

Clinical Problem/Significance

States in the “Deep South” have been disproportionately affected by HIV diagnoses and mortality.¹ Many factors and competing demands may impede a person’s likelihood to link to and obtain appropriate medical care, such as lack of medical insurance or the influence of stigma.^{2,3,4} To combat the spread of infection, our program used 2006 Centers for Disease Control and Prevention (CDC) recommendations to implement routine, opt-out HIV screening during health visits in our emergency departments (ED) among adults (18-65 years).

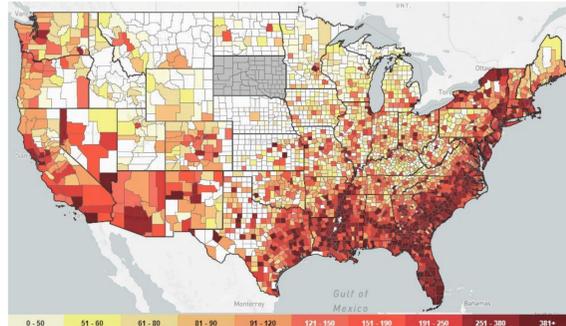


Figure 1. Rates of Persons Living with HIV, 2015.

Background

The CDC recommends all adults be HIV tested at least once in a lifetime for adults. We used CDC’s recommendations to change ED opt-in policies, to develop routine testing and opt-out language protocol and integrate into normal workflow, to utilize the existing electronic medical record, and hire a linkage coordinator to initiate posttest counseling and linkage to care. Therefore, a partnership between the East Carolina University Adult Specialty Care Clinic and Vidant Medical Center in Greenville, NC was started to implement the above. Vidant Medical Center is an academic, Level 1 trauma medical center that served 130,000 unique patients in 2017. The East Carolina University Adult Specialty Clinic is the primary provider of HIV treatment and supportive services for the 29-county eastern North Carolina region and serves approximately 1,500 HIV-positive patients.

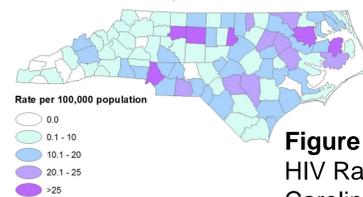


Figure 2. Newly Diagnosed HIV Rates by County North Carolina, 2016

Clinical Question

If CDC recommendations are implemented in Vidant Medical Center’s EDs, would testing increase and would patients be successfully linked to HIV care?

Description of Evidence-Based Protocol

All ED staff participated including triage. All eligible patients presenting to the ED, between 18 and 65 years, from March 2nd, 2017 to February 28, 2018 with no documentation of HIV positivity or of HIV test within the past year, and orders for blood work were included in the intervention. The 4th generation HIV test was used. This study was exempt from IRB approval as this is considered standard of care.

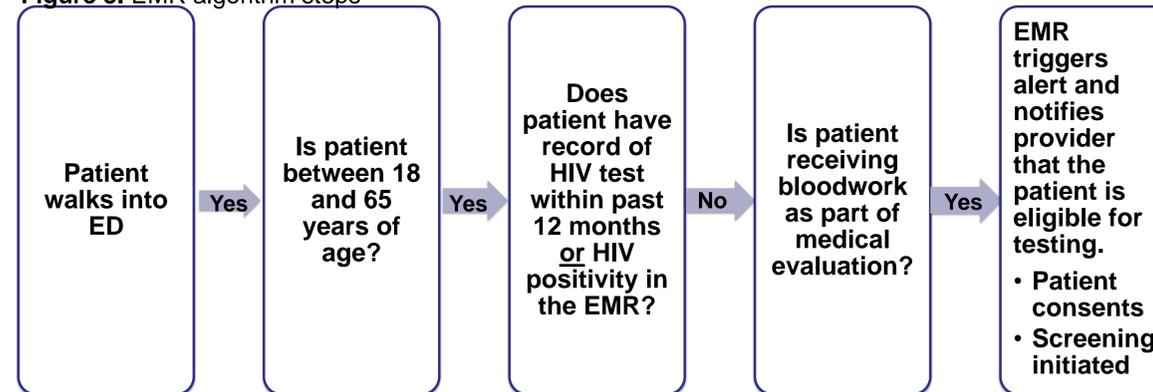
Implementation of Evidence-Based Protocol

During triage, the electronic medical record scanned for eligibility and fired an alert, prompting nurse to inform the patient of routine testing unless they declined. Grant support covered the cost for screening among uninsured patients. Test results were routed to linkage coordinator to link positives to care.

NC law previously required us to obtain separate written consent. Meetings with lawyers, risk management, and state leadership allowed our program to remove separate and required written consent per state law 10 A NCAC 41A .0202 as long as the patient is notified they will be tested and given the opportunity to refuse.

The electronic medical record was modified to automatically prompt the medical provider when patient is eligible for routine HIV screening. Steps made within the EMR are noted below:

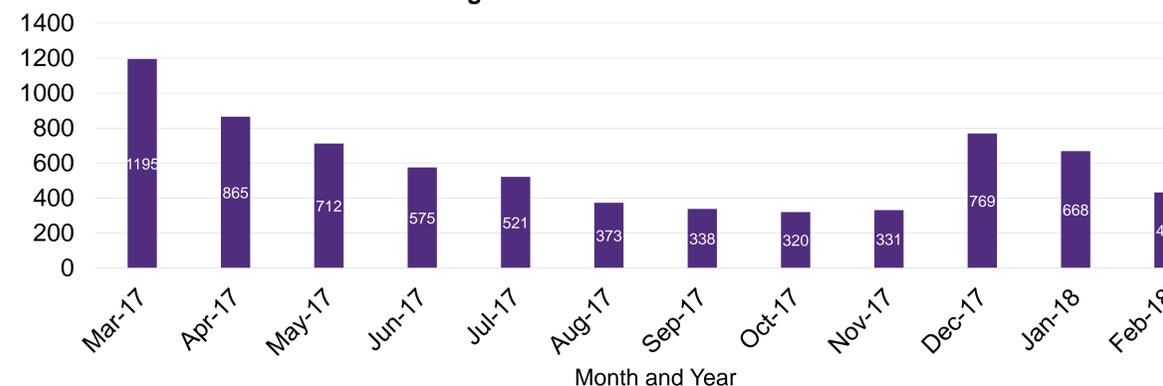
Figure 3. EMR algorithm steps



Results

A total of 7,091 unique patients were tested and 21 patients were found to be positive; of which, 16 were newly diagnosed and 5 were previously diagnosed. 14 of 16 (87.5%) newly diagnosed patients were successfully linked to care and 2 of those previously diagnosed were linked (40%). Reasons why those previously diagnosed were not linked to care include refusal to link, incarceration, and transferring care services. The most common presenting complaints were chest pain and sore throat.

Figure 4. Total Tests Performed



Conclusions / Discussion

We implemented an opt-out strategy for routine testing. Physician and nursing staff were educated on project goals, regulatory requirements, cost and process for testing. We successfully implemented routine HIV testing in our medical center, changed policies, and tested and linked found positives to HIV care.

Implications for Emergency Nursing Practice

- Work with identified patient population to obtain required blood work for testing purposes.
- Ensure that the patient is well informed
- Enable patients to maintain control over testing.

References

1. Reif, S., Safley, D., McAllaster, C., Wilson, E., & Whetten, K. (2017). State of HIV in the US Deep South. *Journal of Community Health*. 42:844-853. doi: 10.1007/s10900-017-0325-8
2. Williams, B., Amico, K.R., & Konkle-Parker, D. (2011). Qualitative to assessment of barriers and facilitators to HIV treatment. *Journal of the Association of Nurses in AIDS Care*. 22(4):307-312.
3. Whetten, K., Leserman, J., Whetten, R., Ostermann, J., Thielman, N., Swartz, M., et al. (2006) Exploring lack of trust in care providers and the government as a barrier to health service use. *American Journal of Public Health*. 96(4):716-721.
4. Berger, M.B., Sullivan, K.A., Parnell, H.E., Keller, J., Pollard, A., Cox, M.E., et al. (2015). Barriers and facilitators to retaining and reengaging HIV clients in care: a case study in North Carolina. *Journal of the International Association of Providers of AIDS Care*. 15:486-493.