

**Routine HIV Testing in High Prevalence
Health Care Settings:
Assessing the Process in Four Case Studies**

**HIV/AIDS Prevention & Intervention Section
Division of Health, Wellness and Disease Control
Michigan Department of Community Health**

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Executive Summary

In 2006, the Centers for Disease Control and Prevention (CDC) released its “Revised Recommendations for HIV Testing of Adults, Adolescents and Pregnant Women in Health Care Settings”,¹ in which it recommended the implementation of voluntary HIV testing as a routine part of care provided in health care settings where the prevalence of HIV is at least 0.1 percent. The intent of the recommendation is for everyone aged 13 – 64 to be tested at least once for HIV, regardless of HIV-related risk. There has been much research to support the value of routine testing in increasing the number of individuals who know their infection status. At the same time, the CDC recommendation of routine HIV testing has fueled significant discussion over its implementation.

To assist and encourage health care providers to implement HIV testing programs, and to explore additional strategies for implementing routine HIV testing, the Michigan Department of Community Health (MDCH), Division of Health, Wellness and Disease Control (DHWDC), HIV/AIDS Prevention and Intervention Section (HAPIS) awarded grants to support planning for, and pilot implementation of, HIV screening² programs in four health care facilities operating in geographic areas of high HIV prevalence.³ During the three-month implementation period, all four organizations used a similar basic model for incorporating HIV testing process into existing clinic flow. All sites used rapid HIV testing conducted on-site, with the process introduced and overseen by clinic assistants, with results available during the same visit. The total number of unduplicated patients seen in the four sites was 13,507, of whom 3,577 (24%) were offered or recommended HIV testing. As a result of this grant, 1,488 people in geographic areas of high HIV prevalence were tested for HIV and learned their status. The number of patients who accepted HIV testing represents 10 percent of the patient population seen during the study period, and 42 percent of the patients who received an offer or recommendation for HIV testing.

The activities supported under this grant identified numerous challenges to some strategies associated with successful implementation of routine HIV testing. As a result of this grant funding, the following key recommendations can be made for implementation of routine HIV testing:

¹ Centers for Disease Control and Prevention. *Revised Recommendations for HIV Testing of Adults, Adolescents, and Pregnant Women in Health Care Settings*. MMWR 2006:55 (no. RR-14)

² The term “screening” has been used to refer to routine HIV testing. While DHWDC initially used the term “screening” in the context of the implementation planning grants, we have adopted the terminology “routine HIV testing” to refer to HIV testing which, as a standard of practice, is recommended to all patients in a clinic population.

³ Michigan Department of Community Health, Division of Health, Wellness and Disease Control, HIV/AIDS Prevention and Intervention Section. *Implementation Planning Grants: HIV Screening in High Prevalence Health Care Settings*. April 2007.

1. HIV testing must be fully incorporated into both standards of care and standard clinic operating procedures.
2. Engagement and participation of all staff, particularly clinicians, is essential.
3. Patient messaging is critical. HIV testing must be recommended to all patients, rather than offered.
4. Reinforcement of the support for and value of HIV testing is important both for providers and patients.
5. HIV testing processes must be streamlined.
6. The model for provision of HIV testing services must be flexible in order to accommodate different facilities, settings and patient populations.
7. HIV testing must be reimbursed by third party payers in order to be sustainable.
8. HIV testing activities should to be monitored and evaluated, especially during initial implementation phases.
9. The public health community should support HIV testing in health care settings.

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INTRODUCTION

Background: In 2006, the Centers for Disease Control and Prevention (CDC) released its “Revised Recommendations for HIV Testing of Adults, Adolescents and Pregnant Women in Health Care Settings”,⁴ in which it recommended the implementation of voluntary HIV testing as a routine part of care provided in health care settings where the prevalence of HIV is at least 0.1 percent. There has been much research to support the value of routine HIV testing relative to increasing the number of individuals who know their infection status and thus increasing the linkage of people with HIV to appropriate medical, prevention and support services and decreasing HIV transmission. Routine HIV testing can be an important strategy for promoting and protecting both individual and public health.

At the same time, the CDC recommendation for routine HIV testing has fueled significant discussion over the meaning, practicalities and logistics of implementation. The National Alliance of State and Territorial AIDS Directors (NASTAD) has identified and discussed some of these logistical issues in relation to implementing routine testing in emergency departments.⁵ Implementation issues identified by NASTAD and its partners include engagement and support of key stakeholders to implement HIV testing as a standard of care (i.e., clinicians, administrators, support staff, community referrals, and others), compliance with existing requirements related to local/state HIV laws or regulations, funding, as well as operational issues such as patient/clinic flow, training and support of staff, counseling, informed consent and client education, and facilitating linkages to care and support services for patients who are found to be HIV-infected. The most effective strategies for addressing each of these issues are still being explored, and gaps exist in the knowledge base around the implementation of routine HIV testing in diverse health care settings.

Planning and Implementation Grants: To assist and encourage health care providers to implement HIV testing, and to explore additional strategies to support implementation of routine HIV testing, the Michigan Department of Community Health (MDCH) Division of Health, Wellness and Disease Control (DHWDC), HIV/AIDS Prevention and Intervention Section (HAPIS) issued a request for applications to support planning for, and initial implementation of, HIV screening⁶

⁴ Centers for Disease Control and Prevention. Revised Recommendations for HIV Testing of Adults, Adolescents, and Pregnant Women in Health Care Settings. MMWR 2006;55 (no. RR-14)

⁵ National Alliance of State and Territorial AIDS Directors. HIV Testing in Emergency Departments: A Primer on Issues and Strategies for Health Departments. September 2007.

⁶ The term “screening” has been used to refer to routine HIV testing. While DHWDC initially used the term “screening” in the context of the implementation planning grants, we

programs in health care settings operating in geographic areas of high HIV prevalence.⁷ For the purposes of the grant, “HIV screening” was defined as “voluntary HIV testing performed for all patients in a health care setting unless the patient specifically declines HIV testing.”⁸

As a result of the request for applications, grants were awarded to four health care facilities to fund three months of planning and set-up (June – August, 2007) and three-months of pilot implementation of HIV screening (September – December, 2007). Grants were awarded to:

- Detroit Medical Center, Sinai-Grace Hospital in Detroit for implementation in the Internal Medicine Primary Care Clinic
- St. John Health System in Detroit for implementation in the Internal Medicine, Internal Medicine Specialty, and Adolescent Clinics
- Hurley Medical Center in Flint for implementation in the Family Ambulatory Health Clinic
- Center for Family Health in Jackson for implementation in multiple clinics in two sites: Family Practice, Women’s Health, Internal Medicine, and Pediatrics clinics in the main site, and a primary care clinic serving a large homeless population

More detailed information about each setting can be found in the site profiles available in Attachment A.

Evaluation Framework:

The objectives of the grant funding were to:

- 1) Achieve an “enhanced understanding of the clinical settings in which the greatest number of HIV-infected individuals can be identified,”
- 2) Identify “the challenges associated with implementation of HIV screening programs,” and
- 3) Identify “strategies associated with successful implementation.”⁹

Several methods were used to evaluate achievement of these objectives. Grant recipients were required to collect and submit data to DHWDC related to HIV testing conducted during the grant period. (See Appendix B for the data requirements). In addition, grant recipients were required to submit monthly progress reports and a final report describing their progress in terms of set-up and implementation processes. Finally, an independent consultant visited each of the sites and conducted in-depth interviews with project coordinators and other key staff regarding the processes, challenges and strategies developed as part of the grant. (See Appendix C for the Interview Guide)

have adopted the terminology “routine HIV testing” to refer to HIV testing which, as a standard of practice, is recommended to all patients in a clinic population.

⁷ Michigan Department of Community Health, Division of Health, Wellness and Disease Control, HIV/AIDS Prevention and Intervention Section. Implementation Planning Grants: HIV Screening in High Prevalence Health Care Settings. April 2007.

⁸ Ibid.

⁹ Ibid.

Summary Findings:

The following provides a general overview of the HIV testing process implemented across the project sites. Site profiles (Appendix A) provide more detail regarding implementation of HIV testing for each site. In general, all four facilities adopted a similar basic approach to HIV testing with respect to how such services were incorporated into existing clinical services and presented to patients. All facilities used rapid testing conducted on-site, with the process introduced and managed by clinic assistants. HIV test results were made available to patients during the same clinic visit.

Presentation of the Test:

All facilities presented HIV testing to patients as an opportunity to learn HIV status, free of charge, for those who were interested in this service rather than as a standard of care recommended to all patients. Although the “script” adopted by one facility to guide clinic assistants in their interactions with patients presented HIV testing as a “recommendation,” in practice, HIV testing was communicated to patients as an “offer.” Across all facilities, the evaluation suggested that during the course of the grant, the health care facilities participating in this grant opportunity were not entirely successful in implementing, HIV testing on a routine basis and as a standard of care. Even so, HIV testing was made more readily available to patients receiving clinical services during the grant period than it had been previously.

There are several possible explanations as to why HIV testing was presented to patients as an “offer” rather than as a “recommendation” to patients. Interviews with staff from each of the facilities receiving grant funding indicated that many perceived the activities supported under these awards time-limited special projects and the objectives and requirements associated with this grant were seen as secondary to the primary medical concerns addressed during the clinical interaction. Thus staff, and in some cases, supervisors, were either reluctant to require all staff to participate fully or were not able or willing to more rigorously emphasize and monitor implementation. Clinicians and ancillary staff in some cases appear not to have fully “bought in” to the rationale or recognized the potential value of routine HIV testing. These staff continued to be influenced by their perceptions of their patient population being a low risk for HIV. Some staff did not feel adequately comfortable to address HIV testing with patients, particularly with regard to the extent that it implied risk for HIV and/or placed providers in the position of having to address some potentially uncomfortable issues, such as sexual and drug using behavior, with patients.

Patient Flow:

Across all four participating facilities, medical assistants or other ancillary medical staff, rather than physicians or nurses assumed the vast majority of responsibility for HIV testing as part of their routine interaction with patients. Patients were verbally introduced to the process and offered HIV testing during the “rooming” process (escorting patients into the examination rooms and taking vital signs). For

patients who agreed to test, written informed consent was obtained and specimens were taken in the exam room immediately, while the patient waited for the clinician. In general, HIV testing was offered to patients, consent and specimens obtained/tests conducted before clinicians had seen the patient. In one facility the clinician delivered the results to the patient, while in the other facilities, HIV test results were given by the clinic/medical assistant. Overall, findings of the evaluation indicate that HIV testing continued to be approached as an “add on” or ancillary service, rather than being fully incorporated into clinical services.

Test Processing and Delivery of Results:

Each of the four facilities conducted HIV tests on-site, rather than through a central laboratory. For three of the facilities, the specimen was taken to an on-site laboratory area for processing. In the fourth facility the HIV test was run in the individual exam room, in the patient’s presence. Staff usually attended to other tasks once the test was set-up, while it was running, and returned to the laboratory area to read the result.

Because the process was integrated into the patient visit and testing was conducted at the “point of care” while patients were in the room waiting for the physician, no or minimal time was added to patient visits (one site reported that patients being seen for acute, 15-minute appointments sometimes had to wait up to 5 minutes extra for test results to be ready) and none of the facilities “lost” patients before they were given their results.

In all cases, reactive rapid test results were given to patients by clinicians. Clinicians in one of the four facilities provided negative results. In the other three facilities the medical assistants or other ancillary staff provided patients with negative results (i.e., non-reactive rapid test).

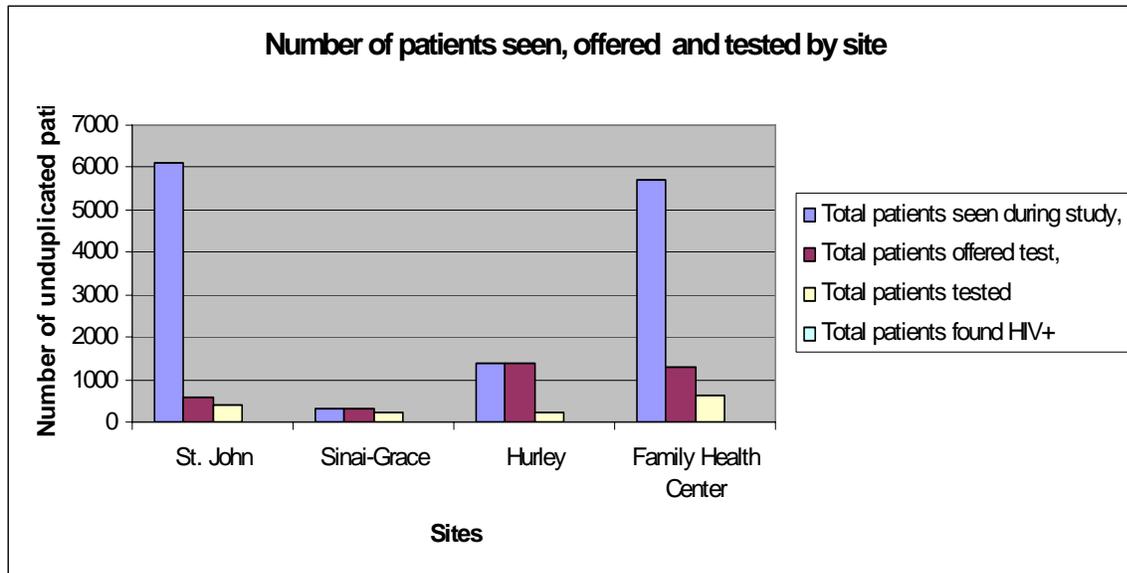
Referral and Linkages:

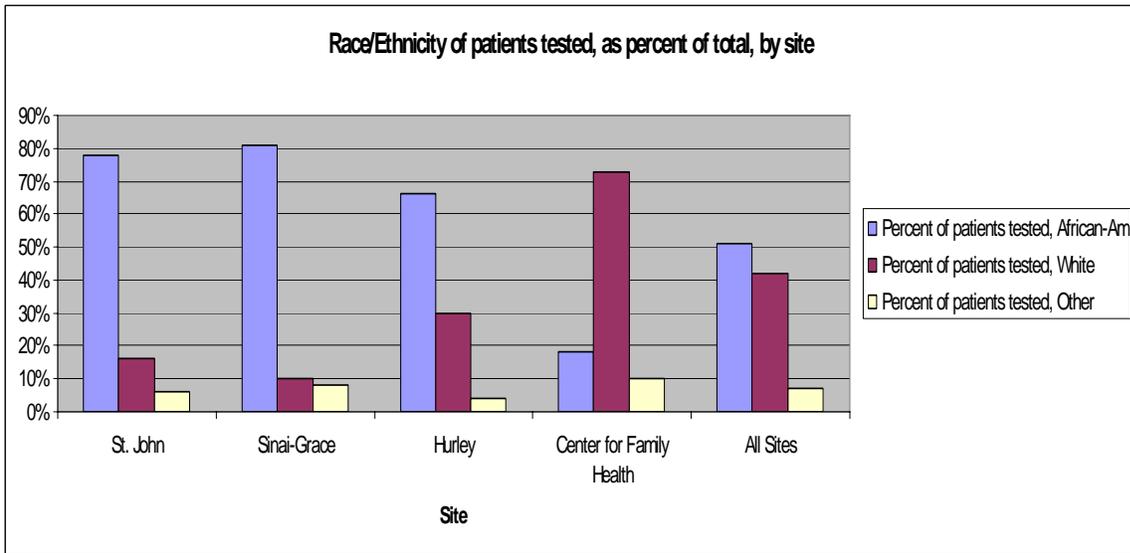
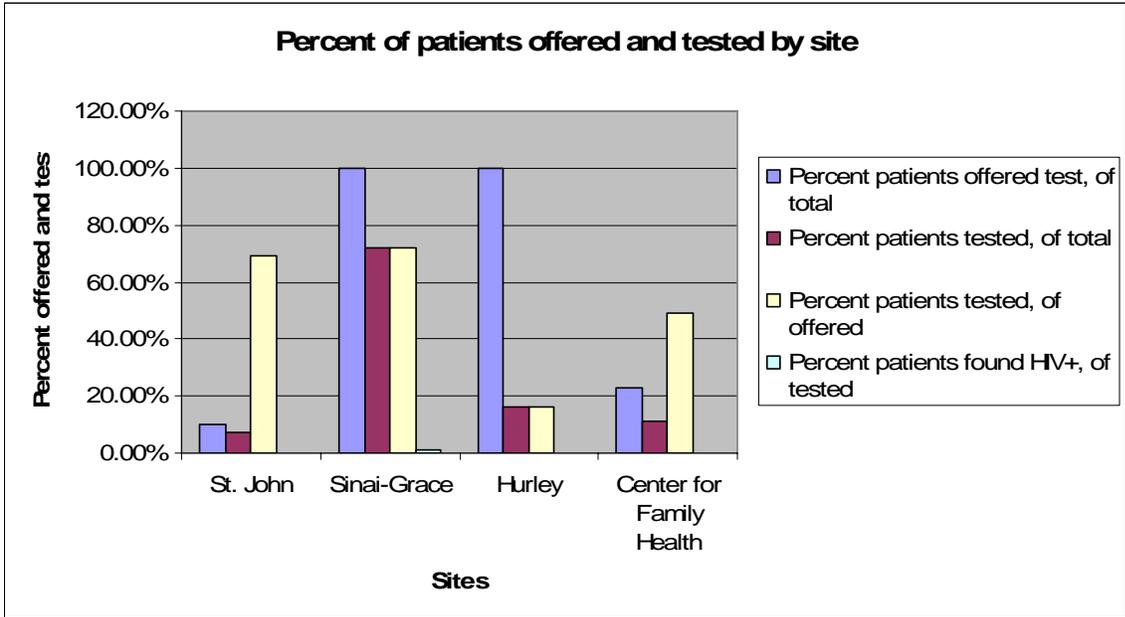
Across the four facilities, only three patients were identified as HIV infected during the project period. Of those three patients, two already knew that they were HIV-infected. Nonetheless, all the facilities had in place written protocol for ensuring that appropriate referrals and linkages would be made for patients found to be HIV infected. Three of the facilities participating in the project have infectious disease (ID) clinics within their system. Of these three infectious disease clinics, one has HIV case managers on staff and the other two have established relationships with local AIDS Service Organizations (ASOs) for case management services. The fourth facility, that does not have an affiliated ID clinic, has a letter of agreement with a local ID physician, and has its own in-house (generalist) case managers who could follow patients found to be HIV infected to ensure and facilitate linkage with needed care and support services. All four facilities demonstrated knowledge of partner services (PS) as well as written protocol to facilitate access to PS. Individual follow-up on all preliminary and confirmed positives was (or would be) done by nurse-managers of all four of the participating facilities.

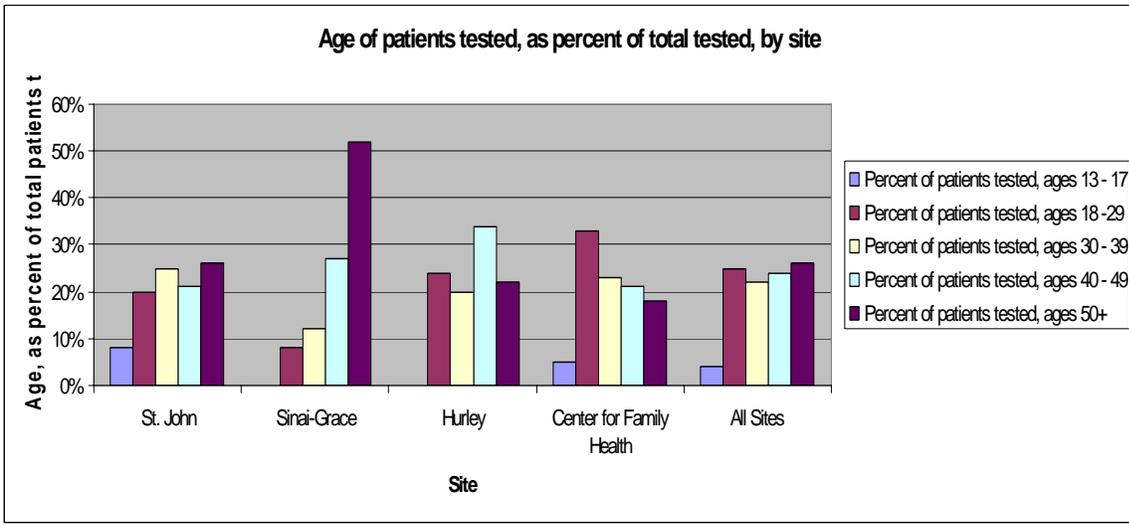
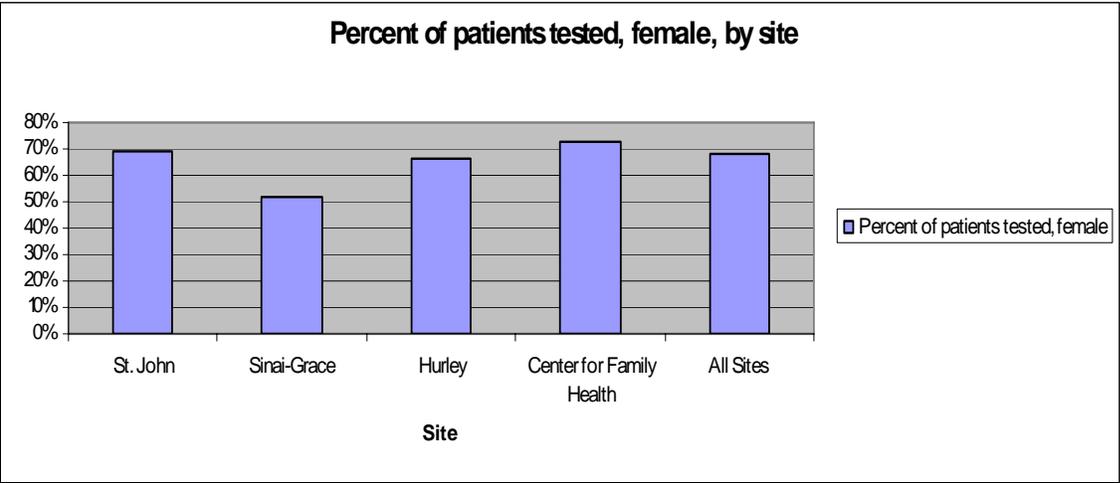
Quantitative Achievements:

During the study period, the total number of unduplicated patients seen in the four sites was 13,507, of whom 3,577 (24%) were offered/recommended the test. As a result of this grant, 1,488 people in high prevalence geographic areas were tested for HIV and learned their status. The number of testers represents 10% of the patient population receiving medical services during the project period, and 42 percent of the patients with whom HIV testing was discussed. In other words, uptake of HIV testing was fairly high (42 percent) among the small proportion of the total population that actually received an offer of HIV testing.

The breakdown of persons tested by race/ethnicity was: 760 African-American (51%), 619 White, non-Hispanic (42%), and 109 other race/ethnicity (Hispanic, Arab/Chaldean, Asian, Native American, Other and Unknown) (7%). Among people tested, a significant majority was female (68%) and testing was split pretty evenly across the age ranges: 18-29 (25%), 30–39 (22%), 40-49 (24%), and 50 and older (26%). Of the 1,488 people tested, three people (0.2%) were found to be infected with HIV, however only one of those three was a new diagnosis. See below for summary overview tables of data on individuals tested:







Achievement of Objectives:

This grant only partially attained its three objectives, fulfilling the second and third objectives although not the first. As can be seen by the quantitative results of the testing, the grant-funded HIV testing process in these four settings did not find enough new diagnoses of HIV infection to fully achieve the first grant objective of attaining an “enhanced understanding of the clinical settings in which the greatest number of HIV-infected individuals can be identified.” While each of the participating facilities was operating in geographic areas of relatively high HIV seroprevalence, the patient populations served by these facilities may not serve communities or populations at increased risk for HIV. It will be important to examine other types of facilities operating in these and other geographic areas characterized by relatively high HIV prevalence in order to inform decisions regarding settings that will result in greater yields of new diagnoses. At the same time, since routine HIV testing was not fully achieved in all of the facilities, it is difficult to determine the extent to which the project activities “missed” HIV infected persons. Beyond attainment of testing numbers, all four grantees

identified the grant as successful for them in other ways. The grantees report that the project increased awareness of HIV and HIV risk among physicians and staff, as well as among patients. In addition, staff reported an increased comfort level in asking patients about HIV related issues.

The data collected do, however, point out great differences between clinical settings in terms of operational features which resulted in relatively greater rates of testing acceptance when facilities are compared.

The facility that tested the highest percentage of patients, in relation to the total population of patients served, was Sinai-Grace, which made testing available to all of the 318 patients receiving clinical services during the study period and had an acceptance rate for testing of 72 percent. In contrast to Sinai-Grace, the other three facilities had larger patient populations and either offered HIV testing to a smaller percentage of patients or had a smaller percentage of patients accept HIV testing. Hurley Hospital had 1,365 unduplicated patients during the study period and reported offering HIV testing to 100 percent of patients receiving services. However, Hurley reported that only 16 percent of the unduplicated patients seen during the testing study period accepted HIV testing. In comparison, St. John and the Center of Family Health saw 6,125 and 5,699 total unduplicated patients respectively, offered HIV testing to 10 percent and 23 percent of patients respectively, had acceptance rates of 69 percent and 49 percent, and ultimately tested 7 percent and 11 percent of the total patient population, respectively.

While Sinai-Grace and Hurley both offered testing to 100% of their patient populations, the two sites had very different results; Sinai-Grace had a much higher acceptance rate--72 percent vs. 16 percent for Hurley. As did Sinai-Grace, Hurley implemented this project in only one clinic within its larger hospital setting. Hurley used a multi-faceted approach to engage patients, which included providing the message about free HIV testing in multiple ways at multiple points in the patients' contact with the clinic. Hurley patients received a brief offer on their appointment confirmation card, saw a sign at the reception area, and were each given a flyer and an ink pen stating "Hurley: Ask your doctor about FREE HIV tests!" Hurley offered patients who took the test a \$5 gift coupon redeemable at either the hospital gift shop or the hospital cafeteria. Despite this intensive approach to advertising the project and the provision of incentives, Hurley had the lowest acceptance rate. Part of the difference may be definitional: staff at Hurley may have been overly reliant on the advertising media to encourage HIV testing, rather than making a recommendation to patients, personally and directly. Although 100 patients at Hurley received notice of the availability of HIV testing, staff did not routinely make a recommendation for HIV testing to patients. Hurley staff appears to have emphasized external media to encourage HIV testing among its patients.

By virtue of the intimate size of the clinic and patient familiarity, staff at Sinai-Grace appeared to be able to achieve both a high offer rate and a higher testing acceptance rate. The Sinai-Grace Internal Medicine Primary Care Clinic is a small clinic with a predominantly older patient population for whom the clinic is their medical home. Patients typically have chronic health problems and visit the clinic

repeatedly. Patients and staff are very familiar with each other. The medical assistants were upbeat in their offer of HIV testing, stressing that it was a new service, a free service, did not require a blood draw and would be done right in the examination room while the patient waited. Sinai-Grace used virtually no external media to reinforce the availability of HIV testing—no posters or brochures in the exam rooms, no patient incentives, only two large, framed posters in the waiting room. Anecdotally, the staff at Sinai-Grace credit good staff rapport with patients, and the convenience and high level of confidentiality of being tested in the exam room as factors in the high acceptance rate. The medical assistants reported that they received responses from patients to the offer of HIV testing such as “I’ve always wanted to know, but didn’t want to go somewhere else to get the test.”

There are several additional factors which may have contributed to Sinai-Grace’s success in both addressing HIV testing with all patients and in getting a high acceptance rate. This did not appear to be a rapid pace clinic; the clinic is part of a teaching hospital and patient appointments were typically longer giving both patients and clinic assistants time to fit in the point of care HIV testing. There was minimal additional paperwork required of staff associated with conducting HIV testing. Medical residents already include sexual history taking in their routine exams. The process for conducting rapid HIV testing at Sinai-Grace used the oral swab for specimen collection, not the fingerstick. Patients in this population visit the clinic frequently and were offered the test up to three times, if they did not accept on the first visit, which may have given patients a chance to think about the issue and accept on subsequent visits. Finally, the project coordinator’s office was physically located in the clinic, offering her ample opportunity to observe and support the process.

In contrast to Sinai-Grace and Hurley, both St. John and the Center for Family Health implemented routine testing in much larger patient populations seen in multiple clinic settings in different physical locations. As noted above, both of these project sites offered testing to a much smaller proportion of their patient population; staff addressed HIV testing with 10 percent of St. John’s total patients and 23 percent of the Center for Family Health’s total patients. Their rates of acceptance, among those offered testing, were 69 percent and 49 percent respectively. Both of these sites identified the key challenge of getting staff to remember and feel comfortable in offering/recommending HIV testing to patients. Barriers for staff discussing HIV testing with patients included: discomfort with anticipated client perception of the offer (e.g., “if I ask a patient if they want to test, will they be offended?”); lack of time and other priority tasks (especially cited were administering flu vaccines, dealing with a new electronic data system); lack of incorporation of testing into the routine and simply forgetting; discomfort with asking patients perceived to be at low risk (elderly, no known behavioral risks); inconvenience of testing (paperwork, time.) Although not cited by project staff, it was observed that for St. John, which had the lowest offer rate, there seemed to be a greater burden of paperwork associated with the test. Administratively, the project coordinators at both St. John and the Center for Family Health were supervising many staff in multiple clinics, including clinics in different geographic locations; the project coordinator at St. John was supervising close to 30 different

medical assistants and licensed practical nurses (LPNs) who were their “point-of-care testers”, in addition to almost 20 different resident and attending physicians.

Operational Issues Associated with Implementation of Routine HIV

Testing. The evaluation identified a range of operational factors that served as both challenges and facilitators to implementation of routine HIV testing. Key challenges and facilitators identified through evaluation activities are summarized below:

Challenges identified through the evaluation included:

- Adoption of a new routine: In the facilities in which HIV testing was approached as a parallel service to other medical services and in which dedicated staff were used to provide all or the majority of HIV-testing related services, staff required frequent reminders to address HIV testing with patients.
- Perceived patient reluctance to accept HIV testing: Staff at each of the four facilities perceived that patients would be reluctant to test for HIV. Staff did report that some patients declined testing or at least were reluctant to accept testing, initially.
- Provider perception of low risk: Some staff admitted a reluctance to implement routine HIV testing because of an expressed a perception that patients, either individually or as a clinic population, are low risk for HIV.
- Competing priorities: Ancillary medical staff have many other tasks (e.g., administering influenza vaccines, learning a new electronic medical record system). The addition of HIV testing was perceived by some staff as burdensome or of lower priority.
- Staff discomfort: Although all clinic staff supported the project conceptually, ancillary medical staff were sometimes reluctant to address HIV testing with people who had been patients in the clinic a long time or patients who were perceived to be at low risk (e.g., married people, older people.)
- Staff time: Across the board it appeared that point of care testing added about five minutes per patient for the clinic assistant, which was a deterrent in the higher volume and faster-paced settings. Some additional staff time was required for data entry, documentation and reporting. The largest investments of staff time were in setting up the program and training staff.
- Access to test kits: Bureaucratic issues related to purchasing caused one site to run out of test kits and delayed restocking of test kits for a month.
- Cost of test kits: Although not a factor in this project, all sites mentioned this as a deterrent to continuing routine HIV testing beyond the end of the grant. Routine testing, using point-of-care rapid HIV tests will likely be difficult to sustain without funding to pay for test kits or the ability to obtain reimbursement for testing among patients who are insured.

Strategies used to enhance offering and acceptance of testing identified through the evaluation included:

- Identifying testing “champions”: One of the facilities consciously sought out and supported resident physician “champions” for the project—residents who were interested in HIV and who, additionally, planned to present papers at

an upcoming national conference on the project and were motivated to support the project. These champions served as on-site supporters of the process and provided reminders and encouragement to other staff.

- Streamlining processes: Practices such as putting needed forms in all charts, putting specimen collection equipment in each exam room and bagging up all materials needed (e.g., consent forms, informational brochures, HIV test materials) to be picked up at a central stop (e.g., the scale) during the patient “rooming” process and collecting the specimen and running the test in the exam room all appear to facilitate provision of HIV testing.
- Direct communication with patients about HIV testing: Facilities which emphasized direct communication between providers and patients (i.e., a physician, nurse or other health worker discussed or recommended HIV testing to the patient) experienced higher rates of uptake of HIV testing when compared with facilities which emphasized passive means of encouragement such as posters or other printed materials. Multiple opportunities to discuss HIV testing, across several clinic visits also appears to have facilitated uptake of HIV testing.
- Physician support: Acceptance of HIV testing increased when physicians reinforced the recommendation for HIV testing. Facilities which relied primarily on ancillary health care workers or printed materials to encourage HIV testing experienced lower rates of HIV testing.
- Supervisory oversight: Supervisory support of HIV testing activities is important in facilitating HIV testing, at least in the initial stages of implementation. Supervisors not only monitored testing activity, but they provided staff with positive reinforcement, praise and recognition on employee performance appraisals which served to motivate staff. Supervisors who demonstrated a willingness to “pitch in” to support HIV testing, particularly during busy times, also served to motivate staff and reinforce the importance of HIV testing.
- Offering staff incentives: Several sites offered staff incentives to encourage HIV testing. One facility offered a \$10 gas card to the clinician who offered the most tests and to the clinic assistant who offered the most HIV tests. Another facility gave a \$20 Macy’s gift certificate to the clinic staff that offered the most HIV tests. One site had a dinner for all the staff involved in the project. While these incentives may have boosted staff morale, the extent to which they resulted in increased testing acceptance is not possible to determine.
- Offering patient incentives: One facility provided patients with \$5 gift coupons to encourage acceptance of HIV testing. Based on the data provided by this facility, the incentive did not boost HIV test uptake.
- Advertising and patient education: All facilities used posters or signs promoting HIV testing in patient examination rooms as well as in waiting areas. One of the facilities mailed out notices to patients regarding the availability of testing and provided flyers promoting HIV testing at registration. All facilities provided or had available educational brochures. Findings from the evaluation suggest that promotional materials by themselves are insufficient to stimulate HIV testing uptake. The facility that most emphasized advertising and patient education materials had the lowest

acceptance rate, while the facility with the least emphasis on advertising and patient education materials had the highest rates of uptake.

Key Recommendations for Implementation of Routine HIV Testing: The findings of the evaluation of these implementation planning grants suggested several key recommendations to support implementation of HIV testing as a routine part of services providing in health care settings. These recommendations are discussed below:

1. HIV testing must be fully incorporated into both standards of care and standard clinic operating procedures.

HIV testing must be fully incorporated into standard clinic operations and approached as a standard of care, such that each patient is recommended HIV testing, regardless of HIV risk or reason for visit. It cannot be approached as a “stand alone” or parallel service, as this will influence the way HIV testing is perceived and prioritized by both staff and patients. In turn, these perceptions will negatively impact on implementation of HIV testing as a standard of care and acceptance rates among patients.

2. Engagement and participation of all staff, particularly clinicians, is essential.

In order to make HIV testing a standard of care, all staff need to take responsibility for and participate in the provision of testing. Three of the four facilities participating in this project relied on staff specifically tasked to HIV testing rather than truly integrating HIV testing into clinical services. Facilities which used “dedicated” staff that were assigned primary responsibility for HIV testing intended that this would both facilitate routine offering of HIV testing and encourage test acceptance. The dedicated staff model, however, appears to have had the opposite effect. Staff with primarily or sole responsibility for HIV testing was often distracted by other competing priorities. Further, the facility which engaged the medical residents in the offering of HIV testing experienced the highest acceptance rates, suggesting that “physician authority” is an important factor influencing HIV test acceptance.

3. Patient messaging is critical.

The language used to encourage HIV testing among patients is critical. HIV testing needs to be “recommended” to all patients, with a right of refusal, not simply “offered.” In general, the facilities participating in this project presented HIV testing as an offer rather than a recommendation. Experience gained from implementation of routinely recommended testing in public health facilities in Michigan suggests that reframing the message regarding HIV testing as a standard of service is relatively simply accomplished and can dramatically increase the acceptance of testing. Facilities should develop and have staff utilize a standard “script” or outline of messages for each phase of the testing

process: e.g., introducing routine testing, explaining the testing process, giving basic information and getting consent, and giving test results.

4. Reinforcement of the support for and value of HIV testing is important both for providers and patients.

The message from all levels within a clinic/health care facility must reflect an understanding that routine testing for HIV is recommended for all patients, regardless of risk for HIV, as an accepted standard of care. The message needs to be delivered consistently through as many points of patient awareness and education as practical, using professionally developed and patient-friendly educational materials with appropriate reading levels.

Similarly, staff must receive a clear message regarding the value of and support for HIV testing as a standard of care and this message should be reinforced throughout the institutional hierarchy. Provider education materials and opportunities must similarly promote and reinforce this message to ensure that HIV testing is adopted as a standard of care and that information provided to patients is accurate and consistent.

5. HIV testing processes must be streamlined.

Practically, HIV testing needs to be fully integrated into existing patient/clinic flow so there is no wait time for patients and no wasted time for staff. Facilities need to explore and adopt strategies which make HIV testing as seamless as possible for staff and make efficient use of their time (e.g., pre-package all testing related supplies and forms; have all supplies in each exam room; inserting consent forms into every patient chart; minimize unnecessary paperwork).

6. The model for provision of HIV testing services must be flexible in order to accommodate different facilities, settings and patient populations.

Because of the high degree of variability in settings in terms of their organization, operations and oversight, as well as differences in patient populations, there is no single "best" model or approach for implementation of routine HIV testing. For example, in high-volume, rapid-pace clinic settings, rapid HIV testing, conducted point of care in examination rooms, may unnecessarily stress the system by increasing the need for dedicated space to run testing, adding additional time to clinic visits or adding additional responsibilities associated with laboratory procedures to staff with multiple competing priorities. In such circumstances it may be more practical to offer flexibility in how testing is provided. For example, if a patient is already going to a lab for other testing, it may make more sense for HIV testing to be done along with other tests, reserving point-of-care testing for patients not getting other tests or for patients who are likely to be lost to follow-up.

Some clinics may triage and assign patients depending on presenting complaints/reason for visit, which may, in turn, influence their interaction with various clinic staff. Thus, responsibility for the various “steps” involved with HIV testing (e.g., making recommendations for HIV testing, obtaining consent, obtaining specimens, delivering results) may appropriately fall to one or more staff. Or there may be one common “point” in the clinical visit, which presents an appropriate opportunity for HIV testing (e.g., during vital signs). Thus, each facility must carefully examine clinic and patient flow to determine the most appropriate model and approach to HIV testing.

7. HIV testing must be reimbursed by third party payers.

All facilities participating in this grant reported an inability to sustain routine HIV testing beyond the duration of the grant, without a mechanism to cover, at least, the cost of the rapid test. Routine testing in particular poses financial challenges both for initial implementation and sustainability. Currently, in Michigan the cost of HIV testing conducted for screening (rather than diagnostic) purposes is not reimbursed by any third-party payer, including Medicaid. This is a significant disincentive to providers.

8. HIV testing activities should be monitored and evaluated, especially during initial implementation phases.

Facilities implementing HIV testing, particularly as a standard of care, should periodically review service data to ascertain which patients are accepting testing and which clinicians or ancillary staff is more likely to have patients accept testing. Monitoring services in this way will suggest areas for program refinement.

9. The public health community should support HIV testing in health care settings.

HIV testing in health care settings is an important strategy by which to increase the number of individuals who know their HIV infection status and, if found to be HIV-infected, are linked to needed care, prevention and support services. Public health can support health care providers in implementing HIV testing by providing epidemiological or other statistical data to assist in planning HIV testing programs. Public health can also provide or arrange for training and technical assistance to support planning for and implementation of HIV testing. Public health can also assist through the development and/or dissemination of a resource guide for materials which would be of use to entities implementing routine HIV testing such as sample educational materials, resources to support provider training and/or recommendations for training content, resources for current statistical information about HIV and STD specific to individual communities. In addition, the public health community can provide and/or facilitate opportunities for networking among organizations to share resources and promote linkages with needed community resources. In some cases,

funding or other support (e.g., rapid test devices) may be available from public health entities to stimulate or support HIV testing efforts in health care settings.

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Ellen Ives, a consultant to the Division of Health, Wellness and Disease Control, Michigan Department of Community Health, conducted field interviews and was the primary author of this report. Liisa M. Randall, Manager, Community Partnerships Unit, DHWDC, provided oversight of the evaluation project and contributed to the report. Erika Garcia provided technical support for data management and analysis. We wish to gratefully acknowledge the cooperation and support of the staff from the four health care facilities represented in this report in completing this evaluation.

**Appendix A:
Planning and Implementation Grant Site Profiles**

Detroit Medical Center Sinai-Grace Hospital

Location: Detroit

Population seroprevalence rate: 602/100,000 (City of Detroit, MDCH January 2008)

Clinical Setting: Internal Medicine Primary Care Clinic

Project Period: November 2, 2007 – January 31, 2008 (with hiatus mid-December – mid/late January)

Model/Approach: clinician mediated/point-of-care rapid testing

Testing Process: OraQuick oral rapid test

Testing Summary:

Total unduplicated patients seen during study period: 318

Total unduplicated patients offered test: 318 (100% of total patients)

Total unduplicated patients accepting and tested: 229
(72% of patients offered and seen)

Total number of patients testing preliminary positive: 2
(1% of tests, both patients previously tested positive)

Staffing Model and Flow:

1. Data sheet put in every chart
2. Medical Assistant (MA) offers test to patient, while taking vital signs
3. If patient accepts, MA completes informed consent form, takes oral specimen
4. MA runs test in on-site lab area, records result on data sheet and gives results to physician
5. Results are given to the patient by physician
6. If negative, no written follow-up or instructions
7. If preliminary positive, give clients with positive results a lab request for a confirmatory blood draw (in same building) and appointment to get result, along with referral to HIV clinic
8. At confirmatory results appointment, physician gives results to patient, emphasizes referral to HIV clinic
9. At next visit, physician confirms attendance at HIV clinic.

Linkages for HIV Positive Patients:

- Ryan-White funded HIV clinic in same building, which has case manager, nurse, pharmacist, etc.

Patient Education:

- "Important Health Information" booklet
- OraQuik subject information booklet
- CDC booklet available but not routinely given: "HIV and AIDS: Are You at Risk?"

Staff Training:

- Resident physicians were oriented to testing process and paperwork during routine half-hour “article discussion” times. Residents already discuss sexual histories.
- Medical assistants self-trained with written information.

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Hurley Medical Center

Location: Flint, MI

Population Seroprevalence rate: 108/100,000 (Genesee County, MDCH January 2008)

Clinical Setting: Family Ambulatory Health Center (adult primary care) in urban hospital

Project Period: October 1, 2007 – December 31, 2007

Model/Approach: Dedicated staff and clinician mediated combination/point-of-care rapid HIV testing

Testing Methodology: UniGold rapid test, fingerstick

Testing Summary:

Total unduplicated patients seen during study period: 1365

Total unduplicated patients offered test: 1365 (100% of patients seen)

Total unduplicated patients accepting and tested: 213
(16% of patients offered and seen)

Total number of patients testing preliminary positive: 0

Staffing Model and Flow:

1. Patients informed about the test by receptionists, and given a flyer, a pen, and the Important Health Information booklet
2. Clinic staff (medical assistants and LPNs) ask patients if they are interested, as they escort them into the exam room
3. If patient accepts, clinic staff gets consent form signed
4. Clinic staff asks patient screening questions to complete CTR form
5. Clinic staff obtains specimen
6. Clinic staff starts test running in the exam room. Turns on the 10-minute timer and returns to inform physician/clinician to read results of test
7. Physician/clinician reads results and informs patient
8. Physician/clinician records result on screening form and chart
9. Clinical staff gives patient \$5 coupon for hospital cafeteria or gift shop and offers male and female condoms

Linkages for HIV Positive Patients:

- Patients testing preliminary positive would be drawn for confirmatory Western Blot and given an appointment to return to clinic for results
- Patients confirmed positive would be given an immediate referral to infectious disease clinic on-site.
- Case manager from local AIDS Service Organization meets with all HIV patients in ID clinic
- ID clinic notifies primary care clinic if patient no-shows.

- Nurse manager of primary care clinic is also nurse manager of ID clinic and would do follow-up on patients
- PCRS handled by case manager in ID clinic and local health department STD liaison

Patient Education:

- Appointment confirmation postcards sent to all patients included information about the test
- Flyers were given to all patients
- Posters were in all exam rooms, waiting room and by the receptionist desk
- Educational brochures from commercial educational companies (ETR and Channing Bete) are in display racks in all exam rooms
- A DVD was available to view on patient education computer and video available for waiting room, but staff often did not remember to turn it on

Staff Training:

- The research department did training with residents at lunch conferences, using a Powerpoint which covered HIV prevalence, rapid testing, grant process/requirements
- In addition, 3-4 sessions were held with nurses and medical assistants, in which videos were shown and the informed consent booklet was covered
- Test training was done by the diagnostic manufacturer
- Updates were given, periodically, and staff feedback was obtained

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St. John Health System

Location: Detroit, MI

Population sero-prevalence: 602/100,000 (City of Detroit)

Clinical Setting: 3 sites: Internal Medicine Clinic, Internal Medicine Specialty Clinic, Adolescent Clinic

Project Period: August 1, 2007 – December 31, 2007

Model/Approach: Dedicated staff/point-of-care rapid testing

Testing Methodology: OraQuik rapid fingerstick

Testing Summary:

Total unduplicated patients seen during study period: 6,125

Total unduplicated patients offered test: 587 (10% of patients seen)

Total unduplicated patients accepting and tested: 406
(69% of patients approached and 7% of patients seen)

Total number of patients testing preliminary positive: 1

Staffing Model and Flow:

Internal Medicine Clinic:

1. At intake, Point of Care Tester (POCT) (clinic assistant or MA) gave each patient a form to sign asking them if they would like more information about HIV testing
2. If the patient signed "yes", he or she was given "Important Health Information" consent booklet to read in exam room, and a special consent to sign
3. POCT performed fingerstick to obtain specimen
4. Specimen taken to lab area to run test
5. Test results given to physician
6. Physicians delivered test results
7. If positive, Physician counseled on preliminary positive, and patient sent to St. John Laboratory for blood draw for Western Blot
8. Follow-up appointment set for one week later to get confirmatory results

Internal Medical Specialty Clinic:

1. Point of Care Testers ask patients in exam room and physicians encouraged to repeat question when they entered
2. – 8. Same steps as above

Adolescent Clinic:

1. Patients asked by physicians if they would like to be tested.
2. Physicians or clinic assistants obtain signed consent form and give booklet.

3. Physicians obtain specimen through oral swab
4. Point of Care Tester run test in lab area
5. POCT gave results to physician
- 6 - 8. Same steps as above

Linkages for HIV Positive Patients:

- Referrals made to internal ID clinic
- Case management provided by local organization through MOA
- PCRS provided by local health department

Patient Education: (given only to patients who accept testing)

- "Important Health Information" informed consent booklet
- OraQuik subject information booklet

Staff Training:

- Laboratory representative trained nurse-manager of clinic (project coordinator) who relayed information to policy and protocol department of health care system
- Policy and protocol developed and given to staff
- Nurse manager developed a slide-show for staff including general information about HIV, the testing process, etc.

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Center for Family Health

Location: Jackson, MI

Population Sero-prevalence: 71/100,000 (Jackson County, MDCH April 2007)

Clinical Setting: Federally qualified community health center, two sites including one adjacent to a homeless shelter. Within the larger center, testing was done in the following clinics: Family Practice, Women's Health, Internal Medicine, and Pediatrics.

Model/Approach: Dedicated staff/ point-of-care rapid testing

Testing Methodology: OraQuik rapid fingerstick

Testing Summary:

Total unduplicated patients seen during study period: 5,699

Total unduplicated patients offered test: 1,307 (23% of patients seen)

Total unduplicated patients accepting and tested: 621
(48% of patients offered and 11% of patients seen)

Total number of patients testing preliminary positive: 0

Staffing Model and Flow:

1. Blank consent placed in each chart
2. Clinic Assistant offers patient testing while taking vital signs in exam room
3. If accepted, patient receives written info (consent form) and signs consent
4. Clinic Assistant takes sample in exam room (supplies kept in exam room)
5. Sample is taken to clinical lab area to run
6. Results given to patient in exam room. Negative result is given by clinician (if still seeing patient) or clinic assistant (if clinician is done); positive result given only by clinician
7. If positive, confirmatory blood draw is taken on-site and in-house case manager would see client and explain about confirmatory testing and further referral issues
8. For acute care patients, process takes about 5 extra minutes of patient's time as well as exam room time

Linkages for HIV Positive Patients:

- All HIV-related case management and referrals would be facilitated or completed by in-house case managers
- Medical referrals would be made to local ID physician, per Letter of Agreement
- Case managers in-house would follow all referrals
- PCRS would be handled by local health department

Patient Education:

- Patient education materials only given to patients who choose to test; materials include:

- “Important Health Information” informed consent booklet
- OraQuick subject information booklet

Staff Training:

- Project was discussed in routine staff meetings of medical assistants and clinicians.
- All clinic assistants took the MDCH on-line Information Based Testing course
- The clinic manager provided rapid test training

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Appendix B: MDCH Grant Data Requirements

Data Requirements for Recipients of HIV Screening Planning and Implementation Grants

1 October 2007

Variable Name	Values ¹⁰	Required?	Comments/Instruction
Unique Client Identifier		Yes: all patients tested	Do not use patient social security number or patient name. DHWDC/HAPIS existing data system constructs a unique number using an algorithm that includes the first and third letters of the patient's first and last names, along with their date of birth.
County of Residence	County of residence	No: preferred for all patients tested	
Zip Code of Residence	5 digit number	Yes: all patients tested	
Date of birth	mm/dd/yyyy	Yes: all patients tested	
Gender	Male Female Transgender	Yes: all patients tested	
Race	African American/Black Arab/Chaldean Asian Native Hawaiian/PI American Indian/Alaska Native White Unknown	Yes: all patients tested	

¹⁰ Values are those currently used by DHWDC/HAPIS in conjunction with its web-based data collection system for HIV counseling/testing services. It may be possible and preferable, in some cases to discuss "mapping" variables and values from existing data systems to the DHWDC/HAPIS variables and values.

Hispanic/Latino?	No Yes Unknown	Yes: all patients tested	
African Born?	No Yes Unknown	No	If you are already collecting this information as part of patient services, it would be helpful to DHWDC/HAPIS's evaluation of these programs.
Patient HIV Risk	Man who has sex with men (MSM) Man who has sex with men & women (MSM/W) Injecting drug user (IDU) Diagnosed STD Commercial sex worker Provides sex for money/drugs Sex partner of HIV+ person Sex partner of IDU Female sex partner of MSM Other heterosexual Other	No: preferred for all patients tested	If you are already collecting some/all of this information as part of patient services, it would be very helpful to DHWDC/HAPIS's evaluation efforts and may provide guidance on identifying a patient "profile."
Date of HIV Test	mm/dd/yyyy	Yes: all patients tested	
Specimen Type Rapid Test	Blood: Venipuncture Blood: Finger Stick Oral Rapid Test Other	No: preferred for all patients tested	If one specific method is used in your facility (e.g., all specimens are blood obtained via fingerstick) you need not submit data for each patient. You need only advise DHWDC/HAPIS as to your primary method for specimen collection.
Result of Rapid HIV Test	Negative/Non-reactive Positive/Reactive Indeterminate Invalid No Result	Yes: all patients tested	

<p>Did client receive result of rapid HIV test?</p>	<p>No No, referred to local health department Yes, same visit Yes, at next visit Yes, because of follow-up Yes, via telephone Yes, other</p>	<p>Yes, all patients tested</p>	<p>DHWDC/HAPIS must know whether patients received the results of their rapid test. It would be preferable to know whether/ what type of follow-up efforts were required, but this is not essential.</p>
<p>Specimen Type for the Conventional Confirmatory Test</p>	<p>Blood: Finger stick Blood: Venipuncture Oral Mucosal Transudate</p>	<p>No: preferred for all patients for whom confirmatory testing is conducted (i.e., all patients with a reactive rapid test result)</p>	<p>If one specific method is used in your facility (e.g., all confirmatory testing is conducted using venous samples) you need not submit data for each patient. You need only advise DHWDC/HAPIS as to your primary method for specimen collection.</p>
<p>Result of Test Confirm a Reactive Rapid Test</p>	<p>Negative Positive Indeterminate No Result Confirmatory testing not done</p>	<p>Yes: for all patients for whom confirmatory testing is conducted (i.e., all patients with a reactive rapid test result)</p>	
<p>Did client receive result of confirmatory test?</p>	<p>No No, referred to local health department Yes, at next visit Yes, because of follow-up Yes, via telephone Yes, other</p>	<p>Yes: for all patients for whom confirmatory testing is conducted (i.e., all patients with a reactive rapid test result)</p>	<p>DHWDC/HAPIS must know whether patients received the results of their confirmatory. It would be preferable to know whether/ what type of follow-up efforts were required, but this is not essential.</p>

Date patient received confirmatory test results	mm/dd/yyyy	Yes: for all patients for whom confirmatory testing is conducted (i.e., all patients with a reactive rapid test result)	
Facility/provider where patient was referred for medical evaluation and treatment.	Name of facility/provider Or "No referral provided"	Yes: for all patients with a confirmed HIV positive result.	
Date patient attended first medial appointment for evaluation/ treatment of HIV.	mm/dd/yyyy	Yes: for all patients with confirmed HIV positive result who received a referral to medical care.	Leave blank if referral status cannot be confirmed.
Partner notification	Partners elicited and forwarded to health department for f/u Patient referred to health department for assistance with PN Patient will notify all partners Patient declined to discuss Other	Yes: for all patients with confirmed HIV positive result	
Is patient in prenatal care?	No, patient is not pregnant Patient is pregnant and in prenatal care Patient is pregnant and not in prenatal care Patient is pregnant and prenatal care unknown Patient declined Patient pregnancy status unknown	Yes: for all pregnant female patients with confirmed HIV positive result	

Date patient attended first prenatal care appointment	mm/dd/yyyy	Yes: for all pregnant female patients with confirmed HIV positive result, not receiving prenatal care who received a referral for such services	
Facility/provider where patient was referred for prevention or support services.	Name of facility/provider Or "No referral provided"	No: preferred for all patients with a confirmed HIV positive result.	If you are already collecting information about referrals it would be helpful to monitor referrals to other services (e.g., case management, counseling)

Appendix C: Interview Guide

HIV Testing in Clinical Settings Interview Guide

Michigan Department of Community Health
Division of Health, Wellness and Disease Control
November 2007

Thank you for assisting the Michigan Department of Community Health (MDCH), Division of Health, Wellness and Disease Control (DHWDC), to evaluate efforts to implement routine HIV testing in clinical settings. In preparing for your visit with our evaluation consultant, please think over the following overarching questions which will frame your discussion with our evaluation consultant. Please note the list of materials to have on hand for the visit. We would appreciate your providing our evaluation consultant with a copy of these materials. Electronic copies are acceptable.

Overarching Questions

What prompted your facility to apply for this grant?

What is a general overview look at the HIV testing process in your clinic (what happens when and by whom)?

On average how much additional staff time (if any) has HIV testing added per patient? By personnel type (e.g., physician, nurse, medical assistant, administrative support) How do you know this?

On average, how much additional time (if any) has HIV testing added to each patient's visit? How do you know this?

What/how much additional paperwork and data collection is required by the HIV testing process?

What have been the greatest challenges associated with implementing routine HIV testing at your facility?

What specific strategies have you used to overcome or resolve those challenges?

What have been the biggest successes of this project at your facility?

What have been your most important “lessons learned” from this project that you feel would be useful for others planning/interested in implementing HIV testing?

How will participation in this grant change your services in the future?

Do you anticipate being able to sustain HIV testing in your facility after the end of grant funding? If yes, at what level do you anticipate being able to provide HIV testing? If not, what are the most important factors that impact sustainability?

What would you tell another agency who was considering implementing routine HIV testing?

Materials/Data to Have on Hand:
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- Implementation protocol/procedures
- HIV testing consent form
- Other medical consent forms, patient intake forms, risk assessment questionnaires, and other forms used in association with services (particularly HIV testing) in your facility
- Patient HIV educational materials used (e.g., brochures, posters, videos)
- Instructional materials for staff (e.g., memos, guidelines, reminders)
- Data collection tools
- Referral materials (e.g., sample discharge orders, referral cards, referral logs)

HIV Testing in Clinical Settings Interview Guide

Michigan Department of Community Health
Division of Health, Wellness and Disease Control
December 2007

Specific Questions

Setting/ Program Characteristics:

What is the clinical setting in which you are implementing routine HIV testing? (Type of services, location, etc.)

How does this site differ from other clinical settings in your organization (e.g., different population demographics, etc.)

How many total patients does this site see, on average, per day/per month?

What are the demographic breakdowns for the overall patient population?

What is the estimated seroprevalence in the community served by this site? Are there any estimates of seroprevalence for the facility itself?

Prior to this grant, how was HIV testing incorporated into services at your site?

Preparing for Routine Testing:

How was it decided to participate in this routine testing grant (e.g., who were the decision-makers? How was staff input obtained?)

Prior to initiating routine testing, how were staff informed about the project?

What training has been done with staff in order to implement routine testing? (e.g., what topics, which staff, what trainers, what training method, etc.)

What other methods have been implemented to enhance staff "buy-in" to the project?

What have you done to encourage full staff participation in the project?

Aside from preparing staff, what changes have had to be made in the site, in order to accommodate routine testing? (e.g., changes in paperwork, changes in data processing, changes in patient flow, changes in supportive services?)

Pre-testing:

Patient Selection:

How are patients selected for testing: Based on diagnoses? Based on risk? Routine—all patients between ages 13 and 64?

Who provides patients with initial information about HIV testing? (i.e., that it is a routine part of all services at site)

What percentage of your total number of patients have been offered testing? Have given consent? Have been tested? Have been given results? Have refused testing? Would be considered "at risk" for HIV (behaviorally or clinically) and what are those risks?

Among patients who have refused testing, what have been their reasons for refusal?

Do refusal rates appear influenced by interactions with specific staff?

Consent and Information and/or Counseling:

What promotional and educational materials about testing are available for clients? (What brochures, posters, videos? Where are they located? How are they distributed?)

When/how is information about and consent for HIV testing given/obtained from client?

Which staff give information about HIV testing and obtain consent?

What kind of information/counseling is done? What is the content of the information/ counseling to obtain informed consent? (Traditional prevention counseling—as trained by HAPIS? Solely written information? Verbal review of consent booklet? (Etc., etc.)

Where is the patient physically when consent is obtained?

How is consent for HIV testing incorporated into other consents obtained?

Testing:

What number and percentage of patients are tested?

What number and percentage of tests are positives? New positives?

What type of assay is done (e.g., conventional, rapid, what manufacturer?)
What collection method/specimen type is used?

How/why was this type of assay and collection method chosen?

Are different types of assay/ specimen collection/test processes used for different clients? If yes, how is the process decided upon?

How is the specimen tested? In the exam room (point of care), in an on-site lab in the clinic, at a central lab? Is the assay run STAT or simply sent out?

What is the wait time/ turn around time for test results?

If the test is a rapid test, where do the clients wait while the test is processing?

What are the clients doing while waiting?

What percentage of clients are "lost" during the wait for results (i.e., don't wait or don't come back for results)?

Post-testing:**Results Notification:**

Where is the client when they are given their results?

Who gives the results? Does it differ depending on the result?

How are results given? Verbally - in person or by phone? In writing?

When are the results given? At time of initial visit? Later?

If results not given as part of initial visit, how are clients instructed to get results?

How are follow-up instructions around test results given to client? (e.g., part of written discharge instructions? Standard written informational packet? Verbal instructions?)

If clients do not get results at time of initial visit, what follow-up is done to deliver results? Who does the follow-up?

Confirmatory/ Supplemental Testing:

Under what conditions are additional related tests offered/done/referred? (e.g., if patient is positive, if patient has certain risks)

What additional tests are offered/done/referred? (e.g., confirmatory Western Blot, HCV, other STD, etc.) Which of those tests can be/are done on-site at time of visit?

What type of HIV confirmatory testing is done, if applicable?

For HIV confirmatory testing, how is follow-up done?

To what degree, and how, is agency able to document that clients have received supplemental tests?

Linkages to Care:

Linkages between HIV information and medical care:

How does information from HIV testing (positive or negative) inform clinical decisions? Do clinicians see HIV test results before patient visit is over? Before hospital stay is over?

Linkages to HIV care:

What HIV-related care and service referrals are given to **all** clients who test preliminary positive (i.e., On rapid test)?

What HIV-related care and service referrals are given to **all** clients who test confirmed positive?

What other HIV-related care and service referrals are given to clients? (What type, what specific providers?)

What types of relationships does agency have with referral providers? (documented? MOA?)

How are referrals to HIV-related care and adjunct services facilitated by agency staff?

What follow-up is done on referrals (primary and others)? To what degree is agency able to document client has linked with medical care, case management, and other services?)

How is PCRS handled?