# IMPLEMENTATION OF ROUTINE SCREENING IN PRIMARY CARE: *PERCEPTIONS, CHALLENGES AND BARRIERS*

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# Primary Care Missed Ops

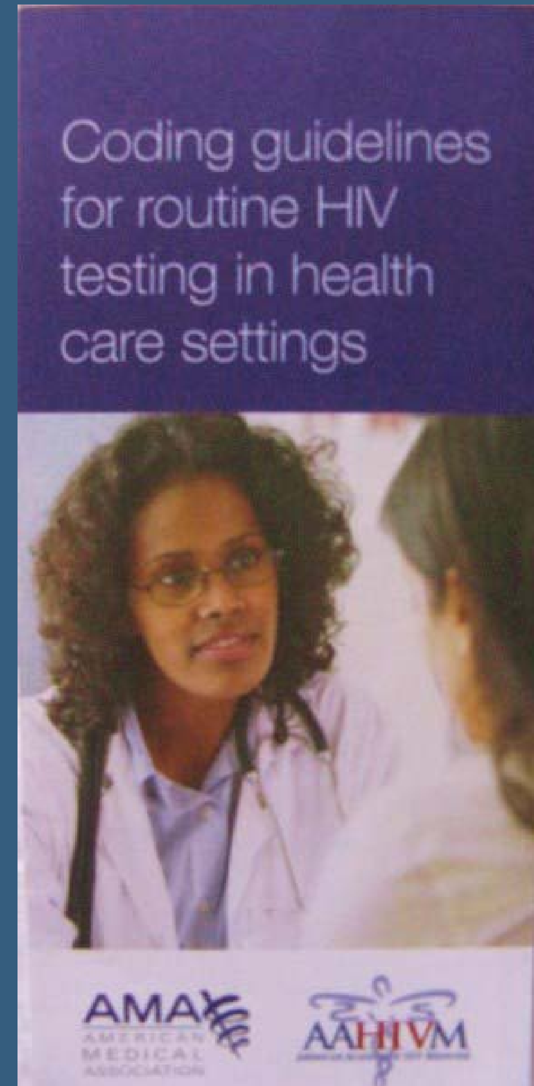
| Age/Gender | Co-morbid conditions | CD4 count at diagnosis | Risk |
|---|---|---|---|
| 38 Male | HTN | 4 | Gay |
| 66 Female | HTN, Diabetes | 166 | Widow |
| 62 Female | HTN, Renal insufficiency | 76 | Heterosexual |
| 42 male | Asthma, heart disease, Chronic cough | 11 | Heterosexual |
| 26 Male | h/o syphilis and gonorrhea | 116 | Gay |
| 33 Male | None | 2 | Gay |

# Why are we missing these cases?

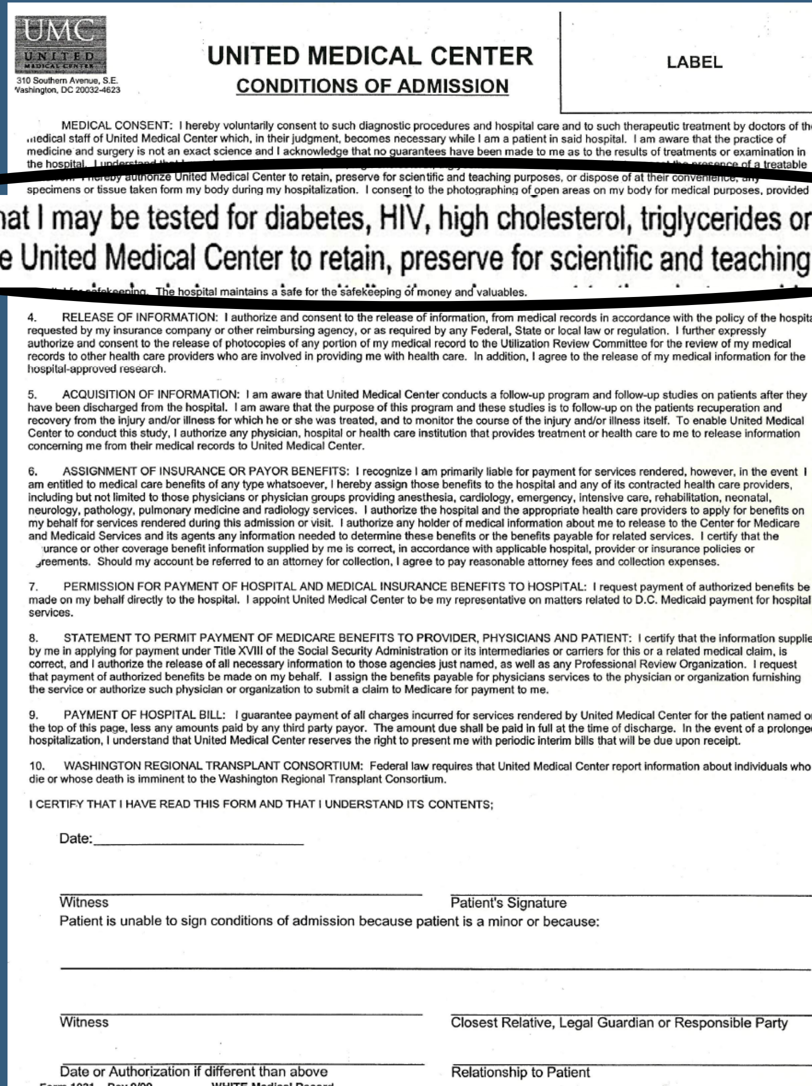
- Low awareness about epidemic and CDC guidelines
- "My patients don't have HIV"
- Unwilling or reluctant to return positive result
- Still believe testing is too time consuming

# Identify and share barriers

- Billing-related
  - Insurance reimbursement
- Referral issues
  - Who and how to refer
  - When to refer
  - Losing patients
- Discussing sexuality and HIV with long time clients
  - Deciding who is at risk
- Consent confusion



# UMC Consent Form



UMC UNITED MEDICAL CENTER
310 Southern Avenue, S.E.
Washington, DC 20032-4623

**UNITED MEDICAL CENTER**

**CONDITIONS OF ADMISSION**

LABEL

MEDICAL CONSENT: I hereby voluntarily consent to such diagnostic procedures and hospital care and to such therapeutic treatment by doctors of the medical staff of United Medical Center which, in their judgment, becomes necessary while I am a patient in said hospital. I am aware that the practice of medicine and surgery is not an exact science and I acknowledge that no guarantees have been made to me as to the results of treatments or examination in the hospital. I understand that ... the presence of a treatable ... I hereby authorize United Medical Center to retain, preserve for scientific and teaching purposes, or dispose of at their convenience, any specimens or tissue taken form my body during my hospitalization. I consent to the photographing of open areas on my body for medical purposes, provided

I understand that I may be tested for diabetes, HIV, high cholesterol, triglycerides or other key markers t

hereby authorize United Medical Center to retain, preserve for scientific and teaching purposes, or dispos

... for safekeeping. The hospital maintains a safe for the safekeeping of money and valuables.

4. RELEASE OF INFORMATION: I authorize and consent to the release of information, from medical records in accordance with the policy of the hospital, requested by my insurance company or other reimbursing agency, or as required by any Federal, State or local law or regulation. I further expressly authorize and consent to the release of photocopies of any portion of my medical record to the Utilization Review Committee for the review of my medical records to other health care providers who are involved in providing me with health care. In addition, I agree to the release of my medical information for the hospital-approved research.

5. ACQUISITION OF INFORMATION: I am aware that United Medical Center conducts a follow-up program and follow-up studies on patients after they have been discharged from the hospital. I am aware that the purpose of this program and these studies is to follow-up on the patients recuperation and recovery from the injury and/or illness for which he or she was treated, and to monitor the course of the injury and/or illness itself. To enable United Medical Center to conduct this study, I authorize any physician, hospital or health care institution that provides treatment or health care to me to release information concerning me from their medical records to United Medical Center.

6. ASSIGNMENT OF INSURANCE OR PAYOR BENEFITS: I recognize I am primarily liable for payment for services rendered, however, in the event I am entitled to medical care benefits of any type whatsoever, I hereby assign those benefits to the hospital and any of its contracted health care providers, including but not limited to those physicians or physician groups providing anesthesia, cardiology, emergency, intensive care, rehabilitation, neonatal, neurology, pathology, pulmonary medicine and radiology services. I authorize the hospital and the appropriate health care providers to apply for benefits on my behalf for services rendered during this admission or visit. I authorize any holder of medical information about me to release to the Center for Medicare and Medicaid Services and its agents any information needed to determine these benefits or the benefits payable for related services. I certify that the urance or other coverage benefit information supplied by me is correct, in accordance with applicable hospital, provider or insurance policies or greements. Should my account be referred to an attorney for collection, I agree to pay reasonable attorney fees and collection expenses.

7. PERMISSION FOR PAYMENT OF HOSPITAL AND MEDICAL INSURANCE BENEFITS TO HOSPITAL: I request payment of authorized benefits be made on my behalf directly to the hospital. I appoint United Medical Center to be my representative on matters related to D.C. Medicaid payment for hospital services.

8. STATEMENT TO PERMIT PAYMENT OF MEDICARE BENEFITS TO PROVIDER, PHYSICIANS AND PATIENT: I certify that the information supplied by me in applying for payment under Title XVIII of the Social Security Administration or its intermediaries or carriers for this or a related medical claim, is correct, and I authorize the release of all necessary information to those agencies just named, as well as any Professional Review Organization. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for physicians services to the physician or organization furnishing the service or authorize such physician or organization to submit a claim to Medicare for payment to me.

9. PAYMENT OF HOSPITAL BILL: I guarantee payment of all charges incurred for services rendered by United Medical Center for the patient named on the top of this page, less any amounts paid by any third party payor. The amount due shall be paid in full at the time of discharge. In the event of a prolonged hospitalization, I understand that United Medical Center reserves the right to present me with periodic interim bills that will be due upon receipt.

10. WASHINGTON REGIONAL TRANSPLANT CONSORTIUM: Federal law requires that United Medical Center report information about individuals who die or whose death is imminent to the Washington Regional Transplant Consortium.

I CERTIFY THAT I HAVE READ THIS FORM AND THAT I UNDERSTAND ITS CONTENTS;

Date:________________________

______________________ Witness

______________________ Patient's Signature

Patient is unable to sign conditions of admission because patient is a minor or because:

________________________________________

______________________ Witness

______________________ Closest Relative, Legal Guardian or Responsible Party

______________________ Date or Authorization if different than above

______________________ Relationship to Patient

Form 1031 Rev 9/09 WHITE-Medical Record

# Concerns

- Transmission is ongoing!
- HIV/AIDS not on provider radar
  - Patients in care undiagnosed
  - Diagnosed clients not in HIV care
  - Providers don't recognize
    - Drug resistance
    - Sub-optimal therapy
- Emerging threat of lawsuits
    - Disease is chronic, treatable

# Educate Private Practitioners

- Utilize champions, i.e. The "converted"
  - What worked:
    - Liability argument
      - HIV is treatable
      - AIDS is preventable
    - Personal experience
      - 73 year old with lymphadenopathy

AIDS