

Physician Barriers To Implementing Routine HIV Testing in Primary Care Settings: A Qualitative Analysis

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RESULTS

BACKGROUND

- In the fall of 2006 the CDC published recommendations for a major change in the approach to testing for HIV infection in the United States: expanded screening in all healthcare settings for all persons age 13-64, with streamlined procedures for consent and pretest information
- The specific recommendations included expanded HIV screening for patients regardless of risk; revisions to procedures for separate, written informed consent; and decreased emphasis on prevention counseling
 - Routine voluntary screening for patients age 13-64 in health care settings*
 - Opt-out testing*
 - No separate consent*
 - Pre-test counseling not required*
 - Low prevalence areas should consider stopping if <1:1000 tests positive*

STUDY OBJECTIVES

- Identify and elucidate the barriers and facilitators to routine HIV testing in primary care settings from perceptions of primary care internists*
- Identify training needs of physicians for implementing the HIV testing guideline*

METHODS

Participants

- A total of 350 General Internal Medicine physicians (pre-registered attendees at the 2007 annual SGIM conference in Toronto) were invited by letter to participate in a focus group study
- A convenience sample of 28 physicians agreed to participate. Purposeful sampling was used to create both demographic and practice setting diversity among participants

Focus group method

- Open-ended questions were formulated
 - facilitators used a structured discussion guide
 - the same questions in same order were asked for each group
- Questions designed to elicit physician expectations about implementing routine HIV testing in their clinical practice settings
 - Attitudes about CDC recommendations
 - Specific barriers and facilitators to implementation
 - Specific training needs to help them implement recommendations

Data Collection

- Four focus groups (6-8 participants/group) conducted at the SGIM annual Conference in Toronto, April 2007
- Facilitated by two members of the research team experienced in qualitative research methods
- Each session lasted 60 minutes and were held in private locations
 - participants received refreshments and a \$30 gift card
- Written informed consent and demographic information obtained from all participants
- Research protocol approved by IRB

Analysis

- Standard qualitative data analysis methods used to analyze data (grounded theory techniques)
 - Focus group sessions were audio-taped and transcribed verbatim
 - Transcripts coded for setting parameters, barriers, facilitators and learning needs
 - Coding done independently by 2 investigators; differences reconciled by repeat coding and consensus confirmation
 - Coded transcripts imported into an analytic software program (Atlas.ti) for further analysis

Physician Focus Group Demographics (n=28)

Gender (female)	62 %
Race/Ethnicity	
White	71%
Asian	7%
Black/African American	15%
Hispanic	7%
Years since Medical School Graduation	10.4 (mean), 3-16 (range)
Practice Setting	
Public Clinic	88 %
Private Clinic	12 %
Practice Locale	
Urban	79 %
Suburban	26%
Rural	11%
# Primary Care Patients/Participant Practice	310 (mean), 50-1200 (range)
% of time in outpatient care	30 % (mean), 10-70 % (range)

Physician Focus Group Results

- Participant responses centered on five key themes:
 - Attitudes about CDC recommendations
 - Clinical settings
 - State and local regulations
 - Financial & other setting barriers
 - Education needs to implement

(1) Attitudes about CDC recommendations

- Participants generally accept the public health rationale for universal HIV screening
- “...all you need is to find a patient with HIV and you’ll want to test everyone...”*
- “...I can see how routine testing would reduce stigma by normalizing testing...”*

(2) Clinical settings

- Participants emphasized the challenge to implementation is clinic setting-specific and not amenable to a general approach
 - rural vs. urban community
 - ethnic mix of the clinic
 - HIV risk and incidence within the community

(3) State and Local Regulations

- Confusion over the informed consent requirements imposed by state and local regulations
 - “...we were filling out informed consent forms but I didn’t know whether it was state law or just clinic or hospital practice...”*
- Concerns about opt-out testing
 - “...is telling someone they have HIV different if you haven’t provided pretest counseling, if they haven’t signed a consent...”* (4) *Financial and other Setting Barriers*
- Concerns about reimbursement for increased HIV testing
 - “...you can get HIV care essentially covered but we can’t do the same for screening...”*
 - “...would insurance pay for it if it was linked to other routine blood work”*
- Time constraint and competing needs during a clinic visit
 - “...squeeze everything into your one encounter...”*

(5) Education Needs

- Participants recommend creating setting-specific materials
 - scripts for dialogue between physicians and patients
 - setting-specific protocols
 - practical strategies and best practice approaches especially for a busy clinic
 - promotion materials to inform patients regarding the value of routine testing
 - “...I’d like my patients to come to clinic asking for an HIV test...”*

LIMITATIONS

- Small sample size (11% of invited participated)
 - Women were over represented
 - Rural physicians underrepresented (not sure?)
- Focus group limitations
 - May stifle socially unacceptable comments
 - Dependent upon group mix
 - Can’t quantify prevalence findings
 - Potential Interpretation bias

IMPLICATIONS

- Generally accepted justification for universal routine HIV testing in internal medicine primary care settings**
- Training should be clinic setting-specific and NOT “one size fits all”**
- Guidance is needed with regard to:**
 - obtaining consent**
 - helping clinicians talk to patients about HIV testing**
 - providing adequate financial reimbursement**
- Need to identify or generate empiric best practice strategies**