program
- TEACH-BMT/HRSA Sub Use Program
- LGBT Program
- Oasis Wellness Center (Ryan White A and B)

- Consumer Advisory Board
- Quality Improvement (Clinical Microsystem)
- Project ECHO
- Research
- Teaching

Key Steps to Integration of HIV Care Program

- ✓ Having grant support.
  - ✓ RW Part C, RW Part A/B
  - ✓ SAMHSA, HRSA
- ✓ Having buy -in and support from senior leadership.
  - ✓ CEO and VP Clinical Services
  - ✓ Chief Medical Officer (CMO), Chief Nursing Officer (CNO)
  - ✓ Regional Site Directors
  - ✓ Other (Chief Behavioral Health Officer, Chief Operating Officer, etc.)
- ✓ Being included as part of leadership structure (administrative and clinical).
  - ✓ Attending organizational meetings
  - ✓ Attending OSMD meetings, site meetings
- ✓ Being included as part of operational and clinical policies and procedures
  - ✓ Performance Improvement (PI) Committee
  - ✓ Medical Quality Improvement (Med QI) Committee
- ✓ Having IT/Business Intelligence(Data) support.***

Key Steps to Integration of HIV Care Program

- ✓ Identifying clinical champions across the agency.
  - ✓ CMO/CNO support, Outreach, ECHO, ongoing support
- ✓ Teaching and educating agency wide.
  - ✓ ECHO, grand rounds, in-services, policies and protocols, trainings
- ✓ Establishing a system for adoption and implementation of initiatives
  - ✓ CKP QI/Clinical Microsystem
    - ✓ Initiative chosen, worked out, PDSAs done
    - ✓ Keeping CMO/CNO, others updated
  - ✓ Med QI
    - ✓ Presented for adoption
    - ✓ Becomes part of policies/procedures/clinical expectations/performance appraisals
  - ✓ PI committee
    - ✓ Presented for approval and agency roll out

Clinical Care Delivery

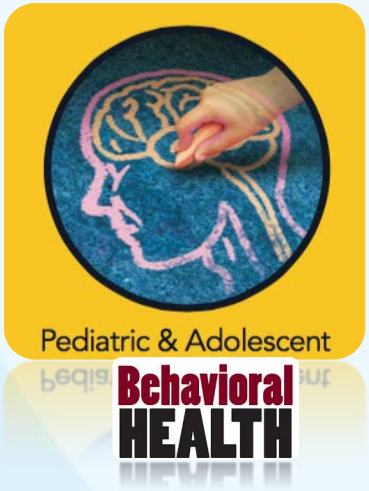
Dr. Sanjeev Arora
University of New Mexico

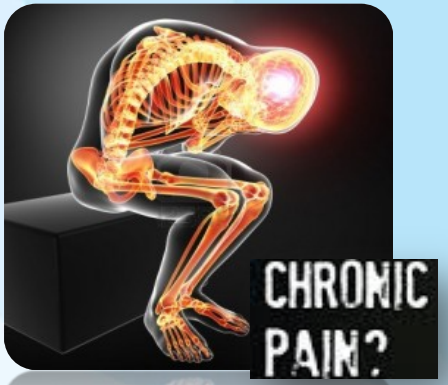
"The mission of Project ECHO is to develop the capacity to safely and effectively treat chronic, common and complex diseases in rural and underserved areas and to monitor outcomes."

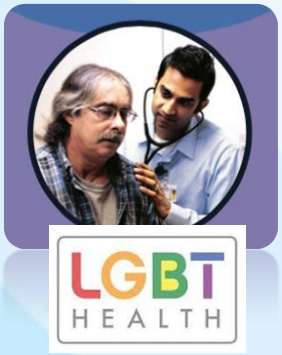
What Does Project ECHO Do?

- Builds communities of practice
- Connects primary care providers and their teams with a panel of expert multidisciplinary faculty
- Improves retention of primary care providers
- Provides brief didactic and case-based learning and management
- Improves health care outcomes with evidence based care plans
- Improves access to specialty care
- Creates a force multiplier

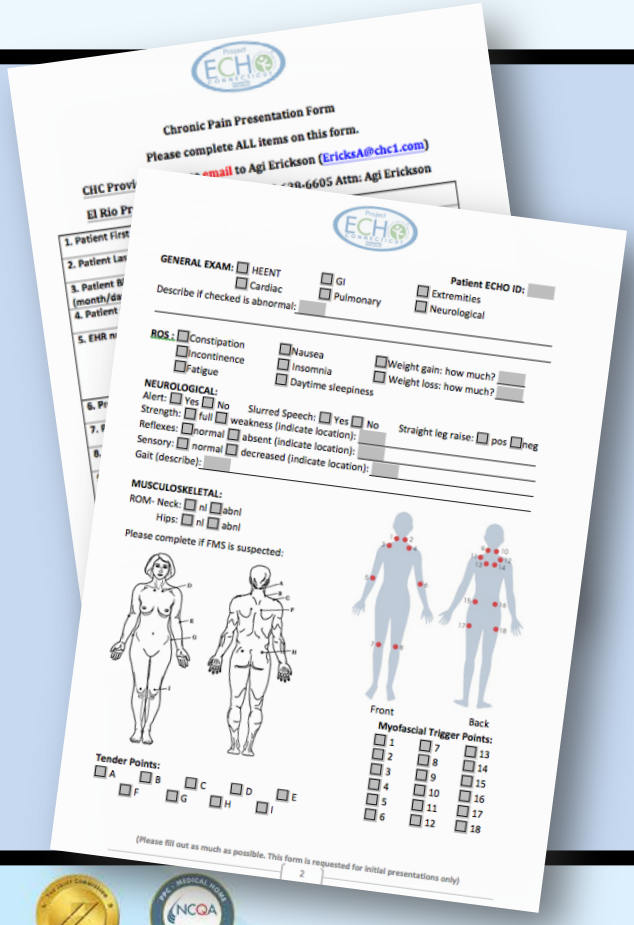
Using ECHO to tackle "Hot Spots"







Key Elements of an ECHO Session



Case Presentations

- 2-3 Cases per ECHO session
- Often co-presented by 2+ care team members
- Complex cases
- Multi-disciplinary consultation available
- Valuable for discussion and teaching
- Total time = 1.5 hours

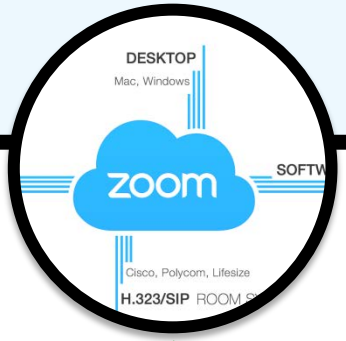
Didactic Presentations

- 1 per session
- Focused and topical
- By expert faculty
- Total time < .5 hour

Technology Infrastructure

Webcam/ Computer iPad/ Smartphone for End-Users

Video Conferencing System for ECHO Team



Cloud-based Teleconferencing Platform (Zoom©)

Recorded/ Catalogued Sessions

Streaming Sessions


Project
ECHO
CONNECTICUT
Community Health Center, Inc.
40th

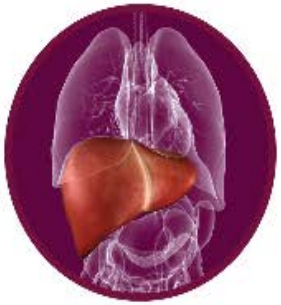

IT
New London
Norwalk Medical

CHC ECHO Website

- about us
- what we do
- programs
- news & events
- contact us
- members
  - buprenorphine
  - hepatitis c/hiv
    - session recordings
    - didactic recordings
    - clinical pearls
    - discussion board
    - helpful tools & resources
  - the team
- lgbt health
- search

home > members > hepatitis c/hiv

Hepatitis C/HIV



Hepatitis C

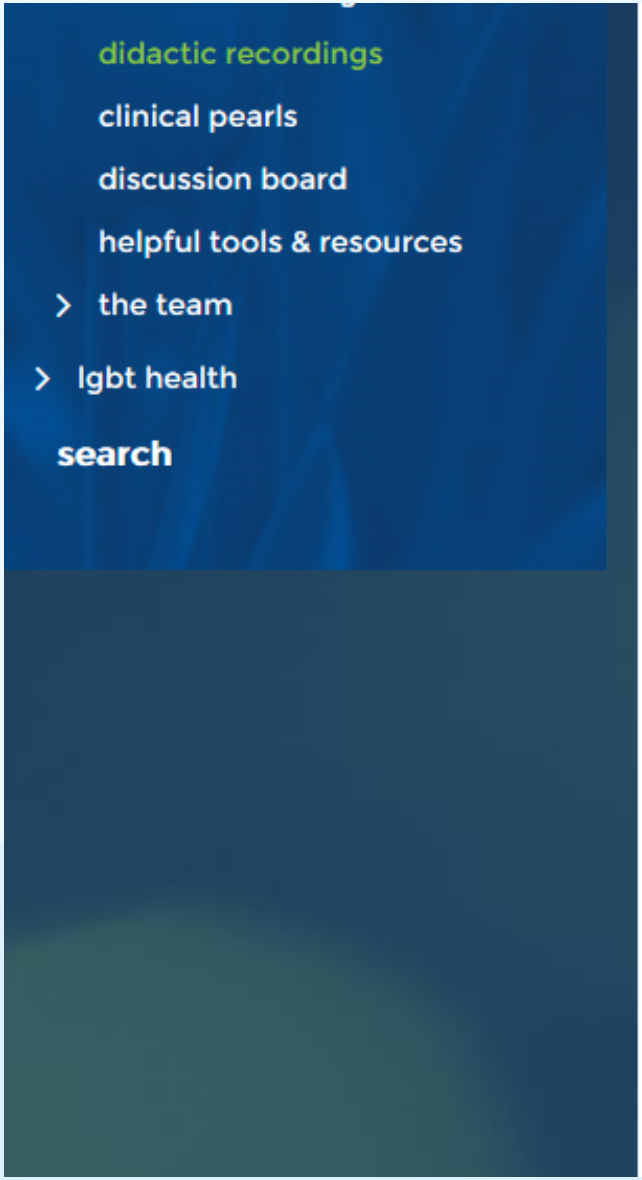
HIV

Welcome to the Project ECHO® HCV/HIV participant page. We are pleased to offer you access to recordings of each session and didactic presentation, as well as resources shared by the expert faculty. Continue to improve your knowledge outside of sessions by using the menu on the left or the links below to view this content.

Session Recordings

Didactics

Helpful Tools & Resources



Core Curriculum HIV

- History of HIV Epidemic
- HIV Screening/Epidemiology
- Prevention of HIV
- Transmission of HIV
- Counseling for a New HIV Diagnosis
- Initial Work-Up for HIV
- HIV Preventative Care/Vaccines
- Classes of HIV Medications
- HIV Treatment Guidelines
- Acute HIV Infection
- HIV Resistance
- Opportunistic Infections
- HIV Related Cancers
- Neurocognitive Deficits
- Geriatric HIV
- Sexual History
- STD Management in HIV
- PrEP
- PEP

Supplemental Didactics HIV

- HIV Jeopardy
- IAUSA Update
- HIV PARTNER Study

CHC Project ECHO HCV/HIV

- In January 2012, CHC Project ECHO launched to increase access to HCV and HIV care to all CHC sites.
- Combined HCV/HIV sessions held every Friday 12:30 to 2:30 EST.
- Expert recommendations documented by provider within EHR .
- CHC ECHO Faculty:
  - 2 FP HIV specialists, Psych APRN, PharmD, Nurse, Medical Assistant, Case Manager
- ECHOist participants:
  - 9 CHC sites throughout CT + Homeless program (WYA)
  - Primary care clinics in PA, MA, NJ, and IN.
  - Substance use facility in MA.
  - NP residents

CHC ECHO HCV/HIV Statistics

# ECHO HCV/HIV sessions	204	
# HCV/HIV ECHOist providers	Current	23
	Total	48
# unique patients presented	HIV	175
	HCV	442
# case presentations	HIV	396
	HCV	695

Project ECHO Buprenorphine Session Data	
# ECHO Buprenorphine sessions since Feb 2013	49
# Unique patients presented	118
# Case presentations (new and follow up)	151

Project ECHO Buprenorphine Participant Data

	Total Since 2013			Currently		
Sites	43			41		
States	CA, CO, CT, IA, IL, KS, ME, MT, NC, NJ, OH, PA, RI			CA, CO, CT, IA, IL, KS, ME, MT, NC, NJ, OH, PA, RI		
	CHC	Non-CHC	Total	CHC	Non-CHC	Total
Medical Providers	21	58	79	8	54	62
BH Providers	11	35	46	5	32	37
Care Team Members	22	36	58	5	33	38

Quality Improvement

Clinical Expectations for ALL Medical Providers for ALL Patients

Policy: **Clinical Expectations for Medical Providers**
Location: **Provision of Care, Treatment, and Services**
Department: **Medical**

Lung Cancer (USPSTF))	Asymptomatic adults aged 55 to 80 years who have a 30 pack year smoking history and currently smoke or have quit with in the past 15 years: Screen annually with low dose Computed Tomography until the patient has not smoked for 15 years.
HIV Screening (CDC)	HIV screening been done/offered to patients ages 13-64 at least once.
HCV Screening (USPSTF)	• HCV screening for persons at high risk for infection • One time screening in individuals born between 1945-1965
Depression Screening – adolescents (AAP/USPSTF)	Annual depression screening for adolescents ages 12 and above.
Depression Screening – adults (USPSTF)	Annual depression screening for adults ages 18 and above.
Developmental Screening	See Pediatric section

Clinical Expectations for ALL Providers for ALL HIV Patients

HIV Care (HHS)	
Antiretroviral Therapy (ART)	Anti-retroviral therapy instituted to reduce the risk of disease progression and to prevent transmission, unless contraindicated (declined/deferred: inability to commit to treatment or clinical and/or psychosocial factors).
Resistance Testing (if viral level detectable)	Drug resistance testing performed at entry into care, at the time of ART initiation (if deferred), and if ART switched, secondary to virologic failure.
CD_4 Count	• Obtained at baseline. • Every 3-12 months during the measurement year based on clinical stability of patient.
HIV RNA	• Obtained at baseline. • Every 3-6 months during the measurement year based on clinical stability of the patient.
Blood Chemistry	• Baseline exams: CMP, CBC with differential. • Every 6-12 months during the measurement year based on clinical stability of the patient.
Metabolic Screening	For patients on ART • Lipid testing at least yearly. • Fasting blood glucose at least yearly.
OI prophylaxis	• PCP prophylaxis for CD_4 <200
	• Toxoplasma prophylaxis for CD_4 <100 • MAC prophylaxis for CD_4 <50
TB Screening	• At least once since diagnosis (TST or IGRA); annually if repeated or ongoing exposure to those with active TB. • If negative and CD_4<200, repeated after initiation of ART and CD_4 >200.
HCV Screening	At least once since diagnosis.
Cervical Cancer Screening	At diagnosis, and 6 months later, then annually if normal.
Immunizations	• Documented immunity or vaccination to HAV and HBV • Documented immunity or vaccination (CD_4>200) MMR and VZ • Tdap at least once; Td every 10 years thereafter • Pneumococcal: PPSV and PCV13 • Influenza, annually • HPV: Women and Men until through age 26 • IPV and Meningococcal, if risk factors

CHC HIV Clinical Dashboard

Enrollment Status: Active, continuing in program
Birth Date:
Gender: M
Ethnicity: Non-Hispanic/Latino(a) or Spanish Origin
Race: Black or African American
First Diagnosis Date:
First Ambulatory Care: 12/26/2006
Client Service Visits: 145
Last Medical Insurance: Medicaid Husky C - MH

Last Medical Encounter Date	Viral Load	CD4 value	PHQ Screen	Hep B Vaccine	Flu Compliance	Case Management
7/20/2016	67	1213	7/1/2015	3	No	8/19/2015

Missing HPI Data

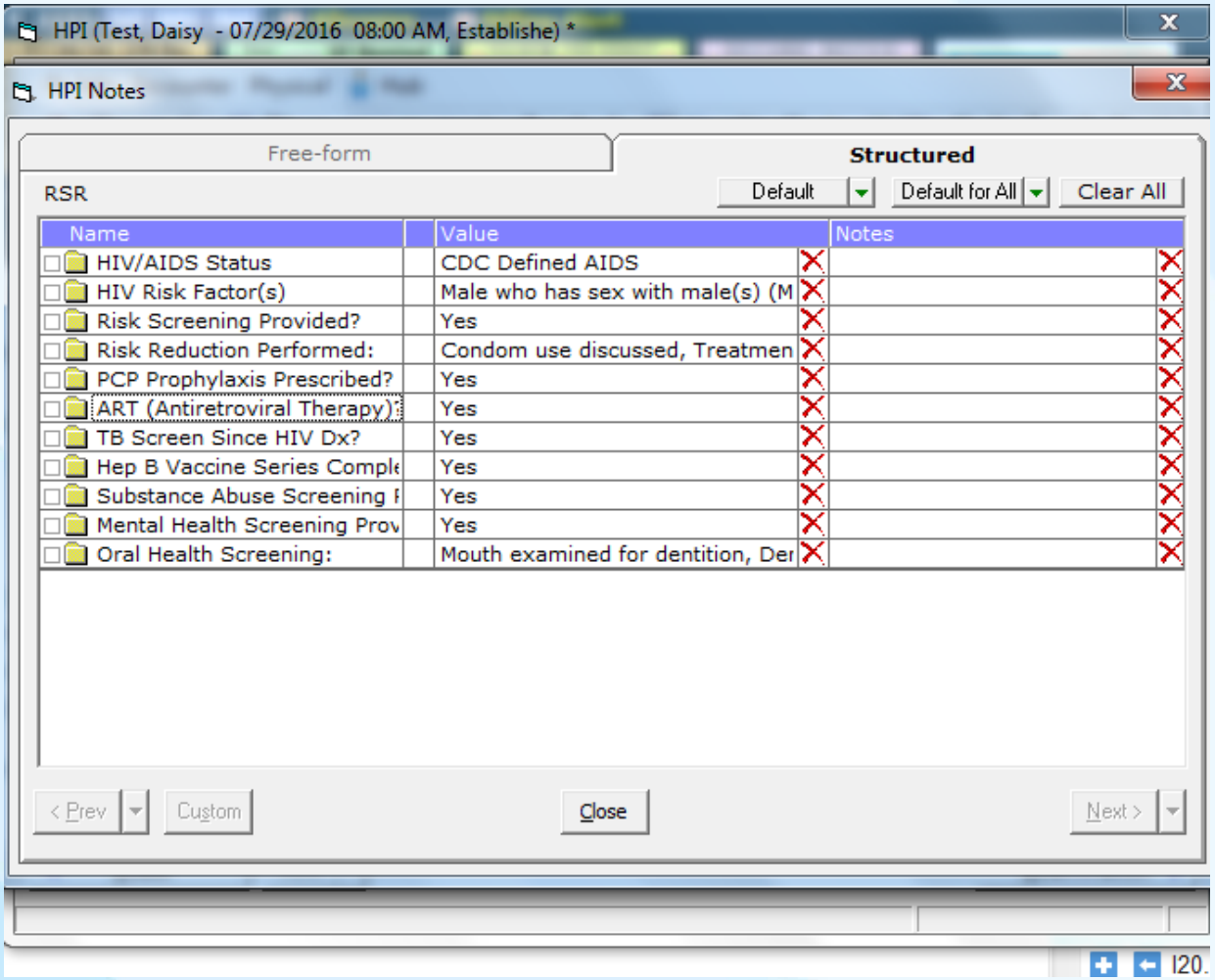
Oral Health Screening

Enrollment Status	Ethnicity	Race	Gender	Sex At Birth	Housing Status	Subgroup	First Ambulatory Care Date	OAMClink Date	Medical Insurance	Poverty Level
Active, continuing in program	Hispanic/Latino/a or Spanish Origin	White	F	Female	stable/permanent	Puerto Rican	11/11/2008	11/14/2008		

Viral Load	HIV Medication	CD4 value	CD4 Prophylaxis	Last LDL Encounter	Last PPD Encounter	Last RPR Encounter	Last Chlamydia Encounter	Last Gonorrhea Encounter	PHQ Screen	Last Hcv Screen Date	Hep B Antibody	Hep B Vaccine	Cervical Cancer Date	Flu Compliance	Case Management
20	Yes	758		12/30/2015	3/21/2014	3/21/2014	11/19/2015	11/19/2015	12/30/2015	11/11/2008			11/19/2015	No	9/29/2014

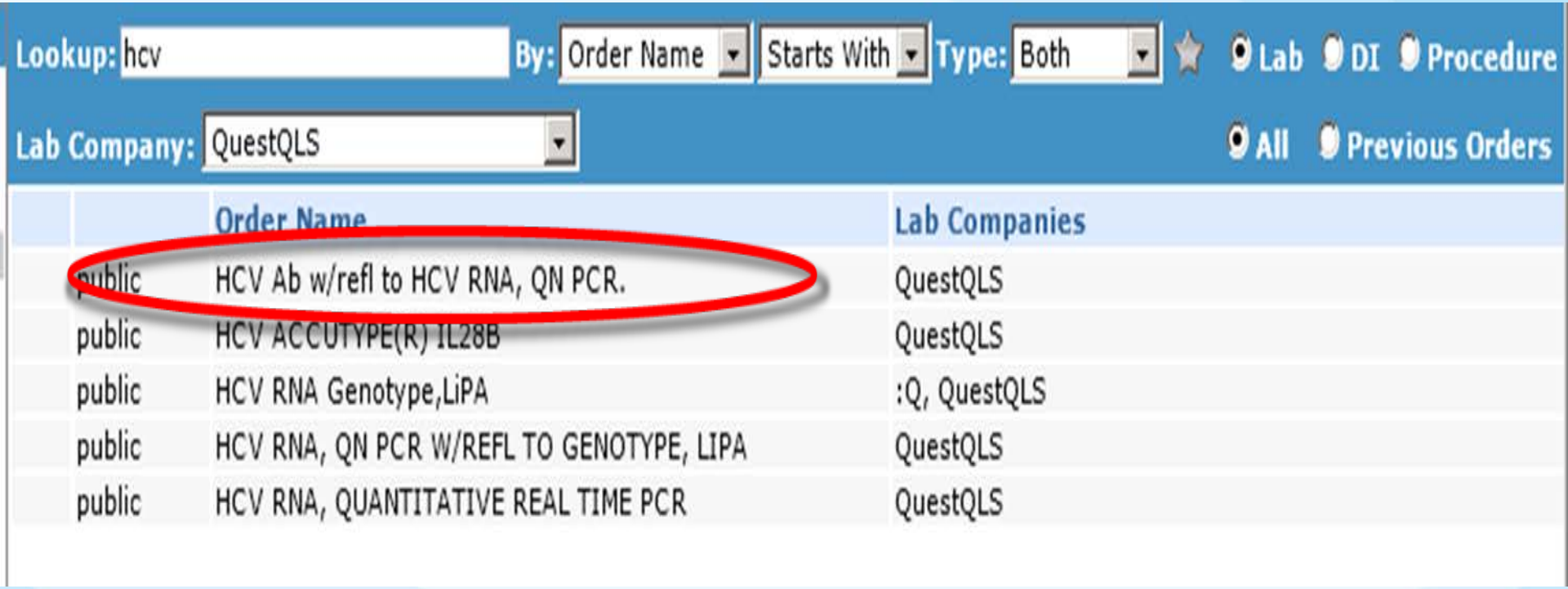
HIV / AIDS Status	Hiv Risk Factor	Risk Screening Provided	Prescribed Pcp Prophylaxis	Prescribed Haart	Screened TB Since Hiv Diagnosis	Vaccinated Hepatitis B	Screened Substance Abuse	Screened Mental Health	Oral Health Screening
HIV-positive, not AIDS	Heterosexual contact	Yes	No	Yes	Yes	No	Yes	Yes	

RW RSR Report



- All other RSR measures are mapped directly in eClinicalWorks to the appropriate sections.
- E.g. CD4 and HIV RNA from Lab section.

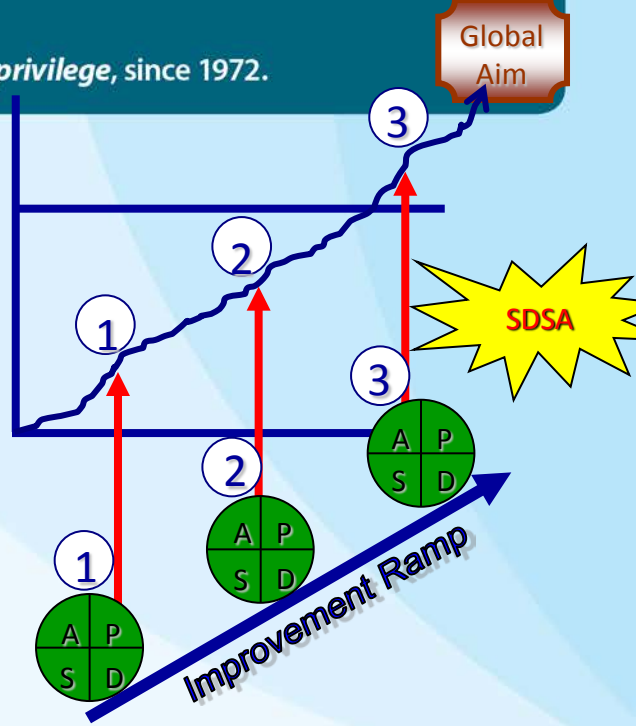
Hepatitis C Infection Confirmation



	Order Name	Lab Companies
public	HCV Ab w/refl to HCV RNA, QN PCR.	QuestQLS
public	HCV ACCUTYPE(R) IL28B	QuestQLS
public	HCV RNA Genotype,LiPA	:Q, QuestQLS
public	HCV RNA, QN PCR W/REFL TO GENOTYPE, LIPA	QuestQLS
public	HCV RNA, QUANTITATIVE REAL TIME PCR	QuestQLS

Clinical Microsystems

Quality Improvement Ramp



PDSA

Collect and review data to support PDSA

Measures

Change Ideas

Specific Aim

Global Aim

Theme

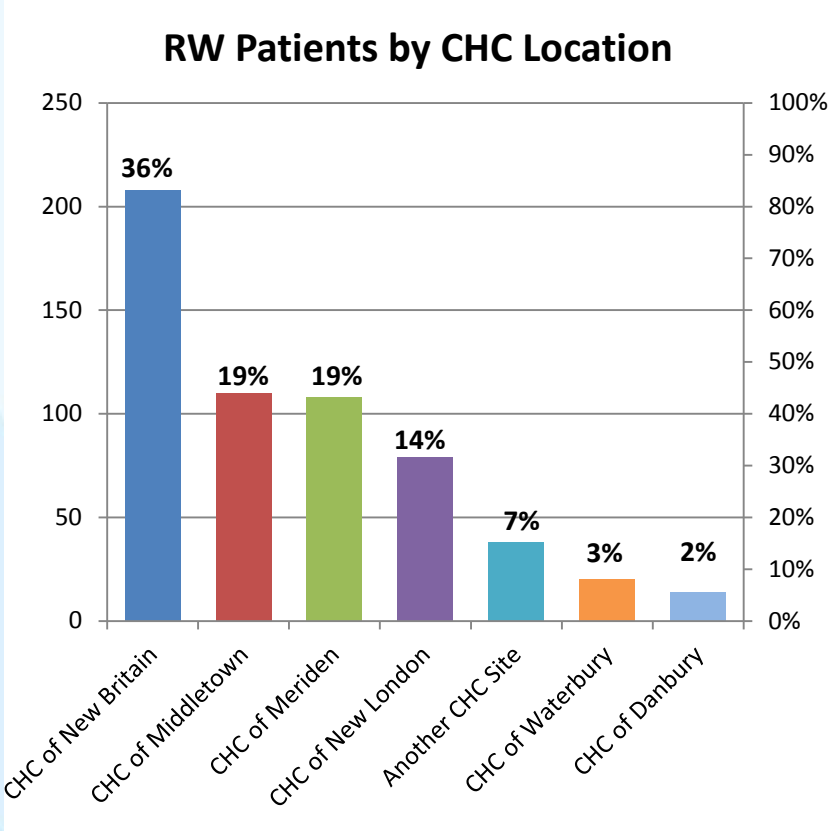
Assessment

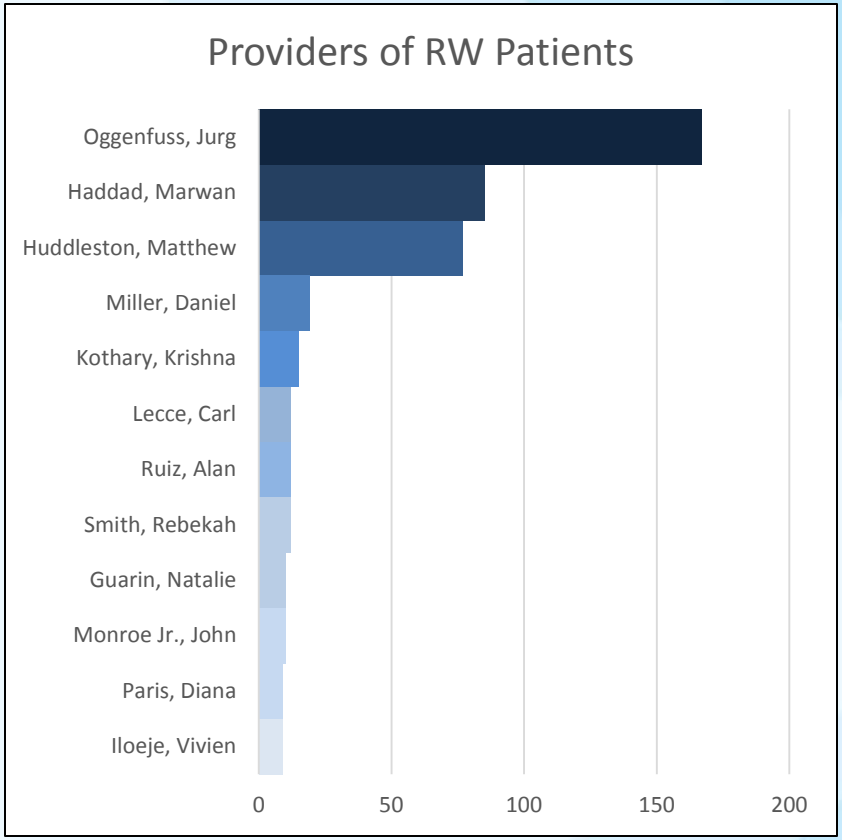
Quality Improvement Ramp
The Dartmouth Institute Clinical Microsystems Quality Improvement Ramp

5P Assessment

1. **Professionals**
   - Team Members
   - Providers that care for the patients
2. **Patients**
   - Population cared for by the clinical microsystem professionals
3. **Purpose**
   - Why the team comes together to focus on quality improvement
4. **Processes**
   - What workflows are in place that help the team function?
5. **Patterns**
   - What measures does the team collect and analyze data on? Where do they see improvements?

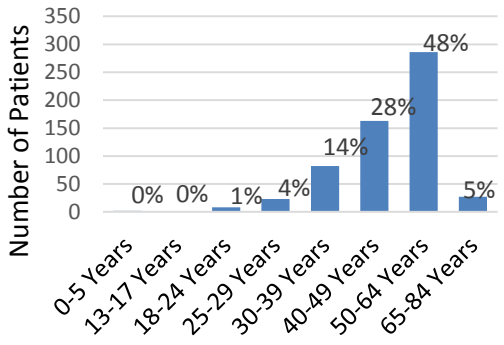
5P Data: Professionals



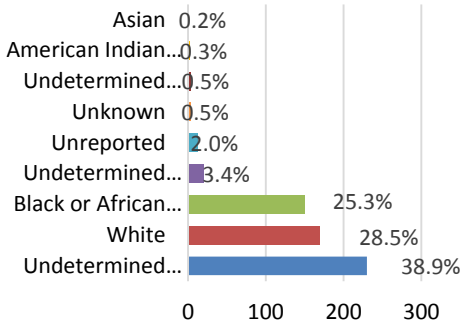


5P Data: Patients

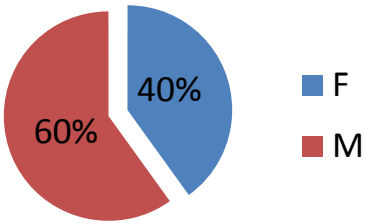
RW Patients by Age



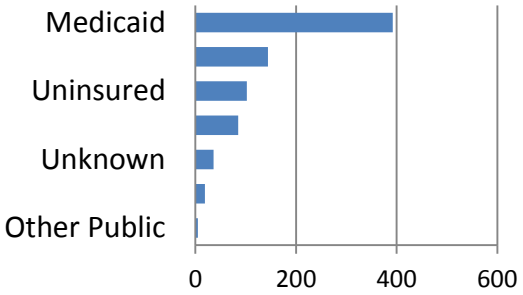
Race/Ethnicity of RW Patients



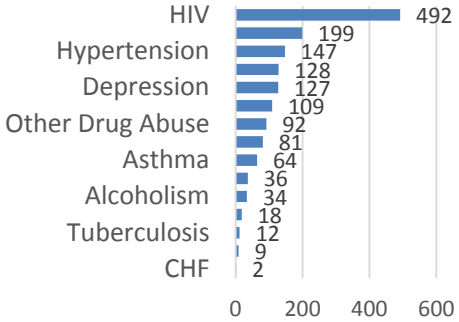
RW Patients by Gender



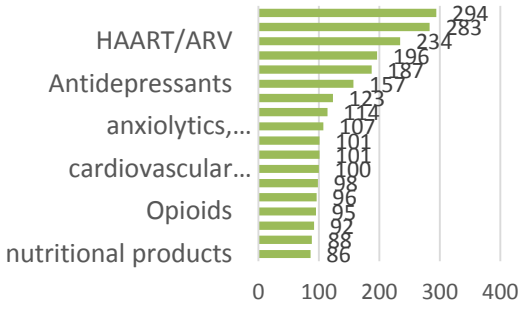
Ryan White Patients by Insurance



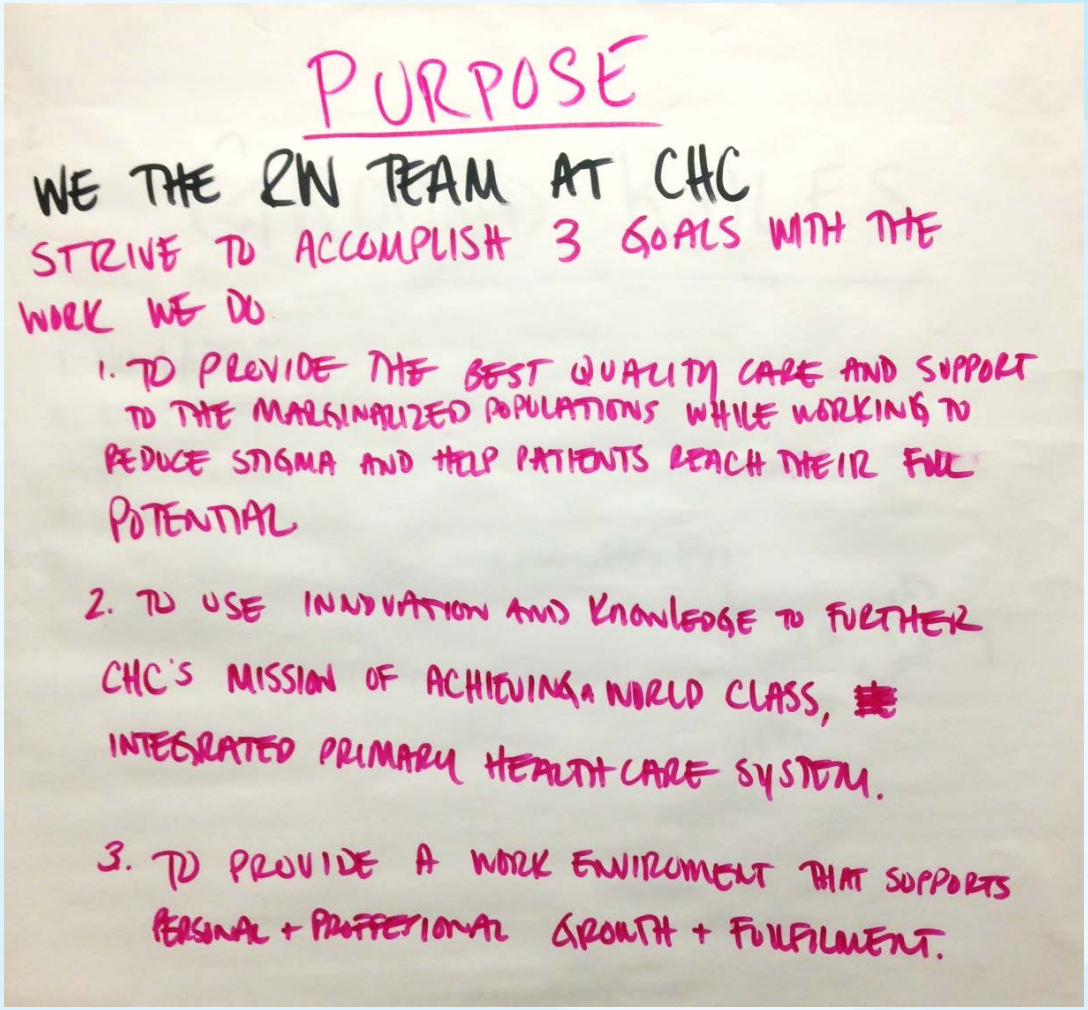
Top Diagnoses among Ryan White Patients



Medications taken by RW Patients



5P Data: Purpose



PURPOSE

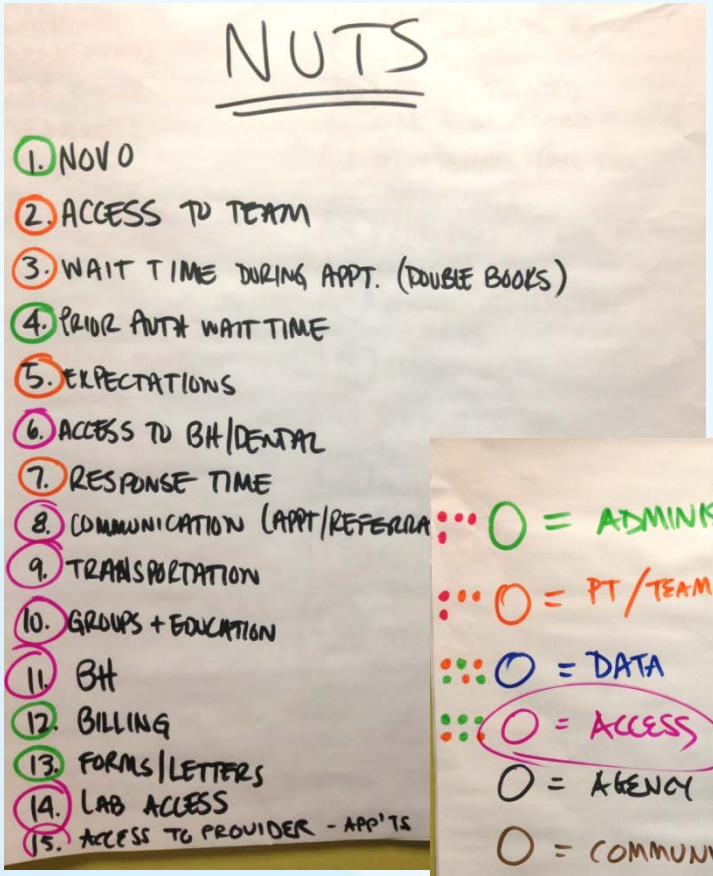
WE THE RN TEAM AT CHC STRIVE TO ACCOMPLISH 3 GOALS WITH THE WORK WE DO

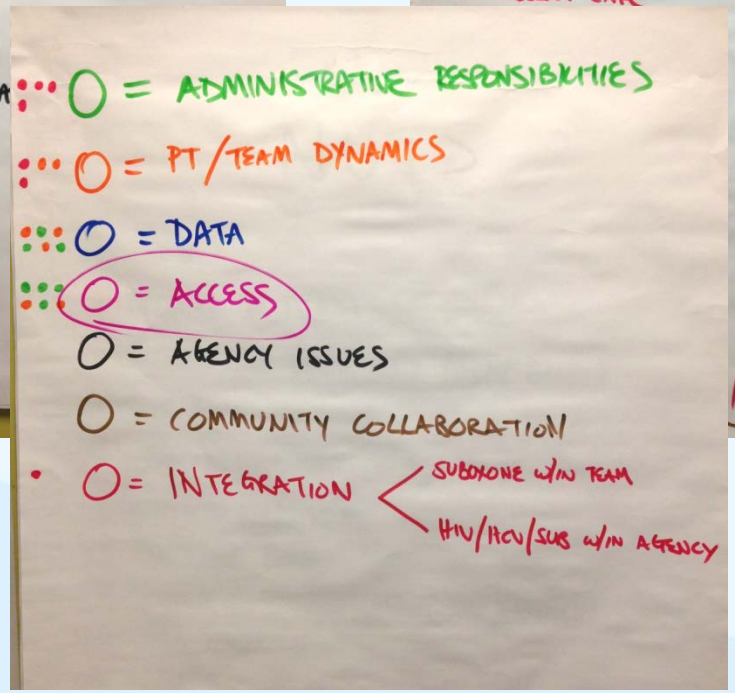
1. TO PROVIDE THE BEST QUALITY CARE AND SUPPORT TO THE MARGINALIZED POPULATIONS WHILE WORKING TO REDUCE STIGMA AND HELP PATIENTS REACH THEIR FULL POTENTIAL

2. TO USE INNOVATION AND KNOWLEDGE TO FURTHER CHC'S MISSION OF ACHIEVING A WORLD CLASS, INTEGRATED PRIMARY HEALTH CARE SYSTEM.

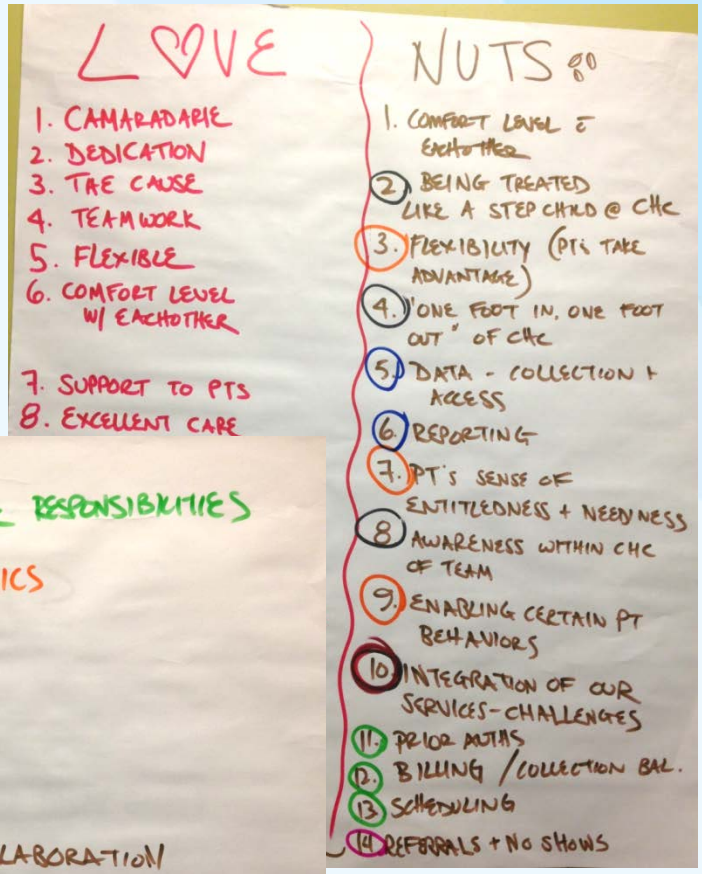
3. TO PROVIDE A WORK ENVIRONMENT THAT SUPPORTS PERSONAL + PROFFESIONAL GROWTH + FULFILLMENT.

What drives the Patients Nuts

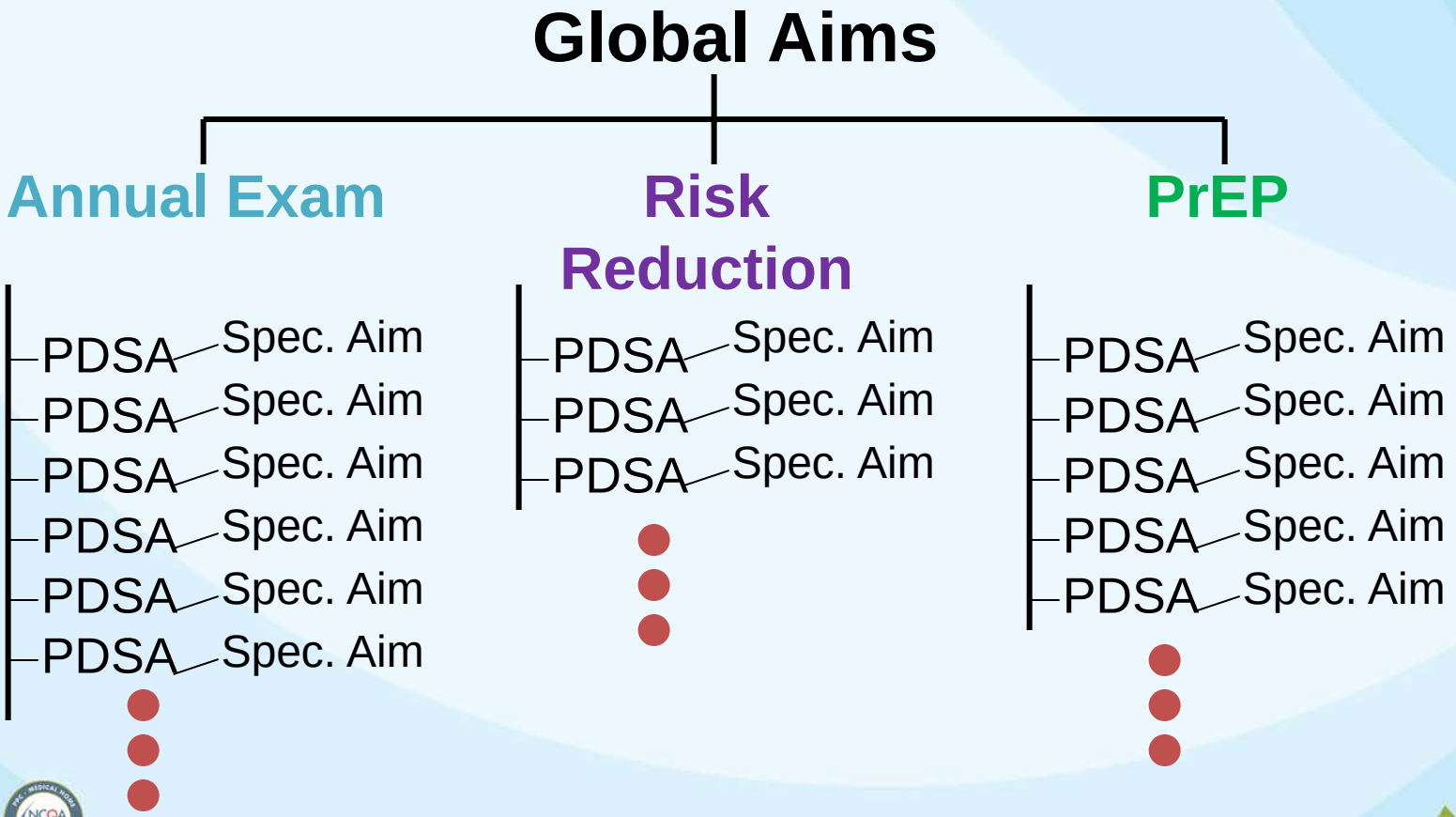




What drives the Team Nuts



Themes, Processes, Patterns, and PDSA Cycles



Write a Theme for Improvement: Access

Global Aim Statement

Create an aim statement that will help keep your focus clear and your work productive:

We aim to improve: The execution & documentation of ICSP clinical performance measures
(Name the process)

In: New Britain
(Clinical location in which process is embedded)

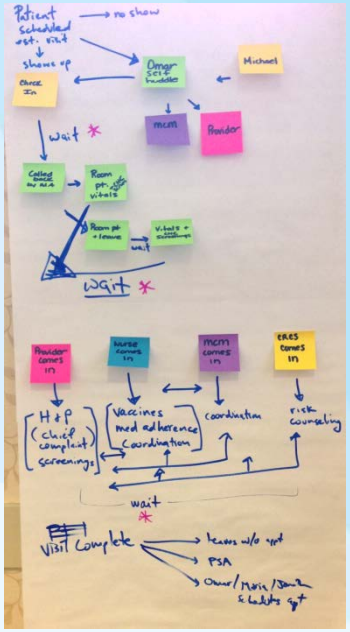
The process begins with: An ICSP patient being scheduled for a visit with a provider
(Name where the process begins)

The process ends with: The successful completion & documentation of the clinical performance measures
(Name the ending point of the process)

By working on the process, we expect: To improve the quality of patient care, improve reporting, and improve efficiency of the team.
(List benefits)

It is important to work on this now because: The RSR is due in December, reporting/data benefits the patient, the patients feel more connected in times where access is limited, team needs to be more efficient in light of schedule changes.
(List imperatives)

Map Current Process



Specific Aim Statement

We will: ☐ improve ☒ increase ☐ decrease

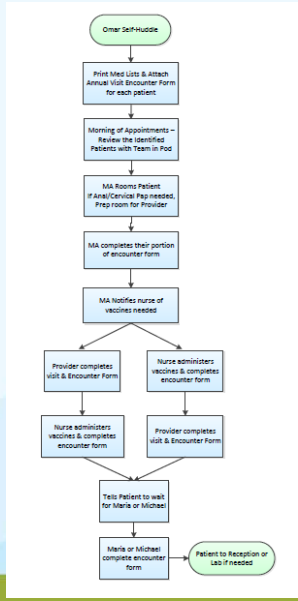
The: ☐ quality of ☒ number/amount of ☐ percentage of
ICSP Patients Attending an Annual Exam
(process)

From: 0 patients
(baseline state/number/amount/percentage)

To: 25 patients
(describe the change in quality or state the number/amount/percentage)

By: September 1, 2014
(date)

Map New Process



PDSA Cycle: Example Annual Exam

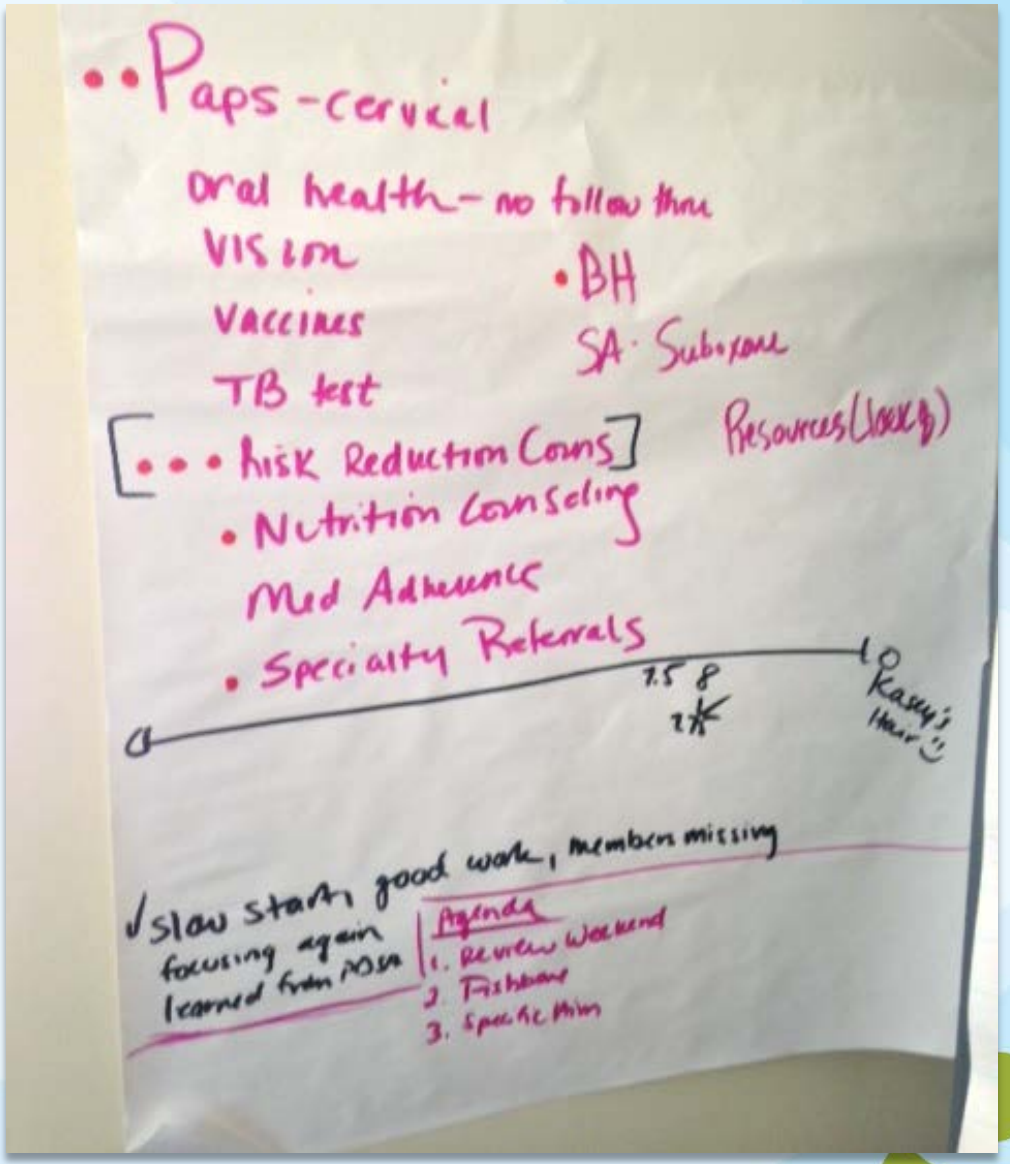
Plan: Test the use of a pre-visit checklist that identifies patients in need of annual screenings. MA completes pre-visit checklist and hands to provider after rooming the patient. Provider completes necessary screenings, orders labs, and documents in the EHR

Do: Measure the number of patients that received an annual exam. Measure the time it takes to complete the annual exam.

Study: Time needed to complete the pre-visit huddle, checklist, and screenings in visit proved too burdensome on the team.

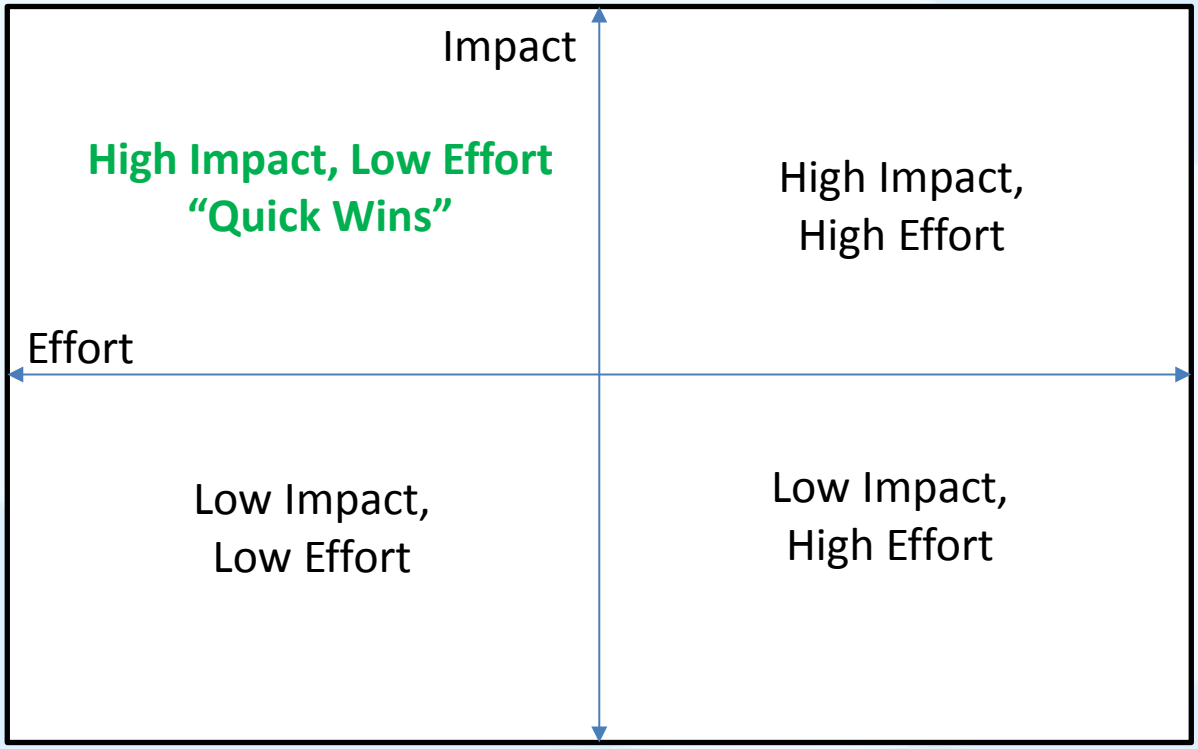
Act: Place the idea of an annual exam on hold due to the time burden. Choose a new global aim for focus based on a piece of the annual exam.

- Identified pieces of Annual Exam
- Multi-Voting to select which to improve further



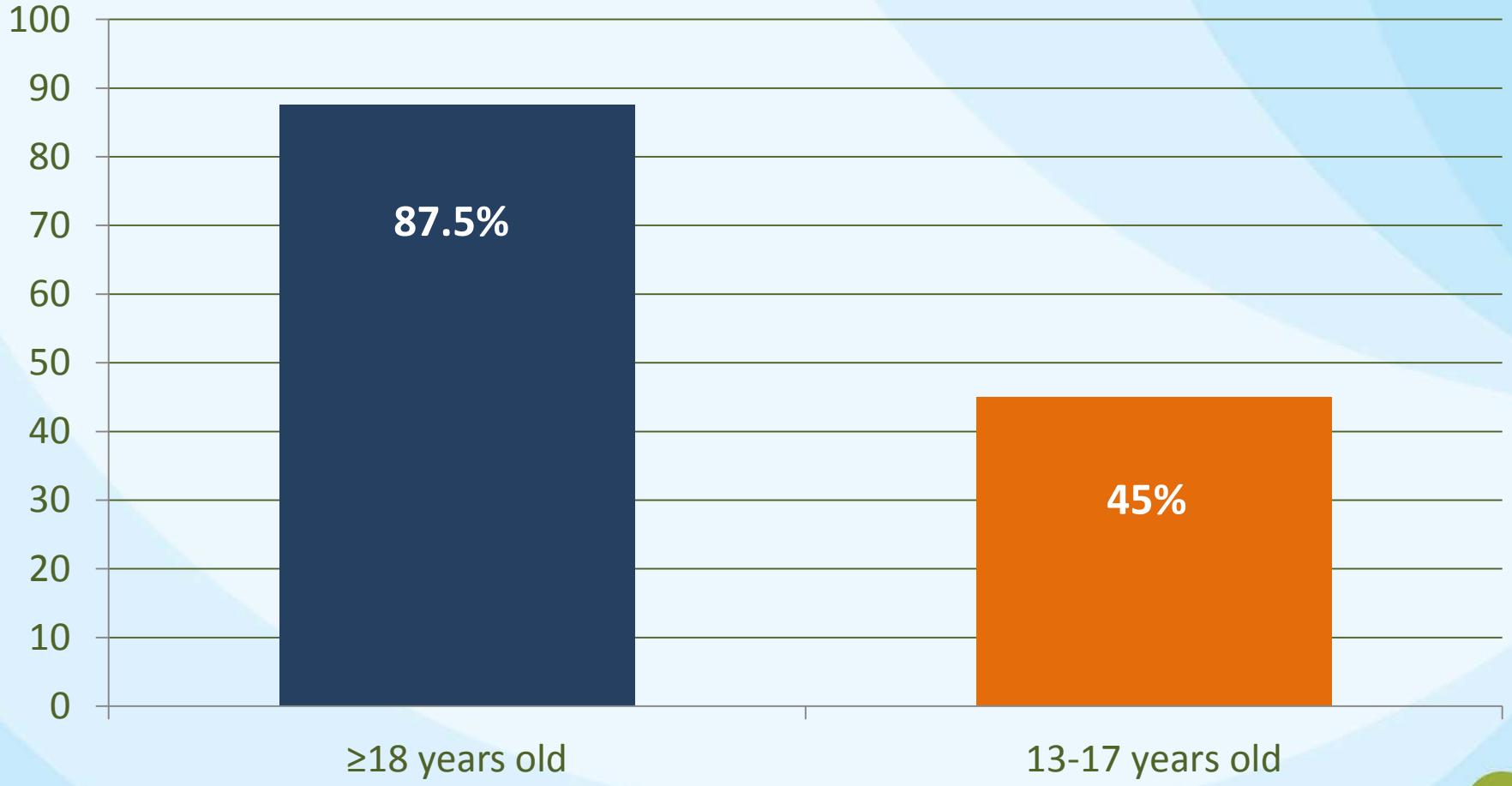
What Next?

To be determined through use of an Impact/Effort grid where the team will map out potential projects & determine the "quick wins" and those initiatives that make take more development and time.

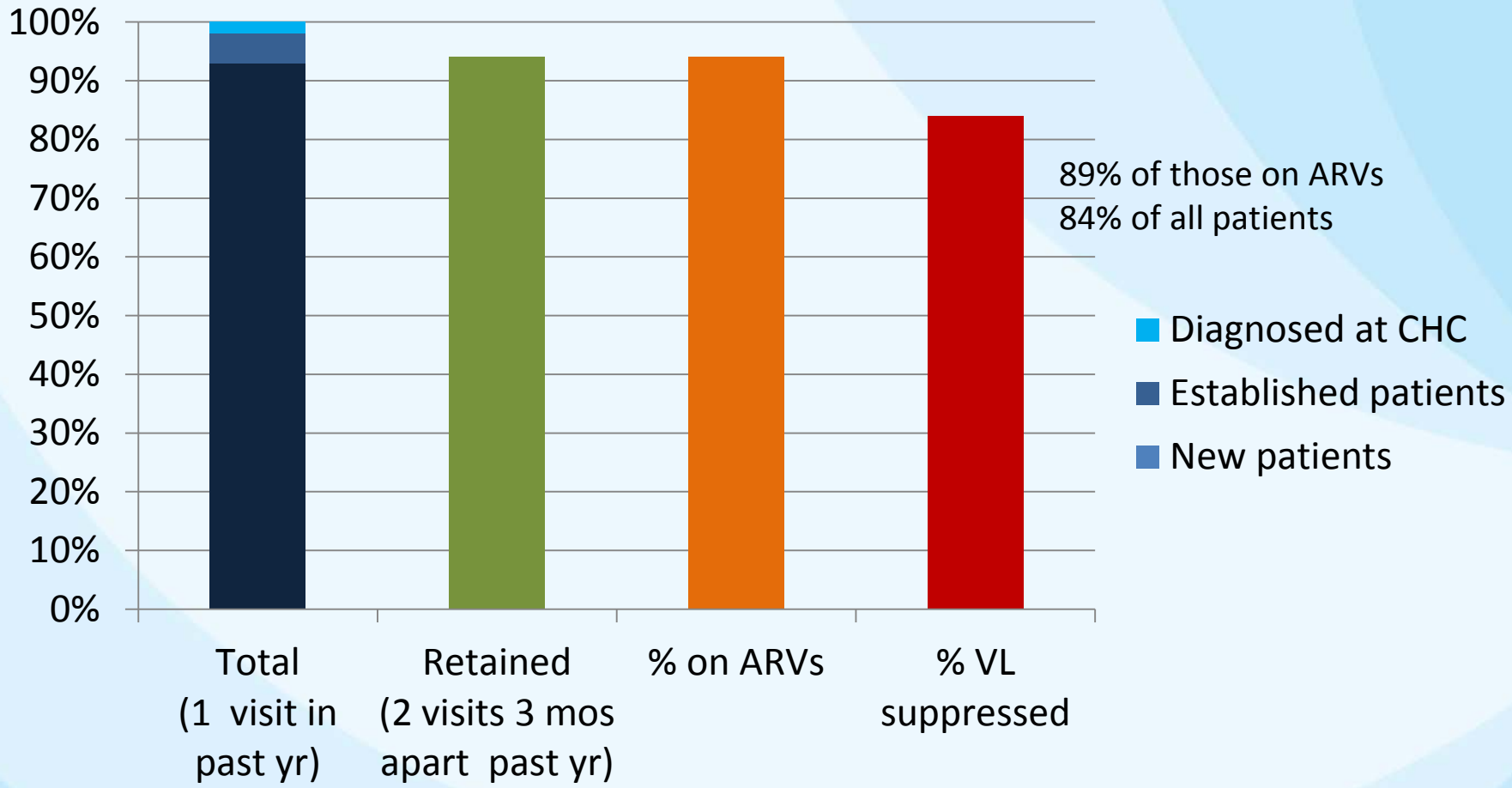


CHC Data on HIV, HCV, and Buprenorphine

Universal One-Time HIV Screening for Patients 13-64 years of age seen at least once in 2015



CHC Modified HIV Treatment Cascade (N=559)

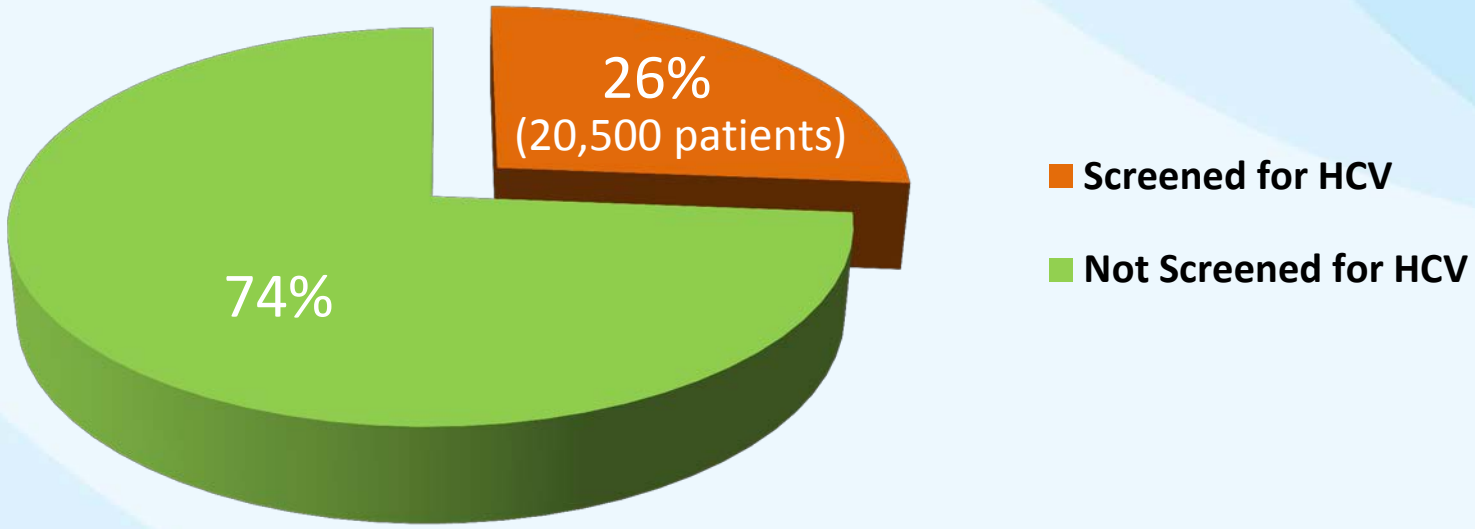


Mean Time from Dx/Contact to Care: 4 days

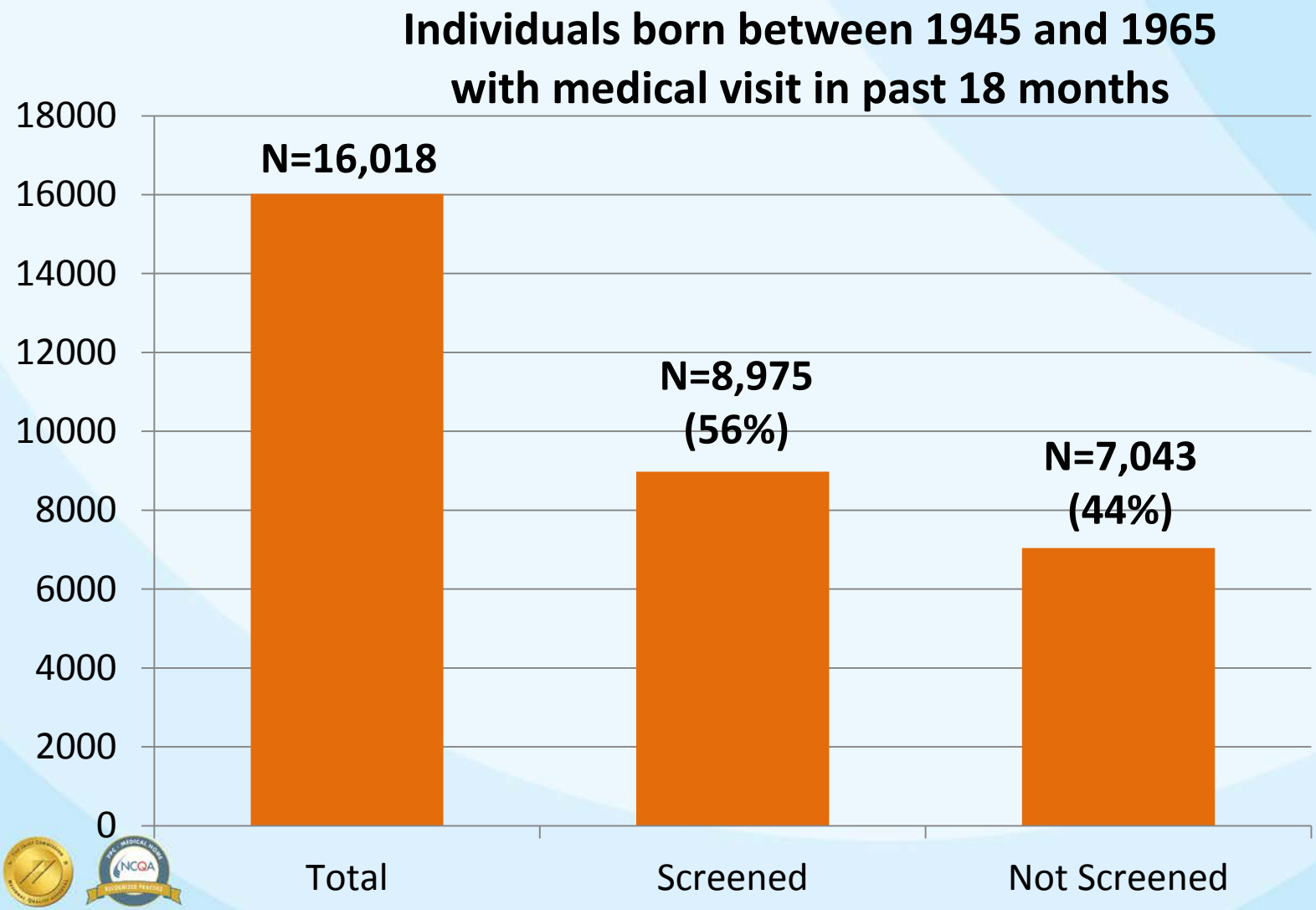
Mean # Visits in last 18 mos: 15 (11 Medical, 4 BH)

CHC Patients and HCV Screening

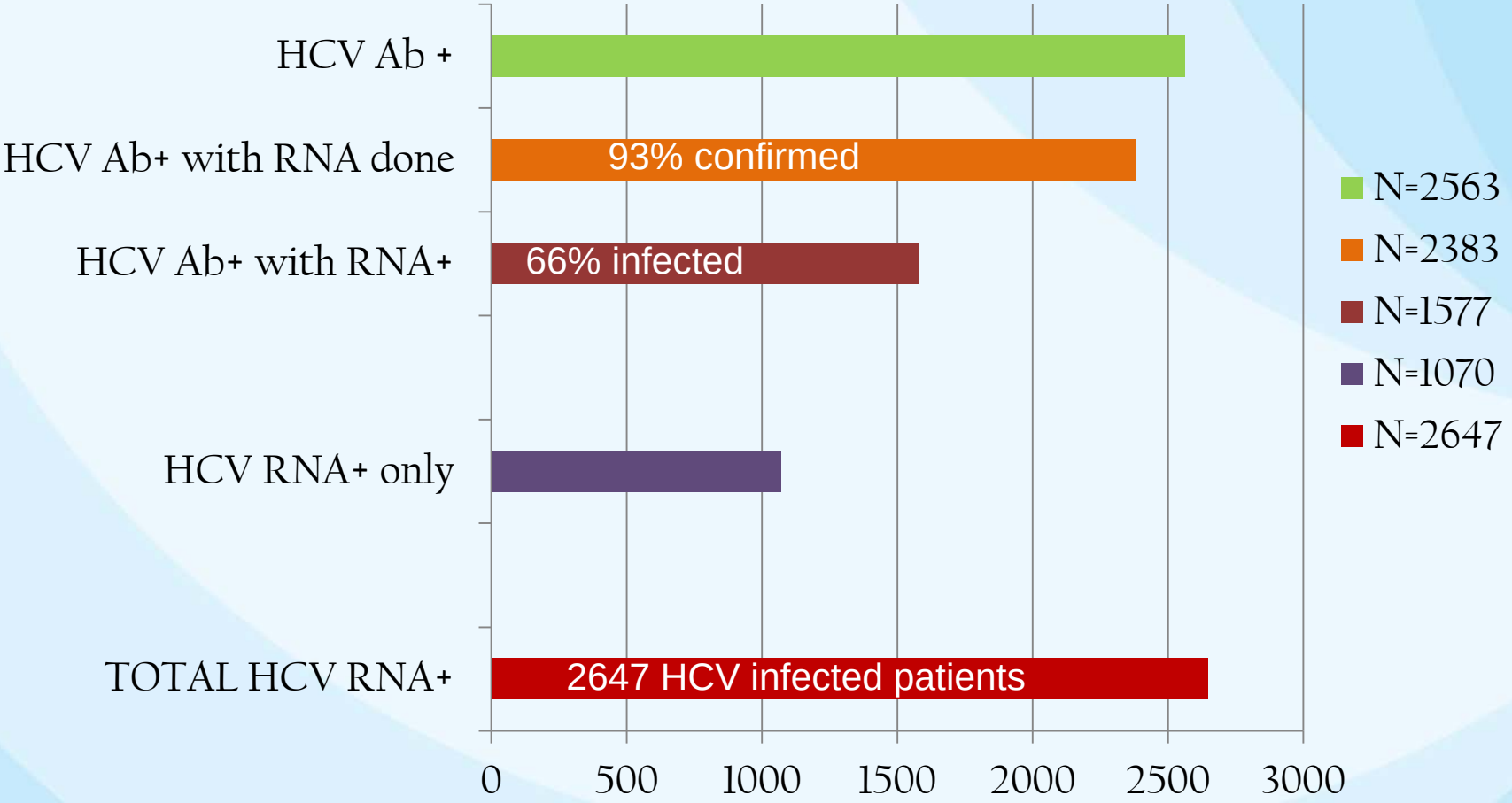
All Patients with Medical Visit in Past 18 Months
N= 78,004



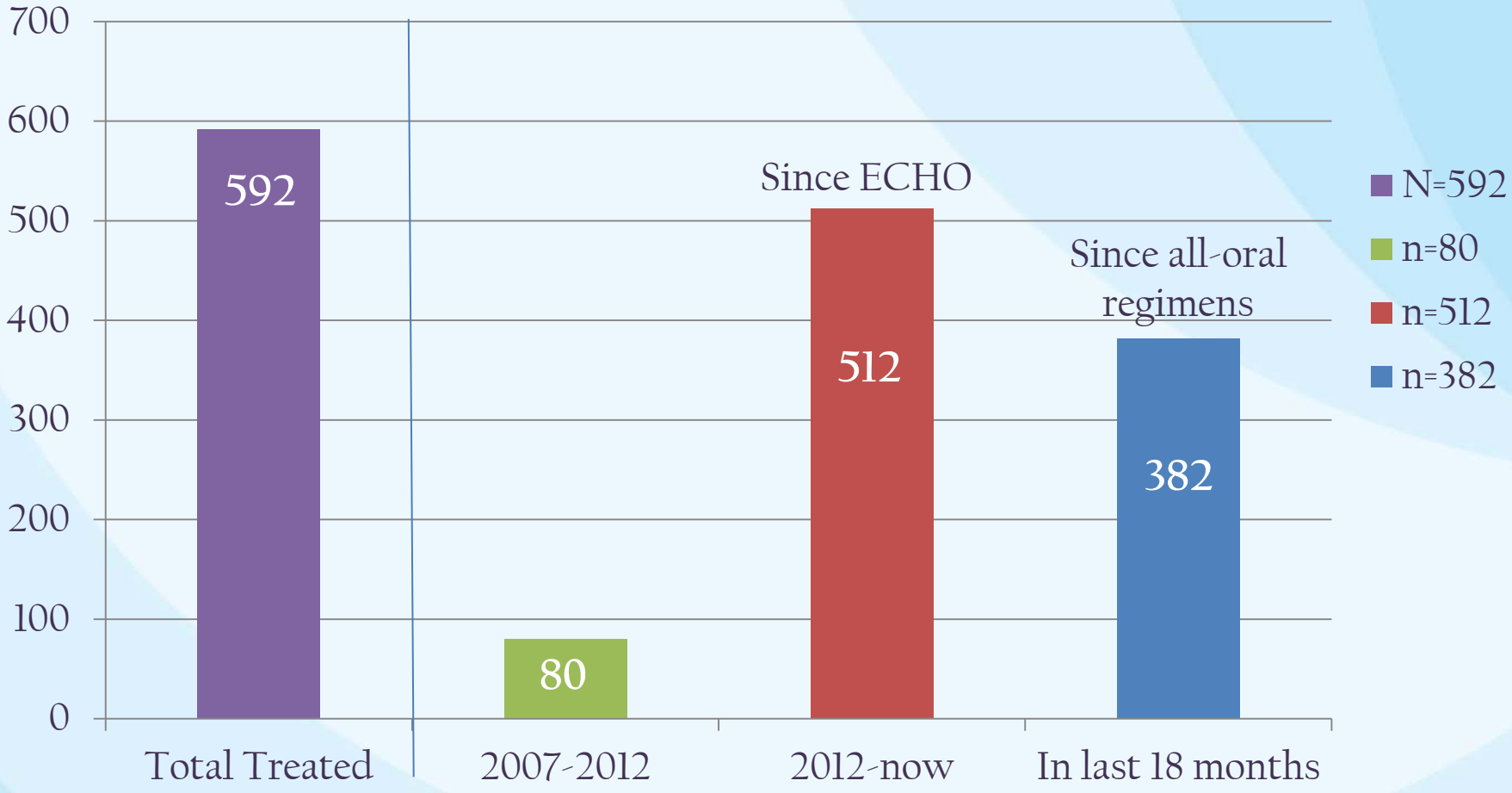
BIRTH COHORT SCREENING AT CHC



HCV-infected Individuals at CHC

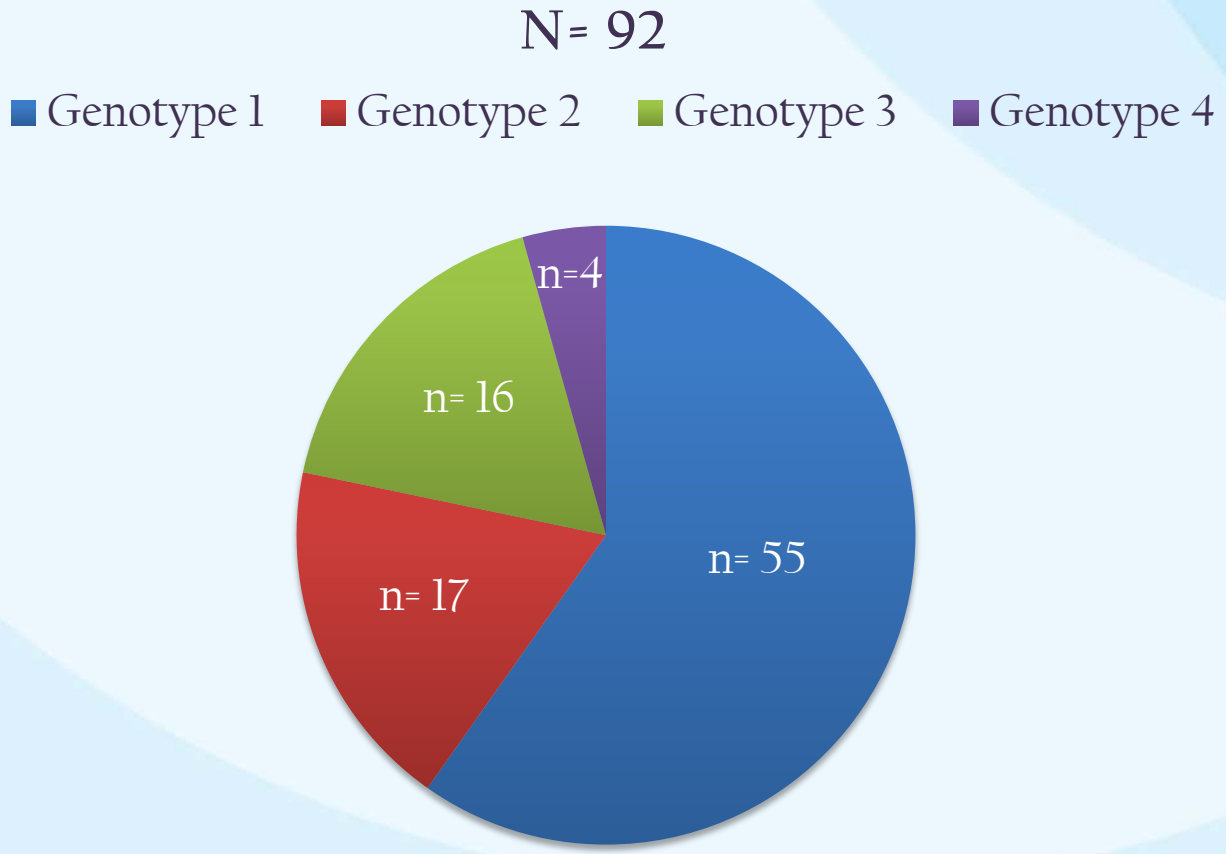


HCV-infected Individuals Prescribed Treatment at CHC

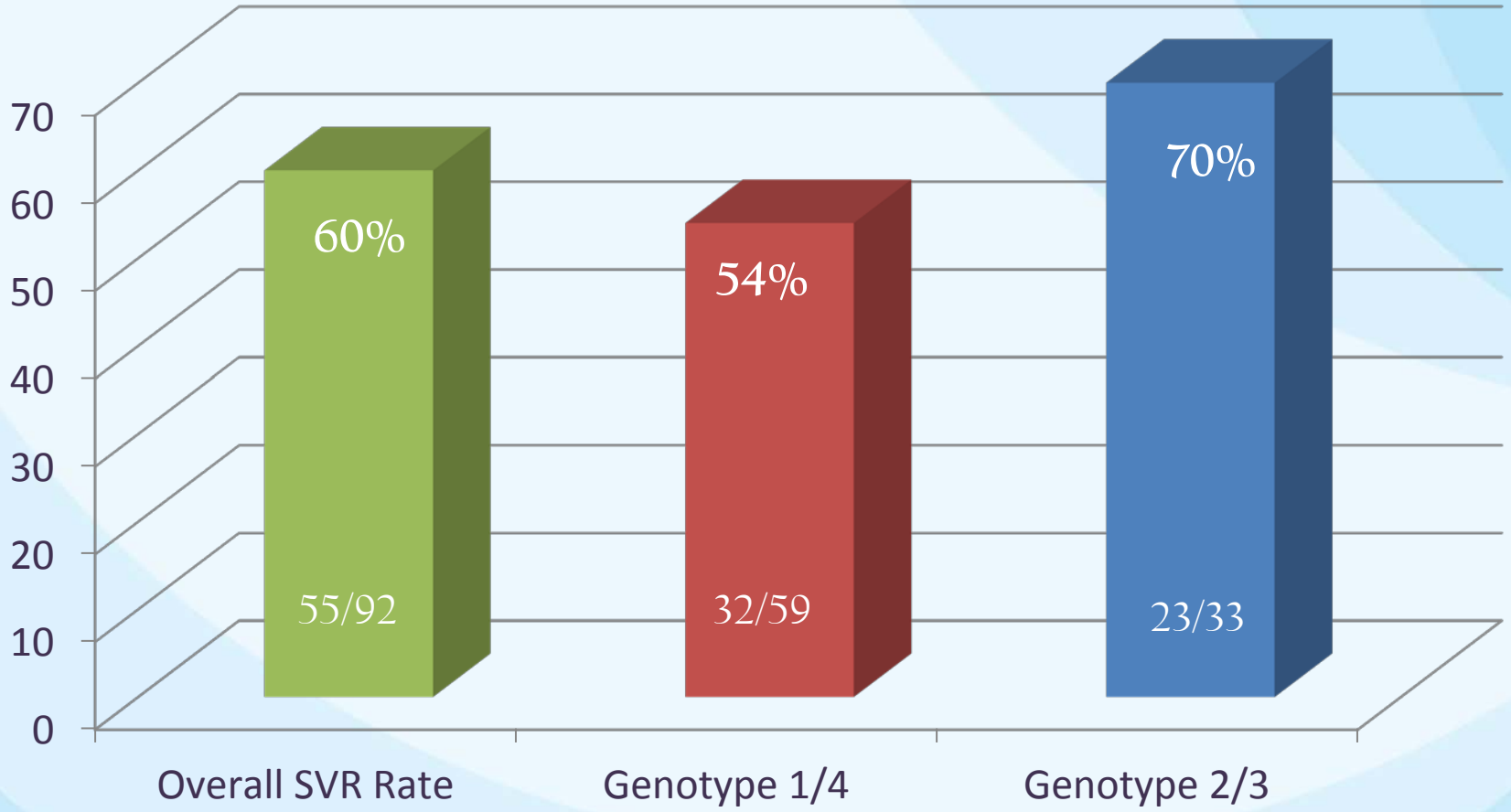


- 22% of those infected have been prescribed HCV medication at CHC.
- 86% prescribed since ECHO began.
- 65% prescribed since all oral regimens available..

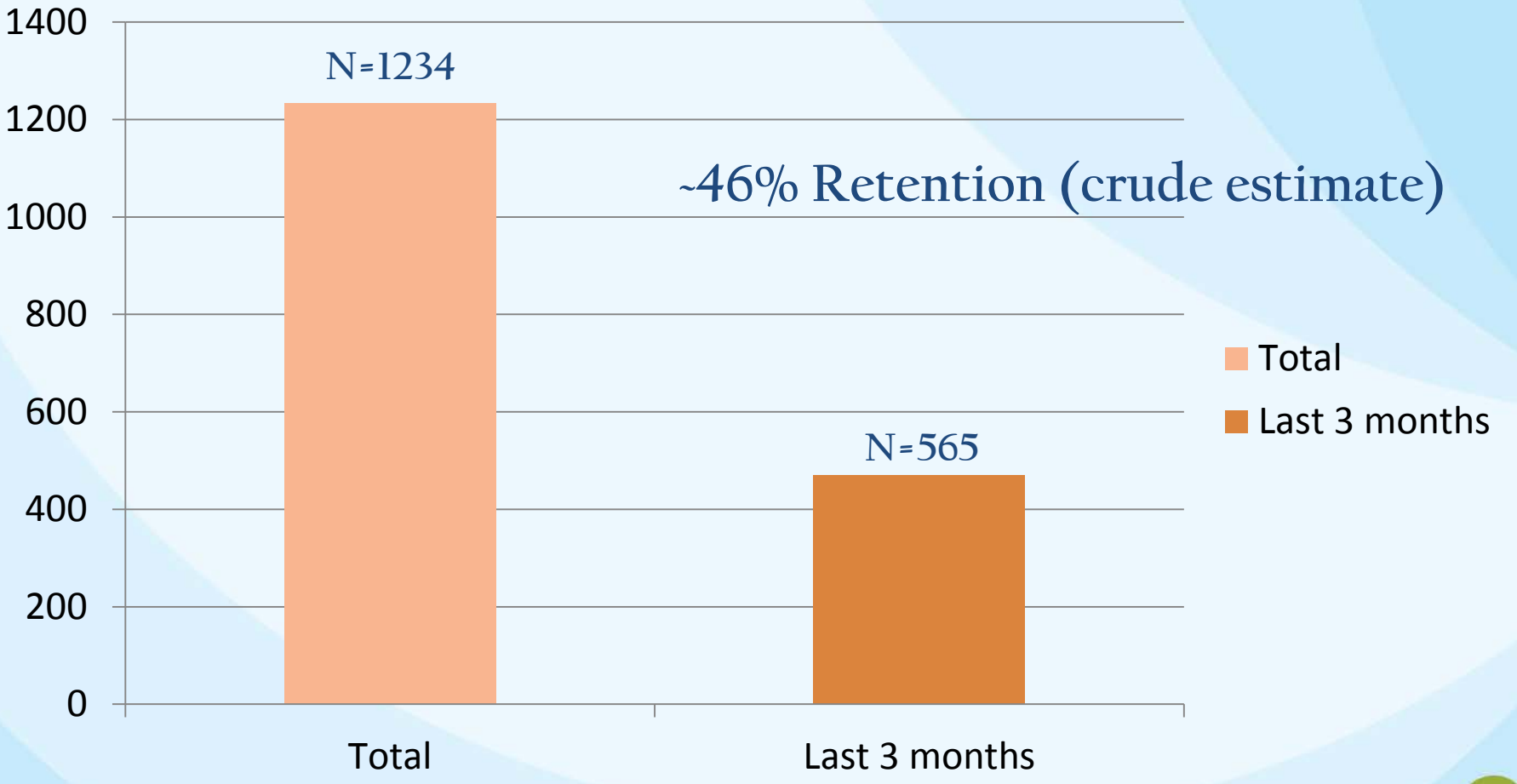
Preliminary CHC HCV Treatment Outcomes in Interferon-based Era



Preliminary SVR Outcomes in Interferon-based Era



Number of Patients Prescribed Buprenorphine



~46% Retention (crude estimate)

Initiatives

PrEP Initiative

- CHC is a DPH referral site for PrEP.
- CHC has
  - a PrEP navigator.
  - a PrEP policy for guidance.
  - PrEP templates and order sets in EHR.
  - ECHOists and agency leaders in PrEP.
- Every CHC provider including Quick Care trained and expected to provide PrEP.

PrEP Initiative

Policy Name: Pre-exposure Prophylaxis for HIV
Location: Provision of Care, Treatment and Services
Department: Medical
Date Effective: January, 2016

A. Rationale:

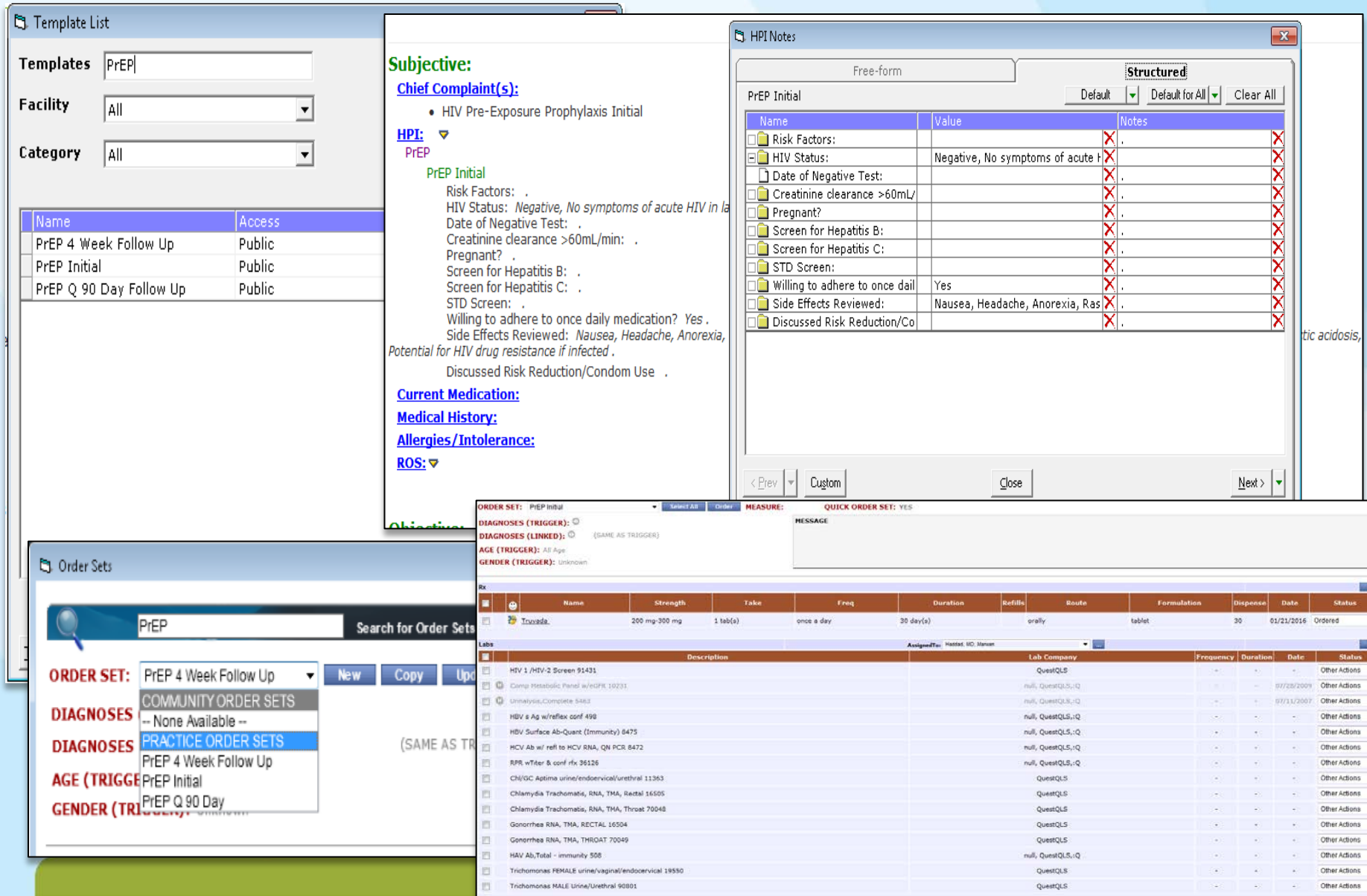
Though increasingly treatable, HIV remains without cure. Prevention strategies include "safe" sex choices, barrier protection, treating HIV positive patients to an undectable viral load, post-exposure prophylaxis, and pre-exposure prophylaxis (PrEP) in HIV negative patients at high risk.

Studies with PrEP have shown that treating high risk HIV negative patients with a medication can decrease acquisition of HIV (Partners-PrEP, TDF2 trial, IPrEx trial, Thai IDU). The decrease in overall risk ranges from 44-75%, but can increase to 92% based on adherence to medication. Based on these data, in July of 2012, the FDA approved the use of 200 mg emtricitabine/300 mg tenofovir (Truvada) for HIV PrEP in adults at high risk of becoming infected with HIV.

B. Definition:

PrEP involves more than writing a prescription. In sum, PrEP must include counseling on risk reduction, access to condoms, screening and treatment of other STDs, monitoring for pregnancy, close attention to adherence, monitoring for drug effects, and prescription of 200 mg emtricitabine/300 mg tenofovir (Truvada) taken once daily.

PrEP Templates and Order Sets



Sexual Orientation and Gender Identity (SO/GI) Initiative

- SO/GI collection part of Uniform Data System (UDS); required to be reported by HRSA.
- CHC planning agency-wide collection.
- Opted to initially collect information in medical visit directly or through questionnaire and entered in EHR.
- Preferred name and pronouns inputted in EHR and pulled to NOVO /Centricity so all staff can address patients correctly.
- PDSAs done by CKP team, nursing, behavioral health through Clinical Microsystem.
- LGBTQ cultural humility and SO/GI collection trainings done.
- Kick off date September 1.
- Next steps: Registration process; Access to Care; Dental

Key Steps in Collecting SO/GI: Medical Assistants

The purpose is to collect sexual orientation and gender identity (SOGI) information on all patients 13 years + coming in for a medical visit

- The MA checks the planned care dashboard during their huddle.
- If the patient requires any SOGI component, the MA prepares the SOGI questionnaire to give to the patient.
- When the patient presents for the visit, the MA rooms the patient and hands the SOGI questionnaire to the patient.
- The MA will inform the patient that CHC is collecting this information on all patients as a standard of care and that the provider will review the questionnaire with them.
- Any questions they may have about the questionnaire can be discussed with the provider if needed.

Sexual Orientation and Gender Identity (SO/GI) CHC Questionnaire

SOGI Screening Questionnaire Form

Thank you for completing this form. Your answers will help us provide you with complete and respectful care.

1. **Do you think of yourself as:**
   - ☐ Straight or heterosexual
   - ☐ Lesbian, gay, or homosexual
   - ☐ Bisexual
   - ☐ Other:_____
   - ☐ Questioning
   - ☐ Don't know
   - ☐ Choose not to disclose

2. **Do you think of yourself as:**
   - ☐ Male
   - ☐ Female
   - ☐ Transgender Male/Trans Man/Female to Male (FTM)
   - ☐ Transgender Female/Trans Woman/Male to Female (MTF)
   - ☐ Genderqueer (neither exclusively male nor female)
   - ☐ Additional gender category/Other, please specify:_____
   - ☐ Questioning
   - ☐ Don't know
   - ☐ Choose not to disclose

3. **What sex were you assigned at birth on your original birth certificate?**
   - ☐ Male
   - ☐ Female
   - ☐ Decline to answer

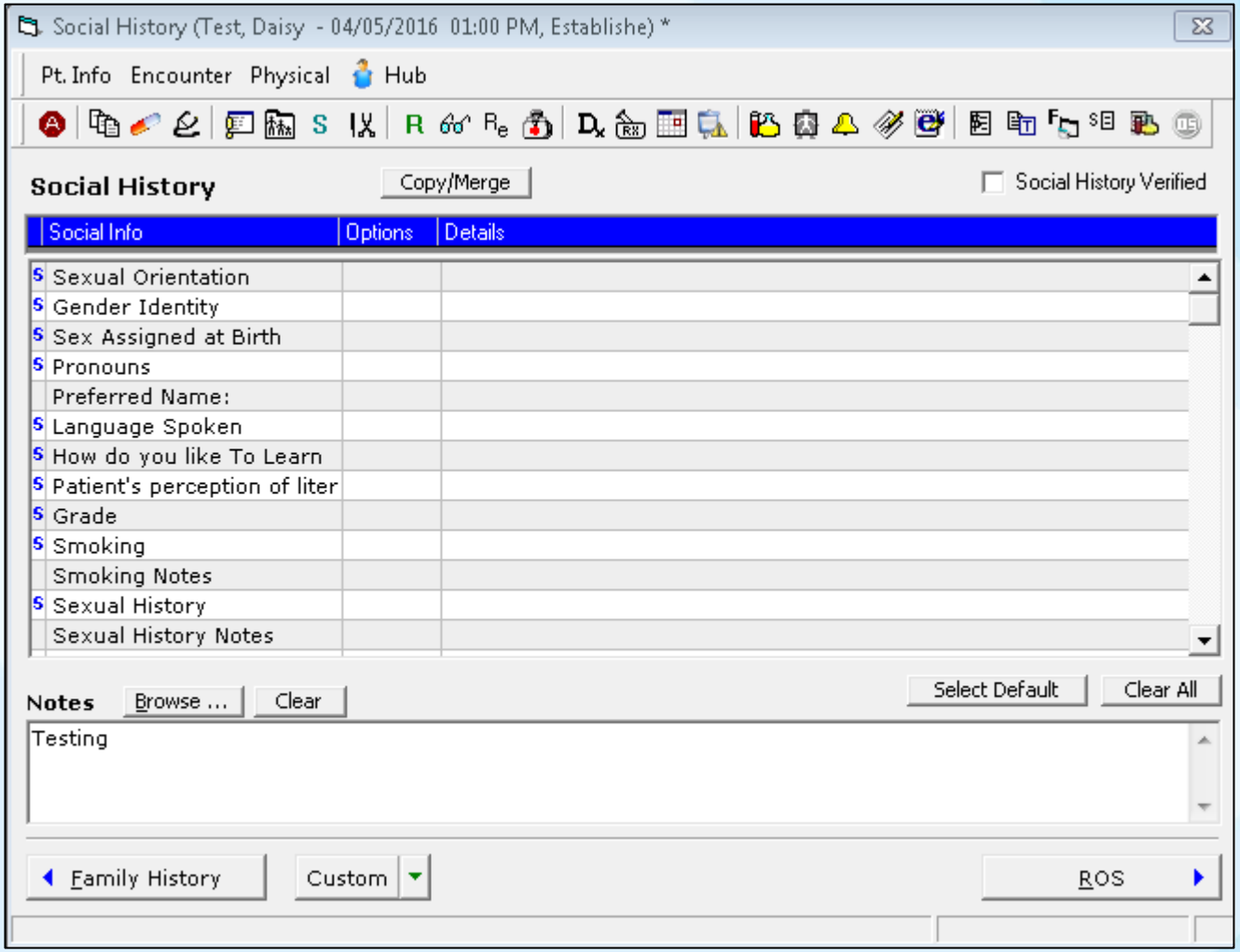
4. **Pronouns to use. Specify:**
   - ☐ He/Him
   - ☐ She/Her
   - ☐ They/Them
   - ☐ Other:_____

5. **Preferred Name:**_____

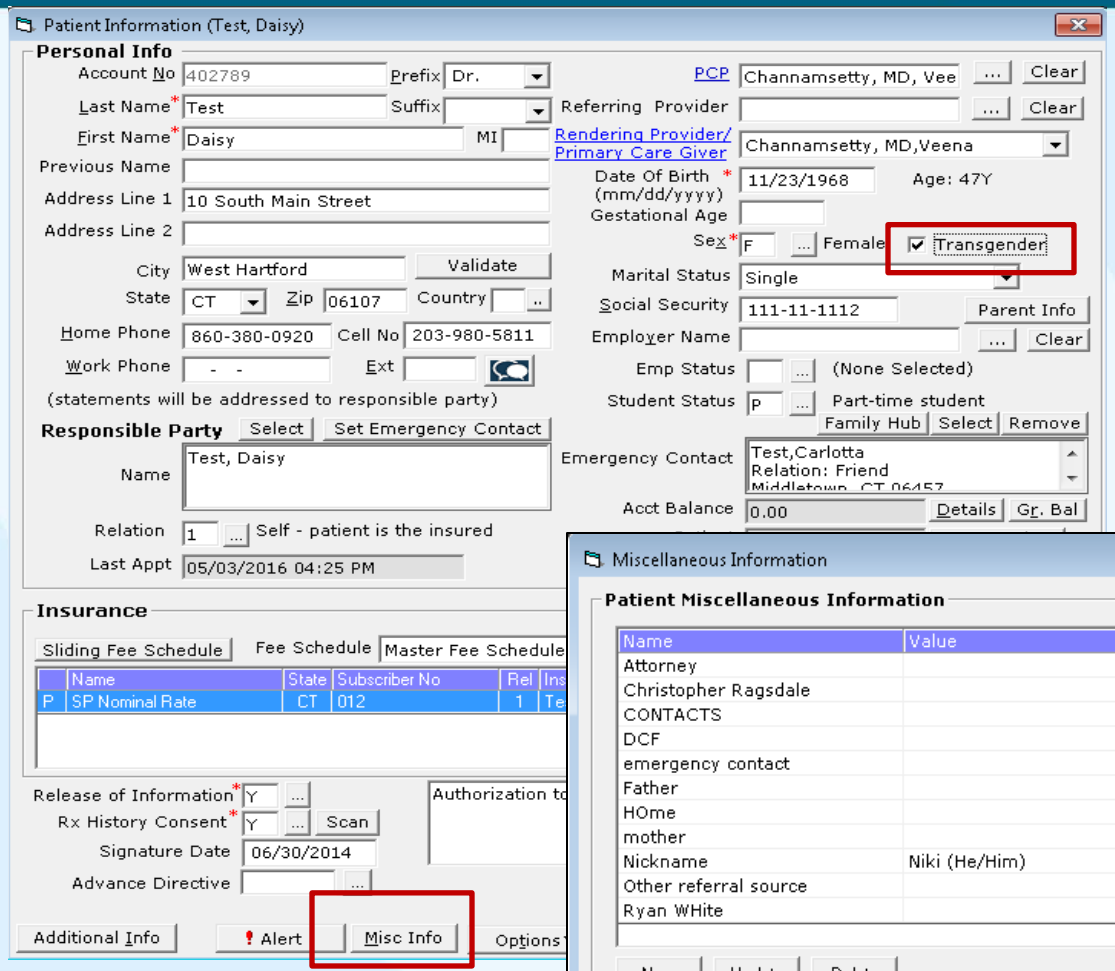
Key Steps in Collecting SO/GI: Medical Assistants

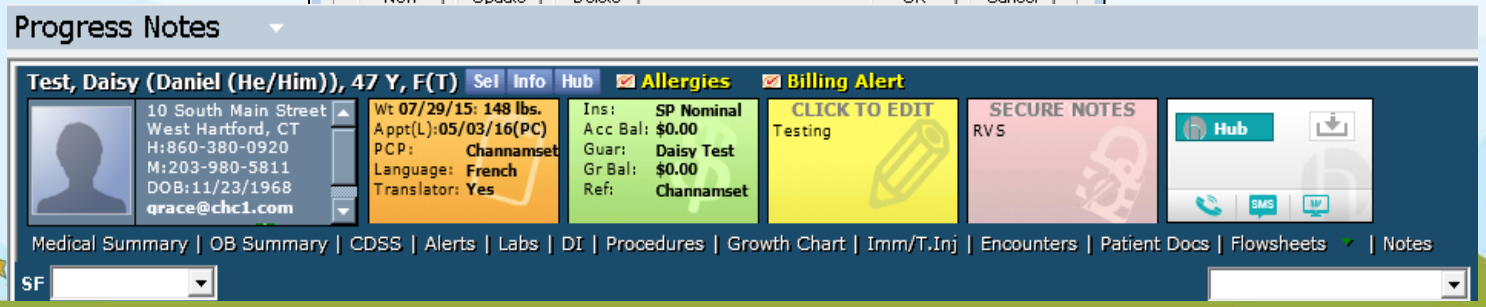
- The patient fills out the questionnaire.
- The provider reviews the questionnaire with the patient during the course of the visit and answers any questions the patient may have.
- The medical provider can enter the SOGI information in eCW under Social History or can hand the questionnaire to the MA to enter the information.
- If the patient's gender identity is different than the gender assigned at birth or if transgender male, transgender female, genderqueer, or other categories are checked, in addition to entering this information in Social History, the T box in Patient Information must be checked. The gender field in Patient Information must remain the same gender as is listed on the insurance.
- If the pronouns indicated do not correspond with the sex assigned at birth and/or the preferred name is different from the name listed on the insurance, the name and pronouns to use should be entered in the Nickname field in Patient Information under Miscellaneous Info in the following format:
    - "John (He/Him)" or "Jane (She/Her)"

SO/GI Information in Social History



Preferred Name and Pronouns





2016 and Beyond

Project	Description	Timeline
Ryan White Practice Transformation Initiative	Partnered with Yale University and CTAETC to serve as a best practices model for TA in practice transformation for RW programs across the state of CT.	December 2015 – August 2019
RSR eCW Seamless Reporting	Working in clinical microsystem to devise a seamless workflow for data collection and input for all HIV patients at CHC.	August 2016 – January 2018
Pre-Exposure Prophylaxis (PrEP)	Monitoring and expansion of access to PreP for new and established patients across the state. Training, education, and outreach to providers, patients, and the community for PrEP including the use of an agency PreP Navigator to eliminate barriers.	January 22nd- Ongoing
SO/GI Data Collection and Sexual Risk Assessment- LGBT Practice Transformation Collaborative	Partnered with Fenway/NACHC/CDC to receive guidance and support for collecting SOGI data, taking sexual risk assessment and STI screening throughout the agency.	Pilot 12/2015 Rollout 8/2016

2016 and Beyond

Project	Description	Timeline
LGBT Project ECHO	Participating in ECHO led by Fenway Institute in collaboration with NACHC/CDC to train clinician champions in LGB and Transgender Health across agency.	April 2016- March 2017
CT HCV Treatment Cascade and Statewide Coordinated Statement of Need	Particpated as one of lead service agencies on providing input and data to develop a CT HCV Treatment cascade and a comprehensive statement of Need for HCV services.	December 2015 – September 2016
HRSA Substance Use Expansion Grant	Training behavioral health clinicians through Project ECHO to run groups and take on an increased role in managing buprenorphine patients in order to support prescribers in increasing capacity.	March 2016 – March 2018
Routine HIV/HCV Testing Initiative	Continuous monitoring of screening rates across agency and looking at ways to improve rates further.	Ongoing
Nurse Practitioner Fellowship	Developing a second year fellowship to the NP residency program at CHC focusing specifically at CKP's key populations including HIV and HCV.	September 2017

Thank You!

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