Barriers to HIV Testing in Primary Care

Making it Routine

In the Clinical Setting

LAFP 68th Annual Assembly and Exhibition

9 August 2015

Lorna Seybolt, M.D., M.P.H.
How many “patients visits” do you have scheduled/available per month?

A. <25
B. 25-50
C. 50-10
D. >100
My patient case load would be best described as

A. Mostly over age 65
B. About half over age 65
C. Most between 21 and 65 years old
D. Mostly under 21 years old
E. I see everyone
In the past month, of the patients you “saw”, how many were offered/tested for HIV?

A. More then 50
B. 25-50
C. 10-25
D. 1-10
E. None
F. We don’t offer HIV testing at my clinical practice
Is HIV Really a Problem in Louisiana

• LA has 3rd highest rate of HIV in the US (30.2 per 100,000 population) (2011)
  – 11th in the actual number of HIV cases

• New Orleans region is 2nd and Baton Rouge region is 3rd in US for HIV rate (43.0 and 41.6 per 100,000, respectively)

• In 2013, 1,365 new HIV cases were diagnosed in LA, only 50% were in NO or BR regions
## Rate of HIV in US

<table>
<thead>
<tr>
<th>State/Area</th>
<th>New HIV Diagnoses, per 100,000</th>
</tr>
</thead>
<tbody>
<tr>
<td>District of Columbia</td>
<td>177.9</td>
</tr>
<tr>
<td>Virgin Islands</td>
<td>39.5</td>
</tr>
<tr>
<td>Louisiana</td>
<td>36.6</td>
</tr>
<tr>
<td>Maryland</td>
<td>36.4</td>
</tr>
<tr>
<td>Florida</td>
<td>33.2</td>
</tr>
<tr>
<td>Georgia</td>
<td>31.4</td>
</tr>
<tr>
<td>New York</td>
<td>30.1</td>
</tr>
<tr>
<td>Puerto Rico</td>
<td>28.6</td>
</tr>
<tr>
<td>Mississippi</td>
<td>25.3</td>
</tr>
<tr>
<td>Texas</td>
<td>24.5</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Cases of HIV by Zip Code
Transmission Rates in Louisiana
Male 2011

New Orleans

- Male-to-Male Sexual Contact (52.3%)
- Injection Drug Use (6.8%)
- Heterosexual Contact (6.5%)
- Other* (27.3%)

Baton Rouge

- Male-to-Male Sexual Contact & Injection Drug Use (7.1%)
- Injection Drug Use (13.1%)
- Heterosexual Contact (11.7%)
- Other* (32.1%)
- Male-to-Male Sexual Contact (38.3%)
Myth Regarding HIV “Risk”

2010 National HIV Behavioral Surveillance System

8,473 were tested

2.3% were HIV +

Not “Gay”

Not IDU

Were Poor

Were less Educated
Key Points Regarding HIV Infections

- 42,000 person in US were diagnosed with HIV in 2011
- More than 1.1 million people in the US are HIV+
- 1 in 6 (16%) of those infected are unaware of their infection
- In LA 40% of New HIV diagnosis already have AIDS
- 50% of new HIV diagnosis had more than 2 health care visits in previous year
HIV has always been about what you do; today it is also about where you live.

92% of new U.S. HIV diagnoses occur in 25% of counties.

...these three cities have the highest new HIV diagnoses rates in America.
Having Patients Diagnosed with HIV as early as possible is most important because

A. Reduce chance of increased morbidity and cost of HIV care
B. Preserve the immune system reduce risk of long term effects of immune dysfunction
C. Potentially decrease the ability to spread HIV to others
D. Improve the care for some who is HIV+
E. Reduce to risk of transmission to health care providers
Which Statement is true regarding HIV testing

A. Most HIV + persons are diagnosed within 1-5 years after infection
B. HIV testing is recommended for all individuals aged 13–65 years
C. Written informed consent is required for HIV testing per US law
D. HIV testing is routinely done on most patients who have blood work via ER’s
E. HIV testing can be done on a patient without out telling them if they are at high risk
Effect of Diagnosis on Transmission

Crepaz et al, 2006, AIDS 20(10)
Current HIV Testing Recommendations

- **CDC**: routine HIV screening for all individuals aged 13–64 years
- **USPHS**: routine HIV screening for all individuals aged 15–65 years (Cat A rec)
  - The Affordable Care Act (ACA) requires/ incentivizes Medicare/Medicaid and commercial, health plans to provide preventive services rated “A” or “B” by USPHS at no cost to patients
- **AAP**: testing of all adolescents at least once between 13-21 years old
Which of the following is **least likely** to create a barrier to HIV testing in a clinical setting

A. Provider lack of knowledge regarding the recommendations for HIV testing
B. Providers concern regarding informing a patient that they are HIV+
C. The patient refuses
D. Insurance programs that do not cover the cost of HIV testing
Provider Reported Barriers to HIV Testing

Burke, Ryan; et al AIDS. 21(12):1617-1624, July 31, 2007. DOI: 10.1097/QAD.0b013e32823f91ff
Providers Reported Barriers to HIV Testing

- Informing an HIV+ patient
- Institutional costs
- Insufficient time
- Consent process
- Lack of knowledge/training
- Language
- Lack of patient acceptance
- Pre-test counselling requirements
- Competing priorities
- Inadequate reimbursement

Burke, Ryan; et al AIDS. 21(12):1617-1624, July 31, 2007. DOI: 10.1097/QAD.0b013e32823f91ff
GET
TESTED
AND
CARRY
ON.

NATIONAL HIV TESTING DAY • THE STIGMA PROJECT
Provider Barriers to HIV Testing

- Lack of knowledge regarding prevalence/incidence in region
- Lack of knowledge regarding how to access test
- Burdensome pretest counselling requirements
- Potential lack of resources/inadequate reimbursement/support of administration
- Concern regarding ability to maintain confidentiality within clinic setting
- Fear/concern of offending the patient by offering test
- Provider lack of knowledge/training/confidence
  - Delivery an HIV + diagnosis/result
  - How/where to refer
  - Address HIV risk factors (sexual practice/drug use)
## Potential interventions to Reduce Barriers to Routine HIV testing

<table>
<thead>
<tr>
<th>Barriers</th>
<th>Potential Interventions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Logistical Issues in Clinic Settings</td>
<td>Adopt oral consent per CDC recommendations</td>
</tr>
<tr>
<td>Burdensome Consent Process</td>
<td>Adopt opt-out consent per CDC recommendations</td>
</tr>
<tr>
<td>Pretest counseling requirements</td>
<td>Streamline face to face pretest counseling by providing HIV test information in writing or video format</td>
</tr>
<tr>
<td>Inadequate reimbursement</td>
<td>Increase reimbursement for providers for HIV testing in fee for service programs</td>
</tr>
<tr>
<td>Resistance from management regarding potential increase cost</td>
<td>Work with commercial carriers to assure adequate reimburse for HIV testing based on standard CMC rates</td>
</tr>
<tr>
<td></td>
<td>Provide information regarding cost and calculation from AHA</td>
</tr>
<tr>
<td>Lack of Provider Knowledge/ Training/ Comfort</td>
<td>Provide convenient training with period update</td>
</tr>
<tr>
<td></td>
<td>provide onsite training with experience HIV providers for clinical practice/ experiences</td>
</tr>
</tbody>
</table>
## Potential interventions to Reduce Barriers to Routine HIV testing

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<tr>
<th>Barriers</th>
<th>Potential Interventions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Language Barriers</td>
<td>Provide consent forms and educational material in multiple languages</td>
</tr>
<tr>
<td></td>
<td>Contract with telephone interpretation service that is available through public and commercial insurance carriers per ACA</td>
</tr>
<tr>
<td>Insufficient Time</td>
<td>Establish reminder systems within medical record</td>
</tr>
<tr>
<td>Competing Priorities</td>
<td>Provide printed fact sheets or scripts for providers to refer to when performing counseling testing providing results</td>
</tr>
<tr>
<td></td>
<td>Provide written material about HIV for distributions</td>
</tr>
</tbody>
</table>
With currently approved and recommended routine HIV testing methods, HIV can be diagnosed how long after infection?

A. Within 3 months
B. Within 1 month
C. Within 14 days
D. Within 1 week
Markers HIV Infection

DT = 21.5 hr

HIV RNA (plasma)

HIV Antibody

HIV p24 Antigen

Theoretical infectivity

Day 0
Day 11
Day 16
Day 22

5 days
6 days

HIV RNA
HIV p24 antigen
HIV antibody
Improvements in HIV Diagnostics
Improvements in HIV Diagnostics
Sensitive HIV-1/2 Immunoassay
(eg, 4th generation Ag/Ab assay)

(+)

(-)

Negative for HIV-1 and HIV-2 antibodies (and p24 Ag*)

HIV-1/HIV-2 differentiation immunoassay

HIV-1 (+)

HIV-1 antibodies detected
Initiate care
(and viral load)

HIV-2 (+)

HIV-2 antibodies detected
Initiate care

HIV-1&2 (-)

RNA

RNA (+)

Acute HIV-1 infection
Initiate care

RNA (-)

Negative for HIV-1

## HIV Testing Results

<table>
<thead>
<tr>
<th>Test performed</th>
<th>Test results</th>
<th>Final interpretation for provider report</th>
<th>Test results to be reported to public health authorities</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. HIV-1/2 Ag/Ab combination immunoassay</td>
<td>1. Nonreactive</td>
<td>Negative for HIV-1 antigen and HIV-1/HIV-2 antibodies. No laboratory evidence of HIV infection. If acute HIV infection is suspected, consider testing for HIV-1 RNA.</td>
<td>Reporting this test result is not required.</td>
</tr>
<tr>
<td>1. HIV-1/2 Ag/Ab combination immunoassay</td>
<td>2. Reactive</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. HIV-1/HIV-2 antibody differentiation immunoassay</td>
<td>2. HIV-1 reactive and HIV-2 nonreactive</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. HIV-1/2 Ag/Ab combo immunoassay</td>
<td>1. Reactive</td>
<td>Positive for HIV-1 antibodies. Laboratory evidence consistent with established HIV-1 infection is present.</td>
<td>Report test results 1 and 2.</td>
</tr>
<tr>
<td>1. HIV-1/2 Ag/Ab combination immunoassay</td>
<td>1. Reactive</td>
<td>HIV antibodies were not confirmed and HIV-1 RNA was not detected. No laboratory evidence of HIV-1 infection. Follow-up testing for HIV-2 should be performed if clinically indicated.</td>
<td>Reporting this test result is not required.</td>
</tr>
<tr>
<td>2. HIV-1/HIV-2 antibody differentiation immunoassay</td>
<td>2. Nonreactive or indeterminate</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. HIV-1 RNA assay</td>
<td>3. RNA not detected</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. HIV-1/2 Ag/Ab combination immunoassay</td>
<td>1. Reactive</td>
<td>Positive for HIV-1. Laboratory evidence consistent with acute HIV-1 infection is present.</td>
<td>Report test results 1, 2, and 3.</td>
</tr>
<tr>
<td>2. HIV-1/HIV-2 antibody differentiation immunoassay</td>
<td>2. Nonreactive</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. HIV-1 RNA assay</td>
<td>3. RNA detected</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. HIV-1/2 Ag/Ab combination immunoassay</td>
<td>1. Reactive</td>
<td>Positive for HIV-1 antibodies. Laboratory evidence of HIV-1 infection confirmed by HIV-1 RNA.</td>
<td>Report test results 1, 2, and 3.</td>
</tr>
<tr>
<td>2. HIV-1/HIV-2 antibody differentiation immunoassay</td>
<td>2. Indeterminate</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. HIV-1 RNA assay</td>
<td>3. RNA detected</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. HIV-1/2 Ag/Ab combination immunoassay</td>
<td>1. Reactive</td>
<td>Positive for HIV antibodies. Laboratory evidence of HIV infection is present. HIV antibodies could not be differentiated as HIV-1 or HIV-2. Additional testing for HIV-1 RNA or HIV-2 RNA should be performed if clinically indicated.</td>
<td>Report test results 1 and 2.</td>
</tr>
<tr>
<td>2. HIV-1/HIV-2 antibody differentiation immunoassay</td>
<td>2. HIV-1 and HIV-2 reactive</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. HIV-1/2 Ag/Ab combination immunoassay</td>
<td>1. Reactive</td>
<td>HIV-1 antibodies were not confirmed and HIV-1 RNA testing was not performed. Testing of this specimen is incomplete. Follow-up testing for HIV antibodies and HIV-1 RNA is recommended as soon as possible.</td>
<td>Report test results 1 and 2.</td>
</tr>
<tr>
<td>2. HIV-1/HIV-2 antibody differentiation immunoassay</td>
<td>2. Nonreactive or indeterminate</td>
<td></td>
<td></td>
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</tbody>
</table>

Abbreviations: Ag/Ab, antigen/antibody; RNA, ribonucleic acid.
Provider Barriers to HIV Testing

- Lack of knowledge regarding prevalence/incidence in region
- Lack of knowledge regarding how to access test

- Burdensome pretest counselling requirements
- Potential lack of resources/inadequate reimbursement/support of administration
- Concern regarding ability to maintain confidentiality within clinic setting
- Fear/concern of offending the patient by offering test
- Provider lack of knowledge/training/confidence
  - Delivery an HIV + diagnosis/result
  - How were to refer/
  - Address HIV risk factors (sexual practice/drug use)
Opt-Out HIV Testing

• Based on the principle that general consent for medical care is sufficient for HIV testing
• As with all medical procedures / test, patient should be made aware that HIV testing will be occurring and be given the opportunity to decline testing.
  – HIV testing is voluntary and never coerced
  – If refuses, reasons should be explored and documented in chart
  – Testing should be offer at subsequent visits.
• Oral or written information given at time of testing at an appropriate health literacy level for the patient is ideal and should include
  – Explanation of HIV and means to prevent transmission
  – Meaning of positive and negative results
  – Follow up for either positive or negative tests
State HIV Testing Law

• Informed Consent: Required. Opt out process is deemed sufficient to meet standard
  – HIV testing is included in general medical consent.

• Counseling: No specific provisions were found.

• Routine Testing: HIV testing may be offered to a person as part of a routine medical screening
  – HIV testing is required to be offered to pregnant women during the third trimester (3rd Trimester Law)

• CDC recommendations do not supersede local laws

• Facilities/institutions may have their own requirements
Some Place Between

• Providing HIV test information in writing or video format prior to actual provider visit
  – Review any questions during visit
  – Maintain list of available resources (community programs, websites, hotlines)

• Assure HIV information/educational material are available in multiple languages
  – Assure availability of telephone interpretation service (that is available through public and commercial insurance carriers per ACA)

• Prepare “written script” for providers to use when discussing/ offering HIV testing
Provider Barriers to HIV Testing

- Lack of knowledge regarding prevalence/incidence in region
- Lack of knowledge regarding how to access/interpret test
- Burdensome pretest counselling requirements
  - Potential lack of resources/inadequate reimbursement/support of administration
  - Concern regarding ability to maintain confidentiality within clinic setting
  - Fear/concern of offending the patient by offering test
  - Provider lack of knowledge/training/confidence
    - Delivery an HIV + diagnosis/result
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## Coding for HIV Testing

**www.aahivm.org**

### ICD-9-CM diagnosis codes

<table>
<thead>
<tr>
<th>Situation</th>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient seen as part of a routine medical exam</td>
<td>V70.0</td>
<td>Routine general medical examination at a health care facility</td>
</tr>
<tr>
<td>Patient seen to determine his/her HIV status (can be used in addition to</td>
<td>V73.89</td>
<td>Special screening for other specified viral diseases</td>
</tr>
<tr>
<td>routine medical exam)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Asymptomatic patient in a known high-risk group for HIV (can be used in</td>
<td>V69.8</td>
<td>Other problems related to lifestyle</td>
</tr>
<tr>
<td>addition to routine medical exam)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Counseling provided during the encounter for the test</td>
<td>V65.44</td>
<td>HIV counseling</td>
</tr>
<tr>
<td>(add additional code if applicable)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Returning patient informed of his/her HIV <strong>negative</strong> test results</td>
<td>V65.44</td>
<td>HIV counseling</td>
</tr>
<tr>
<td>Returning patient informed of his/her HIV <strong>positive</strong> test results AND</td>
<td>V08</td>
<td>Asymptomatic HIV infection status</td>
</tr>
<tr>
<td>patient is <strong>asymptomatic</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Returning patient informed of his/her HIV <strong>positive</strong> test results, AND</td>
<td>V042</td>
<td>HIV disease</td>
</tr>
<tr>
<td>patient is <strong>symptomatic</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>HIV counseling provided to patient with <strong>positive</strong> test results</td>
<td>V65.44</td>
<td>HIV counseling</td>
</tr>
<tr>
<td>Patient seen as part of prenatal medical examination</td>
<td>V73.89</td>
<td>Patient seen as part of a routine prenatal care.</td>
</tr>
<tr>
<td>Patient seen for first pregnancy</td>
<td>V22.0</td>
<td>Supervision of normal first pregnancy</td>
</tr>
<tr>
<td>Patient seen for other-than-first pregnancy (second, third, etc.)</td>
<td>V22.1</td>
<td>Supervision of other normal pregnancy</td>
</tr>
<tr>
<td>Management of high-risk pregnancy</td>
<td>V23.8</td>
<td>Other High-Risk Pregnancy</td>
</tr>
<tr>
<td>Management of high-risk pregnancy</td>
<td>V23.9</td>
<td>Supervision of unspecified high-risk pregnancy</td>
</tr>
</tbody>
</table>
## Coding for HIV Testing

www.aahivm.org

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>99385</td>
<td>Initial comprehensive preventive medicine service evaluation and management</td>
<td>Initial comprehensive preventive medicine service evaluation and management</td>
</tr>
<tr>
<td></td>
<td>(new patient)</td>
<td>18–39 years of age (new patient)</td>
</tr>
<tr>
<td>99386</td>
<td>Initial comprehensive preventive medicine reevaluation and management</td>
<td>Initial comprehensive preventive medicine reevaluation and management</td>
</tr>
<tr>
<td></td>
<td>(established patient)</td>
<td>40–64 years of age (established patient)</td>
</tr>
<tr>
<td>99395</td>
<td>Periodic comprehensive preventive medicine reevaluation and management</td>
<td>Periodic comprehensive preventive medicine reevaluation and management</td>
</tr>
<tr>
<td></td>
<td>(established patient)</td>
<td>18–39 years of age (established patient)</td>
</tr>
<tr>
<td>99396</td>
<td>Periodic comprehensive preventive medicine reevaluation and management</td>
<td>Periodic comprehensive preventive medicine reevaluation and management</td>
</tr>
<tr>
<td></td>
<td>(established patient)</td>
<td>40–64 years of age (established patient)</td>
</tr>
<tr>
<td>99211-</td>
<td>Office or other outpatient visit for the evaluation and management of an</td>
<td>Office or other outpatient visit for the evaluation and management of an</td>
</tr>
<tr>
<td>99215</td>
<td>established patient that may not require the presence of a physician.</td>
<td>established patient that may not require the presence of a physician.</td>
</tr>
</tbody>
</table>
HIV Testing under Medicare

- Claims should be submitted with the following diagnosis codes:
  - Routine screening (initial or repeated) V 73.89
  - When increased risk factors are reported, V73.89 [other specified viral diseases] as primary, and V69.8 [other problems related to lifestyle] as secondary
- HCPCS codes ("G codes") to bill for HIV screening in Medicare
  - G0432 - Infectious agent antigen EIA, qualitative or semi-quantitative, multiple-step method, HIV screening,
  - G0433 - Infectious agent antigen detection by ELISA, antibody, HIV screening,
  - G0435 - Infectious agent antigen detection by rapid antibody test of oral mucosa transudate, HIV-1 or HIV-2, screening.
Medicaid Programs that Cover HIV Testing
Is it Worth Testing
Convincing Administration

- HIV Testing and Screening Cost and Reimbursement Toolkit
- Program of the Health Research Education Trust of the American Hospital Association
- A package of information on HIV testing and screening, including cost and reimbursement calculation tools, to assists clinics in establish routine HIV testing’s finical risk/benefit
- The scope of these resources is limited to screening and testing, and does not explore linkage-to-care issues.
Provider Barriers to HIV Testing

Lack of knowledge regarding prevalence/incidence in region

Lack of knowledge regarding how to access/interpret test

Burdensome pretest counselling requirements

Potential lack of resources/inadequate reimbursement/support of administration
  • Concern regarding ability to maintain confidentiality within clinic setting
  • Fear/concern of offending the patient by offering test
  • Provider lack of knowledge/training/confidence
    – Delivery an HIV + diagnosis/result How were to refer/
    – Address HIV risk factors (sexual practice/drug use)
Addressing Risk of Disclosure Within the Clinic

- Studies have shown that as routine HIV screening becomes the standard of care for all patients within a specific setting, stigma around the actual testing and results greatly reduces
- HIPAA
- Increase vigilance regarding HIPAA compliance and patient confidentiality as routine testing is initiated
- Conduct an objective measure of the degree of stigma within organization
Implementing Routine Testing

• Identifying the flow of patient visits
  – map the current patient flow
  – identify where HIV testing is to occur/ be offered

• Assign someone to administer the test (if rapid)
  – Establish system for reporting testing to State as required

• Determine how results are reported to patient based on current clinic practices

• Establish system to record test/results in medical record
  – Assure documentation that positive tests were discussed with patient and reported to State as required
NATIONAL HIV TESTING DAY
Provider Barriers to HIV Testing

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Lack of knowledge regarding how to access/interpret test

Burdensome pretest counselling requirements

Potential lack of resources/inadequate reimbursement/support of administration

Concern regarding ability to maintain confidentiality within clinic setting

- Fear/concern of offending the patient by offering test
- Provider lack of knowledge/training/confidence
  - Delivery an HIV + diagnosis/result How/ were to refer/
  - Address HIV risk factors (sexual practice/drug use)
Case 1

Mr A is a 45 year old man. He has come in today to follow up after being treated in the ER for a wound that needed sutures. During the visit you realize he has not been in for a “check-up” in over 3 years. Also, his blood pressure today is 148/88 and his BMI is 19. You recommend that he comes back in the next few weeks for a “check-up” and have some lab work done before the visit that you can review when he returns. He agrees.
Case 1

Based on current guidelines and Mr. A’s clinical picture you order: CDC Diff/Plat, Chemistries, Fasting Lipids, PSA, HCV Ab (why not a HBV and HAV too!) and HIV Ag/Ab

You review the plan with Mr. A, ask him to begin to work on decreasing his sodium intake, review the labs you have ordered and remind him to get them fasting.

When hearing “HIV”, Mr. A promptly responds, “HIV? What do think? I am gay or something?”
Sample Pretest Counseling Script for Routine HIV Testing

• **Downplay it**
  - “We do an HIV test on all our patients, it is a standard routine, just like cholesterol and blood pressure checks”

• **Flatter him**
  - “I would presume, being that you are a 45 year old man that you have had some sexual activity in your past. HIV can be transmitted through any type of sex, and you can have it without symptoms for many years. But by finding out and starting treatment you can easily keep it under control”

• **Make it “common”**
  - “HIV is very common in our community and we want to make sure any one who has it get appropriate care. That is why we are testing all our patients at least once. Just like HCV”
Sample Pretest Counseling Script for Routine HIV Testing

• Dim the spot light
  – “Part of my job is to prevent you from getting any illnesses and identify potential problems early so they can be fixed. For instance, do you have any one in your family has ever had a heart attack before the age of 50....if so we may also want to get an EKG. And we need to talk about getting a flu vaccine this year”
Destigmatizing HIV

• **Determine** the extent of stigma in an organization by conducting valid research to measure the degree of stigma

• **Identify** stigmatizing behaviors, make them visible and critique publicly
  – Stand united: Do not separate groups within condition as “innocent” vs “guilty”
  – Correct misinformation or incorrect assumptions regarding condition that adds to stigma

• **Identify behaviors that destigmatize** a condition: openly discuss and encourage discourse
  – Recognize positive attributes of those with condition
  – Publicize data that the results in destigmatizing

• **As with most “stigmatizing” conditions,** familiarity with someone who has the condition greatly reduces stigma
Provider Barriers to HIV Testing

- Lack of knowledge regarding prevalence/incidence in region
- Lack of knowledge regarding how to access/interpret test
- Burdensome pretest counselling requirements
- Potential lack of resources/inadequate reimbursement/support of administration
- Concern regarding ability to maintain confidentiality within clinic setting
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- Provider lack of knowledge/training/confidence
  - Delivery an HIV + diagnosis/result How/ were to refer/
  - Address HIV risk factors (sexual practice/drug use)
Giving Results

• **Positive results**
  - Conveyed in person with specific plan for referral/follow up care (linkage)
  - Assure confidentiality
    • do not assume others in attendance are meant to know
    • do not use family members as translators
  - Discuss partner notification/risk/assistance
    • Roll of state Disease Intervention Specialist (DIS)
  - Plan follow up to ensure engagement in HIV care

• **Negative test results**
  - Can be conveyed without personal direct contact
  - High risk patients should be encouraged to get retested in future
  - Resources to address any high risk behaviors
Explanations for HIV Indeterminate

• Early infection, seroconverting
• Advanced infection with decreased p24
• Cross-reactive antibodies or auto-antibodies from CVD, autoimmune process, or malignancy
• HIV-2 infection; O clade HIV-1
• Experimental HIV vaccine recipient
• Late pregnancy
Which of the following statements regarding HIV Treatment is TRUE?

1. To decrease long term side effects, HIV treatment with HAART is best delayed until a patient become symptomatic

2. Despite advance in HIV therapy, damage to the immune system caused by HIV can not be corrected

3. Most immune suppression caused by HIV will occur 7-10 years after diagnosis

4. In most cases, HIV disease follows a recognizable course of immune suppression characterized by specific clinical conditions if not treated.

5. Due to complex treatment guidelines, monitoring requirements and potential severe HAART side effects, HIV + person should only be treated at clinics with specialized care providers
Making the Referral

• Make the connection with HIV care provider before sending patient
  – LA HIV 411
  – Louisiana HIV Health Access Program
  – Delta AETC (http://www.deltaaetc.org/)
    • 504-826-2186 or tnewto@lsuhsc.edu
  – National HIV Clinical Consultation Center
    • (800) 933-3413 M-F, 9 a.m. – 8 p.m. EST

• Make the Patient the Appointment
  – They can always change it but it will get them on the clinic’s “list” and promote case outreach
Discussing “Sensitive” Issues

• Desensitize issues by leading into more sensitive topics via less sensitive topics
  – Urinary frequency, burning, pain: lesions, discharge, erectile or ejaculation issues, libido, sexual activity
  – Constipation, diarrhea, pain with bowel movements, hemorrhoids: lesions
  – Cough, SOB: smoking, any thing other the tobacco
  – Nausea, vomiting, abdomen pain: history of hepatitis infection, how much do you drink?(ETOH)
  – How are things at home? Sleeping: Issues with depression, relationships, dating

• Focus on the information you need for the visit
HIV Testing Preceptorship

• Goal: increase a community based provider’s comfort in offering/ordering routine HIV and addressing patients questions/ concerns
• An experienced HIV clinician (preceptor) will spend time with you, at your clinic, while you see your patients and offer routine HIV testing
• Preceptor will attend as provider sees patients and offers/orders routine HIV testing, provides support and guidance during the patient interaction
HIV Testing Preceptorship

• **Requirements**
  – Complete online HIV Testing Training
  – Schedule a full “complement” of patients during the preceptor’s visit
  – Promote the preceptor’s attendance during each patient’s encounter
  – Provide a professional commitment to institute routine HIV testing in clinical practice
  – Participate in a post experience discussion to identify short term goals to institute routine HIV testing
  – Participate in a 1 month post training discussion
    • review steps taken to institute routine HIV testing
    • number of tests ordered and completed since preceptorship
    • means to address additional training or technical needs
HIV Testing Preceptorship

• **Recommendations**
  
  – Obtain commitment of clinic administration to institute routine HIV testing
  
  – Identify appropriate HIV Ag/Ab test ID numbers of preferred clinical laboratories
  
  – Identify means to compute the number of HIV tests ordered in the previous month and calculate
  
  – Identify means to compute the number of HIV tests ordered/ performed in the month following the preceptorship
Positive Approaches to HIV Testing
Provider Barriers to HIV Testing

- Lack of knowledge regarding prevalence/incidence in region
- Lack of knowledge regarding how to access/interpret test
- Burdensome pretest counselling requirements
- Potential lack of resources/inadequate reimbursement/support of administration
- Concern regarding ability to maintain confidentiality within clinic setting
- Fear/concern of offending the patient by offering test
- Provider lack of knowledge/training/confidence
  - Delivery an HIV + diagnosis/result How/ were to refer/
  - Address HIV risk factors (sexual practice/drug use)
Resources for HIV Testing and Counseling

• **AIDS Education and Training Centers**
  – Clinic routine HIV testing curriculum, guides, and resources:
• **American Academy of Family Physicians**
• **American Academy of HIV Medicine**
• **American College of Obstetricians and Gynecologists**
• **Centers for Disease Control and Prevention**
• **Health Research and Educational Trust**
• **HIV Medicine Association**
• **Compendium of State HIV Testing Laws**:
  – State and local health departments and state offices of AIDS
• **New York City Department of health**
  – office flowchart, chart stickers, patient resources, and physician script
Which of the following statements is FALSE regarding HIV

A. It is preventable disease
B. It is chronic disease
C. It is a manageable disease
D. It is a curable disease
Contact Information

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