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Texas Collaborative for HIV Education and Prevention (TCHEP) Learning Series

Updates and Recommendations for Primary and Emergency Care Services

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Texas Collaborative for
HIV Education & Prevention

Implementing Routine HIV Screening in Texas Emergency Departments

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Disclosure to Learners

Texas Collaborative for HIV Education & Prevention Learning Activities:

“Implementing Routine HIV Screening in Texas Emergency Departments ”

June 08, 2021

Successful Completion

Successful completion of this continuing education event requires that you:

- Complete registration and sign in,
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- Participate in education activities, and
- Complete the participant evaluation.

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This event received no commercial support.

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Continuing Education

Other professions:

Certified Health Education Specialists

Certified in Public Health

Social Workers

Thank you!

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Upcoming TCHEP Webinars

- [6/10/21 - 12:00 pm | Fighting HIV Stigma to End the HIV Epidemic: Evidence Based Solutions for Healthcare in Texas
- 6/16/21 - 12:00 pm | A Status Neutral Approach: Redefining HIV Prevention and Care in Texas Healthcare Settings
- [**ED Focus**] 6/22/21 - 11:30 am | Critical Partnerships to Ensure Successful Routine HIV Screening Programs & Linkage to HIV Care: The Role of Nursing, Social Workers, Navigators, & Educators in Healthcare Settings
- 6/23/21 - 11:00 am | Biomedical HIV Prevention Strategies – PrEP and nPEP: Essential tools to end the HIV epidemic in Texas
- 6/30/21 - 12:00 pm | Cultural Humility: Improving Patient Trust and Health Outcomes
- [**ED Focus**] 7/14/21 - 12:00 pm | Financial Benefits and Barriers to Routine HIV Screening in Emergency Departments: Best Practices in Texas

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Speakers:

James J. McCarthy, MD, FACEP, FAEMS

Memorial Hermann Health System

Samuel J. Prater, MD

Memorial Hermann TMC-ED, UT System McGovern Medical School

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Implementing Routine HIV Screening in Emergency Departments

James J. McCarthy, MD, FACEP, FAEMS

Samuel J. Prater, MD, CMQ, FAAP, FACEP

Financial Disclosure

- Dr. McCarthy has no relevant financial disclosures

- Dr. Prater receives grant support from Gilead sciences to maintain a Hepatitis C screening program in the Emergency Department
  - Grant support helps fund linkage to care for patients infected with HCV and/or HIV

Learning Objectives

- Discuss the importance of implementing a universal routine, opt-out HIV screening program in emergency departments.
- Explain the CDC and USPSTF recommendations for routine, opt-out HIV screening in healthcare settings.
- Identify the essential resources required to implement a successful and sustainable routine HIV screening program in the ED and strategies to overcome potential barriers.
- Summarize Texas law that applies to HIV screening including consent, delivering test results, and reporting positive cases to the public health authority.

Discuss the importance of implementing a universal routine, opt-out HIV screening program in emergency departments

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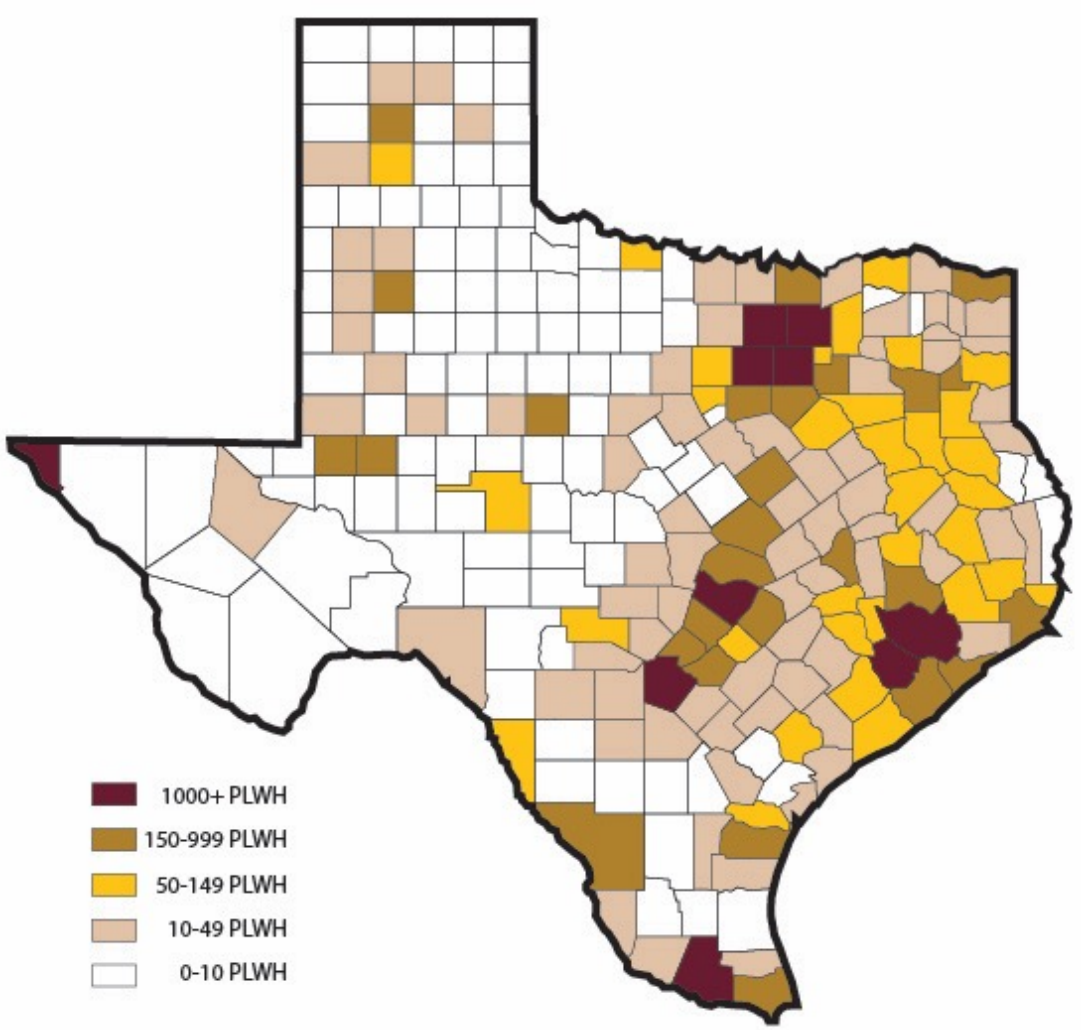
Healthcare Executive



PLWH = Person living with HIV

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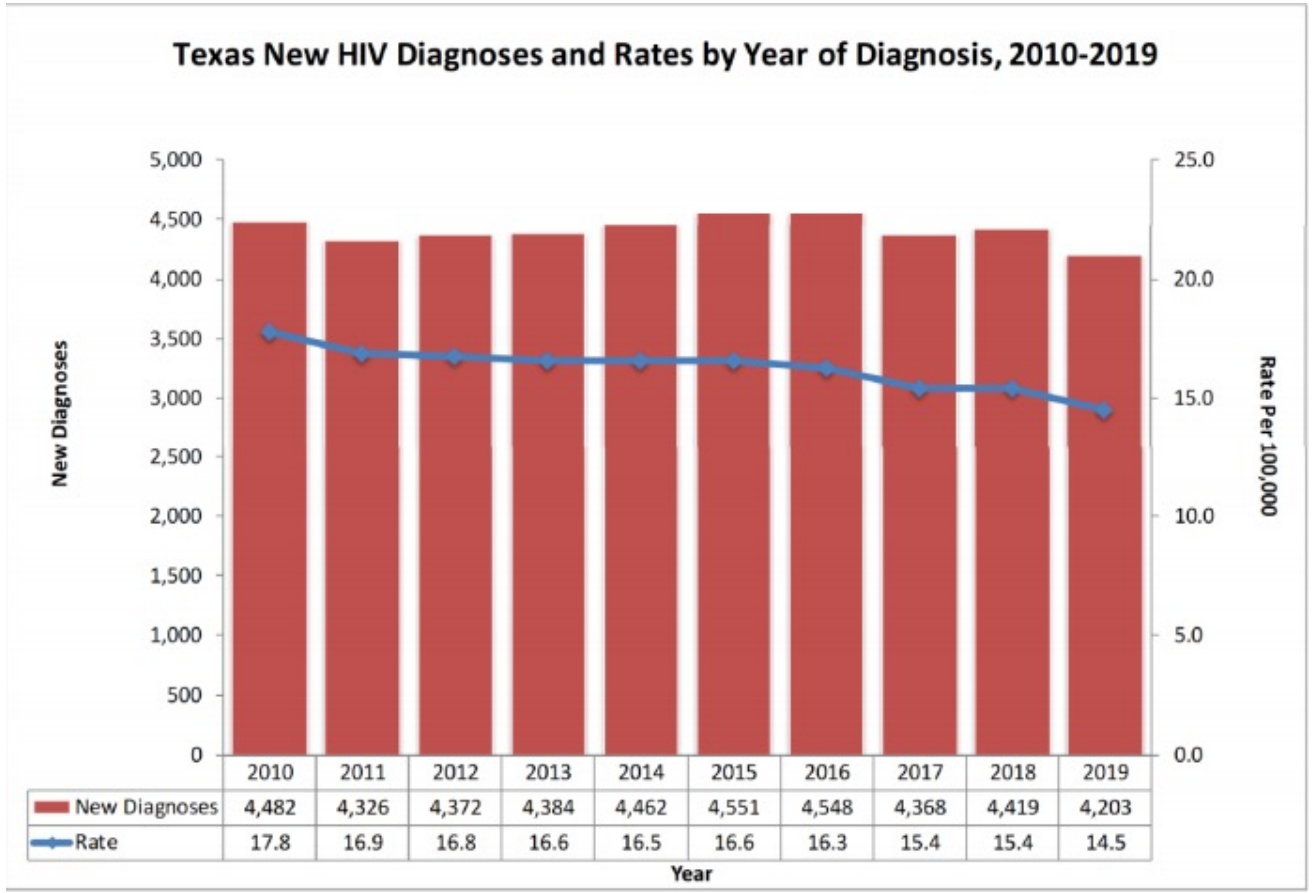
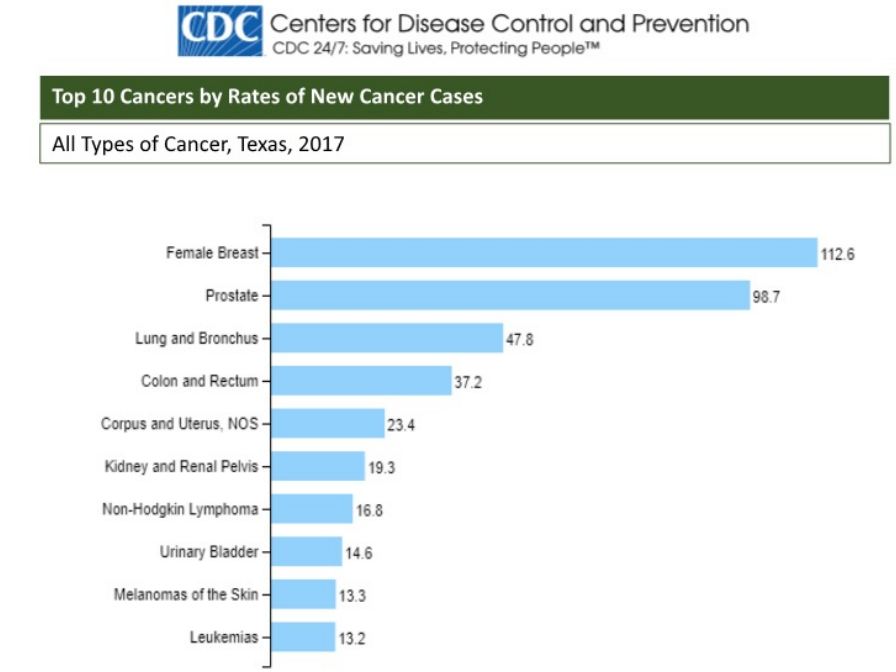
HIV as common as some Cancers



	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019
New Diagnoses	4,482	4,326	4,372	4,384	4,462	4,551	4,548	4,368	4,419	4,203
Rate	17.8	16.9	16.8	16.6	16.5	16.6	16.3	15.4	15.4	14.5

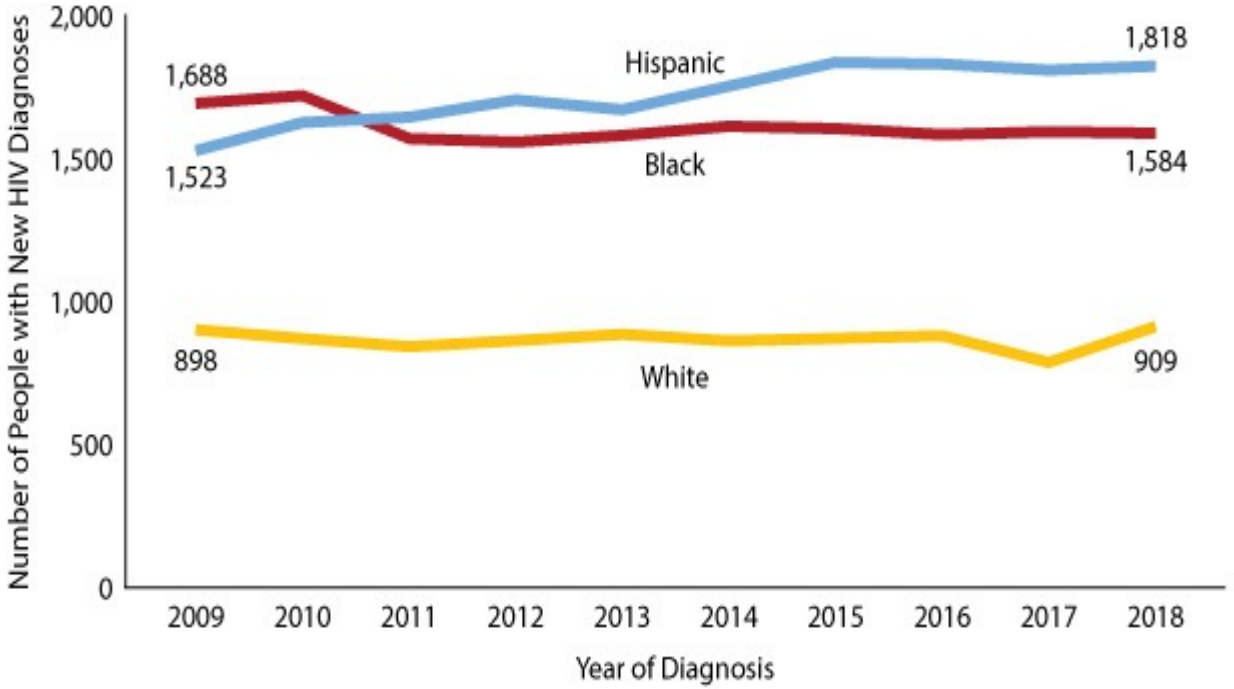


Rate per 100,000 people

Data source – U.S. Cancer Statistics Working Group. U.S. Cancer Statistics Data Visualizations Tool, based on November 2019 submission data (1999-2017): U.S. Department of Health and Human Services, Centers for Disease Control and Prevention and National Cancer Institute; https://www.cdc.gov/cancer/dataviz, June 2020.

https://www.dshs.state.tx.us/hivstd/reports/HIVSurveillanceReport.pdf

Disparities in HIV



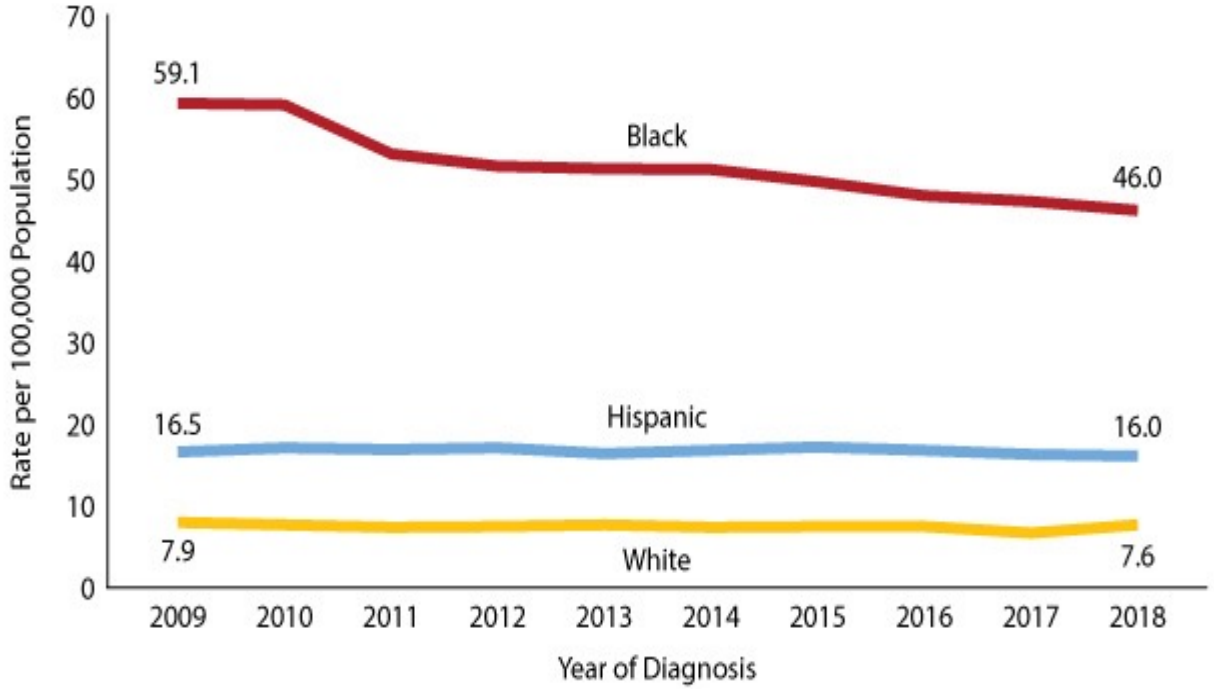


Table 17: Cause of death rankings in adults age 25-44, Texas 2016

Cause of Death	All Races		White		Black		Hispanic		Other	
	Rank	Number	Rank	Number	Rank	Number	Rank	Number	Rank	Number
Accidents	1	2,872	1	1,459	1	366	1	968	2	79
Malignant Neoplasms (Cancer)	2	1,378	3	539	4	218	2	521	1	100
Diseases of the Heart	3	1,244	4	525	2	332	3	345	4	42
Intentional Self-Harm (Suicide)	4	1,235	2	771	6	103	4	307	3	54
Assault (Homicide)	5	761	5	164	3	293	5	277	5	27
Chronic Liver Disease and Cirrhosis	6	316	6	147	15	16	6	147	7	*
Cerebrovascular Diseases	7	229	8	78	8	46	7	93	6	12
Diabetes Mellitus	8	226	7	88	7	51	8	83	10	*
HIV Disease	***9***	***211***	***11***	***44***	***5***	***111***	***10***	***50***	***8***	*
Septicemia	10	155	9	59	9	38	9	55	11	*

* Number of deaths masked due to low numbers

Source: Texas eHARS, 2018

https://www.dshs.state.tx.us/hivstd/reports/epiprofile/sec06.shtm

Why Routine Screening?

- Augment risk-based testing
- Identify missed opportunities associated with risk-based only testing
- Identify PLWH unware of their HIV status
- Identify PLWH before they have advanced HIV disease or AIDS

Why Routine Screening?

- Educate PLWH regarding risk behaviors associated with HIV transmission
- Re-engage PLWH who are out of care into care to achieve viral suppression
- EDs accounted for highest percentage (75.4%) of new cases in DSHS screening program

Why Routine Screening?

Routine screening addresses and reduces stigma and bias

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The right thing to do

- Falls
- Abuse
- Neglect
- Suicidal ideations
- Food insecurity
- Tuberculosis……

Explain the CDC and USPSTF recommendations for routine, opt-out HIV screening in healthcare settings

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CDC Recommendations (2006)

- Screening is a basic public health tool used to identify unrecognized health conditions so treatment can be offered before symptoms develop and, for communicable diseases, so interventions can be implemented to reduce the likelihood of continued transmission.
- Opt-out screening = Performing screening after notifying the patient that 1) the test will be performed and 2) the patient may elect to decline or defer testing. Assent is inferred unless the patient declines testing.

CDC Recommendations (2006)

HIV infection is consistent with all generally accepted criteria that justify screening:

1) HIV infection is a serious health disorder that can be diagnosed before symptoms develop;

2) HIV can be detected by reliable, inexpensive, and noninvasive screening tests;

3) infected patients have years of life to gain if treatment is initiated early, before symptoms develop; and

4) the costs of screening are reasonable in relation to the anticipated benefits

CDC Recommendations (2006)

- In 2002, estimated 25% (~300k) of PLWH were unaware of their status.
  - Estimated transmission is 3.5 times higher among persons who are unaware of their infection
- Risk-based screening was becoming more ineffective.
  - Increasing proportions of infected persons were aged <20 years, women, members of racial or ethnic minority populations, persons who reside outside metropolitan areas, and heterosexual men and women who frequently are unaware that they are at risk for HIV.
  - A substantial number of persons, including persons with HIV infection, do not perceive themselves to be at risk for HIV or do not disclose their risks

CDC Recommendations (2006)

- Universal screening for HIV in other instances had already been demonstrated to be highly effective:
    - Nearly eliminated transfusion-association HIV transmission through universal screening.
    - Substantial reduction of perinatal HIV transmission through universal screening of pregnant women.

CDC Recommendations (2006)

- Emergency Departments recognized to be a unique opportunity for HIV screening:
  - Persons known to be at risk for STI/HIV were screened at low rates in EDs.
  - Experience in early 2000s at some EDs found prevalence rates as high as 7% (well above the 1% threshold).
  - ED patients rarely seeking care specifically for HIV and thus represent unique opportunity to diagnose HIV <u>early.</u>

CDC Recommendations (2006)

- Routine HIV testing reduces the stigma associated with testing that requires assessment of risk behaviors.

- More patients accept recommended HIV testing when it is offered routinely to everyone, without a risk assessment.

- Rates of HIV screening are consistently higher at Obstetric settings that provide prenatal and STD services using opt-out screening than at opt-in programs, which require pre-test counseling and explicit written consent.

CDC Recommendations (2006)

- In populations for which prevalence of undiagnosed HIV infection is ≥0.1%, HIV screening is as cost-effective as other established screening programs for chronic diseases (e.g., hypertension, colon cancer, and breast cancer).

- Because of the substantial survival advantage resulting from earlier diagnosis of HIV infection when therapy can be initiated before severe immunologic compromise occurs, screening reaches conventional benchmarks for cost-effectiveness even before including the important public health benefit from reduced transmission to sex partners.

CDC Recommendations (2006)

- 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.

USPTF recommendations (2013)

Recommendation Summary

Population	Recommendation	Grade
Pregnant persons	The USPSTF recommends that clinicians screen for HIV infection in all pregnant persons, including those who present in labor or at delivery whose HIV status is unknown.	A
Adolescents and adults aged 15 to 65 years	The USPSTF recommends that clinicians screen for HIV infection in adolescents and adults aged 15 to 65 years. Younger adolescents and older adults who are at increased risk of infection should also be screened. See the Clinical Considerations section for more information about assessment of risk, screening intervals, and rescreening in pregnancy.	A

USPTF recommendations (2013)

Estimate of Magnitude of Net Benefit

The USPSTF concludes with high certainty that early detection and treatment of HIV infection would result in substantial benefits. Screening for HIV infection in all adolescents and adults aged 15 to 65 years, persons at increased risk of infection, and pregnant persons would allow for earlier and expanded detection of HIV infection, thus resulting in earlier medical and behavioral interventions and treatment.

The USPSTF found convincing evidence that early initiation of ART for HIV infection, regardless of CD4 cell count, improves clinical outcomes and reduces the risk of sexual transmission. The USPSTF found adequate evidence that the harms of early detection and treatment of HIV infection are small, and the clinical benefits of ART substantially outweigh the potential risks of treatment in persons living with HIV. The USPSTF also found convincing evidence that screening for HIV infection in pregnant women confers substantial clinical benefits for both the mother and infant, with adequate evidence that the potential harms are small.

On the basis of these findings, the USPSTF concludes with high certainty that early detection and treatment of HIV infection results in substantial net benefit.

Identify the essential resources required to implement a successful and sustainable routine HIV screening program in the ED and strategies to overcome potential barriers

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Required Program Resources

- ED Physician and Nursing Leadership Support
- Hospital Leadership Support
- Clinical Champion
- ISD Partner
- Lab Partner
- **Linkage to Care**

Required Program Resources

- Identify patient consent process for opt-out screening with process for documentation in EHR.

- Identify process to trigger a reflex test order:
  - EHR automated
  - Nursing screening triggered
  - Nursing order via standing delegated order sets
  - Provider ordered

Required Program Resources

- Reflexive Testing technology (4th generation):
  - Antigen/antibody immunoassay approved by the US Food and Drug Administration that detects HIV-1 and HIV-2 antibodies and the HIV-1 p24 antigen, with supplemental testing after a reactive assay to differentiate between HIV-1 and HIV-2 antibodies.
  - If supplemental testing indeterminate or nonreactive, an HIV-1 nucleic acid test is recommended to differentiate acute HIV-1 infection from a false-positive test result.
  - What to do with “QNS?”

Required Program Resources

- Identify your process for face-to-face disclosure of results.
  - Be prepared to have rare false-positive results and a plan of action.
  - How and who will disclose confirmed results of discharged patients?
  - How and who will disclose confirmed results of admitted patients?
  - What will be your process for patients with poor contact information?
  - Telemedicine capabilities?

Required Program Resources

- Identify your process for LINKAGE TO CARE.
  - You will need Points of Entry (POE) agreements with your community partners for both funded and unfunded patients.
  - You will need Memorandum of Understandings (MOU) to exchange PHI with community partners and allow community partners to confirm patient *successfully* engaged in care.

Required Program Resources

- Identify the following public health follow up activities:
  - Laboratory process for reporting positive results to local health department
  - Submit confidential case report form to regional health authority
  - Establish relationship and recurring communication with local health department's disease intervention specialist (DIS)

Barriers to routine, opt-out screening

The cost of HIV screening often is not reimbursed.

Providers in busy health-care settings often lack the time necessary to conduct risk assessments and might perceive counseling requirements as a barrier to testing.

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Overcoming Barriers

- How to overcome a busy ED environment?
  - Establish a process that works through EHR in the background.
  - Establish a process that is minimally intrusive to provider and nursing bedside workflow.
    - Requiring bedside ED providers and nurses to perform a risk-based assessment testing strategy is a recipe for failure.
  - Educate your team on the benefits of a robust opt-out screening program.
  - Identify a separate team for linkage to care and counseling.

Overcoming Barriers

- Most significant barrier to routine, opt-out testing in ED is cost.
  - Un-reimbursed testing
  - Personnel for linkage to care
    - Will this be an additional FTE?
    - Can an existing ED social worker assume role?
  - EHR work to create an automated process
  - Personnel to track data and program outcomes

Overcoming Cost Barriers

- The average annual cost of HIV care in the ART era was estimated to be $23,000 in 2010 dollars.
- Currently, the lifetime treatment cost of an HIV infection is estimated at $379,668 (in 2010 dollars), therefore a prevention intervention is deemed cost-saving if its Cost-Effective ratio is less than $379,668 per infection averted.
- Early diagnosis will lead to decreased transmission of cases.
- Early diagnosis will result in treatment before AIDS defining illness identified.

https://clinicalinfo.hiv.gov/en/guidelines/adult-and-adolescent-arv/cost-considerations-and-antiretroviral-therapy

Summarize Texas law that applies to HIV screening including consent, delivering test results, and reporting positive cases to the public health authority

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Texas law

- Consent
  - When a general consent form for medical treatment has been signed and verbal consent for HIV testing is documented (thus constituting informed consent), a separate consent form for HIV testing is not required (Texas Health and Safety Code Sections 81.105 and 81.106).

  - https://statutes.capitol.texas.gov/Docs/HS/htm/HS.81.htm#81.105

Texas law

- Disclosure
  - Texas Health and Safety Code Section 81.109 requires that persons receiving a positive HIV test result be given the opportunity for immediate, face-to-face counseling.
  - Health care providers can comply with Texas Health and Safety Code Section 81.109 by providing post-test counseling themselves or by contacting their local health department so a Disease Intervention Specialist (DIS) can deliver the result.
  - https://statutes.capitol.texas.gov/Docs/HS/htm/HS.81.htm#81.105

Texas law

- HIV is a reportable condition according to Texas law
  - Physicians (or a designee) are required to report any case of HIV and AIDS according to Texas Administrative Code, Title 25, Part 1, Chapter 97, Subchapter F, Rules §97.131- §97.134.
    - Acute HIV infections (confirmed via HIV-1 RNA) need to be reported via telephone to your local reporting authority within 24 hours, or one working day from when you receive the result
    - Non-acute cases reported via age-specific confidential case report form within 7 days to your local Public Health Authority (11 regions in Texas)
  - https://www.dshs.texas.gov/hivstd/reporting/#hivaids

Failure to diagnose

Summary

- Emergency departments represent unique opportunities to screen large segments of our population.

- Routine, opt-out screening is recommended by numerous agencies (CDC, USPSTF, ACP, ACOG, AAP, AAFP).

- Routine, opt-out screening reduces the stigma associated with HIV.

Summary

- Routine, opt-out screening is attainable and sustainable in busy Emergency Departments.

- Routine, opt-out screening increases early detection allowing for early treatment and reduced transmission leading to increased quality of life and lower overall cost of healthcare burden.

- Routine, opt-out screening can save lives, if not done too late.

That’s all, folks!

Any Questions?

Thank you!

TCHEP Webinar 2

Presentation layout

1. Dr. David Lakey
    a. Welcome and opening remarks by **[Slide 1]**
    b. Overview of the presentation and speakers **[Slide 2]**
    c. DSHS Disclosures **[Slides 3-7]**
    d. CE Credits **[Slides 8-10]**
    e. For more information **[Slide 11]**
    f. Introduce Dr. McCarthy and Dr. Prater- both at the same time **[Slide 12]**
2. McCarthy and Prater's Presentation **[Slides 13-54]**
3. Dr. David Lakey **[Slide 54]**
    a. Thank the speakers and invite Dr. Ank Nijhawan to moderate the Q& A session.
4. Dr. Lakey - Closing Remarks **[Slide 55]**