

WEBINAR VIDEO TRANSCRIPT

Partnership for Care HIV TAC

Electronic Health Records, Session #4

28 June 2016

STEVE LUCKABAUGH: Good afternoon. My name is Steve Luckabaugh. And I'd like to welcome you to the Electronic Health Records, Session Number Four, Community of Practice webinar. This webinar as brought you by the Partnerships for Care HIV Training, Technical Assistance, and Collaboration Center, or HIV TAC. The Partnerships for Care project is a three year, multi-agency project funded by the Secretary's Minority AIDS Initiative Fund and the Affordable Care Act.

The goals of the project are to one, expand provision of HIV testing, prevention, care, and treatment in health centers serving communities highly impacted by HIV; two, to build sustainable partnerships between health centers and their state health department; and three, to improve health outcomes among people living with HIV, especially among racial and ethnic minorities. The project is supported by the HIV Training, Technical Assistance, and Collaboration Center, HIV TAC.

Our speaker today is LuAnn Kimker. Ms. Kimker has dedicated much of her career to improving the delivery of health care. She combines her clinical, technical, and business expertise to design, implement, and leverage health information technology to drive change at the practice, physician organization, and the health system. Ms. Kimker has successfully led large teams through quality and performance initiatives, practice redesign, and transformation, as well as patient-centered, medical home recognition projects.

She works to create a culture of change that leads to joy in practice, while keeping the patient at the center. LuAnn is certified as a National Committee for Quality Assurance patient-centered, medical home certified content expert and as a certified professional in health care information and management systems, working with large academic medical centers, community health organizations, and large physician organizations. Please join me in welcoming Ms. Kimker.

LUANN KIMKER: Thank you, Steve. I want to thank folks for asking me to be here today. I want to talk about first a slide that you've seen before if you've attended previous webinars. And that is Bridging the Quality Chasm. And this really highlights the approach that we're going to take today and that you should be taking in general as you look to redesign your care processes using and trying to leverage the technology.



It's not just about the systems and the technology, but how we integrate the operations, the care processes, that are going to help us actually to get better results, improved outcomes, and also be able to do that in a much more efficient and cost-effective way, in terms of meeting that triple aim. So we're not just going to talk about the technology today, but we'll incorporate all of these aspects into the conversation.

So we'll approach today's conversations from two perspectives. One is from the care coordination and engagement perspective and how HIV care is provided and thinking about the three phases that we gather and use information, from screening and diagnosis to the intake and to the management and care of the patient. And how do we use that structured data? And what other approaches might we use that's not just the structured data itself, but how we're actually going to use that to make a difference?

The other perspective that we're going to look at is the 10 things that can help create an inclusive environment. This slide is from the LGBT Health Education and the Fenway Community Center. And we're going to focus today's conversation on some of these things. If you look at the top one here, many of you already have engagement of your senior management. It's not one that we're going to spend a lot of time on.

The same with creating policies-- I'm sure that you're starting to do that as you've been in this collaborative now for a while and trying to shape what that care looks like in a policy perspective. But we will focus on these four main topics-- processes and forms to reflect the diversity of your population, sexual orientation and gender identity, routine sexual health histories, which I sort of incorporate more into the clinical care and services. And also, we will talk some about the training. Or rather, I would say, know that training is important for all of these things that we're going to talk about.

In terms of gender identity, I know this seems really basic. But I think it's important just to call out the differences between the gender identity versus sexual orientation and to think about how we're going to use those in practice and what impact they have when they're missing from information that's available to us. So you've got your gender identity, which is that person's internal sense of being.

And then you've got transgender for those who have a gender identity that's not congruent with one's sex assigned at birth. And over on the right, you can see you've got some of the common terms which are how you will see that represented. You then have sexual orientation, which is how that person characterizes their sexual and emotional attraction to others. Really important to keep these two things separated.

So why is it important that we collect this information? Most importantly is how it is relevant to provision of care. And if you think about transgender population, if you're looking at them as male or female, you need to know what their identity at birth is so that you can provide the right care, depending on where they are in that process.



It's also important for making sure that we look at the quality and satisfaction of the care of that population. And Steve mentioned that earlier when he said that part of the goal of this project is around relational and ethnic diversity and disparities. And so this falls right into that category also. It also is going to help create a welcoming atmosphere.

The questions which seem difficult, just as asking race and ethnicity was balked at a few years back, it's important that we gather that information so that we know we're caring for. And it is now recommended and accepted by the Joint Commission Meaningful Use, as well as the Institute of Medicine and will be required in 2017 for your UDS measures. You might wonder this conference is mostly about people living with HIV and screening for HIV. And so this is more of an LGBT focus.

But I think that it's important to know that while they don't always mean-- if you have HIV, that doesn't mean you're LGBT or vice versa. There are a lot of risk factors and characterizations that do overlap that make it make sense to look at it from this perspective. So when you're looking at structured data for this information, I've listed up here on the next two slides questions that can be asked when you're intaking a patient or doing registration for a patient. And I'm not going to read all of these on the slide, but I want you to just see what those questions are.

Do you think of yourself as-- so it's how do they perceive themselves? And then notice there for marital status, you don't just see married or divorced. You also see partnered. And you see other. There are many of these questions and characterizations that we want to make sure reach all populations and don't leave anybody feeling excluded because they don't quite fit into one of the words or categories that have been identified. And so you'll also see that here in terms of the gender identity questions.

Most importantly, note that when you create these forms or templates in your EHR, you can check all that apply for this question, so that if sometimes that's one or the other, both, or you have a line to actually add your own category so that we can understand that better, or the practice can as they're providing that care. We'll also then ask about the sex assigned at birth, where they can check one. Having these two different categories will allow you to address the patient in a manner that's respectful and welcoming, and then also be able to provide the right care for them.

And the last option you'll see written up there is the preferred name and pronouns. It can be really difficult to figure that out if you don't have it written down sometimes. And examples of doing that in terms of calling the patient in waiting room, your practice will want to decide what's the best way to do that. And always go back to the age-old approaches. It's important to ask the patient what they prefer to be called. Even if you've got it written down, you can still ask that question to them as you bring them back into the room.

So I want to ask a couple of questions of the audience. This is one where you get to participate. And so the first question is, do you collect comprehensive structured information on gender

identity? And if yes, where do you collect that information-- at registration, with support staff in the exam room, during the visit with the provider, or you're not currently collecting this data?

STEVE LUCKABAUGH: OK. Just take a few seconds here to answer the first poll question.

LUANN KIMKER: OK. So 67% are doing that registration and the other 11% by the provider. And then 22% are not currently collecting the information. OK. Now, this is the same question, except we're asking it about sexual identity. So do you collect structured information on sexual identity? And if yes, where are you collecting that information-- at registration, in the exam room, during the visit, or you're not collecting it? And I should say, this should probably be written as sexual orientation. My apologies.

OK, so a little less are collecting this information at registration, about the same in the exam room, and a much larger percentage, 25%-- or not much larger, but a few percentage points higher for during the visit. And then 13% aren't collecting it all. Great.

And then the last question is, do you collect and document pronoun preferences? So none of you currently are collecting that information. So it's one of the things that I'd like to come back to. And maybe we can open it up in a few for a little bit of conversations, Steve, but not right now, in terms of what's getting in the way of doing that.

So there is a study done in 2013 by the Community Health Applied Research Network. And I looked at four health centers. And they asked 251 patients questions about their sexual orientation. These health centers, one of them was primarily a heterosexual population, I would say, and not focused on care of the LGBT population. And the other ones were a mix but more specialized in treatment of patients that were LGBT.

And so you can see that of the respondents, 47% were heterosexual and 29% gay, lesbian, or homosexual, and 9% bisexual. That's how they identified for themselves. And you will know that there were a decent range, in terms of their responses. So in the heterosexual group, there was a range of responses from 34% to 82% at the for four health centers versus the 29% actually ranged from 2% to 42%, which you can see that the 2% was from the clinic that was not specializing in care of that particular population.

But three out of the four said that asking these about sexual orientation was important. And four out of five said that they thought it was important for their provider to know their sexual orientation. And if you think about that in terms of your responses, that's 80% think it's important. But we're still only asking that question around sexual orientation 25% of the time based on the attendees today. So there's a lot of opportunity there to open that up and try to get at that information a little better.

The other thing is, is that in terms of the study, they wanted to know how easy it would be to gather this information if you were going to roll it out in another practices. And were they

asking the right questions? And 80% of the population said that they understood the questions and that they were willing to answer them. And that includes the heterosexual population.

So I think that's important to understand and that you should use-- this is a good study to help you as you're implementing these changes in your practice. And you've got the link to it at the bottom if you want to see some more of the details about how they did that or what their results were. It may be useful as you're trying to have those conversations and guiding people going forward who are maybe afraid to be offensive to one or the other population.

So what are some of the different ways that we can promote engagement using the population? The one thing that I like to say is that the early adopters, some of you who are already collecting this information and have developed ways to do it, as it becomes more standardized, sometimes that makes it a little bit harder for you. Because you've developed ways to do it, and now the EHR is going to come along and tell you how they've decided to do it. And sometimes that means having to transition your data to different fields and making it usable again.

You also want to make sure that that data is visible in the EHR where staff can see and use it. If it only lives in registration or buried beneath a few layers of data, it's not going to be available for the medical assistant, for the care manager, for the advocate who's actually working with those patients. It needs to be out there where people can see it, use the right pronouns, understand where that patient's coming from.

The other one is around collecting registration data on the patient portal. And I'm curious how many people are actually doing that or using tablets to be able to gather this information. In some conversations recently that I've been engaged in, there were people who were collecting some of this information in the registration area. But then some of the other information was back in the exam room, even if it was by an MA. And that was not because-- it was more about privacy. And even though they may have been doing it on a form, there's still some of those fears associated with where that data's being collected that people may be a little bit more reluctant to answer.

And in that study that I referenced of the four clinics, each of them did it a little bit differently. So it wasn't routinely all collected in the same space. They did what worked best for their environment, staff and patients, and where they thought they were going to get the best results. And then whatever you do, you want to make sure that you update any forms that you're handing out to help gather that information into the electronic health record.

So the next area that we're going to focus on beyond the sexual orientation is around the clinical care and services. And so we're going to do just a quick poll, and that is, in which group is the incidence of HIV rising? And you've got four options there-- black men having sex with men, white men having sex with men, black heterosexual women, or injection drug users.



STEVE LUCKABAUGH: OK. Please take a moment here to answer our final poll. Want to thank everyone that has contributed so far. We really appreciate it.

LUANN KIMKER: So 70% said men having sex with men. And that is the group that is increasing the most right now with their incidence of HIV. And so again, this is-- I just want to highlight here what populations you're going to want to be focusing on as you gather this information and look to reach out to these patients. You're going to want to make sure that the care that you're providing in the programs that you are implementing recognize that as one of the groups most at risk as you look to do prep or some other things like that, and how you create an environment, and ways to reach out then that will keep them engaged with your center.

So this slide just demonstrates that a little bit so that you can see the spread of where you're seeing the most new HIV infections, in terms of IV drug abuse and the heterosexual population. So again, it's increased 20% in the black MSM population between 2008 and 2010. So how does this actually come into play, in terms of providing care?

So the minority stress model indicates that there are about five different things that are impacting people's reaction to stress-- stressful prejudice events, microaggressions. The biggest one on here, even probably a little bit more than the rejection recently spoken about, was the cognitive burden of negotiating outness. And a lot of that was surrounded around questions that they get asked, and how they respond to them, and whether the person needs to explain why they're answering how they're answering. And that might have to do with who they're dating, who their wife is when their wife is not a female, et cetera.

And so this, again, exemplifies the training necessary and how important it is to make sure that the words that you're putting in your EHR and that your staff are using align with the population that you're working with. If you are on a screen that is for female physicals, when you think about your well visits for males and females, if you go through a series of female questions for someone who is transgender or in another type of relationship, you're not going to get the right answers. And you're actually going to potentially alienate the patient and not get the responses needed so that you can provide the right care.

The other thing, in terms of your templates and identifying your risk populations, is that when you look at these three populations right here, men having sex with men, women having sex with women, and transgender, you'll notice that the top four risks which are not in bold are the same across all populations. But then you'll see where the differences sort of align. Sexual assault and partner violence are still very prevalent across all three. But you'll have more risks for the men having sex with men, in terms of both syphilis, and HIV, and anal cancer, which may not be as easily picked up or screen for.

In terms of the people living with HIV, there is a high incidence of trauma. Recently participated in an all-day session around care of patients with HIV. And one of the speakers that we listened to spoke about his own experience with trauma as someone who was gay, diagnosed as HIV,

and how his early childhood traumas that were not in any way related to his sexual identity, sexual orientation, at that time came back and were really lived through much of his life and how it impacted his experience as an IV drug user and also as somebody who was diagnosed with HIV.

And a couple of things that you can see on this slide that he highlighted is A, high prevalence of sexual assaults-- 45% of HIV positive participants over the age of 15. You'll also see that initiating drugs, drug therapy, was difficult for those who have PTSD symptoms and often brought out more of their PTSD symptoms than just being told they had HIV. It also has a negative effect on their adherence to antiretroviral therapy. And in fact, some of the medications that are prescribed for that have been shown to exacerbate the PTSD symptoms.

And so one of the things we want to make sure that we're doing as we address these patients, and really all of our patients, is understanding what are the traumas that they've experienced, and that in addition to just treating the condition, we also need to be able to treat that trauma and make sure that they're getting the right supports to help them deal with that, their own self-worth, and self-soothing abilities, as this one person described it, as they receive their treatment and care.

So this leads me to the screening for social determinants of health. And this is at a much higher level. It will not get into all those details around their sexual history. But we've heard for a long time that we've got a social history section. And there are questions that we ask. But this tool, the PREPARE, really starts TO ask us to incorporate that into the general care of all of our patients, so that we understand what those risks are. And then in particular, how that will help us guide the care for the HIV population.

So PREPARE is the Protocol for Responding to AND Assessing Patients' Assets, Risks, and Experiences. And the first half of the questions associated with this have to do with the simple things that you're already asking, what their insurance is, what their race, their ethnicity is, their household income, things that are routinely captured in the registration aspect of the chart.

But then you'll see here, and this is an example from one the EHR, where they've built the questions as structured data that can be then asked by anyone on the care team. And most of these would probably be asked by a medical assistant on intake. Or depending on how you're structured, you may have an advocate, or a caseworker, or someone who is helping to gather this information.

But I want to point out a couple of things in terms of the technology and how you want to be able to gather the information. So one is by the use of structured text in your templates or your forms. And this could look differently in another EHR. But I also think the important thing is figuring out what's the best workflow? Who's going to ask the questions? Where are they going to ask it? And how often?

Are these questions that get asked once a year, more frequently or less frequently? And some of that may have to do with the population that you're dealing with. The other thing that you'll notice here is that there's some built-in prompts to the support staff. And in particular, if you look about-- I think it's in the middle of the screen there-- how stressed are you?

So it then goes on to define. Stress is when someone feels-- and they give some examples for that. And that's really important for people who are learning to be able to ask those questions. In addition to the training, having the prompts is helpful. And then you can see, they've also got very structured responses as to how to answer the questions. This is another great example, where if you were using some sort of self-service apparatus, you could have the patient complete these and have it go straight into the EHR or be able to do that from your portal.

So once you have that information, now we're moving into a little bit more of not just the screening piece and getting the information when they come in, but also the management of that patient. And what are the ways, when you're caring for patients, that you're going to be able to recognize the population and make sure that you're prepared for them when they arrive and that you can make providing that care an efficient process?

Historically, a lot of that information has all waited until they get into the exam room to see the patient. And that may not be the most efficient way or the best for the patient, in terms of what needs to be done. So I'm going to show you on the next slide here a tool for visit prep, which can really enhance how you prepare for your patients that are coming through the door and then what needs to be done for them that day.

In addition, all the information that's on this report comes straight from the EHR. And it is the information that you would also want to have available in a registry, so that if you had a case manager who was working with a particular population, that they could look at that whole population and see what kind of gaps in care there were.

On this report, I want to highlight a couple of different things. One is that in the blue call out, you can see that there's a risk level. So this is a risk stratification that can be identified by a payer. It can be identified by the individual practice, in terms of how they identify risk. It could be things like the Hierarchical Condition Categories or [? CDIPs ?] that are for the Medicaid and Medicare population, in terms of defining risk.

Right above that or below it in the box, you'll see we've also got gender at birth, as well as gender identity. This way, this information is right up front. It could be in your EHR as a face sheet. It could be on a visit planning report, such as this.

You'll also see, over on the far right in the middle under visit reason, headaches. You'll see there's the name of a case manager, if this particular patient is being followed by someone else on the care team and you would want to know that. There's also a place over on the left by the name. In parentheses, you see this as Sonja Perkins. Her gender at birth was female, but her

identity is transgender male. And so you see Sunny in parentheses. You could also have a preferred pronoun type thing there. But these are examples of the kind of information that can be available for you.

There's a couple other pieces that I want to highlight here. So what this report actually does is identifies the patients who have chronic conditions. And you see that on the far left with their diagnoses. And if you look at the patient at the bottom, we're looking at patients who have diabetes, hypertension, depression, COPD. If the patient had HIV, which you can see in the patient up above, that diagnosis would also be listed there, which would be, again, your clue that they may have some other special needs than the general population.

And then you see their risk factors. In particular-- and I apologize, the box cut it off a slight bit-- you'll see it says SAD, which is a substance abuse and dependency risk factor or SMIP, which is for your severe mental illnesses or psychoses. So patients who have those risk factors would also be easily identified and flagged. And when you're prepping for them coming in, those would be cues to you as to what type of care they might need, what kind of issues you might be dealing with.

You'll also notice that it says open referrals-- making sure that these patients are following up or getting the care that they need and that you've referred them to is important. Some of it maybe referrals within your system. Some of it may be out to specialists. And this would, again, be your clue that you've got some investigative work to find out to see whether they've kept those referrals. And if not, why.

And then at the very bottom of the screen in the box, you'll see it says HIV screen and hep C missing. So this is a patient who clearly would be identified as at risk but hasn't had their HIV screen. And so what we've seen some centers do as they're doing their pre-visit prep-- and this is determined by the individual center. Some centers leave that conversation for the docs. Other centers, the medical assistant will say, so I'm going to offer them HIV screening. And they'll go ahead and do that either rapid test or a regular test.

They'll often have questions or conversations with the doc when they do their huddle just to confirm that that's what they're going to do. But they're thinking about it proactively and incorporating it into the care as a regular part of their work. And the same is true for a hep C screen, which a lot of practices are also starting to incorporate with their HIV care, in terms of flagging it and making sure that they get what they need.

These alerts, as well as all the other ones listed there, are ways for you to better understand what that patient needs. And in this case, these alerts, like a mammogram, are based on the fact that the gender at birth is female, even though the patient standing in front of you may be presenting as a male. So as we think about some of these screening, and planning, and leveraging the IT to do that, we've talked about sort of recognizing their name and who the patient is, including the HIV as chronic condition and incorporating HIV as an alert test.

This is-- one of the goals of this collaborative is to increase screening and to have this care happen more in the primary care practice and not all at the specialist level. And so by incorporating the HIV screening, just as you would other types of screenings like mammogram and colonoscopy for the appropriate age range, you're building that right in.

Eliminating templates that are specific to male or female-- we talked about that. And when we open up for questions, that's one of the questions that I want to also get a little feedback from you guys on. And then utilizing order sets and templates-- if there are routine things that need to be done, creating templates for ordering HIV, hep C, certain referrals to the community or a specialist, those can be built right into the templates to be able to do that and make it easier. Are there any questions, or can we open up for a minute and see if we can get any conversation on how well some folks are doing this?

STEVE LUCKABAUGH: Well, we have one question came in. Wouldn't the Azara DRVS fields need to be mapped from somewhere in the source EHR?

LUANN KIMKER: Yes, they would be, absolutely. And so once-- it is something that Azara is working on. And Heather, if you want to add anything here, you are welcome to. But it needs to be in both places. We need to be able to get that in from the EHR perspective and have it be in the structured data. And then we would map that into the Azara tool. Or if you're using some other sort of tool, that same type of mapping would have to happen to be able to do this type of reporting.

HEATHER BUDD: Exactly, LuAnn.

STEVE LUCKABAUGH: As a follow up there, the asker says, so if we don't have it in the EHR, we can't get it in DRVS?

HEATHER BUDD: That's correct. Mhm. This is Heather. This is Heather Budd from Azara Healthcare. And yeah, I'll just add on to what LuAnn said. What we've noticed as a reporting and analytics software company is that the EHR vendors have been doing a great job of kind of figuring out what the workflows ought to be for this. And I know from working with a couple of different vendors that they've, at least some of them, have involved community health centers to help them really understand what the developing workflows are and.

I think we're really all very much in a learning phase about how to do this well. And I think we're all really grateful to have the Fenway Institute and other leaders in this field to give us a sense of what that should look like. But the reality is that the technology is still really catching up. So the reason why we've waited a little bit to do this in the DRVS platform is to see where people are actually, in fact, capturing it.

And LuAnn alluded to this a little bit earlier. But what I know about is that there are a number of practices or EHRs that are still only capturing it right now in the registration section. And



oftentimes, the registration tool is separate from the EHR itself. And so that connection that LuAnn was referencing between being able to see it at the front desk versus being able to collect it and see it in the exam room, whether you're the support staff doing the intake versus the provider, is an important question.

And so all of those things are still being ironed out. And so we're just, we're watching and we're wanting to make sure we set this up for success. So it's absolutely in process, particularly because it's required for UDS in this coming year, even though the HRSA is very aware that this is a growing and building year for this particular set of data. It's absolutely going to be part of the tool as a result of that.

STEVE LUCKABAUGH: OK. And we have-- Cindy Cabales would like to elaborate on some of this, I think. Go ahead, I've unmuted you.

CINDY CABALES: Hi. Thank you very much. So we're using Centricity. And one of the challenges that we're experiencing here-- and you were very much on point to say that UDS has mandated it for 2016 reporting. Yet, it wasn't really mandated for the EHR vendors for attestation until maybe 2018. And one of the things that we've had to do is find external vendors like, I think we're looking at Visualutions for one, that can [INAUDIBLE] the practice management module and add SOGI fields.

The challenge is that the practice management module doesn't have any really tight interoperability with the clinical record. So whereas the registration staff can go ahead and start collecting SOGI data, and they'll probably need more training to do so, because they're not typically included in a lot of our LGBTQ health conversations, unfortunately.

There's an assumption that in our organization, everybody's cool with it. But you know, that may not necessarily be true. So there's transformational things in addition to the technological fixes that are needed. On the technological side, it's a challenge for us, because a lot of our data that goes into a population management system gets fed from our clinical module. But that's not going to be able to accommodate. We haven't figured out yet how we can get from practice management into the clinical module.

And the concern is then that if we create a workaround at the form in the EHR, then [? one ?] GE or whatever other EHR vendor does kind of update to meet the [INAUDIBLE] requirements for SOGI, then we're going to have to figure out how we backfill all that data that we've already entered.

HEATHER BUDD: Exactly.

CINDY CABALES: It's a fine line. And I think it's just so challenging. I've talked to people who are on Epic, as well as on Centricity. And we're all kind of struggling with the same thing. So it's [INAUDIBLE] population management and figure out how to do it. But it's still a matter then of



mapping it from our EHR into population management. Then on the EHR side, we've got a solution and practice management, but not for the clinical module.

HEATHER BUDD: Yeah, absolutely. So well said, Cindy. And I'm not sure that there's--

CINDY CABALES: [? Are there ?] [? theories ?] for that?

HEATHER BUDD: Mhm. Yeah. You know, I think if I were in the shoes practices that we're trying to handle this right now, I would probably be really pressing my EHR vendor to give me a sense of what is the actual timeline for the development of the fix, where there's better communication between the practice management system and the EHR and really kind of try to align the solidification of my workflow around that timeline and kind of do the best I can.

I mean, obviously, you want to be collecting this information. We want to be meeting patients where they are. And that's a key component of this. So I'm not quite sure. You know, it's like the balancing of, as you said, Cindy, the technology and what the right thing to do for patients is. So at least if you're capturing it in one side, you're doing the right thing from a reporting perspective.

It may not be as perfect. My guess is that there's almost always a strategy for migration. But I would probably kind of focus my energy and my resources to be more aligned with whatever the vendor's timeline is for getting a more integrated solution, knowing that this coming year is a building year for the data. And I'd probably spend a lot of time training staff around why this is important and why it's so needed and kind of developing the technology solutions alongside that so they're ready to go.

CINDY CABALES: [INAUDIBLE] break up the training, because we just did a journal review of an article written. It was an experience from UC Davis Health Systems. They were the first major academic center to actually implement SOGI into their documentation. And the article is titled, "Introducing Sexual Orientation, Gender Identity Into the Electronic Health Record and One Academic Health Center's Experience."

What I thought was most compelling, what we thought was interesting about that, is there's so much that it goes beyond the technical fix. There was so much education. And it actually took them three and a half years to implement their SOGI documentation practices. It's much less time to do the technical fix. But I think it can't be overlooked how much cultural coaching needs to happen in order to support figuring out what's going to work for the workflow.

HEATHER BUDD: Absolutely. Particularly if you-- Cindy, you referenced kind of the working assumption that the culture of your practice was actually very accepting of LGBTQ. But there are certainly other, potentially other areas of the country, other practices with cultures that may not be as accepting. And so understanding where you are on the spectrum of that, both



regionally as well as for your own culture in your practice, I think is a really important component for understanding what the process is to make that shift.

LUANN KIMKER: And I think [? Lisa would add ?] to--

CINDY CABALES: Add on to that is that there has to also be consideration when you're thinking about the culture and like cultural transformation. There's been focus a lot on staff. But one thing that clinicians are telling us now as we have more conversations about this is that our transgender patients have reported harassment from other patients. And so it's kind of led us to an awareness that we hadn't really thought about, how do we get the culture of our patient population to understand we are an LGBTQ-friendly facility.

I think there's a lot of assumptions that HIV centers already have that down. But when you're looking [INAUDIBLE] and the idea of integrating HIV care into primary care settings, I kind of wonder whether [? P4C ?] sites are dealing with that same cultural shift on the patient side, too.

HEATHER BUDD: Makes sense, lot of sense.

LUANN KIMKER: Yeah, So let me-- I want to move us along real quick before we're at the end of our time and to allow a little bit more time for questions if we need to. I talked a little bit about the referral tracking. You know, I think this is another one of those where you're EHR can definitely help you. But you need to know who's going to track those referrals. It can also be a great resource, in terms of knowing where your patients are most frequently going and whether you're getting information back from those centers that you're referring to to help guide the care.

So as we think about questions that are going to come up, communicating with the community and other promote providers. One of things I'm curious about is how much or how well people are able to use HIE and are they connected to that? Or are they still having to do workarounds? Also thinking about the technology, in terms of cell phones and how you're communicating with these patients.

Oftentimes, what I hear is that the populations that you're dealing with don't have regular phones, are on the move. How do we get test results back to them? How do we reach out to them when we know they need to come in for care or they've missed something for care? Mobile apps, there are a lot of mobile apps that are out there, or at least a few that are actually doing care management through mobile. And they have actually found that it's reduced the amount of time needed by a care or case manager to connect with that patient.

Or using that phone to help remind them to take their meds. And then they can see through some of these apps if the meds were taken or if they weren't taken and try to then communicate with that patient to bring them in or understand, what are the issues that are



getting in the way of them adhering to their care? And as we talked about earlier, sometimes that might be their experiences that they've had that's doing that.

So we'll hold those questions sort of for the end, in terms of whether folks are actually using any of the action plan apps. I'm also curious whether people are using any of the tools that help the patient, in terms of patient activation. Judy Hibbert has a tool that she uses, in terms of determining whether a patient is actually activated to make change and at the right stage.

And there are some other programs like How's Your Health that were developed by John Wasson and Dartmouth that look at having the patient answer a few questions. And it brings to the top what their key issues are. And that information can be brought right back into the chart, depending on the kind of app you're using to collect the data, or at least scanned in as a document for the provider to see or the care team, so that they know that maybe there are issues around hunger, and food, and food instability that are preventing them from actually doing some of the other things that they need to to manage their HIV.

The last piece that I'll talk about from a more systematic perspective is actually how you're using the data. And in a recent session that we had, realized that there were a lot of people that were still managing these populations, not through registries but through Excel sheets. And how can we assist folks to be able to use the systems that are available to them? And are they looking at the data on a regular basis?

So if you're looking to implement screening for all of your patients and not just the high risk patients, how well are you doing that? And do you track that on a weekly or monthly basis to understand what are the barriers that might be getting in the way of doing that, whether they're patient-related, staff-related, resource-related, or workflow related? Sometimes doing things like that just feels like it takes up too much time in your workflow. And what do you need to change so that you can actually achieve that goal of increasing your screening rates for the general population?

So we've talked a little bit about the training necessary and the environment needed that creates a welcoming environment for patients. So let's go to the next screen, Steve, and then just open it up for any other questions that folks have. Cause some of these questions are ones that I've alluded to throughout the session. And while we're waiting for that, the one thing that I'll say sort of as we start to close is that I think it's really important that we consider all of these three things, in terms of the environment, the resources, the staff and training that's necessary to actually change that culture.

And on the last slide that we have, I was struck again by this presentation that we heard just a short time ago of the individual who was working in this field, experiencing it himself as a patient. And the one thing that he said it struck me the most was a quote by Maya Angelou that said, "People will forget what you said. They'll forget what you did. But they'll never forget how you make them feel."



And so as you're approaching your system change, keeping that in mind will actually help you to be more successful so that we don't just ask the questions to check them off on a box, but we ask the questions, document information, and use that information to make a difference.

STEVE LUCKABAUGH: We did have one follow up here. Could we get links to see examples of patient action plan apps?

LUANN KIMKER: I can give you the name of a couple, yeah. Twine is one, Caremerge, Care Manager. But I can pull together a short list. Again, there's no vested interest in any of those programs. But they are pretty cool. One of them even has a version that they call Snap Chart. So from a privacy perspective, they'll send a private message or a piece of your chart. It'll last for seven seconds. And then it disappears, for those who are afraid of who might get that information and what they do with it, or that it's just out there.

STEVE LUCKABAUGH: I'm not seeing any more questions right now.

HEATHER BUDD: May be that we've talked about a lot of these things over the course of a number of the webinars that we've done. And people are feeling full.

LUANN KIMKER: If there are any things that people come up with afterwards, please contact us or Steve, Victor, whatever. And we'll be able to help you out.

STEVE LUCKABAUGH: So any closing thoughts before I wrap it up here?

LUANN KIMKER: No. I did that. I think this is good. You know, it's a lot to undertake. And there are challenges. And I think there are lots of ways that technology can be leveraged. It's important to get the basics, so that you know how that you can do that. But be looking ahead to the future, as to where you want to go and how you want to use that information.

STEVE LUCKABAUGH: OK. All right. Well, I want to--

LUANN KIMKER: Thank you.

STEVE LUCKABAUGH: I want to thank everyone for participating in today's webinar. We hope that you're able to find the information provided useful as you continue your P4C project and ask that you take a few moments to complete the feedback survey that you will receive when you close out of this webinar. You will also receive it via email.

Today's webinar was recorded. And audio-video versions of the entire webinar, as well as the slides from today's webinar, will be available on the P4C website within the next few weeks. Copies of our prior P4C webinars are currently available on the website on the P4C Resource Materials page at p4chivtac.com. You will need to log in to access the materials. If you need login credentials, send an email to p4chivtac@mayatech.com.



Thank you again for participating in today's webinar. And thank you, Ms. Kimker and Ms. Budd for an excellent presentation and comments. If you have any additional questions for the P4C project or for Ms. Kimker, please email us at p4chivtac@mayatech.com. Take care, everybody. And we'll see you next time.

