Emergency Department (ED) HIV Testing

• Formally endorsed by the American College of Emergency Physicians in 2007
• National ED HIV Testing Consortium convened in 2007 to create a common conceptual framework for research and practice
• Over 20 ED testing programs in 2009
A Common Vocabulary

- “Routine” means different things to different people (can refer to selection of patients for testing without regard to risk factors, the opt-out consent process, or both)
- Screening vs. Diagnostic
- Non-targeted vs. Targeted
- Opt-in vs. Opt-out
- Passive vs. Active Linkage to Care
Variable Definitions of Linkage to Care

- Receipt of confirmatory results
- HIV clinic intake (medical and social work assessment)
- Visit with medical provider

→ **Linkage to care is really more of a process**
Key Issues and Lessons Learned

• Importance of an ED “champion”
• Early buy-in from key partners (ED docs, RNs, hospital administration, HIV clinicians, hospital lab, risk management)
• Test choice
• Staffing models
• Protocols for education, disclosure and linkage to care
• Feedback
• Funding/reimbursement
• Sustainability

HIV Testing in Three Bay Area EDs

- CDC-funded initiatives through the California State Office of AIDS
- CAPS contracted to perform a qualitative evaluation of the process of development and implementation of these ED testing programs
- Goals: to characterize models, barriers and facilitators, reasons for acceptance/refusal
- Interviews with key informants and patients
Findings

• Three different operational models
• Central difference was the use of existing staff vs. staff hired specifically for testing
• Adoption of models influenced by whether
  – the developers were ED providers, HIV providers, or both
  – patient selection was targeted or non-targeted
  – the program viewed linkage to care as a primary responsibility of the testing program, rather than of HIV providers
## Findings

**Characterization of Three Bay Area ED Testing Models**

<table>
<thead>
<tr>
<th>Testing Model</th>
<th>Type of Test</th>
<th>Patient Selection</th>
<th>Test Offer &amp; Consent</th>
<th>Pre-test Counseling</th>
<th>Test Performer</th>
<th>Disclosure</th>
<th>Linkage to Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Parallel Model</td>
<td>Rapid Oral swab</td>
<td>Screening</td>
<td>Signed opt-out at registration</td>
<td>At the discretion of the tester</td>
<td>Tester, almost 24/7</td>
<td>Tester discloses negative results and physician discloses positive results</td>
<td>Referral to guaranteed clinic drop-in appointment</td>
</tr>
<tr>
<td>Provider Model</td>
<td>Rapid Venipuncture specimen</td>
<td>Targeted to all admitted patients &amp; symptoms/ risk factors</td>
<td>Verbal opt-in by physician; implied consent if will impact care</td>
<td>At the discretion of the physician</td>
<td>Hospital laboratory 24/7</td>
<td>Physician discloses negative and positive results</td>
<td>Dedicated HIV clinic based linkage to care team who will meet patient at disclosure</td>
</tr>
<tr>
<td>Provider-Parallel Model</td>
<td>Rapid Oral swab</td>
<td>Screening</td>
<td>Verbal opt-in by triage nurse</td>
<td>None</td>
<td>Tester, almost 24/7</td>
<td>Physicians disclose negative and positive results</td>
<td>Dedicated linkage to care liaison who will meet patient at disclosure</td>
</tr>
</tbody>
</table>
Findings

• Common barrier: concern over how to disclose a positive result

• Common facilitators
  – Serving vulnerable urban populations
  – The “secondary gain” of re-engaging known HIV positive patients back into care
  – The support of the medical setting