



Connecting HIV Infected Patients to Care: **A Review of Best Practices**

The American Academy of HIV Medicine

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Executive Summary

In 2006, the CDC released revised recommendations for HIV testing that recommend routine screening of patients ages 13 to 64 in all health care settings. These revised testing recommendations respond to epidemiologic data and concrete evidence that routine screening can identify infected individuals earlier. Earlier diagnosis and treatment can both substantially improve the health of those infected with HIV and prevent new infections. Research shows that there is a brief window period after diagnosis during which newly diagnosed patients are most likely to seek care. Timely diagnosis and timely follow-up care must go hand in hand.¹

Based on a review of existing literature and interviews with a range of clinicians, this document is written for providers who want to screen for HIV more routinely, but need ideas or strategies on how to arrange follow-up care. Part One summarizes common elements of successful follow-up care strategies from a variety of settings and Part Two highlights approaches employed by primary care clinicians in a variety of settings. The goal is to provide a tool for clinicians to help newly diagnosed HIV positive individuals have access to the care they need. A related primer for clinicians can be accessed by visiting the American Academy of HIV Medicine's website (www.aahivm.org).

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Introduction

In 2006, the CDC released revised recommendations for HIV testing that recommend routine screening of patients ages 13 to 64 in all health care settings, including hospital emergency departments, urgent care clinics, inpatient services, substance abuse treatment clinics, public health clinics, community clinics, correctional health-care facilities, and primary care settings.

Based on a review of existing literature and interviews with a range of clinicians, this document is written for providers who want to screen for HIV more routinely, but need ideas or strategies on how to arrange follow-up care. Part One summarizes common elements of successful follow-up care strategies from a variety of settings and Part Two highlights approaches employed by primary care clinicians in a variety of settings. The goal is to provide a tool for clinicians to help newly diagnosed HIV positive individuals have access to the care they need. A related primer for clinicians can be accessed by visiting www.aahivm.org.

Importantly, and in many ways, the basics of arranging follow-up care for HIV infected patients are similar to arranging follow-up care and referrals for other serious or chronic conditions. Providers need only dedicate a small amount of time and resources to learning about HIV/AIDS follow-up care. By incorporating this knowledge and corresponding procedures into the operation of their health care practices, primary care providers can make a significant difference in HIV/AIDS care.

Part One – Basic Steps

Section 1: Follow-up Care – Getting Started

Successful strategies for follow-up care begin by putting in place strong routine screening procedures. While this document focuses on follow-up care after screening and initial diagnosis, the following basic information will help guide the design of routine screening for most health care practices.

Major changes from previously issued CDC HIV testing guidelines are as follows:

For patients in all health care settings:

- HIV screening is recommended for patients in all health care settings after the patient is notified that testing will be performed unless the patient declines (opt-out screening).
- Persons at high risk for HIV infection should be screened for HIV at least annually.
- Separate written consent for HIV testing should not be required; general consent for medical care should be considered sufficient to encompass consent for HIV testing.
- Prevention counseling should not be required with HIV diagnostic testing or as part of HIV screening programs in health care settings.

For pregnant women:

- HIV screening should be included in the routine panel of prenatal screening tests for all pregnant women.
- Opt-out screening is also recommended for pregnant women.
- Separate written consent for HIV testing should not be required; general consent for medical care should be considered sufficient to encompass consent for HIV testing.
- Repeat screening in the third trimester is recommended in certain jurisdictions with elevated rates of HIV infection among pregnant women.

To view the full recommendations, visit www.cdc.gov/mmwr/preview/mmwrhtml/rr551a1.htm .

The case for these recommendations is solid. The HIV/AIDS epidemic in the U.S. meets widely accepted public health requirements for routine screening. Further, the face of the disease has changed, leaving many at risk of acquiring the infection even though they do not perceive themselves to be among those likely to be infected.² CDC estimates that 25% of people living with HIV do not know they are infected. The majority of new infections are transmitted sexually and it is estimated that the 25% who are unaware of their infection account for over half of the approximately 56,000 new infections that occur each year. Routine screening has the promise of identifying infected individuals earlier. Earlier diagnosis and treatment can both substantially improve the health of those infected with HIV and prevent new infections, since studies have shown that people substantially reduce high risk sexual behaviors once they know they are HIV positive.

Armed with an understanding of these testing guidelines, the following steps should be taken with regard to routine testing:

- Clinicians should become aware of state/regional HIV testing laws and incorporate HIV testing into general consent processes or develop consent tools that work in their setting. The website www.nccc.ucsf.edu has information on relevant state-specific testing laws, including information on informed consent. Click here for an example of an informed consent form that incorporates HIV testing. (Appendix 1)
- “Basics of HIV Screening and Testing” from the Pacific AIDS Education and Training Center (http://www.sfaetc.ucsf.edu/resources/PDF/HIVTestingBasics_March2008.pdf) (Appendix 2) and the HIV testing module from the California STD/HIV Prevention Training Center (www.stdhivtraining.org/resource.php?id=190&ret=clinical_resources) (Appendix 3) will help clinicians understand the issues surrounding HIV/AIDS testing, including which test to use, and help them develop a plan for testing their patients. A useful HIV Testing Checklist has been developed by the Southeast AIDS Education and Training Center. Click here or visit (www.aidsetc.org/doc/etres/se-testingchecklist.doc) (Appendix 4) to view this document. For further information or to request training on a topic related to HIV screening, contact the regional or local AIDS Education and Training Center (AETC). Visit the AETC National Resource Center website at www.aidsetc.org to access the AETC directory.

Clinicians choosing to implement rapid testing should develop a specific plan for confirmatory testing that assigns responsibility for confirmatory testing, explains the process and results to patients, and schedules follow-up appointments for patients to receive test results.

The benefits associated with routine screening can only be realized if routine screening is coupled with successful approaches to assure that newly diagnosed patients receive timely, appropriate and necessary follow up care and services. Non-HIV primary care clinicians should develop relationships and referral systems with HIV care clinicians. Since there is a brief window period after diagnosis during which newly diagnosed patients are most likely to seek care, timely diagnosis and timely follow-up care must go hand in hand.³

Section 2: Connecting to Care

Just as with other aspects of medical practice, a plan addressing key issues surrounding patient care and referrals must be formulated prior to implementing an HIV testing program. These issues include:

- What are the state laws and processes related to HIV/AIDS
- Where to refer patients and how to assure successful referrals
- When to refer patients
- How to discuss test results with patients

Connecting to Care - Step 1: Learn about state laws and processes related to HIV/AIDS

Clinicians can contact state departments of health to learn about state specific laws and processes, including informed consent, reporting requirements, partner notification and the availability and responsibilities of Disease Intervention Specialists. The CDC recently released new recommendations regarding partner services. These recommendations can be viewed by visiting www.cdc.gov/mmwr/preview/mmwrhtml/rr57e1030a1.htm . Most states and some cities or localities have laws and regulations related to confidentially informing partners that they have been exposed to HIV. Clinicians should know and comply with any such requirements in the areas in which they practice. Health departments often can assist patients by notifying, counseling and providing HIV testing for partners without revealing a patient's identity, but the extent of partner notification requirements differs from state to state. For example, some health departments require that even if a patient refuses to report a partner, the clinician must report to the health department any partner of whom he or she is aware. And finally, ask the state and/or local health department about the availability of Disease Intervention Specialists (DIS) to assist in follow-up care efforts. While the DIS is usually associated with partner notification efforts and the range of their responsibilities differ from state to state, they are often asked to facilitate linkage to care for HIV positive individuals. State and local health department information can be accessed by visiting www.cdc.gov/mmwr/international/relres.html. States vary regarding how to access information, but if local health department links are not available, narrow your search to HIV/std prevention programs.

It's also important to ask the state and/or local health department about the availability of case management and/or peer intervention programs to assist follow-up into care efforts. Research has shown that case management for HIV/AIDS follow-up into care can be highly effective.⁴

Connecting to Care - Steps 2 and 3: Choosing where to refer patients, establishing referral relationships, and putting in place successful referral systems

First steps to making sure HIV infected patients receive the care they need are similar in many ways to what clinicians do to make referrals for other serious or chronic conditions. This includes researching local clinicians, establishing relationships with those clinicians, and developing referral processes that help assure patients get the care they need. And, while the basic referral process is similar, special care should be taken to understand the unique issues facing many newly diagnosed HIV infected patients.⁵ It's helpful to break down the referral process into three categories: local health care system-level steps, practice-level steps, and patient-level steps.

□ *Local health care system-level steps*

- **Credentialed clinicians.** Identify area HIV/AIDS credentialed clinicians and their health care coverage requirements, including identifying clinicians who accept patients without health care coverage. Visit www.aahivm.org and www.hivma.org to identify area clinicians, including Ryan White Care Act clinicians who provide care to low-income and uninsured patients. The HIVMA website provider locator tool includes the ability to search clinicians by health care coverage criteria (i.e. private insurance, Medicaid, no insurance, etc.). Contact the National Association of State AIDS Directors (NASTAD) at www.nastad.org (then go to the membership directory) or visit <http://hab.hrsa.gov/programs/granteecontacts.html> for a list of Ryan White clinicians. Many Ryan White clinicians also see patients who are covered by health insurance.
- **Support services.** Identify HIV/AIDS support services. Useful links which provide region specific search capabilities include: www.avert.org, www.thebody.com/index/hotlines, www.directory.poz.com, and www.cdcnpin.org. State and local HIV/STD branches should have useful contact information on these.

□ *Practice-level steps*

- **Referral relationships.** Build relationships with area HIV/AIDS care and service clinicians. A letter of inquiry and introduction can help make an initial contact (Appendix 5). Put in place convenient appointment scheduling arrangements with referral clinicians, such as standing times for new appointments, and work with local clinicians to minimize waiting times for appointments. Evidence shows that longer waiting times to get appointments correlate with lower rates of referral completion by patients.⁶

- Clinician roles and responsibilities.** Where necessary, establish written Memoranda of Understanding (MOU) (Appendix 6) with other clinicians and agencies in order to specify roles and responsibilities, including how referrals will be made and easy to reach contact people within each clinicians' office.^{7,8} Click here for an MOU template or see the accompanying CD. Include clarification of whether patients will be co-managed by your practice and those to whom you refer patients. If patients will be co-managed, clarify who is managing which medications, who orders what tests, and how such information will be consistently communicated among involved clinicians. It is well accepted that better communication among clinicians improves patient outcomes.⁹
- Referral forms.** Use a simple, standardized referral form that indicates how and when the referring clinician wants to be notified re: a patient's progress/status. (Appendix 7). Forms could be emailed or faxed to specialists. Make sure that specialists receive all pertinent information on a patient prior to appointments. Studies show that when referring clinicians have personal contact with specialists and when complete information is available to specialists, ongoing communication about the patient is much more likely and the referral process runs more smoothly and is of higher quality.¹⁰
- Support for referrals.** Understand that passive referrals lose HIV/AIDS patients. Characteristics that generally are important for all referrals become critical for HIV/AIDS referrals, such as the scheduling of appointments, insurance/financial information, and strong and ongoing communication among clinicians. Extra effort will significantly increase the chances for successful referrals – efforts such as provision of transportation information and assistance, ongoing patient education, and additional appointment reminders go a long way.¹¹
- Sensitivity.** Develop sensitivity regarding patient age, cultural issues and lifestyle issues. Referral choices should be made accordingly.¹²
- Patient involvement.** Consider involving patients in the referral process by giving patients pertinent referral information to give to the specialist. This is both convenient and empowers patients since they become involved in the referral process and gain a greater understanding of how the system works.
- Tracking referrals.** Track referrals and put into place a strategy for when patients do not seek the care arranged by the referral. Electronic tracking systems are used by many clinicians. When an electronic system is not available, however, referral tracking can be accomplished by a process that simply saves copy of the referral form. After a certain number of days, if the practice hasn't heard back from the specialist, the tracking system would remind the referring practice to check whether or not the patient followed through with the appointment.^{13, 14}

❑ **Patient-level steps**

- **Patient Education.** Educate patient on need for ongoing, regular health care – even though they may feel healthy, it's very important to be monitored regularly. Monitoring and treatment significantly slow the development of symptoms and progression of the disease. HIV patients often cite “feeling healthy” as a reason for not following through with health care appointments. For information that can be printed and given to patients, visit www.cdc.gov/hiv/resources/brochures/livingwithhiv.htm or www.aidsinfo.nih.gov. Also help patients understand how the health care they need to receive is organized, including who will do what for them and how HIV is managed.¹⁵
- **Appointment scheduling.** Schedule specialty appointments for patients, when they still are in the referring clinician's office, to increase chances they will follow-through and keep the appointment¹⁶.
- **Clinician/Patient Relationships.** Create and nurture trusting, supportive relationships with patients to help alleviate fear.¹⁷ Patient follow-up into care is significantly improved when clinicians are able to connect with patients, when patients feel they are accepted and valued as a whole person, instead of being labeled as HIV positive, and when patients feel their relationship with their provider is one of two-way respect.¹⁸
- **Acceptance.** Convey acceptance and a non-judgmental attitude toward patients to help alleviate stigma associated with sexual orientation, drug use, or race and ethnicity which can be a significant barrier to care for HIV infected patients¹⁹
- **Common goals.** Develop common goals with the patient. This increases patient trust which in turn increases patient motivation to keep appointments²⁰
- **Insurance status.** Determine patient's insurance status so that follow-up care arrangements can be made accordingly.
- **Post –test counseling.** Provide post-test counseling. This is discussed in more detail later. Helpful scripts are available to guide clinicians through this process. Emphasize that medical care is available that can successfully help HIV/AIDS patients stay healthy. Include information on prevention and partner notification.
- **Patient assessment.** Conduct a brief patient assessment – identify barriers that patient may face in getting follow-up care, such as time/location of referral, their support system, substance abuse or mental health issues. Together with the patient, work out a plan to help them successfully and regularly access the care they need.²¹

Connecting to Care - Step 4: Determining the primary care clinician's role

Just as with most medical conditions, opinions vary regarding how much care the primary care clinician should provide to a patient with specialized medical needs. Comfort levels of clinicians vary as well. But just as primary care clinicians often challenge themselves to address and manage to the extent possible the care needs of patients with hypertension, diabetes, and asthma, just to name a few, to a certain extent clinicians can do the same with patients who have been diagnosed with HIV infection. Excellent resources exist for clinicians who need clinical guidance in this area.

- “First Visit Basics” (Appendix 8) from the Mountain Plains AIDS Education and Training Center provides useful basic clinical information. For more detailed information, visit: (http://mpaetc.org/downloads/sourcebook_web_2005.pdf and <ftp://ftp.hrsa.gov/hab/PCGchap3.pdf>).
- In addition, the National HIV/AIDS Clinicians Consultation Center (NCCC) which is part of the AIDS Education and Training Centers (AETC), provides clinical consultation with HIV experts about indeterminate tests, HIV diagnosis, HIV management and referral issues. Clinicians with questions about HIV are encouraged to call the NCCC Warmline at 1-800-933-3413. Other NCCC consultation services include: the National Clinicians' Post-Exposure Prophylaxis Hotline (**PEPline** 1-888-HIV-4911) for advice on managing occupational exposures to HIV and hepatitis; and the National Perinatal Consultation and Referral Service (**Perinatal HIV Hotline** 1-888-448-8765) for consultation on preventing mother-to-child transmission of HIV. The NCCC website is www.nccc.ucsf.edu.

Connecting to Care - Step 5: Discussing test results with patients

Clinicians need a specific and practical plan for discussing test results with patients. The California STD/HIV Prevention Training Center (www.hivstdtraining.org) has also developed useful documents to help clinicians feel comfortable with discussing test results with patients who have tested preliminarily positive and those who have been **confirmed** to be HIV positive. The following summarizes this framework:

- State the test result in a direct, neutral tone.
 - *“Your HIV test result is positive.”*
 - *“You may need to take time to adjust to this.. Many people say that it gets easier once you get over the initial shock. With proper medical and social support, people with HIV can expect to lead very productive lives.”*
- Educate patients on the importance of ongoing, regular health care for their HIV – even though they may feel healthy, it's essential they be monitored regularly. Appropriate care and treatment can significantly slow the development of symptoms and progression of the disease. HIV patients often cite “feeling healthy” as a reason for not following through with health care appointments.

→ *“Now that you have HIV it’s important that you receive regular medical follow-up, even if you are feeling healthy.”*

- Address individual needs and concerns, including sources of emotional support, information on HIV infection and transmission, and the need to reduce risk behavior.
 - *“Who can be supportive of you in dealing with this?”*
 - *“What questions do you have about HIV infection?”*
 - *“Knowing that you have HIV, what are your concerns about giving HIV to someone else?”*
- Emphasize that test results are confidential, but that recent sex and/or needle sharing partners need to be contacted somehow. Tell the patient that the local health department can help them notify partners and that this service is always confidential and that patient names are never disclosed.
 - *“Who do you believe may need to know about your result? Are there particular partners you are worried about?” (inform patient about confidential Partner Counseling and Referral Services)*
 - *“What happens when you and your partner fight?” (This screens for domestic violence.)*
- Make a short term plan that includes a plan for what the patient will do after leaving your office and the provision of necessary referrals.
 - *“What will you do after you leave here? Who will you talk with about this news?”*
 - *“How interested would you be in getting a referral for services to help you live with HIV?”*
- Offer and assure your continued support to the patient. Tell the patient who to contact should they have questions or concerns to be addressed before their next appointment.
 - *“You may think of other questions after you leave today. Feel free to call me, or to come back.”*
- Complete necessary case reporting forms for your local health jurisdiction.

Delivering a **reactive rapid test result** is similar, but must also address confirmatory testing:

- Remind patient that it is a screening test and another blood test must be sent to the lab for confirmation. If the confirmatory test comes back positive, it means they have HIV infection.
 - *“Your rapid test result is reactive.”*
- Review with the patient that sometimes reactive rapid tests end up as false positives.
- Do not yet discuss partner notification, but advise patient to reduce risk behaviors.

- Collect a specimen for confirmatory testing, tell the patient how long it will take for the results to come back and schedule a follow-up appointment.
- If your practice does not conduct confirmatory testing, be prepared to assist your patient in scheduling a confirmatory testing appointment elsewhere.

For the complete document from the California STD/HIV Prevention Training Center, see www.stdhivtraining.org/resource.php?id=192&ret=clinical-resources. Additional guidance on discussing positive HIV test results with patients can be found at www.nyc.gov/html/doh/downloads/pdf/csi/hivtestkit-hcp-actionplan.pdf. The following website has guidance specific to labor and delivery settings: www.aidsetc.org/pdf/tools/nrc_rapid_test_counseling_guide_11-03.pdf.

Connecting to Care - Summary of Key Steps:

- Research state and local laws, processes and services related to HIV/AIDS
- Research local HIV/AIDS care and service providers
- Establish relationships with providers and develop appropriate referral processes
- Determine your role in the delivery of care to your HIV infected patient
- Educate yourself and other clinicians on your staff about how to discuss preliminary or confirmed positive results with patients

Part Two -- Best practices in follow-up care for patients newly diagnosed with HIV infection

Providers who offer HIV tests to their patients should be prepared to play a role in helping assure patients newly diagnosed with HIV infection are linked to appropriate care. The examples below describe different ways successful follow-up care can be achieved in a variety of settings, focusing on the most important aspects of each approach. Some of these approaches vary on a statewide and regional basis depending on what kind of system has been developed in a particular area. Others vary based on the characteristics of the patients being served. You are encouraged to take a look at each of these descriptions; you'll see repeated themes and unique tactics -- what works in a given setting might include a combination of strategies. Common to each approach, however, are the elements of strong communication and collaboration across the board -- among all involved individuals, clinicians, community-based organizations, and government organizations -- and a keen

understanding of what each patient needs and sensitivity to the often unique issues facing each individual patient.

Section 1: General Approaches for Connecting to Care in Primary Practice settings

❑ Case Management

Based on research supporting the success and cost effectiveness of case management for HIV/AIDS, certain local areas and states have worked hard to assure the availability of case management services.²² For example, the Kansas Targeted Outreach Education Project (funded by the Kansas AIDS Education and Training Center (AETC), a local performance site of the Mountain Plains AETC (MPAETC)), has successfully gotten the word out to many rural clinicians in Western Kansas regarding the availability of case management. Locally conducted workshops have allowed the HIV primary care provider to establish relationships with many non-HIV primary care physicians throughout Western Kansas. The educational program conducted during the workshops includes information on how to implement more routine testing, but also emphasizes steps to take to assure that newly diagnosed HIV infected individuals are linked to appropriate care and services.

In this example, the process of linkage to care is very simple and successful at the same time. Clinicians participating in the workshops learn that if a patient tests positive, they are to call a case worker or the HIV primary care physician's clinic. "One phone call to the HIV primary care provider and her clinic establishes the patient quickly and easily in their satellite clinics." The patient is immediately connected with the case worker, who then addresses any unique barriers to care that the patient may face. Clinicians cite strong provider relationships with an open dialog as the most important part of their testing and referral systems.

❑ Peer Intervention programs

Some localities have developed peer intervention programs that have demonstrated meaningful results. Peer intervention programs educate, train and employ staff who have similar socioeconomic and health characteristics as the patients being served. These trained peers work to build trusting relationships with patients and help them improve their understanding of how to successfully access services. The CareLink Program in Portland, Oregon has experienced success with this approach. In the Portland CareLink program, peer staff work together with case management services, explaining the HIV care system to patients and helping them transition into using the case management system. A program in Boston trains and hires peers as Health Systems Navigators. Health Systems Navigators in the Boston project support case management services by helping patients follow through with referrals. HSNs use a variety of strategies to do this, including accompanying patients to appointments, helping them learn how to be their own advocates, coaching patients on how to effectively talk with their clinicians, and providing translation services.²³ In areas where transportation is a common barrier for patients, partnerships with community organizations,

such as local churches, may be able to facilitate access to volunteers willing to provide transportation to patients in need.²⁴

❑ ***National HIV/AIDS Clinicians' Consultation Center (NCCC) - nationwide telephone consultation service***

Physicians who take advantage of a nationwide telephone and consultation service receive advice for obtaining and interpreting HIV tests as well as for the initial management of HIV. The National HIV/AIDS Clinicians' Consultation Center's (NCCC) Warmline at 800/933-3413 is a confidential and free service that can be especially helpful for those clinicians identifying new cases of HIV infection when HIV experts are unavailable or referrals to HIV experts have not yet been identified. This service provides free expert consultation on HIV testing (e.g., interpreting indeterminate tests and false positive tests) and can help guide the initial steps in workup and management of newly diagnosed patients. The following two examples demonstrate how physicians and other clinicians utilize the warmline:

- A physician with minimal HIV experience called the Warmline seeking guidance on managing a possibly-HIV-infected 27-year-old woman. An HIV test was obtained as part of a routine health care checkup and returned positive. The physician asked whether a single test was sufficient to diagnose HIV, what other tests would be appropriate at this time, and whether treatment should be initiated. The Warmline clinician advised about the need for confirmatory testing, how to counsel the patient when she comes in for test results later in the week, and how the physician can access an HIV-experienced clinician if the test results are indeed positive.
- A physician called the Warmline for HIV test interpretation regarding a 41-year-old man with diabetes mellitus whose routine and confirmatory HIV tests were interpreted as indeterminately positive. The physician asked the Warmline clinician if the test results were because of the patient's diabetes. The Warmline advised that diabetes itself does not cause positive or indeterminate HIV tests, but additional follow-up with a clinician familiar with HIV testing would be appropriate.

These are examples of Warmline calls that necessitate discussion about who is going to provide ongoing care for newly-diagnosed patients. The Warmline helps the caller determine whether he/she will provide that continuing care (as many patients and their non-HIV expert physicians will want to retain that physician-patient relationship in their own community), either alone or in co-management with an HIV expert, or whether the patient will be referred to an HIV expert for primary HIV care. The Warmline has access to current AAHIV and HIVMA provider lists as well as the AETC local site information. HIV-positive pregnant women are referred to the NCCC's Perinatal HIV Clinicians' Network coordinator, who arranges appropriate follow-up.

Section 2: Connecting to Care – Methods employed in a variety of Primary Care Settings

❑ ***Family Practitioner – Direct referral to Specialist practice with staff social worker***

A large family practice group has a patient's Western blot test come back positive for HIV infection. The patient receives the result and preliminary counseling from the family physician or general internist. With the patient still in the office, the practice calls the HIV specialist to set up an appointment, and the patient will be seen as soon as possible. Sometimes, to encourage patient involvement, the patient will carry their record (test results and any other pertinent lab data) to the HIV Clinic, but it may also be faxed to the clinic as long as necessary consent has been obtained by the practitioner. At the HIV clinic, the patient first meets with a social worker who provides further counseling and helps the patient feel comfortable in the new clinician's setting. This procedure, utilizing the social worker for first visits, has cut down appointment no-shows significantly. In addition to building trust and providing further patient education, the social worker also keeps track of patients and follows up with no shows. Monthly queries of the patient data base inform the social worker of which patients need to be contacted for follow-up. The patient's second visit to the clinic is to see the HIV specialist. The HIV specialist communicates regularly with the family practitioner, copying the family practitioner on all dictation (and lab testing) regarding the patient. At this same clinic, if a clinician chooses to remain a patient's primary care provider, the HIV specialist urges the physician to call the HIV clinic with any questions that may arise. These clinician to clinician consults are very useful for helping primary care clinicians determine when to refer a patient to a specialist.²⁵

❑ ***Community Health Centers***

Based on proven strategies in the delivery of care for chronic conditions, the National Association of Community Health Centers, together with the Health Resources and Services Administration (HRSA), has developed a model for the implementation of the CDC guidelines at community health centers across the country. Clinicians in other settings may find the tools developed for community health centers useful in their practices as well. The model delineates steps to be taken for successful implementation, including:

- Determine where HIV follow-up care will be provided, either in-house or through referral
- Build/enhance referral arrangements
- Specify to whom referrals will be made
- Identify contacts to call when a referral is needed
- Clarify role of health department Disease Intervention Specialists (DIS) in referrals
- Determine if the state or local health departments have systems to assist with patient follow-up
- Identify case management resources for patients; and, importantly
- Identify one staff person who will have the responsibility of tracking newly diagnosed patients to assure they receive needed care and services

See Appendices 9 and 10 for helpful tools developed by the NACHC. This model was piloted very successfully by a number of community health clinics nationwide.

❑ *Pediatric care Health Care Settings*

Several key aspects need to be considered and addressed when seeking to screen and then link to care adolescents who are newly diagnosed as HIV positive. Specifically, clinicians must:

- Learn about local laws pertaining to the care of minors
- Respect the confidentiality of adolescents and have a plan regarding what information will be shared between adolescent patients and their parents or guardians
- Make clear with adolescent patients and their parents or guardians that sometimes young patients will be examined and spoken with privately

For most young people, learning they are HIV positive is a crisis but it doesn't have to be a trauma. The following tips can help newly diagnosed youth cope with their diagnosis and engage in treatment and support:

- Provide a clear explanation of the test results
- Allow the patient time and space to process the results and express their feelings
- Address Coping: Ask about and respond to the patient's concerns
- Address Treatment: Immediately link the patient to medical and psychosocial care and stress the benefits of engaging in care for treatment and support
- Address Prevention: Discuss the need for prevention and the benefits of partner disclosure
- Attempt to secure adult support for the patient, preferably a family member

In the early stages of processing their HIV diagnosis, many young people share a few common fears that clinicians should proactively address:

- Fear of immediate death or lack of a future
- Fear of altered body image
- Fear of loss of sexuality/fertility
- Fear of social isolation if they disclose their status

❑ *Adolescent care Health Care Settings*

Key Strategies for Making Successful Linkages to Care for Adolescents:

- Make your facility friendly to youth
- If your clinic treats a range of ages, identify a youth-friendly staff member to welcome youth and guide them through the registration process
- Have a real person to answer the phone (automated phone trees can be very intimidating to youth in crisis)
- Schedule immediate appointments for newly diagnosed patients

- For ongoing appointments, consider having “youth days” or blocks of time on specific days when youth are scheduled for appointments to make the clinic atmosphere more appealing to them
- Be available for walk-in appointments while also teaching youth receiving ongoing treatment about the importance of advanced planning and honoring appointments
- Advertise comprehensive information about your clinic/program online and in resource directories
- Offer services for free or arrange insured care that preserves confidentiality
- Encourage clinicians to make themselves available to deliver HIV-positive test results with the tester and/or to see the client on the same or the next day.
- Develop referral resources with clinicians who are youth-friendly and who commit to seeing your newly-diagnosed patients immediately or same day.
- Institute a simple intake process.
- Prepare staff to engage in sustained outreach to newly diagnosed HIV+ patients. If patients don't immediately engage in care, commit to making monthly follow up phone contact for 6 months if necessary, i.e. “Hey, how are you doing? Just calling to check on you.”
- Work with your local department of health, who may be able to go out into the community to meet with clients and partners of clients to bring them into care.
- Use a medically secure and confidential communication system, including email, which allows patients to contact clinicians.

Other resources:

www.AdolescentAIDS.org

www.HIVCareForYouth.org

www.advocatesforyouth.org/publications/iaq/hivpositive.htm

❑ OB/GYN and prenatal care settings

In Illinois, a state-wide 24/7 hotline effectively links HIV positive pregnant women with enhanced case management. OB/GYN practices and other clinicians throughout the state know to call the hotline if a pregnant woman is diagnosed as HIV infected. Illinois ACOG and other private practice associations have assisted in spreading the word about this important service through mailings and other marketing materials. While each case is handled individually, clinicians first call the hotline to start the process of linking to care an HIV positive pregnant woman. The program has many useful resources available for clinicians, including advice and scripts regarding how to talk with a patient about a positive diagnosis. Once contacted, the hotline staff fax necessary release paperwork to the provider so that they can begin work on the case right away. The hotline immediately connects the provider and patient to a case manager to determine how best to provide follow-up care for the patient. Interventions to assist in linkage may include transportation assistance, home visits, and/or child care. For clinicians in Illinois, or for others who may wish to learn more about how this program was established, the hotline number is 1-800-439-4079. Additionally, and as discussed earlier, the National HIV/AIDS Clinicians' Consultation Center (NCCC) has a Perinatal HIV Clinicians' Network

coordinator who can be used by clinicians in any state and who arranges appropriate local or regional follow-up care for HIV positive pregnant women.. The NCCC number is 1-800-933-3413.

Section 3: Connecting to Care – the Emergency Department example

□ Emergency Departments

The National Association of State and Territorial AIDS Directors (NASTAD) has also issued a “Primer on Issues and Strategies for Health Departments” on HIV testing in Emergency Departments (accessible through NASTAD.org). Included in the primer is a list of strategies a variety of EDs have used to achieve successful follow-up into care for newly diagnosed HIV infected patients.

Helpful Emergency Department strategies for successful HIV follow-up care:

- Using staff to escort patients to the HIV or ID clinic or practice (ED or HIV clinic staff);
- Arranging same/next day appointments with a nearby or co-located HIV or ID clinic;
- Providing referral information and appointment scheduling as part of discharge instructions;
- Using incentives to encourage patients to return for scheduled appointments;
- Referring patients to case managers who will help ensure they make their first and subsequent appointments;
- Using partner services staff to follow-up on patients who do not return for a scheduled medical appointment.

The George Washington University Emergency Department illustrates the use of some of these strategies. In particular, staff participants in GW ED’s linkage to care efforts site one characteristic of their program stands as most important. Namely, as soon as a patient is identified with a preliminary positive test result, an ID physician becomes responsible for arranging all follow-up care for that patient. Preliminary positive patients are given this person’s name and number and are encouraged to contact them with any questions or concerns they may have while they are waiting for their confirmatory test results. Additionally, staff diligently verify contact information so the patient can reliably be reached when the results of their confirmatory test are available. Initial follow-up appointments are made for 3-5 days after a patient is confirmed positive. If the patient chooses or needs to go to another clinic, the ID physician and clinic will help make an appointment at the patient’s preferred clinic within the next 3-5. Another important characteristic is that the Emergency Department is within walking distance to the Hospital’s Infectious Disease Clinic. Once identified as HIV infected, staff from the ED walk the patient to the GW Infectious Disease clinic so the patient is familiar with the clinic’s location.

All GW ED patients newly diagnosed with HIV infection can have their first appointment after diagnosis at the GW ID Clinic. Future visits, however, are dependent on insurance. The ID physician helps determine where they need to go for additional care, whether their next appointment is at the GW ID Clinic, a local community clinic, or elsewhere and schedules the follow-up appointment. For uninsured patients, social workers at the community health clinic can help them enroll a public

insurance program. Patients also receive help in enrolling in the drug assistance programs (ADAP) so they can afford medications

It is important to point out that the GW ED follow-up into care strategy for HIV/AIDS addresses critical patient level issues. First, use of the rapid HIV test means that a patient with a preliminary positive can have blood drawn for a confirmatory test immediately. And, if at all possible, the newly diagnosed patient has the opportunity to immediately meet with the ID physician who will be coordinating their immediate follow-up care. Research shows that interaction with a clinician, giving a patient the chance to ask questions and voice concerns, has a positive impact on a patient's care seeking behavior. Additionally, the ED and ID collaborative strategy further anticipates a patient's needs by having established relationships with HIV primary care clinics outside of the hospital system, so that if a patient needs to seek care in a different setting due to insurance, transportation, cultural, or language reasons, they are able to assist the patient in selecting a provider and setting up an appointment.²⁶

The Health Research and Educational Trust (HRET) EDHIVtestguide.org provides further instruction and information regarding linkage to care after a positive HIV diagnosis and is based on HRET's review of Emergency Departments implementing rapid testing. While the Emergency Department Test Guide provides much useful and detailed information, it highlights the following considerations that need to be addressed when determining how to appropriately and successfully link to care patients newly diagnosed with HIV infection:

- Does the hospital maintain onsite or community-based infectious disease or primary care clinics that can treat and manage the care of patients with HIV?
- What other, unaffiliated clinics are available in the community? If the ED refers patients to these clinics, does a formal agreement or contract need to be in place?
- What processes will the ED and each referral clinic use to communicate about new patients?
- Will ED staff, counselors, or clinic staff walk patients to the clinic to initiate the follow-up process? This works well when the clinic is co-located or in close proximity to the ED.
- Will the clinic maintain same-day appointments for patients tested in the ED?
- Will the clinic have standing appointment times for which testing staff can schedule patients?
- How will the ED provide real-time, daily, or other timely updates to clinic staff on new patients?
- How will the clinic report information back to the ED on the number of patients who keep their initial visit? This will be important information for the ED to track its effectiveness in linking patients to care.
- What measures can be taken if follow-up rates are low? Transportation vouchers, retail gift certificates, child care, and transportation service are some incentives that have been used at different sites with varying levels of success.

Summary

The preceding examples describe different ways successful follow-up care can be achieved in a variety of settings. These approaches vary on a statewide and regional basis depending on what kind of system has been developed in a particular area or on the characteristics of the patients being

served. By examining each of these approaches and strategies, repeated themes and unique tactics emerge -- what works in a given setting might include a combination of strategies. Each approach, however, shares the elements of strong communication and collaboration among all involved in the care process and a clear understanding of what each patient needs and sensitivity to the often unique issues facing each individual patient.

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¹ Torian, L.V., Wieweal, E.W., Liu, K., Sackoff, J., Frieden, T. Risk Factors for Delayed Initiation of Medical Care After Diagnosis of Human Immunodeficiency Virus. *Archives of Internal Medicine*, 168 No. 11, June 9, 2008.

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¹ Tobias, Carol. Center for Outreach Research and Evaluation. Health and Disability Working Group. Boston University School of Public Health.

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¹ Simpkins, Carolyn. Medical Director, Barrier Islands Free Medical Clinic.

¹ Kirchner, Jeffrey. Physician

¹GW Emergency Department HIV Screening: A Linkage to Care Model in an Urban ED Setting, by Maggie Czarnogorski, MD

Appendix 1

Consent for Care at (the name of your health care practice)

I authorize the employees of _____ (Clinician's health care practice) to render primary care and related services. I understand that _____ (the health care practice) is committed to offering superior quality of care to all patients regardless of race, ethnicity, religion, sex, age, or handicap status.

I understand that I will be fully informed of anticipated benefits, possible discomforts, and potential side effects prior to the performance of any medical treatment, and I release _____ (the health care practice) from liability that may arise as the result of such treatment, unless due to sole negligence of its staff. I consent to examinations, treatments, procedures and blood tests ordered by my physician and health care providers, including blood tests for communicable diseases such as hepatitis and HIV/AIDS.

I understand my medical record and information related to my care at _____ (the health care practice) is confidential. I have been provided a Summary Notice of Privacy Practices that details the various ways that information about me may be disclosed for treatment, payment, healthcare operations, and other purposes permitted or required by law, as applicable. I understand that state law requires the reporting of certain positive results such as hepatitis and the antibody for the AIDS virus to the health department. I authorize the release of any medical or other information necessary to process a claim for payment.

Services rendered are expected to be paid for on the date of service. A minimum charge for services rendered is \$_____ which will cover your office visit and any needed lab work. Sources of acceptable payments are:

Cash
Check
Medicare
Medicaid
Champus
Private Insurance
ATM card (debit card)
Major Credit cards (MasterCard, VISA, Discover)

If you do not have insurance, you may qualify for the sliding fee scale. The sliding fee scale is based on your household size and income. In order to qualify for the sliding fee scale, you must provide one of the following sources of information:

Current pay stub	Copy of a disability check	
Copy of your SSI check	Court order settlements	
Child support check	Current unemployment check or statement	Income tax
statement	Any other written verifiable income statement	

I have read and understand the above information and hereby consent to care at _____ (the health care practice). I further understand that if I do not provide the necessary information, I will be expected to pay 100% for all services rendered.

Signature: _____

Date: _____

Consent for Care at (the name of your health care practice)

Agreement:

By signing this form I agree to:

- Approve the staff of The Health Center to give me basic health care and services alike.
- Release The Health Center from any charges if something happens because of treatment.
- Not to release The Health Center if something happens due to the neglect of its staff.
- Have **checkups**, cures, surgery and blood tests by my doctor and health care staff.
- To have blood tests done for illnesses like swollen liver (hepatitis) and HIV/AIDS.

Acknowledgement:

By signing this form I agree to know that The Health Center:

- offers quality care to all patients.
- offers quality care regardless of patients' race, faith, sex, age, disability state or origin.
- will tell me before any treatment if there are any benefits, pain and side effects.
- keeps my health record private.
- gave me the legal papers showing the many ways my data and records may be given out to others in the case of treatment, payment and surgery.
- can give out my records for reasons allowed, wanted and valid by law.
- can give out my positive results to the health department. These could be positive results for swollen liver (Hepatitis) and the AIDS virus.

Payment for services:

By signing this form I agree that:

- I should pay on the same date I receive the services.
- I should pay the low payment of _____. This amount will cover my visit and any lab work I need.
- Good ways I can pay for services are:

<input type="radio"/> Cash	<input type="radio"/> Champus	<input type="radio"/> Known Credit cards
<input type="radio"/> Check	<input type="radio"/> Private Insurance	(MasterCard, VISA,
<input type="radio"/> Medicare	<input type="radio"/> ATM card (debit card)	Discover)
<input type="radio"/> SC Medicaid		

Payment if I cannot cover the cost:

By signing this form I agree that:

- If I cannot cover the full cost, I may have to pay just a small amount.
- The amount I pay will depend on my income.
- To pay a small amount, I must show one of the papers below:

<input type="radio"/> Current pay stub	<input type="radio"/> Current work check or proof of payment
<input type="radio"/> Copy of a disability check	<input type="radio"/> Income tax statement
<input type="radio"/> Copy of my SSI check	<input type="radio"/> Any other written papers that prove my income
<input type="radio"/> Court order for getting funds	
<input type="radio"/> Proof of child support check	
- If I do not bring any of these papers, I will have to pay the full amount. This is the same as 100% of the cost of all services I get.

Signature:

I agree that I have read and know all the content above. I also consent to get care at *Insert the Name of your health care practice*.

Signature: _____ Date: _____
 (consent form developed by the National Association of Community Health Centers)



The Basics of HIV Screening and Testing

INTRODUCTION

It is estimated that 1 to 1.2 million people are living with HIV/AIDS in the United States. As many as 25% of these people, or approximately 300,000, are unaware they have HIV infection. It is important to identify these individuals because they may be unknowingly transmitting HIV. Studies have shown that once individuals learn about their HIV infection, they substantially reduce their high-risk sexual behaviors. The transmission rate among those who do not know they are infected is 3.5 times higher than for people who know about their HIV infection.

There are 40,000 new infections every year and this number has not changed for the last 10 years. Many of these individuals have advanced disease at the time of their first positive HIV test. It is estimated that 50% of patients develop AIDS within one year of first testing positive for HIV. Early recognition of HIV infection is important because antiretroviral therapy has been shown to improve morbidity and mortality.

Traditionally, screening for HIV has been targeted to high-risk individuals and required separate, written consent ("opt-in" testing), along with pre- and post-test counseling, by trained personnel. In the 1990's, an "opt-out" approach was adopted for pregnant women, meaning HIV tests were performed as a routine component of prenatal care and did not require separate written consent or extensive pre-test counseling. Subsequently, rates of screening increased and neonatal infections declined substantially. Based on the success of opt-out HIV testing of pregnant women, and the need to decrease the number of new infections per year in the U.S., in September 2006 the Centers for Disease Control and Prevention (CDC) recommended **routine HIV screening for all individuals between the ages of 13-64 years, in all health care settings, on an opt-out basis.**

SUMMARY OF CDC RECOMMENDATIONS

CDC recommends that opt-out HIV screening be a part of routine clinical care in all health care settings, *while also preserving the patient's option to decline HIV testing* and ensuring a provider-patient relationship conducive to optimal care.

Initial Screening for HIV Infection

In all health care settings, screening for HIV infection should be performed routinely for:

- ☑ **All patients aged 13-64 years.** Health care providers should initiate screening for HIV unless prevalence of undiagnosed HIV infection in their patients has been documented to be <0.1% (<1 per 1,000 patients). In the absence of existing data for HIV prevalence, health care providers should initiate voluntary HIV screening until they establish that the diagnostic yield is <0.1%, at which point such screening is no longer warranted.
- ☑ **All patients initiating treatment for tuberculosis (TB).**
- ☑ **All patients seeking treatment for sexually transmitted diseases (STDs),** including all patients attending STD clinics. An HIV test should be done during each visit for a new complaint, regardless of whether the patient is known or suspected of having specific risk factors.
- ☑ **All pregnant women.**

Repeat Screening

Health care providers should perform repeat screening for:

- ☑ **All persons likely to be at high risk for HIV.** High risk individuals should be tested annually and include injection drug users and their sex partners, persons who exchange sex for money or drugs, sex partners of HIV-infected persons, and men having sex with men (MSM) or heterosexual persons who themselves or whose sex partners have had more than one sex partner since their most recent HIV test.
- ☑ Any person whose blood or potentially infectious body fluid is the source of an **occupational exposure to a health care provider.**
- ☑ Any patient and their prospective sex partner **before initiating a new relationship.**
- ☑ A **high risk pregnant patient who is in the third trimester.**

Consent and Pretest Information

Consent for HIV screening should be incorporated into the patient's general informed consent for medical care on the same basis as are other screening or diagnostic

tests. A separate consent form for HIV testing is NOT recommended. Screening should be voluntary and undertaken only with the patient's knowledge and understanding that an HIV test is planned. Before the test is performed, information explaining HIV infection and the meaning of a positive and negative test should be provided either orally or in writing in a language the patient can understand. Patients should be offered an opportunity to ask questions and decline testing. **If a patient declines an HIV test, this decision should be documented in the medical record.**

TYPES OF HIV DIAGNOSTIC TESTS

Screening Tests

Standard Tests

ELISA antibody test: looks for antibodies to HIV in the patient's blood. A patient's serum is placed in contact with particles of HIV in the presence of an indicating substance. If there are any HIV antibodies in the serum, they will bind to the HIV particles and cause the serum to change color. **If this test is positive, the laboratory automatically will perform a confirmatory test.** This test is considered the standard test for diagnosing HIV.

Rapid Tests

Rapid tests are similar to the standard ELISA test in that they look for antibodies to HIV in the patient's blood. They are called "rapid" because the results are available within an hour or less. **If a rapid test is positive, it needs to be followed up with a confirmatory test.**

The six FDA-approved rapid HIV antibody screening tests currently on the market are listed in the table below:

FDA-Approved Rapid HIV Tests

Test Name & Manufacturer	Specimen(s) to be tested	CLIA-waived specimens	Time to complete
OraQuick ADVANCE ½ OraSure Technologies, Inc. www.orasure.com	Whole blood, saliva, serum/plasma	Whole blood and saliva	25-30 minutes
Reveal G-3 HIV-1 MedMira, Inc. www.medmira.com	Serum/plasma	None	30-60 minutes
Uni-Gold Recombigen Trinity Biotech www.unigoldhiv.com	Whole blood, serum/plasma	Whole blood	10-15 minutes
MultiSpot HIV1/HIV2 BioRad Laboratories www.biorad.com	Serum/plasma	None	10-15 minutes
Clearview 1/2 Stat-Pak and Clearview Complete HIV 1/2 Inverness Medical Professional Diagnostics www.invernessmedicalpd.com	Whole blood, serum/plasma	Whole blood, serum, plasma	20 minutes

All of the tests listed in the table detect HIV-1; all tests detect HIV-2 except Uni-Gold and Reveal G-3.

The sensitivity and specificity for these tests is in the range of 98.4-100%.

Confirmatory Tests

Western blot (WB): This is the most widely used confirmatory test. It uses an electrophoretic technique that separates out specific HIV particles, or antigens. Rarely, the WB will be indeterminate if the patient was recently (i.e. within the last 3 months) exposed to HIV.

Immunofluorescence antibody (IFA): Infected HIV cells are fixed to a microscope slide. Serum with HIV antibodies is added and allowed to react with the HIV. A fluorescent label will light up the slide if positive for HIV.

Standard Versus Rapid Testing

Standard HIV tests utilize the ELISA and WB or IFA to confirm a diagnosis of HIV infection. These tests can take up to a week to complete, and many patients do not return to obtain the results. Studies have shown that from 12-31% do not return to receive their results.

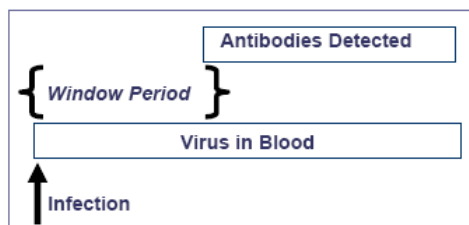
With rapid HIV testing, patients can receive their results during the same visit. Preliminary studies have shown a higher return for their confirmatory test results when they get an initial positive rapid test result.

How Should Rapid HIV Test Results Be Interpreted?

A positive HIV rapid test means the patient most likely is HIV positive. The *positive predictive value* of a single positive HIV rapid test, defined as the likelihood that a positive test means a person truly does have the disease, depends on the specificity of the test and the HIV prevalence in the community. In other words, if the rapid HIV test result is positive, the likelihood that a patient is truly infected with HIV depends on how common HIV is in the community. In a population with a high HIV prevalence, a positive rapid test result is likely to be a true positive, but in a population with a low HIV prevalence, that result may be a false positive. **Therefore any positive rapid test MUST be followed with a confirmatory test.**

The *negative predictive value* of a negative rapid test, defined as the likelihood that a negative test means a person truly does **not** have the disease, is close to 100%. This means that **a patient who receives a negative rapid HIV test result is almost assuredly not infected, barring recent exposures** (risky sexual contact or needle-sharing with an infected person within 3 months). A patient with a history of recent HIV risk behaviors or possible exposures should have a

repeat rapid HIV test because it may take up to 3-6 months for HIV antibodies to be detectable after infection with HIV. **Testing during this “window period” (see diagram, below) may result in a false negative test or indeterminate test result.**



DIAGNOSIS OF AN HIV POSITIVE INDIVIDUAL

A positive ELISA or a positive rapid HIV antibody test followed by a positive confirmatory test means the patient has HIV.

LEGAL ISSUES

What Patients Should Be Told

For all tests:

- ☑ Knowing you have HIV infection can improve your prognosis with treatment.
- ☑ Knowing you have HIV infection can help you take precautions from passing HIV to others.
- ☑ Refusing an HIV test will not affect the care you receive.
- ☑ Test results are kept confidential. However, in certain states, if a confirmatory test is positive, the law requires that the results be reported to the health department.
- ☑ A negative test means you do not have HIV infection; however the test may not show recent infection within the past 3 months.
- ☑ A negative test in patients recently exposed to HIV should prompt repeat screening in 3-6 months.

For rapid tests:

- ☑ Results from rapid HIV tests are available at the same visit, usually in less than 1 hour.
- ☑ Results are very accurate – as accurate as the standard HIV test.
- ☑ If the rapid test is positive, a confirmatory test is always done to be sure the rapid test was accurate. It is important that you come back for the results of the confirmatory test. If the confirmatory test is negative, you do not have HIV infection unless you were recently exposed (i.e. within the past 3 months).

While the CDC has recommended universal testing for all persons aged 13-64, laws regarding HIV testing continue to vary from state to state. Therefore, health care providers need to familiarize themselves with the current laws of their state and stay abreast of any changes which are likely to come about because of the new recommendations. Areas where state laws may differ include verbal versus written consent, opt-out testing, and pre-test and post-test counseling. The National HIV/AIDS Clinicians' Consultation Center (NCCC) provides a national **State HIV Testing Laws Compendium**, describing key HIV testing laws and policies for each state, online at:

<http://www.ucsf.edu/hivcntr/StateLaws/Index.html>

HIV Testing In California

In California, the laws around written consent for HIV testing have changed to support routine testing. The HIV/AIDS Testing Bill, Assembly Bill 682, took effect January 2008. This legislation essentially supports the CDC recommendations in making HIV screening a routine part of medical care. Specifically, it repeals the need for written informed consent to perform HIV testing. It also states that a patient has the right to decline the test and if he/she does so, it should be noted in the medical chart. There are still provisions in the law for maintaining and safeguarding patient confidentiality. **Anonymous testing is also still available in California.**

DEFINITIONS

CLIA-waived: simple laboratory examinations and procedures that are cleared by the Food and Drug Administration (FDA) for use outside of an approved laboratory.

Diagnostic testing: performing an HIV diagnostic test based on the presence of clinical signs or symptoms.

Health care settings: hospital emergency departments (EDs), urgent-care clinics, inpatient services, STD clinics or other venues offering clinical STD services, tuberculosis (TB) clinics, substance abuse treatment clinics, other public health clinics, community clinics, correctional health-care facilities, and primary care settings.

HIV prevention counseling: an interactive process to assess risk, recognize risky behaviors, and develop a plan to take steps that will reduce risks for acquiring (or transmitting) HIV infection.

Indeterminate test results: the Western Blot test is unclear and requires repeat testing with a new blood sample, usually several weeks later. This may occur if the person is tested during the window period.

Informed consent: a process of communication between patient and provider, through which the patient participates in choosing whether or not to undergo HIV testing. Typically, it includes providing oral or written information about HIV, the risks and benefits of testing, the implications of HIV test results, how test results will be communicated, and the opportunity to ask questions.

Negative predictive value: the likelihood that a negative test means a person truly does not have the disease being tested

Opt-in screening: performing an HIV diagnostic test on patients only after risk is assessed, patient provides explicit consent (usually written), and pre- and post-test counseling is administered

Opt-out screening: performing an HIV diagnostic test after notifying the patient that the test will be done. An additional process for written consent or pre-test counseling is not required beyond what is usually performed for routine medical tests.

Positive predictive value: the likelihood that a positive test means a person truly does have the disease being tested

Prevalence: the proportion of individuals in a population having a disease.

Routine screening: performing an HIV diagnostic test for all persons in a defined population

Sensitivity: the proportion of persons with the disease who are correctly identified by a screening test.

Specificity: the proportion of persons without a disease who are correctly identified by a test.

Targeted testing: performing an HIV diagnostic test on persons at higher risk, defined on the basis of behavioral, clinical, or demographic characteristics. Targeting testing has been the main strategy for HIV testing until now.

Window period: the time it takes for a person to be HIV antibody positive after having been exposed to the virus. This usually occurs within 3 months of exposure.

**Contact your local Pacific AIDS
Education and Training Center:**
<http://www.ucsf.edu/paetc>

References and Resources

Reference:

Centers for Disease Control and Prevention. Revised Recommendations for HIV Testing of Adults, Adolescents, and Pregnant Women in Health-Care Settings. MMWR 2006;55 (No. RR-14):1-17.

Available online at:

<http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5514a1.htm>

HIV Testing Information and Resources:

AETC National Resource Center

<http://www.aids-etc.org/>

Clinician training and reference materials developed by the AETC network

AIDSinfo

<http://aidsinfo.nih.gov>

Current, federally approved guidelines; health information for patients; resources for clinicians

AIDS InfoNet

<http://www.aidsinfonet.org/>

HIV/AIDS testing and treatment information provided in the form of single-topic fact sheets

CDC HIV Testing Topics

<http://www.cdc.gov/hiv/topics/testing/index.htm>

HIV testing information, fact sheets, tools and resources for health care providers

CDC National HIV Testing Resources

<http://www.hivtest.org/>

Where to find testing sites, frequently asked questions, and basic HIV/AIDS information

State HIV Testing Laws Compendium

<http://www.ucsf.edu/hivcntr/StateLaws/Index.html>

Description of key HIV testing laws and policies by state

HIV Testing in Emergency Departments: A Practical Guide

<http://edhivtestguide.org/>

Practical guide developed by Health Research and Educational Trust (HRET)

National HIV Telephone Consultation Service

(Warmline):

1-800-933-3413

National Clinicians' Post-Exposure Prophylaxis Hotline

(PEPlne):

1-888-HIV-4911

Perinatal HIV Hotline:

1-888-448-8765

<http://www.ucsf.edu/hivcntr>

Appendix 3

Module 1 Summary

Testing for HIV Infection:

A Curriculum for Medical Providers in CA
California STD/HIV Prevention Training Center

Module 1: Screening for HIV

HIV in the United States and California

The CDC estimates that there are 1 to 1.2 million people living with HIV in the United States. Of these, about a quarter does not know that they are infected, and approximately 40,000 new infections continue to occur each year in the United States, 6,000 of which are in California.

Sexual transmission accounts for the majority of new infections in the United States, and it is estimated that the 25% of people who are unaware of their infection account for over half of the new infections.

Many clients in the United States do not return to obtain conventional HIV test results, but few fail to receive initial result from rapid HIV test results. Many HIV-infected persons who are unaware of their infections access health care but are not tested for HIV until they are symptomatic.

Recommendations for HIV testing have changed

In September 2006, the CDC released Revised Recommendations for HIV testing in Adults, Adolescents and Pregnant Women in Health Care Settings.

The following changes have been made for **health-care settings**:

- All patients should be screened unless the patient declines
- Persons at high risk for HIV should be screened annually
- Separate written consent is NOT required for HIV testing
- Prevention counseling is NOT required with HIV testing
- All pregnant women should be screened unless she declines
- Pregnant women with increased HIV risk are recommended to repeat screening in the third trimester



The new recommendations were designed to increase the number of persons aware of their HIV-infection status to bring them into care and reduce transmission to susceptible partners. Shifting to an opt-out testing paradigm streamlines consent procedures by eliminating the need for written consent, and normalizes HIV testing. Although HIV testing in health-care settings has been de-linked from counseling, brief counseling and linkage to care and disclosure services are key public health interventions.

California Law about HIV Testing has changed

As of January 2008, opt-out testing in medical settings is permissible without written consent or prevention counseling. The new law requires providers, prior to ordering a test, to inform the patient that:

- HIV testing is planned,
- information about the test will be provided,
- information about treatment options and further testing needed will be given, and
- the patient has the right to decline the test.

If a patient declines and HIV test, the medical provider must note that fact in the patient's medical record.

Module 2 Summary

Testing for HIV Infection:

A Curriculum for Medical Providers in CA
California STD/HIV Prevention Training Center

Module 2: HIV Testing: Practical Implementation Issues

HIV Testing Approaches

There are multiple methodologies for HIV testing. Antibody tests (like ELISA) and viral detection tests (like RNA, HIV antigen tests).

Unlike traditional HIV tests, results from rapid HIV tests are available within 30 minutes of specimen collection. Though this may indicate that more HIV-positive patients will receive their test results, some tests will be reactive without confirming as a positive HIV test.

Interpreting Rapid HIV Test Results

Test Result	HIV Result
Non-reactive	NEGATIVE
Reactive	Preliminary POSITIVE
Reactive confirmed by a second test type	POSITIVE

Who to Test for HIV

Different approaches to HIV testing are available:

- **Opt-in HIV testing** requires risk assessment usually in the form of pre- and post-test counseling, and explicit consent is obtained for the test.
- **Opt-out HIV testing** requires notification of the patient that the test will be done, without requiring risk assessment. Consent is inferred unless the patient declines.

The current CDC recommends routine testing of all persons 13-64 in health care settings (opt-out HIV testing). Routine testing means that explicit consent is not needed to test for HIV, but HIV testing should never be done without the patient's knowledge.

Procedure for HIV Testing

Step 1: Obtain consent

Ensure that the patient knows and understands about the HIV test. Written consent is no longer required for HIV testing in California (AB 682).

Step 2: Collect and process the specimen

When collecting specimen, follow the manufacturer's directions. Use universal precautions with blood specimens. Run the sample in a different location than where the patient is sitting.

Step 3: Interpret Results

HIV-positive traditional test results have been confirmed by additional testing, whereas HIV-positive rapid test results are preliminary. Note that as the prevalence of HIV in your population decreases, the predictive value of a single HIV test also decreases.

Step 4: Disclose result to the patient

HIV-negative test disclosure can occur over the phone or by mail, whereas HIV-positive test disclosure should occur in person. Risk assessment and risk reduction counseling are important during these sessions. HIV-positive test disclosure sessions should include a warm handoff to medical care.

Step 5: Document and report

Positive or negative HIV test results should be documented in patient's medical record. Reporting HIV cases by name is required in California, and should be sent to the local health department within 7 calendar days.

Module 3 Summary

Testing for HIV Infection:

A Curriculum for Medical Providers in CA

California STD/HIV Prevention Training Center

Module 3: Delivering HIV Test Results to Patients

Delivering Negative HIV Test Results

When delivering HIV-negative test results, be sure to state the result in a direct neutral tone, check in and respond to the patient's reaction, and then continue to conduct a brief risk assessment and risk reduction counseling.

When conducting a **risk assessment**, use open ended questions about gender and number of partners, sexual practices and context, and current prevention practices. Encourage patients to talk when needed, and always be non-judgmental.

Risk reduction counseling focuses on developing prevention objectives and strategies with the client, rather than simply providing information. The three steps to effective counseling are to identify the patient's perception of risk, set a safer behavior goal, and identify the first step in the risk reduction plan.

Delivering Positive HIV Test Results

Patient responses to positive HIV test results vary widely. Many patients are aware of their own risk. It is important to acknowledge your own feelings and HIV-specific biases. Some providers may need to work through these to deliver results in a way that is most effective for the patient.

There are three main components of delivering positive HIV test results. Every disclosure session will be different - do not feel married to the sequence listed below. Follow your patient's lead on the information that is needed in the moment.

- **Stating the result**
 - Results should be stated in a direct, neutral tone. Wait for the patient's response, and provide for any immediate needs.
 - Most patients are not completely surprised by the test result.
- **Address individual needs and concerns**
 - *Sources of emotional support:* Ensure that the patient has a local support network - friends, family, partner, counselor.
 - *Information about HIV:* discuss transmission and answer questions about what this means for the patient's health
 - *Partner notification:* consider referral to Partner Counseling and Referral Services (PCRS) if the patient does not want to notify partners him/herself
- **Make a short term plan**
 - Ask the patient for the most important first step for them.
 - Make a first appointment if you will be providing care, or refer to a provider with the patient's insurance or to a Ryan White clinic for care.

Notes for Rapid HIV test results

- State result in a direct, neutral tone and wait for the patient's response
- Explain the meaning of preliminary positive result again
- Obtain confirmatory specimen
- Make an appointment for a return visit

Appendix 4

HIV Testing Checklist

Patient Name/Number _____

Pre-test Discussion

Initials/Date _____

- ☐ HIV testing is routine for everyone ages 13-64
- ☐ HIV vs. AIDS definition
- ☐ HIV test checks for antibodies, not the virus. Explain the possible test results. During “window period” test will be negative while virus is present
- ☐ Methods of transmission: sexual, sharing drug equipment
- ☐ Risk reduction: avoid sexual fluids (abstinence, condoms, long-term monogamy), avoid blood
- ☐ Testing is confidential. If confirmatory test is positive, patient’s name will be forwarded **only** to state health department as required by law

Consent Process

Initials/Date _____

- ☐ Oral consent
- ☐ Signed form
- ☐ Declined to be tested

Results – Screening Test (rapid or conventional EIA)

Initials/Date _____

- ☐ Nonreactive
- ☐ Reactive or Reactive/Preliminarily Positive
- ☐ Inconclusive/Invalid

Results – Confirmatory Test (if needed)

Initials/Date _____

- ☐ Negative
- ☐ Positive
- ☐ Indeterminate

Post-test Discussion

- ☐ Results are *indeterminate* or *preliminarily positive*
 - ☐ Tell patient further testing needs to be done
 - ☐ Arrange follow-up after confirmatory testing to complete post-test discussion (see below)

Initials/Date _____

- ☐ Results are *nonreactive*
 - ☐ What the results mean, including “window period”
 - ☐ How to prevent HIV transmission
 - ☐ Suggest repeat testing based on recent and/or future exposures

Initials/Date _____

- ☐ Results are *reactive and confirmed*

Initials/Date _____

- ☐ What the results mean
- ☐ Compassionate support, as needed
- ☐ Health care is available for you, including HIV treatment, mental health
- ☐ How to prevent transmission of HIV to others
 - Importance, benefit of locating and informing sex/drug partners for testing
 - Anonymous notification of partners available through Health Department
- ☐ Referral(s) made today to:

1. _____
2. _____

Appendix 5

HIV/AIDS Providers Sample Letter

(place on letterhead)

HIV/AIDS Provider

Address

Dear **HIV/AIDS provider**

I am writing to you on behalf of our clinical staff here at _____.

Describe the practice demographics, insurance accepted, services provided, and professionals on staff.

We are intensely aware of, and concerned about, the HIV/AIDS epidemic in our country and are working to implement the CDC's 2006 revised HIV testing recommendations.

As we do so, it is imperative that we develop relationships with providers such as yourself so that newly diagnosed HIV positive individuals receive appropriate and timely follow-up care. We are very interested in collaborative and/or co-location arrangements with HIV/AIDS providers.

We would like to know more about your practice and your interest in referrals from our practice, as well as any interest you may have in a co-location model. Please complete the enclosed HIV/AIDS provider form which will assist us in making appropriate referrals. I would be happy to talk with you further and would be glad to arrange an introduction for you to our clinical staff.

Thank you in advance for your response.

Sincerely,

Appendix 6

Memorandum of Agreement

This Memorandum of Agreement is between (name referring clinician practice) and (name referral clinician practice). This memorandum outlines the working relationship between these two clinician practices as it concerns patients newly diagnosed with HIV infection.

The goal of this relationship is to coordinate and collaborate on linking patients to care.

1. (Referring clinician practice) agrees to:

a. Ensure that clients referred by (referring clinician practice) have signed a HIPAA compliant release form to permit the sharing of information between the health care clinician practices.

b. If patient is a confirmed positive, begin patient education process by explaining the meaning of a confirmed positive test and providing patient a general understanding of the importance of appropriate medical care to help them stay as healthy as possible. Provide an overview of how their care is likely to be arranged, including whether or not (referring clinician practice) will remain active in their care.

c. For confirmed positive patients, complete all state and local health department case reporting requirements and information to initiate partner services.

d. Provide (referral clinician practice) necessary patient information in a timely manner. This will include any existing medications list, most recent history and PE

for patient, and results of pertinent laboratory tests.

Also provide any information to support the culturally appropriate treatment of patient and help ensure the medical care is sensitive to patient's racial, cultural, and language issues.

e. Clearly communicate expectations of referral, including how much feedback from (referral clinician practice) is desired and if (referring practice) intends to stay actively involved in the patient's care. Specify mechanism (i.e. fax, phone, email, mail) and provide form for receiving feedback from (referral clinician practice). If both clinician practices will remain actively involved in patient's care, delineate responsibilities for ongoing medical care.

f. Where appropriate, help patient connect with the case management system.

2. (Referral clinician practice) agrees to:

a. Provide appropriate medical care to HIV positive patients referred by (referring clinician practice).

b. Ensure that patients have signed the Release of Information form.

c. If conducting confirmatory testing, and test result is positive for HIV infection, complete necessary state and local health department case reporting requirements and information to initiate partner services.

d. Work with patients to continue to orient

them to the care system and how their care will be delivered, clarifying various provider roles.

e. Where appropriate, assure that patient is connected with a case management system.

f. Provide requested feedback to (referring clinician practice) and coordinate care responsibilities accordingly.

g. If patients misses their first scheduled appointment, contact the (referring clinician practice) and if available, the case manager, within two business days.

h. If patient misses two subsequent appointments without rescheduling, contact the (referring clinician practice) and case manager within two

business days of last missed appointment.

Referring clinician practice authorized signature

Printed name of referring clinician practice

Date

Referral clinician practice authorized signature

Printed name of referral clinician practice

Date

Appendix 7

Physician Referral and Feedback Form Template

Date: _____ () Initial () Follow Up

Referring Physician Name:

Address: _____

_____ (Street/PO Box) City State Zip

Fax: (____) _____ Phone: (____) _____

Patient's Name: _____

_____ DOB: _____

Parent's Name: _____ Address: _____ Phone: _____

Date(s) Patient Seen:

Reason for Referral:

Any Specific Questions or Requests:

Physician Signature

Thank you for evaluating this patient. To facilitate communication and treatment, please mail or fax this completed form to the physician listed above. Thank you for your collaboration.

- ☐ Patient did not make appointment
- ☐ Patient made an appointment but did not keep appointment
- ☐ Patient not seen within 60 days

Initial Diagnoses:

1. _____
2. _____
3. _____

Recommendations:

Medications Prescribed:

Follow-up Planned: (this needs WORK – input from clinicians)

- ☐ Medication management
- ☐ Medical lab requests
- ☐ Referral for additional diagnostic testing
- ☐ Return to your care for medication management
- ☐ Recommend follow-up in _____ weeks
- ☐ Other _____

Name (type or print)

Signature

Adapted from the American Academy of Pediatrics Chapter Action Kit for Mental Health

First Visit Basics:

Initiating Care for the HIV-infected Patient

Belinda Brown, N.D., FNP

August 2004



First Visit Basics: Initiating Care for the HIV-Infected Patient

Welcome to this short guide to initiating care for a new patient with HIV infection. We have found that the first visit can be critical in establishing an on-going relationship for patients with this chronic disease, but we are also aware that time is limited. The following overview provides a succinct description of the initial history and physical, lays the groundwork for continuing care, and lists easily accessible resources.

In addition, we have taken the liberty of providing two examples of flow sheets that can provide continuing documentation for these patients. Please feel free to copy the forms for your personal or clinic use.

CHIEF COMPLAINT. Patients may present with a complaint such as thrush, but initial visits often occur as a result of having a positive HIV antibody test.

ASSESS HISTORY

HISTORY OF PRESENT ILLNESS. Determine history:

- Inquire about prior HIV testing and recent illnesses. An individual diagnosed within 6 months of HIV infection may benefit from early intervention regardless of labs.
 - / Evidence such as a negative HIV test prior to the positive test, a history of a flu-like illness prior to HIV diagnosis, or a history of recent high risk activities may help determine time of infection.
 - / If it is determined that the infection was recently acquired, consultation with an HIV expert provider is recommended.
 - / Unfortunately, most patients are not diagnosed with HIV until chronic infection is established, but it is worth making this determination as soon as possible.
- If the initial visit is with a patient with a history of HIV, obtain date of diagnosis and any treatment history.
 - / For antiretroviral medications, include all regimens, dates of use, and reasons for discontinuation. Since many patients recognize their meds only by color or size, it helps to have a picture chart of HIV medications to assure accurate identification.
 - / Include a history of lab values (lowest CD4 count) and most recent labs, if available.
 - / Find out where previous care was provided and ask if records can be obtained from that provider.

PREVIOUS MEDICAL HISTORY. Ask about significant previous medical history including:

- Transfusions
- Opportunistic diseases
- Hospitalizations
- Mental health or substance use treatment history

MEDICATIONS. Discuss use of all current medications:

- HIV treatment
- Medications to prevent opportunistic infections
- Medications prescribed for conditions other than HIV
- OTC medications
- Herbal remedies

ALLERGIES. Record allergic reactions; inquire about previous antibiotic use

IMMUNIZATIONS. History of vaccinations, childhood and adult

REVIEW OF SYSTEMS. Ask about:

- Weight loss/gain
- Fever
- Night sweats
- Dysuria
- Nausea/vomiting
- Loss of appetite
- Fatigue
- Diarrhea
- Genital/anorectal lesions, discharge and/or tenderness
- For women, include last menstrual period, menstrual irregularities, and pregnancy history

HEALTH MAINTENANCE. Ask about:

- Previous primary, dental, and eye care
- Last Pap smear (cervical and/or anal), history of abnormal Pap smears
- History of PPD and/or chest X-ray

SOCIAL. Start with less threatening areas to establish communications and build rapport:

- Employment (financial resources)
- Housing (stability, safety of neighborhood)
- Living arrangements (who patient lives with)
- Responsibilities (children, other relatives, partners, pets, property)
- Travel, especially to areas with endemic infectious diseases
- Alcohol and tobacco use
- Other substance use – “Do you now or have you ever used drugs that weren’t prescribed by a physician? How do/did you use them (i.e. inject, smoke, snort, etc.)? Do/did you share your equipment with others?”
- Sexual activity – “Are you sexually active? Do you have sex with men, women, or both? How do you protect yourself and your partners from sexually transmitted diseases?”
- Inquire about history of violence, including forced sex and domestic abuse
- Ask about support – “Who have you told about your diagnosis? How are they helping you with your diagnosis?”

PHYSICAL ASSESSMENT

PHYSICAL EXAM. Focus on the following during comprehensive physical exam:

- Skin: Note any rashes or lesions
- HEENT: Perform thorough oral, eye, and ear exams
- Lymph: Determine extent of lymph node enlargement, if any
- Heart: Assess rate and note presence of murmurs or extra beats
- Lungs: Assess breath sounds throughout lung fields
- Abdomen: Measure liver span, note splenomegaly
- Neurologic: Test reflexes and sensations in lower extremities, assess mental status

NOTE: depending on time, prioritization of needs, and patient comfort, GU and rectal exams may be deferred, but should be mentioned in the plan to complete the physical exam.

- Genitourinary: Check for discharge, lesions, or tenderness
- Anal/ Rectal: Check for discharge, lesions, or tenderness; a history of anal receptive sexual intercourse should initiate complete rectal exam including anoscopy

LABS. Complete labs to establish current problems/disease state:

- HIV antibody (ELISA & Western blot) as needed
- HIV RNA Quantitative (viral load)
- CD4 profile
- CBC with differential
- Basic metabolic panel including liver function tests
- Baseline random glucose & cholesterol
- Hepatitis profile (anti-HAV [IgG], anti-HBV, HBsAg, HbcAb, & anti-HCV)
- STD testing, if appropriate, including gonorrhea, chlamydia, and syphilis (RPR or VDRL)
- Consider resistance testing (genotyping/phenotyping) especially with recently-infected patients

ASSESSMENT. Determine HIV stage (asymptomatic, symptomatic, or AIDS); include other diagnoses

PLAN

ADDRESS DIAGNOSES AND PLANS FOR CARE. Provide comprehensive health care using referrals and consultations as required.

HEALTH MAINTENANCE. Considerations include:

- Vaccinations, including pneumovax
- PPD placement
- Pap smear and breast exam
- Anal cytology, if appropriate
- Age appropriate health and wellness exams and follow-up

EDUCATION. Discuss:

- HIV pathophysiology including significance of viral load & CD4 count
- Routine lab tests with expected monitoring intervals
- Plan of care including need for immunizations and routine health maintenance
- The importance of adherence to antiretroviral regimens
- HIV transmission and methods to decrease risks to partners
- Follow-up – when to return, how to contact providers between appointments if needed

RESOURCES

AIDSinfo

www.aidsinfo.nih.gov

A service of U.S. Department of Health and Human Services providing information on HIV/AIDS clinical trials and treatment.

1-800-HIV-0440 (1-800-448-0440)

AIDS InfoNet

www.aidsinfonet.org

Provides fact sheets on treatments, prevention, social services, and web resources. Easy to print, appropriate for patient and clinician education; updated on a regular basis. Available in English and Spanish.

HIV Telephone Consultation Service for Health Care Providers

www.ucsf.edu/hivctr

A national HIV telephone consultation service for health care providers offering up-to-date clinical information and individualized consultations from clinicians experienced in HIV care.

1-800-933-3413

Mountain Plains AIDS Education and Training Center

4200 East Ninth Avenue, Box A089 • Denver, Colorado 80262

Phone: 303-315-2516 • FAX: 303-315-2514

www.uchsc.edu/mpaetc



HIV ADULT/ADOLESCENT HEALTH MAINTENANCE

Patient Name: _____ Date: _____ Chart #: _____

		RECOMMENDATION	DATE	DATE	DATE	DATE	DATE
PERIODIC SCREENING	health history update	q 3 mo					
	complete physical exam	annual					
	interval physical exam	q 3 mo					
	breast exam/testicular exam	with physical					
	dental exam	q 6 mo					
	hearing/vision exam	annual					
	retinal exam	annual/q 6 mo CD4<100					
	Pap/pelvic exam	annual/q 6 mo CD4<200					
	anal Pap	annual if anal intercourse					
	digital rectal exam	annual 40 y/o or earlier					
	stool guaiac	annual over 50 y/o					
	EKG	if applicable					
	BE/sigmoidoscopy	over 50 y/o, q 3-5 years					
	mammogram	annual over 40 y/o					
	PPD/CXR	annual					
IMMUNIZATIONS	cholesterol/triglycerides	q 6 mo					
	liver function tests	q 6 mo					
	HIV panel (CBC, CD4, VL)	q 3 mo					
	hepatitis screen	initial & PRN					
	RPR/STD screen	Initial, annual, & PRN					
	tetanus/diphtheria	q 10 yrs after 1 st series					
	pneumococcal	q 6 years					
	influenza	annual					
	MMR	under 40, no hx of disease					
	hepatitis B	if no hx of disease					
	hepatitis A	if applicable					
	varicella	CD4>500, no hx of disease					
	tobacco	annual					
	alcohol	annual					
	drugs	annual					
RISK ASSESSMENT	mental health: stress, anxiety, depression, suicide ideation	annual					
	diet/exercise	annual					
	HIV/STD prevention	annual					
	geriatric functional status	annual over 60 y/o/PRN					
	seat belt/helmet use	annual					
	pregnancy/contraception	annual					
	advanced directives	annual					
	emotional support	annual					
	domestic violence/abuse	annual					
	hepatitis A, B, C	annual					

*Please note updated vaccination schedule should include one-time revaccination after 5 years. For people 65 years of age or older, administer a one-time revaccination if primary vaccination occurred at greater than or equal to 5 years of age and less than 65 years of age.

Additionally, adults should receive a Tdap booster. See Recommended Adult Immunization Schedule – United States, October, 2007 – September 2009 MMWR. October 19, 2007 / 56(41);Q1-Q4.

The American Psychological Association (APA) logo, featuring a stylized red ribbon forming a knot, with the text "American Psychological Association" in black.

Chart #: _____

[illegible]

Reactive Tracking Tool

Medical Record Number: _____

Date: ____/____/____ 43
mm dd yyyy

Appendix 9

Confirmatory Testing

1. Confirmatory Tests

↓ ☐ Western Blot ☐ Confirmatory Testing Refused

Date specimen collected: ____/____/____
mm dd yyyy

Date of visit when pt received results: ____/____/____
mm dd yyyy

Result:

☐ Positive

☐ Negative

→ If negative, date of 3 month F/U visit for repeat test: ____/____/____
mm dd yyyy

☐ Indeterminate

→ If indeterminate, collect another specimen on this visit and send to lab.

Date specimen collected: ____/____/____
mm dd yyyy

Date of visit when pt received 2nd results: ____/____/____
mm dd yyyy

Result: ☐ Positive

☐ Negative

☐ Indeterminate

Notification

2. Was the Disease Intervention Specialist (DIS) notified?

☐ Yes

→ Date: ____/____/____
mm dd yyyy

☐ No

3. Initial HIV Visit

Date of 1st completed HIV medical visit after confirming infection:

____/____/____
mm dd yyyy

The above completed HIV medical visit was conducted:

☐ At the health center

☐ At a referral agency

Name: _____

4. Results of first HIV tests after diagnosis

CD4 Count ____ . ____

Date of test: ____/____/____
mm dd yyyy

Viral Load ____ . ____

Date of test: ____/____/____
mm dd yyyy

Opportunistic Infection

☐ No ☐ Yes

Appendix 10

Reactive Rapid HIV Test Results: A Step-by-Step Response

Step 1 Confirm Reactive Test Result with a Second Staff Person

A staff member who observes a reactive HIV rapid test result should get a second person (preferably a supervisory clinical person or provider) to confirm reactive result.

Step 2 Inform Provider of Result

If provider is not yet informed of reactive result, staff or clinical supervisor should discuss result with provider and give provider a copy of the handout "What Does My Reactive Result Mean?" to bring into exam room along with the name and telephone number of the local DIS (Disease Intervention Specialist) so the patient has an additional resource to call with any questions/concerns before their follow-up visit.

Step 3 Counsel Patient Regarding Reactive Result

Provider discusses reactive result with patient and explains that the rapid test result is preliminary and blood needs to be drawn for a confirmatory test. Patient is instructed to exercise protective measures until confirmatory results are back. Provider and/or nurse gives patient a follow-up appointment in five business days.

Step 4 Draw Blood for Western Blot

Obtain Western Blot sample and ship to the Ohio Department of Health (*refer to specimen shipping instructions*).

Step 5 Inform Local Department of Health DIS of Reactive Result

Call your local DIS to inform him/her of reactive HIV rapid test and provide the person's name in the event patient calls for support or questions. Inform the DIS of the date and time of patient's five-day follow-up visit and request that they "hold" that appointment for on-site counseling at the health center.

Step 6 Complete and Fax Reactive Tracking Tool

Complete first part of Reactive Tracking Tool (checking off whether Western Blot was done and the date specimen obtained); fax Tool to data center.

Step 7 Call DIS with Western Blot Results

When Western Blot results are received from the DOH via fax, call DIS with results. If the Western Blot is positive or indeterminate, confirm that DIS can be on-site for patient's five day follow-up appointment. If Western Blot result is negative, request whether DIS can be onsite for patient's follow-up appointment to provide more in-depth counseling.

Step 8 Provide Western Blot Results to Patient

At patient's five day follow-up visit, provider initially informs patient of Western Blot result then, with patient's permission, the DIS offers post-test counseling and referral to HIV specialty care and other needed services (DIS may not agree to be present if Western Blot result is negative). In summary,

Positive Western Blot: Provider informs patient of HIV infection. DIS conducts post-test counseling and referral services. Clinical Supervisor gives the DIS worker a copy of the partially completed Reactive Tracking Tool to complete questions #3 & #4 after patient's first HIV follow-up visit.

Indeterminate Western Blot: Provider informs patient that the confirmatory test was inconclusive and the test needs to be repeated. A second Western Blot sample is obtained and sent to ODH. The DIS counsels patient in this result and discusses protective measures.

Negative Western Blot: Provider informs patient that confirmatory test was negative and that this likely means the patient does not have HIV unless there has been some recent exposure (e.g., the "window period" during which a patient's body has not had time to develop antibodies to the virus). The DIS may, or may not, agree to be present at this visit to provide counseling. A patient who has

a reactive rapid HIV test, followed by a negative Western Blot, needs to be scheduled to return to the health center in three months for a repeat Western Blot test.

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