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

ED Vol

# Tested

July  Aug  Sept  Oct  Nov  Dec  Jan  Feb
Road to Routine Screening

ED, OB

ED Triage

I understand that I may be tested for diabetes, HIV, high cholesterol, triglycerides or other key markers. I hereby authorize United Medical Center to retain, preserve for scientific and teaching purposes, or dispose of a part orshawl of tissue or blood from my body during my hospitalization. I consent to the collection, storage, and use of my medical records, insurance, hospitalization, and any medical data collection, analysis, and research 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 to the release of photocopies of any portion of my medical record to the UMC Review Committee for the review of my medical records to other health care providers who are involved in providing care with health care. In addition, I agree to the release of my medical information for the hospital-approved research.

5. ADJUSTMENT OF INSURANCE OR PAYOR BENEFITS: I recognize that I am primarily liable for any services rendered, however, 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, records, radiology, pathology, pulmonary medicine and radiology services. I authorize the hospital and the appropriate health care providers to assign any benefits on my behalf for services rendered during this admission or visit. I authorize any holder of medical information about me to release information to the Center for Medicare and Medicaid Services and its agents any information needed to determine whether the benefits or the benefits payable for related services. I certify that the above or any other coverage benefit information supplied by me is correct, and if my account is 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 agent 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, PHYSICIAN AND PATIENT: I certify that the information supplied by me in applying for payment under Medicare and Social Security Administration is correct, and I authorize the release of all necessary information to those agencies. I further agree that 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 understand that United Medical Center is authorized to bill for services rendered during this 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 CORPORATION: Federal law requires that United Medical Center report information about individuals who die whose death is imminent to the Washington Regional Transplant Organization.

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: 10-101, Rev 1/99

UMC Medical Records
ED Testing Volume 2011

![Bar chart showing the monthly testing volume for ED across different months in 2011.]
Percent ED Clients Tested

![Graph showing the percent ED clients tested over months 1 to 6 for 2011 and 2012. The graph indicates an increase in the percentage tested from month 1 to month 6 for both years.]
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”.
<table>
<thead>
<tr>
<th>Age/Gender</th>
<th>Co-morbid conditions</th>
<th>CD4 count at diagnosis</th>
<th>Risk</th>
</tr>
</thead>
<tbody>
<tr>
<td>38 Male</td>
<td>HTN</td>
<td>4</td>
<td>Gay</td>
</tr>
<tr>
<td>66 Female</td>
<td>HTN, Diabetes</td>
<td>166</td>
<td>Widow</td>
</tr>
<tr>
<td>62 Female</td>
<td>HTN, Renal insufficiency</td>
<td>76</td>
<td>Heterosexual</td>
</tr>
<tr>
<td>42 Male</td>
<td>Asthma, heart disease, Chronic cough</td>
<td>11</td>
<td>Heterosexual</td>
</tr>
<tr>
<td>26 Male</td>
<td>H/O syphilis and gonorrhea</td>
<td>116</td>
<td>Gay</td>
</tr>
<tr>
<td>33 Male</td>
<td>None</td>
<td>2</td>
<td>Gay</td>
</tr>
</tbody>
</table>
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.

Methods: The USPSTF reviewed new evidence on the effectiveness of treatments in HIV-infected persons with CD4 counts greater than 0.200 \times 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 younger adolescents and older adults who are at risk for HIV. For author affiliation, see end of text.

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

Main symptoms of Acute HIV infection:

**Systemic:**
- Fever
- Weight loss

**Central:**
- Malaise
- Headache
- Neuropathy

**Pharyngitis**

**Mouth:**
- Sores
- Thrush

**Esophagus:**
- Sores

**Muscles:**
- Myalgia

**Liver and spleen:**
- Enlargement

**Lymph nodes:**
- Lymphadenopathy

**Skin:**
- Rash

**Gastric:**
- Nausea
- Vomiting
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

Patient admitted

HIV Screening in ED?

Yes

HIV-Positive?

NO

Exit algorithm

Social services contacts navigator/referral coordinator

NO

MD orders HIV ELISA via phlebotomy

NO

HIV-positive?

YES

Navigator meets clients within 24 hours, identifies provider

YES

Client has HIV provider?

Call provider

Link to ROSE

NO
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
Diagnostic Testing for ARS

![Graph showing diagnostic testing for ARS]

- HIV RNA
- HIV-1 Antibodies
- Symptoms
- P24 +

**Days**

- Exposure
- Days 0-20: HIV RNA increases
- Days 20-40: Symptoms appear
- Days 40-50: Antibodies (Ab) appear

**HIV RNA Levels**
- 0-10: Negative
- 10-100: Low
- 100-1,000: Moderate
- 1,000-10,000: High
- 10,000-100,000: Very High
- 100,000-1 mil: Extremely High

**HIV-1 Antibodies Levels**
- P24 +
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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