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RESULTS

BACKGROUND

- In 2006 the CDC published recommendations for expanded routine HIV screening:
 - For patients regardless of risk*
 - 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*
- General internists are expected to have a major role in implementing routine HIV testing in clinics and other practice settings
- Many questions remain regarding the feasibility and optimal strategies for implementing these recommendations in office based primary care settings, where HIV prevalence is often low

Society of General Internal Medicine (SGIM)

- A medical association of more than 3,000 physicians and other health professionals
- Members are faculty of every medical school and teaching hospital in the U.S.
 - Leadership roles in patient care, teaching, clinical research, and health care policy*
 - Responsibilities for training residents and medical students*
- Members work in institutions serving a large percentage of minority and other vulnerable populations, affected by and at risk for HIV infection

STUDY OBJECTIVES

- Describe the perceived successes and failures of general internists' experiences implementing routine HIV testing in their clinic*
- Identify barriers and facilitators to routine HIV testing in primary care internal medicine settings*

METHODS

- The SGIM HIV Prevention Program initiated a 6 month multi-provider pilot demonstration project to assess the knowledge, attitudes and behaviors of a national cohort of practicing general internists (*Clinician Advisors*), as they attempt to implement the CDC's routine HIV testing recommendations

Participants

- Recruited 8 Clinician Advisors to implement routine HIV testing in their clinical practices
 - Physician members of SGIM practicing in general internal medicine clinics
 - A convenience sample of 8 SGIM physicians agreed to participate
 - Purposeful sampling was used to create both demographic and practice setting diversity among participants
 - Willing to participate in regular conference calls
 - Interactive forum to problem solve and promote best practices
 - Willing to provide assessments at baseline, 3 and 6 months and weekly *progress reports*

Data Collection

- A mixed methods approach was employed
 - Participants
 - Completed weekly on-line progress reports of their HIV testing activities
 - Completed baseline, 3 and 6 month self reported assessments
 - Attended a summative focus group

Analysis

- Standard qualitative data analysis methods used to analyze data (grounded theory techniques)

Clinician Advisors

- Generalist and HIV Specialist – NYC
- Generalist and Resident Clinic Director – New Haven CT
- Generalist Clinician Educator – Minneapolis MN
- Generalist Clinician Educator – Portland OR
- Generalist, rural clinic – Chelsea MI
- Generalist and Resident Clinic Director –Portland OR
- Generalist and Urgent Care Clinic Director – San Francisco CA
- Generalist and HIV Clinic Director – NYC

<i>Clinician Advisor Demographic Characteristics</i>	
Characteristic	N=8
Age, mean years (SD), (range)	42 (9), (30-54)
% Male, (n)	25% (2)
Race/Ethnicity	
% White, (n)	75% (6)
% African-American, (n)	25% (2)
Years since graduating from medical school, mean (range)	11 (1983-2003)
Specialization	(%)
Internal medicine	100%
Family medicine	0
HIV medicine	25%
Infectious disease	0
Other	0
Board certified (%)	100%
Number of patients you currently provide primary care (range)	100 to 600
Number of clinic session per week, mean (range)	4.3 (1 – 8)
Setting of your clinic (%) , n	
General medicine public	62.5%, 5
General medicine private	25%, 2
HIV Medicine	25%, 2
Community based	37.5%, 3
Hospital	75%, 6
Emergency Department	12.5%, 1
Other	12.5%, 1
Amount of time spent with each patient	
< 10 min	0
10-20 min	4
20-30 min	3
>30 min	1
Range of % of patients who are men	40 – 60
Age of patients, range	17- 100
Perceived % undetected HIV in patient population, mean (range)	4.3% (1.5 -10%)

<i>Cumulative 6 month HIV Testing Activities</i>		
	N	%
# Patients seen	2226	100
Of those seen, # eligible	558	25
Of those eligible, # routine testing	294	53
# Offered HIV test	330	59
# Accepting	215	65
# Requesting test	47	
# Return visits for test results	112	52
# HIV tests positive	0	0

<i>Clinician Change in Attitudes and Behaviors</i>			
Attitude/Behavior	Baseline	3-month	6-month
For which patients do you perform HIV counseling and testing? % (n)			
For all patients	2	5	6
Only for at-risk patients	6	2	0
Not for any patients	0	0	0
Strongly Agree			
I am comfortable discussing sexual risks with my patients	6	4	4
I am comfortable discussing substance use with my patients	4	3	3
I am skilled at conducting risk assessments with patients	2	3	3
Barriers preventing discussion about HIV testing with patients			
Lack of reimbursement	2	2	0
Lack of time	6	4	2
Other priorities at time of visit	8	3	4
Patient reluctance / refusal	5	4	4
Lack of staffing	2	1	0
Language barrier	3	2	4
Gender difference between you and patient	0	0	0
Cultural difference between you and patient	4	3	3
Patients do not have high risk behavior	2	3	3
Which of the following are available to you in your main practice location?			
Printed information or resources on referral counseling or other support services for patients undergoing HIV testing	3	0	1
Website or hotline with referral sources for counseling or other support services for patients undergoing HIV testing or their providers to use	1	3	4
Personnel trained in counseling services on call for your office/practice	3	3	1
Printed HIV prevention education materials, e.g., brochures, posters, fact sheets	4	3	1

Define “Eligible” Patient

3 month assessment

- “Under the age of 65, not screened in the past 2 years, not meeting criteria for “high-risk”, not symptomatic”*
- “New patients”*
- “HIV negative no recent test”*
- “Everybody I see under the age of 70 who hasn't already been tested”*
- “...not HIV+, and not just tested by me...”*

6 month assessment

- “HIV negative, no recent test”*
- “Establish care, annual exam, risk behavior”*
- “Never screened, new partner since last screening, risk - annual or establish care appointment”*

Barriers to Routine HIV Testing

1st 3 months

- “We are working on doing routine HIV testing in clinic as a whole. Ironically - the work of getting that implemented (ie- paperwork, meetings etc) are making it harder to remember to ask my patients in clinic. I'm being more conscious of that this week”*
- “no sexual encounters x 20 years so did not feel at any risk”*
- “patient did not feel any risk of potential HIV infection”*
- “concerned that insurance wouldn't pay for testing”*
- “did not want on health record that checked”*

2nd 3 months

- “little old ladies with multiple other medical problems--seemed like testing them for HIV was silly”*
- “lack of time”*
- “distracted by other issues that seemed more paramount at the time”*

Facilitators for Routine HIV Testing

1st 3 months

- “Having residents evaluating patients with me and doing teaching gave me an opportunity to discuss routine HIV testing and to offer it”*
- “Residents seem comfortable with the concept”*
- “having forms pre-filled and ready in the rooms”*
- “some patients at low risk view the testing as a good thing even though they believe themselves at low risk, they like to have things “checked out”*

2nd 3 months

- “Did not see many patients so did not feel a time pressure. Brought issue up with a patient I wouldn't have otherwise”*
- “now part of my standard preventative health discussion”*
- “Placing a reminder on my computer”*
- “I've been including it along with other routine screening measures and patients have been very receptive to this”*

SUMMARY

- Patient awareness of testing recommendations and emphasis on routine screening should occur prior to clinician encounter
 - “...I want my patients to arrive already prepared to be tested...”*
- Clinicians have traditionally focused on risk-based HIV testing
 - Difficulty transitioning clinician reasoning and behavior to a routine screening approach
 - Difficulty differentiating patients for “risk-based” vs. “routine-based” testing
- Clinic specific procedures both facilitated and created barriers to the implementation of routine testing
 - Informed consent-related barriers are clinic site-specific
 - Paperwork to order a HIV test varied from severe hassle to non-factor
 - Insurance reimbursement for routine HIV testing was not a barrier
 - HIV test follow up for providing results was not a barrier
- Prevalence-based recommendations for routine testing is confusing
 - “...what does < 1 in 1,000 really mean?...”*
 - Most of the clinician advisors over estimated the HIV prevalence in their practices
 - Is that good? Will that discourage the continuation of routine testing?*
- Enthusiasm waned as the “clinic hassle factor” increased and no HIV cases were identified
 - Patient acceptance, however, was greater than anticipated
- Resident physicians were effective in implementing routine testing

LIMITATIONS

- Small sample size
 - Women were over represented
 - Rural physicians underrepresented
- Qualitative analysis
 - Can't quantify findings
- Potential Interpretation bias
- No information on the role of rapid HIV tests [in routine testing]

IMPLICATIONS

- Successful uptake of routine HIV testing was clinical site and practice specific
 - Set “reasonable” goals for implementation by clinic and clinician
- Need for streamlined procedures in the clinic
 - Paper work simplification
 - Reduction in informed consent hassles
- Implementation strategies should address the patient and community education gap to “normalize” the recommendation for routine testing
 - De-emphasize prevalence-based recommendations for routine testing
- Successful testing dissemination should emphasize the training of the future generation of clinicians