



THE CLINICIAN'S ROLE IN DESTIGMATIZING HIV DIAGNOSIS AND TREATMENT

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Not-for-Profit Hospital Corporation aka UMC

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My experience

- **AIDS Education Training Center**
 - **Primary Care Physicians**
 - **Nurses**
- **HIV Prevention Trials Network 065**
 - **Testing and Linkage to Care-Plus**
 - **Emergency Department**
 - **Inpatient**
- **Clinician/Advocate**
 - **Sick and tired of seeing patients sick and tired**

Achieving Routine Screening

Our barriers

- People
 - Will
 - No public health lens
- Poor communication and misperceptions

Solution= KUMBAYA



Destigmatizing HIV Testing

- *“The most impactful way to reduce and possibly eliminate HIV testing stigma is to shift healthcare provider perceptions to make HIV testing as routine as screening for high cholesterol, diabetes or kidney disease”*

Lisa Fitzpatrick, MD

Road to Testing Soapbox

□ 2008

- 37 year old gay man AIDS, CD4 = 6
- Visit to his healthcare provider
- Inpatient rounds revealed many more with late diagnosis

□ 2009

- Discussions with primary care doctors
 - Few testing
 - Many unaware of CDC guidelines

□ 2010

- HPTN 065 implementation required engagement with ED providers

Utopia



- HIV prevalence well known
 - Public health case

- Few insurance barriers
 - Medicaid expansion implemented

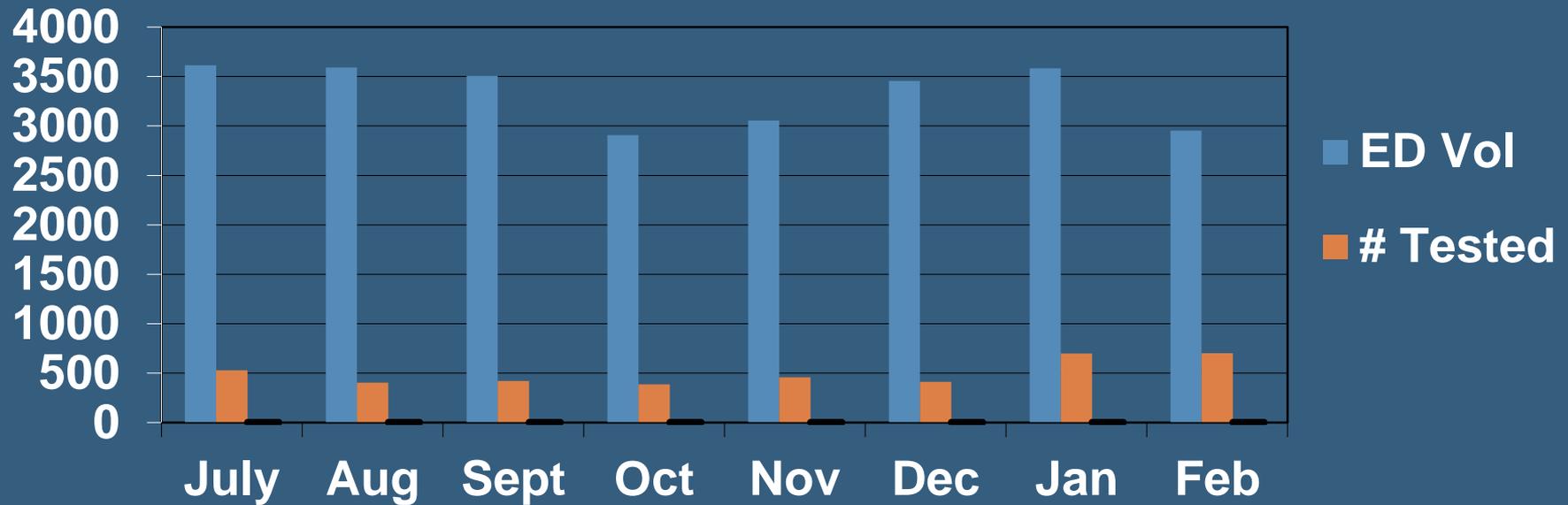
- Treatment available
 - No ADAP waiting list

- No law governing screening

- Supportive public officials

Yet....

ED Testing volume 2010-2011



UMC Consent Form

 <p>UMC UNITED MEDICAL CENTER 310 Southern Avenue, S.E. Washington, DC 20032-4623</p>	UNITED MEDICAL CENTER CONDITIONS OF ADMISSION	LABEL
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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 hospital maintains a safe for the safekeeping of money and valuables.

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 from my body during my hospitalization. I consent to the photographing of open areas on my body for medical purposes, provided that the photographs are used only for medical purposes.

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 insurance or other coverage benefit information supplied by me is correct, in accordance with applicable hospital, provider or insurance policies or agreements. 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: _____

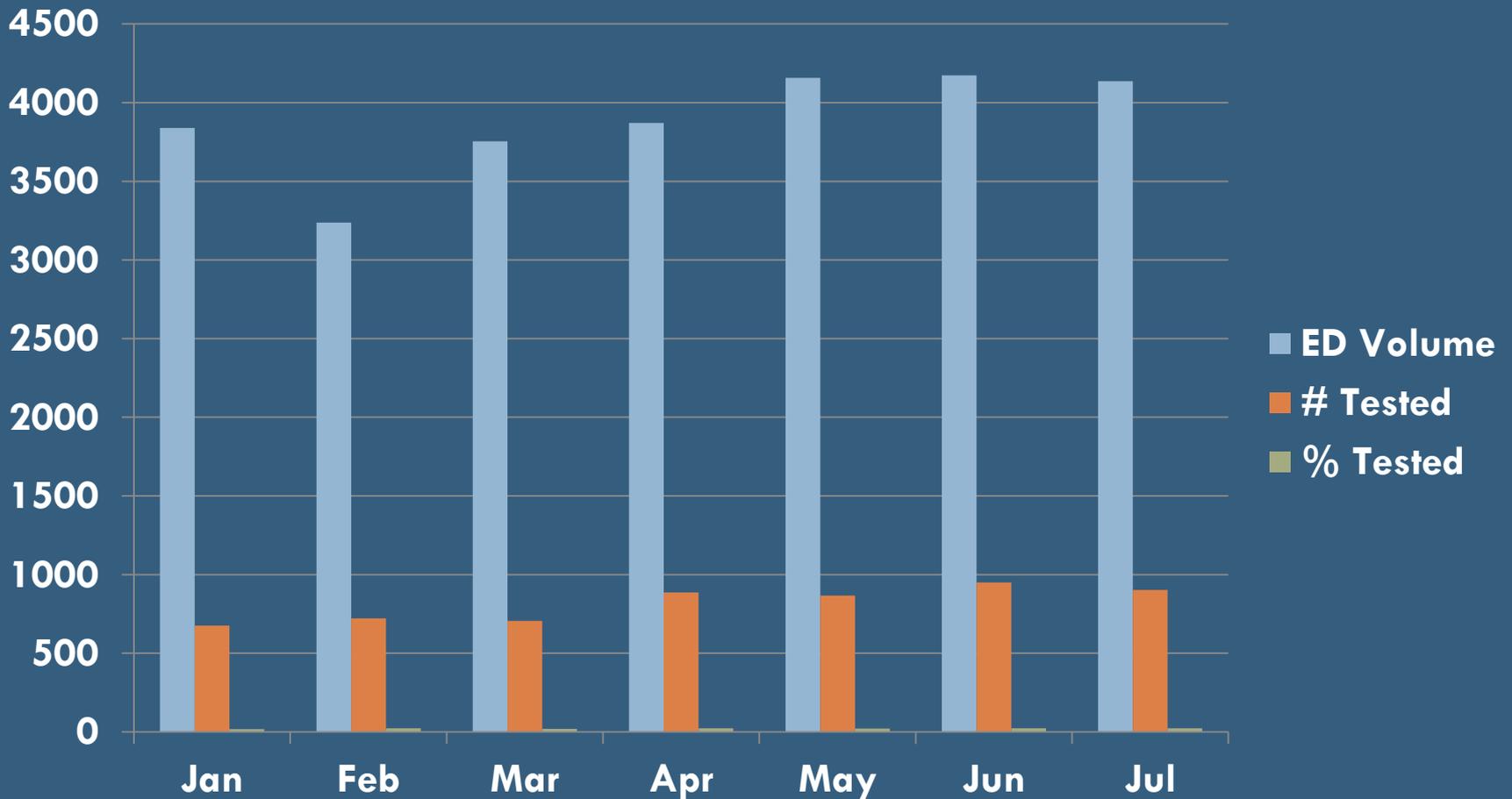
Witness _____ Patient's Signature _____
Patient is unable to sign conditions of admission because patient is a minor or because: _____

Witness _____ Closest Relative, Legal Guardian or Responsible Party _____

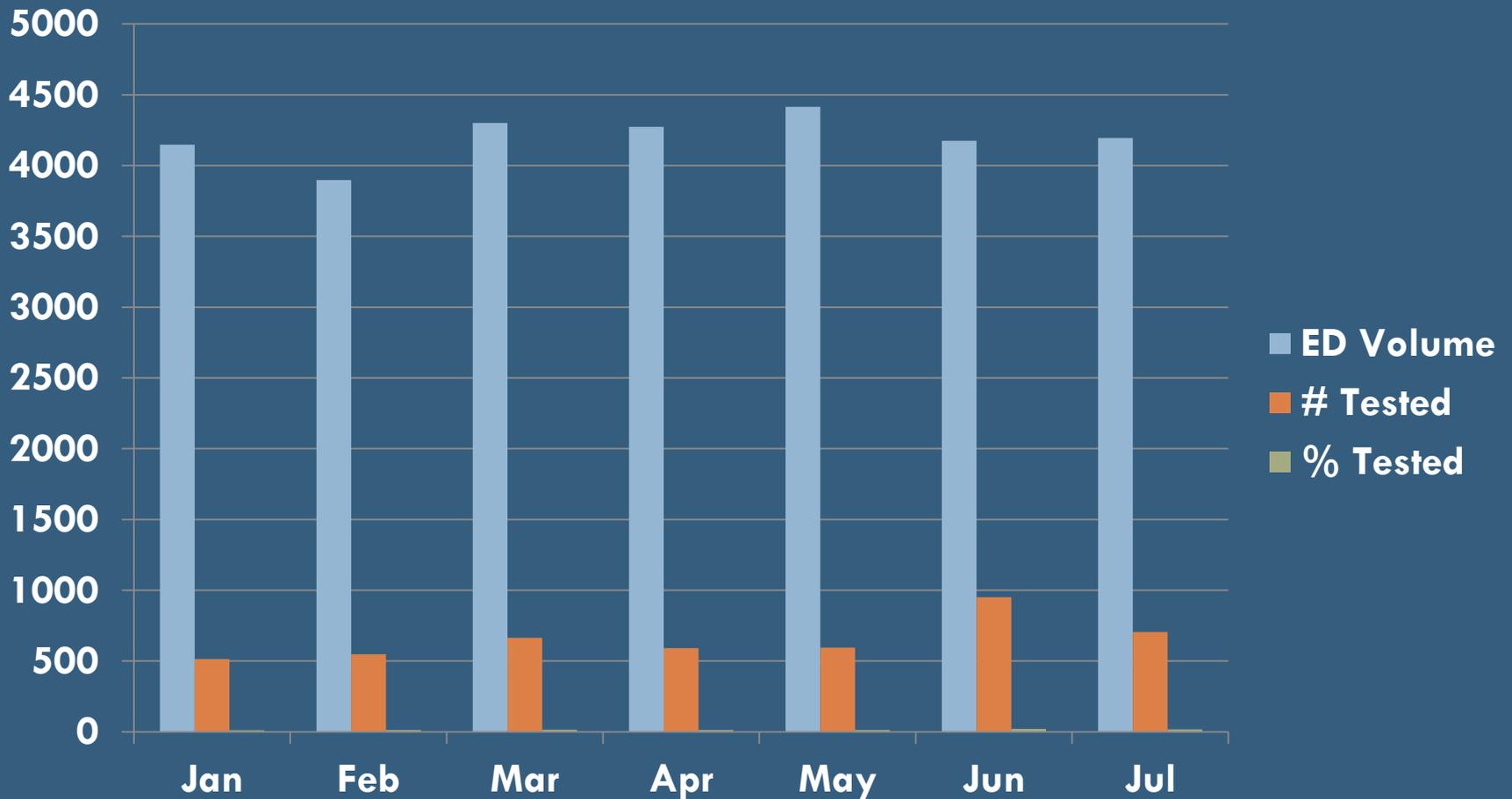
Date or Authorization if different than above _____ Relationship to Patient _____

Form 1031 Rev 9/09 WHITE-Medical Record

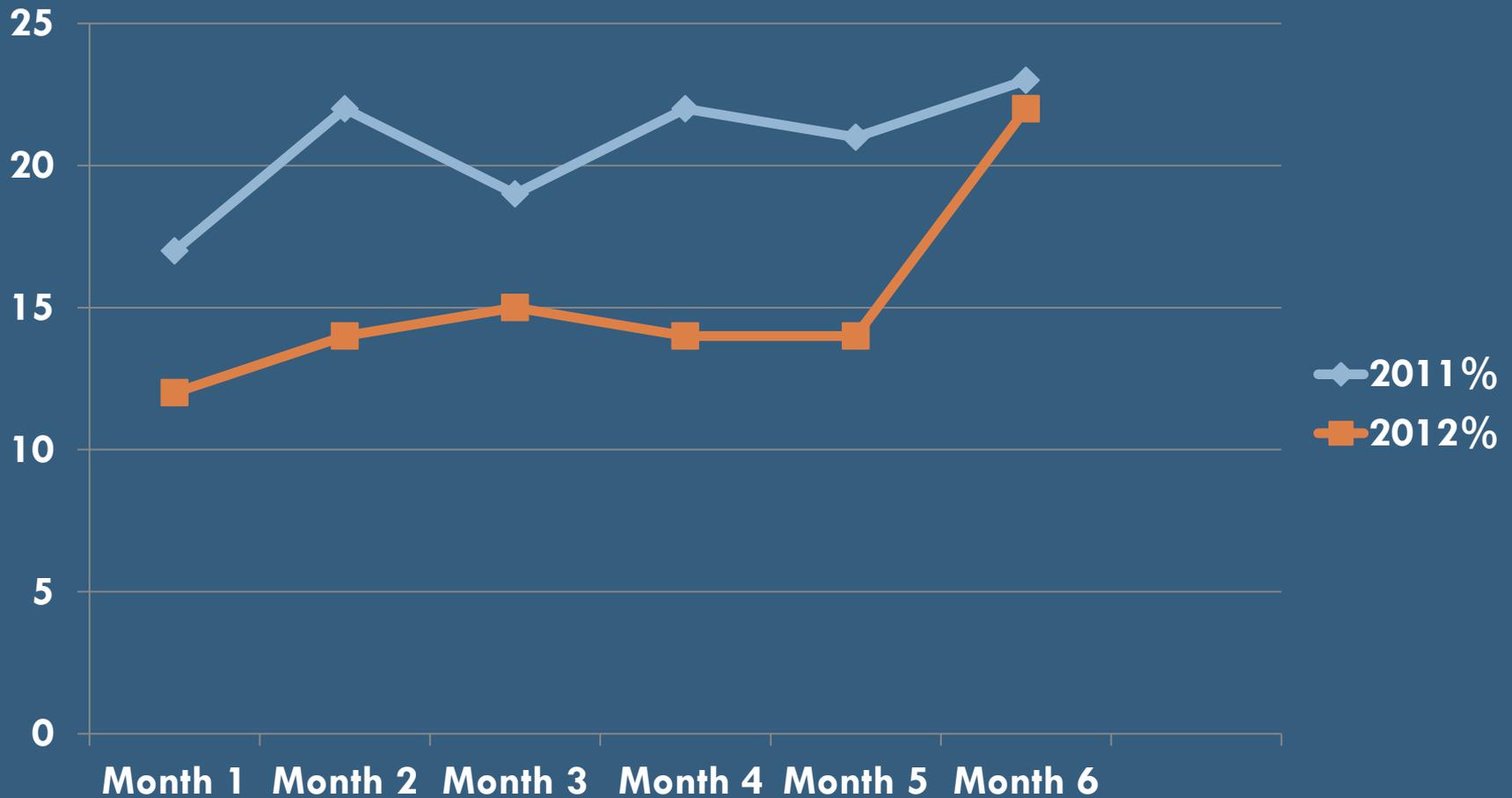
ED Testing Volume 2011



ED Testing Volume 2012



Percent ED Clients Tested





WHY?

Process Evaluation

- Why are numbers consistently low?
- Where are opportunities to:
 - Increase testing
 - Modify current process
 - Improve teamwork
- Which part of the process/flow required 100%!

Methods

- **Shadowed testers**
 - **3 shifts**
- **Interviewed providers, med techs, registrars**
- **Reviewed data collection**
- **Reviewed inpatient process**

Discovery

- The “Whisper” Offer!
- Approach not streamlined/harmonized
 - Arbitrarily tailored by tester
 - Language and HIV understanding variable among testers
 - Documentation variable?
 - What is a refusal?
- EMR documentation inconsistent

Lessons Learned

- **Requires cultural and systemic shifts**
- **Consistent program oversight and monitoring imperative**
 - **Consistent feedback to stakeholders**
 - **Maintain interest and engagement- “Purpose”**
- **Champions and buy-in needed at all levels**
 - **Admin leadership**
 - **Lab**
 - **ED**
 - **Healthcare providers!**
 - **Docs need to order the test**



Educating providers

Case 1, Mr. Smith

- 76 y/o male
- PMH- DM II, HTN, recurrent dysuria
- PCP- “one of those clinics”
- HIV+, diagnosed June ‘09
 - Urology pre-op



Missed Ops, cont'd

- **CD4 =173, CD4%= 11**
- **“How did I get HIV?”**
- **“I have been seeing the doctor for years and I get tested for everything. Nobody ever told me I had HIV”.**

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

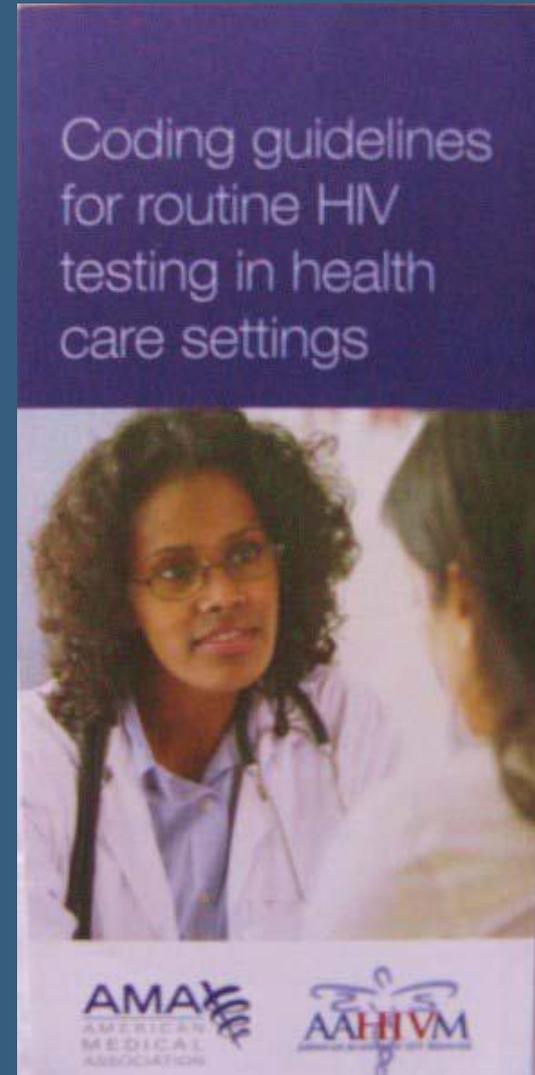
Barriers to routine screening

- **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**



Why are we missing these cases?

- **Low awareness about epidemic and CDC guidelines**
- **“My patients don’t have HIV”**
- **Uncertainty about next steps for new diagnosis**
- **Unwilling or reluctant to return positive result**
- **Believe testing is too time consuming**
- **Fear of losing patient to a specialist**

Screening for HIV: U.S. Preventive Services Task Force Recommendation Statement

Virginia A. Moyer, MD, MPH, on behalf of the U.S. Preventive Services Task Force*

Description: Update of the 2005 U.S. Preventive Services Task Force (USPSTF) recommendation statement on screening for HIV.

Younger adolescents and older adults who are sexually active should be screened for HIV. A one-time data-based screen for HIV is recommended for clinicians who screen for sexually transmitted infections (STIs) or for ends of life clinicians who screen women for HIV, including those who present with symptoms of HIV infection, those who are untested and whose HIV status is unknown, and those who are at high risk for HIV (see recommendation)

GAMECHANGER?

Methods: The USPSTF reviewed new evidence on the effectiveness of treatments in HIV-infected persons with CD4 counts greater than 0.200×10^9 cells/L; effects of screening, counseling, and antiretroviral therapy (ART) use on risky behaviors and HIV transmission risk; and long-term cardiovascular harms of ART.

Population: These recommendations apply to adolescents, adults, and pregnant women.

Recommendation: The USPSTF recommends that clinicians screen

Ann Intern Med.

For author affiliation, see end of text.

* For a list of the members of the USPSTF, see the Appendix (www.annals.org).





MMWR™

Morbidity and Mortality Weekly Report

Recommendations and Reports

September 22, 2006 Vol. 55 / No. RR-14

19%!

Revised Recommendations for HIV Testing
of Adults, Adolescents, and Pregnant Women
in Health-Care Settings

“.....Consent for HIV screening should be incorporated into the patient's general informed consent for medical care on the same basis as are other screening or diagnostic tests; a separate form for HIV testing is not recommended”

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**
-

Provider reminders

- An HIV test can be conducted via blood specimen and added to panel of traditional lab tests
 - ▣ Treat HIV as other chronic disease conditions
- Pre-test counseling not recommended
- Emerging threat of malpractice liability
 - ▣ Patients are sick with easily treatable, chronic condition

UMC Clients, Clinical

- **Median CD4 at diagnosis**
252!
 - **49%** Treatment eligible at 350 cells/mm³
 - **67%** Treatment eligible at 500
- **Median VL at diagnosis**
389K (<20-4x10⁶)
- **Hepatitis B= 14%**
- **Hepatitis C- 9%**
- **14% drug resistance**
 - **M184V and K103**

Acute Retroviral Syndrome

Case 2, EJ

- 37 year male executive
- 1 week fever, headache, rash malaise
- No travel, sick contacts or pets
- Cervical and axillary lymphadenopathy
 - 5-8cm
- Generalized erythematous rash
 - Trunk worse than extremities



Hospital Course

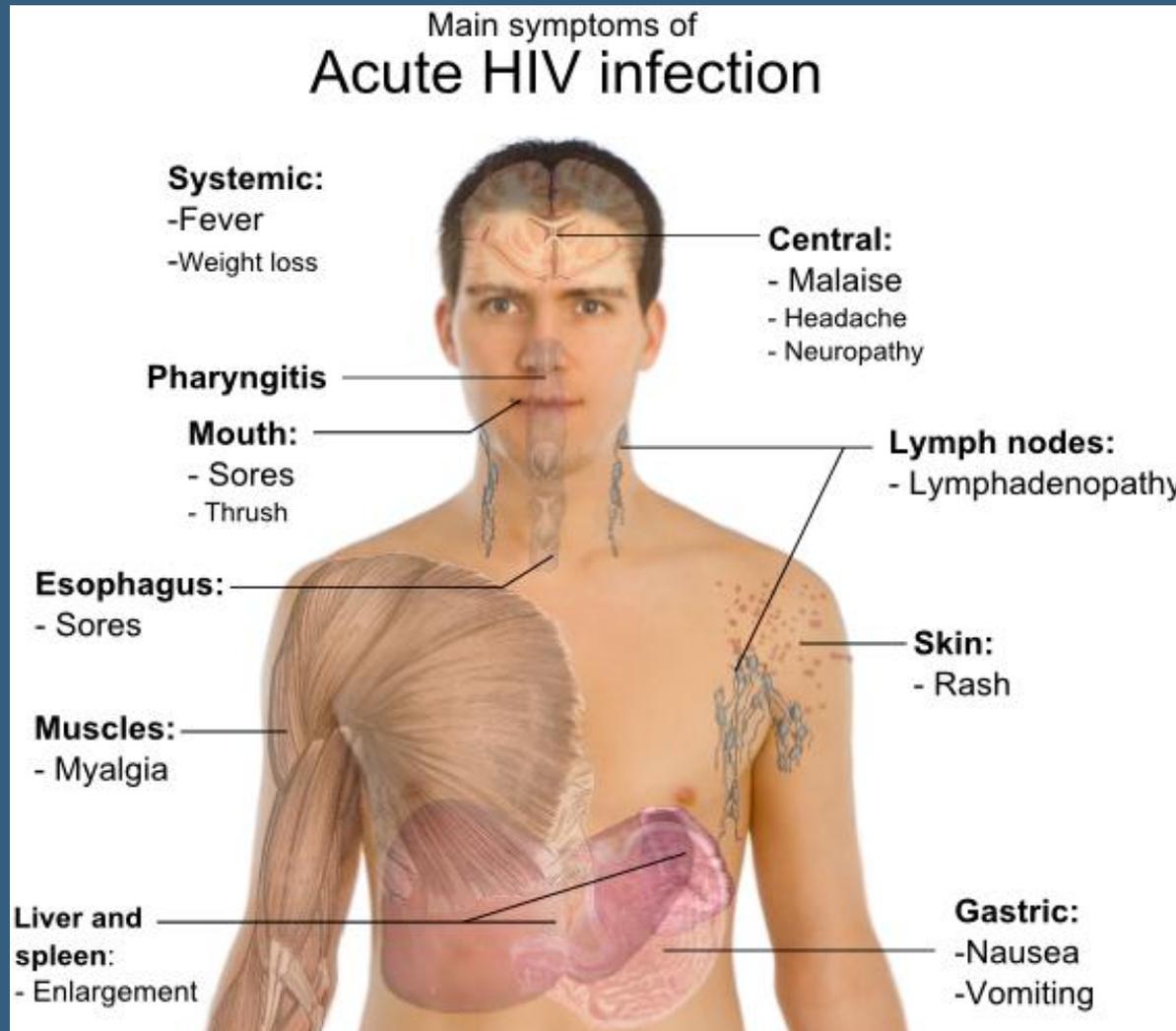
- WBC 2.1, Hb 9.3, Plt 53K
- Spinal tap
- HIV rapid test negative
- Numerous blood tests
- Diagnosed with meningitis
- Antibiotics, lymph node biopsy

Acute Retroviral Syndrome (ARS)

- **Mononucleosis-like illness**
 - **Non-specific signs and symptoms**
- **40-90% of patients symptomatic**
- **Typically presents 1-4 weeks post-exposure**
- **High index of suspicion is critical**
- **Diagnosis via HIV viral load**

Acute Retroviral Syndrome

ARS— a Great Mimicker!



Public health importance of diagnosis

- **Patients are highly infectious**
 - Warrants urgent identification
- **Viral load and transmission directly correlated**
 - Probability of HIV transmission increases as viral load increases
- **Frontline providers and community must recognize and consider ARS**
 - Flu-like symptoms may be your only clue
 - Suspicious cases?
 - HIV and viral load testing

INTERVENTIONS



Action Steps

□ ED

- Automatic HIV test all phlebotomized patients
- Pilot study via Abbott Architect
 - Acute HIV infection
 - Hepatitis C

□ Inpatient

- Standing vs. pre-approved order all admissions
- Nighttime linkage coverage
- Communication and relationship building with providers
 - Primary care, CMO, Chief Med Staff

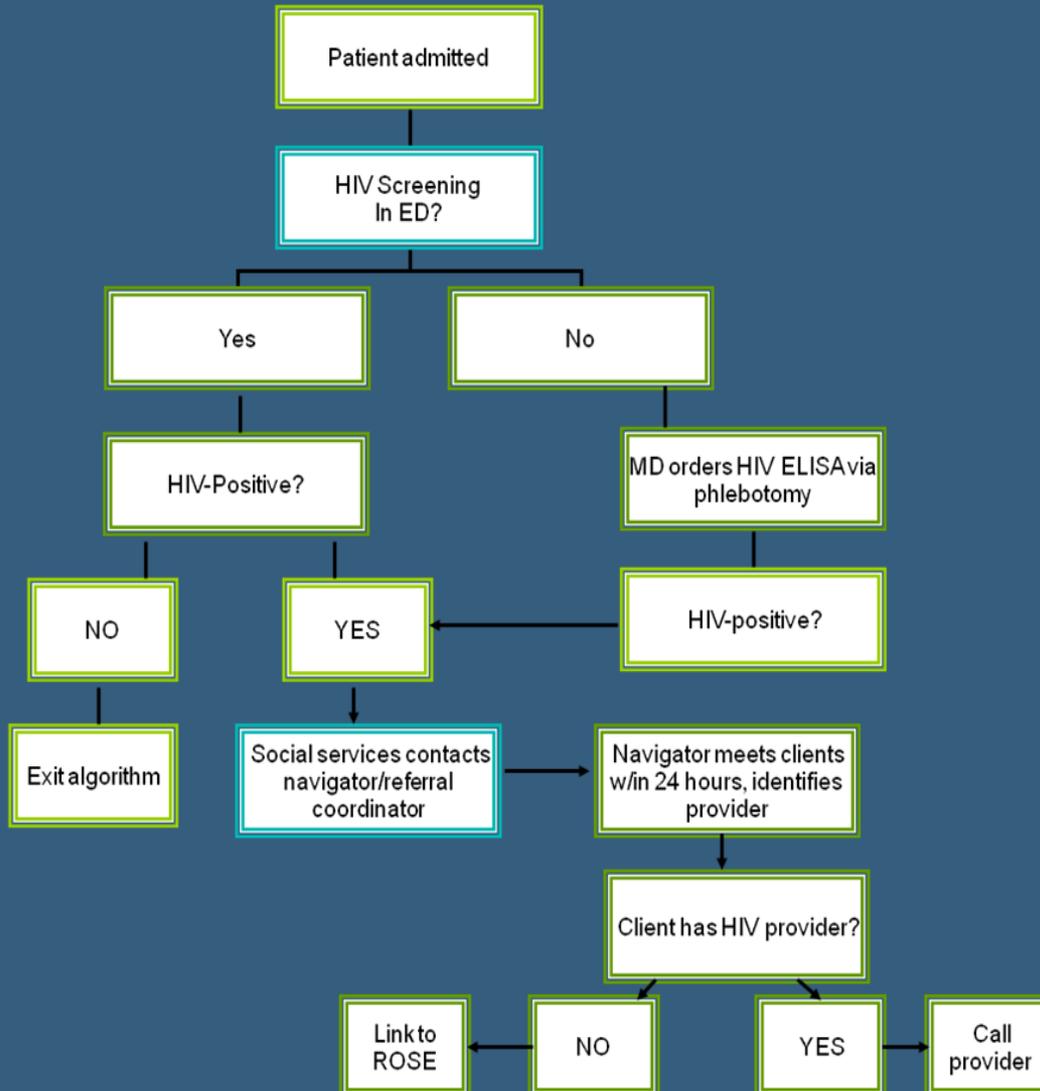
□ Support staff education

- Nurses, medical assistants

Interventions

- **Implement triggers to remind providers to order routinely**
 - “Directive” from CEO and CMO
 - Standing orders for phlebotomy
- **Streamline communication between lab, social work (SW) and infectious diseases**
 - Lab calls navigator and/or SW with positives
 - EMR flag to automatically trigger notification of SW or navigator
- **Raise awareness among ED physicians and physician assistants**

Inpatient Navigation

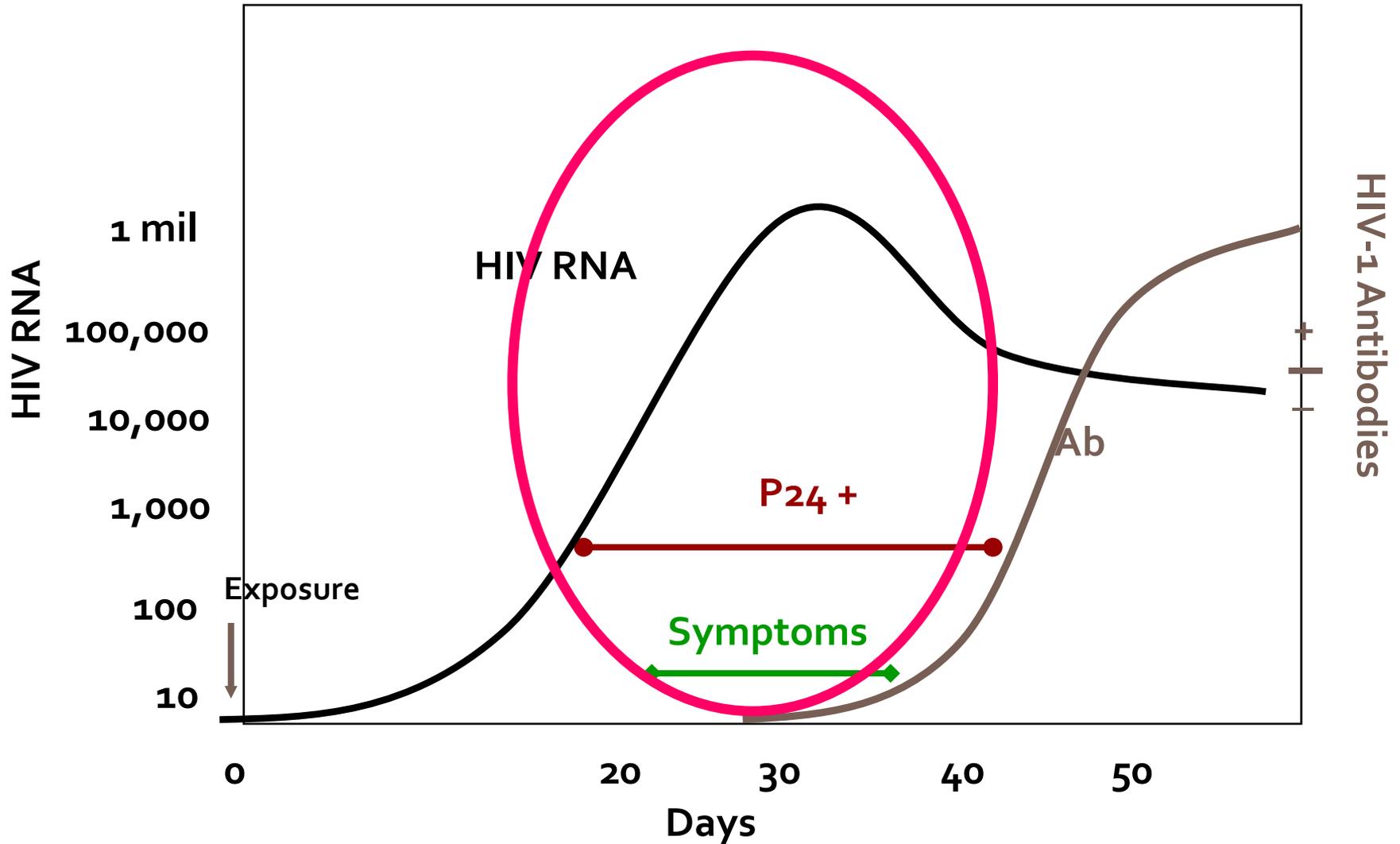


Educate Private Practitioners

- Utilize champions, i.e. The “converted”
 - Personal experience
 - 73 year old with lymphadenopathy
- Successful strategy
 - Liability argument
 - HIV is treatable
 - AIDS is preventable

~~AIDS~~

Diagnostic Testing for ARS



Abbott's *ARCHITECT*® HIV Ag/Ab Combo assay- 4th Gen



- Detects Antigen and antibody
 - 20 days before Ab

- Multi-tasker
 - Hepatitis
 - Vitamin D

- Pilot study
 - Change culture
 - Shift behavior
 - Assess rates

Closing Messages

- **Primary care providers are a critical public health partner**
- **Utilize liability argument**
- **Remember ARS**
- **Solutions are multi-pronged, multi-level**
 - **If you're working alone, don't tackle everything at once!**
 - **Find other champions to help you**

Strategic Actions

- **Educate**
 - **Providers including trainees**
 - **Administrators**
 - **Frontline staff**
 - **Risk managers**
- **Identify barriers**
 - **Administrative**
 - **Systems**
- **Implement solutions**
 - **Systems and Processes**
 - **Buy-in critical from all who touch the process**

Thank you!



Questions?

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