

needed because patient needs change over time. The organization, operation, and administration of EDs change over time, thus requiring adjustments as well.

DISCUSSION OF CRITICAL ISSUES AND CONCERNS

Despite the wealth of experience offered by meeting participants about implementing HIV testing in EDs, there remain large gaps in our knowledge about HIV testing in EDs relative to their feasibility, operationalization, and effectiveness (including cost-effectiveness). There is also a lack of clear consensus on whether and/or to what extent ED-based testing programs should constitute part of health department HIV prevention portfolios. Several critical areas for additional discussion, inquiry, and research emerged as a result of discussion at the meeting among health departments and their ED partners.

Health departments must think critically about how and whether HIV testing in EDs fits into their overall prevention portfolio. Health departments participating in the meeting saw a potential value in implementing HIV testing in EDs. Most health departments that have implemented ED-based HIV testing have done so based on thoughtful review of surveillance and service data which enabled them to identify gaps in services. Identification of specific EDs in which to implement HIV testing was

based on a number of factors including service area, characteristics of the patient population, interest/buy-in of the facility, as well as financial and operational feasibility. Health departments expressed concern, however, about how to prioritize support of ED-based testing relative to other HIV prevention services. For many health departments, particularly during periods of level or declining funding, supporting implementation and expansion of ED-based testing means redirecting resources from other important prevention services.

Health departments also expressed concern that CDC and others are overemphasizing the utility and importance of ED-based testing for identifying new cases. ED-based programs may result in an increase in the volume of tests conducted in a state and may result in an increase in the number of HIV-infected individuals diagnosed who would not have sought testing in other venues. However, health departments feel that the potential yield of ED-based programs, in terms of numbers of individuals tested and number of new positives identified, must be considered against the yield of other programs, including highly-targeted community-based efforts to locate infected individuals. The success in ensuring linkages with, and engagement in, prevention and care services is also a critical consideration for health departments as meeting participants described mixed success in facilitating such linkages.

Health departments expressed that testing is not just a “numbers game” and that they have a responsibility to ensure access to HIV testing services among those at risk for HIV, particularly those who are not likely to be reached in health care settings. Thus, for health departments, an increase in volume of tests conducted and new positives identified may not be sufficient justification for redirecting funding away from highly-targeted services.

Recommendations:

Health departments should consider a range of data and information sources in deciding to implement and/or expand HIV testing in EDs including:

- HIV prevalence and/or incidence data (if available) to guide decisions regarding where, geographically, to focus efforts;
- HIV testing service data to identify gaps in services by location and population, coverage of hard to reach populations which might not access hospital-based services, and yield of existing programs; and,
- Facility-specific data to understand the patient population (e.g., demographics, insurance coverage, proportion of patients receiving urgent care versus emergency care).

Health departments should also engage hospitals, with representation from multiple departments, to gauge interest in ED-based testing and to understand the financial and operational feasibility of implementing services.

The feasibility and appropriateness of a population-based screening approach to HIV testing in EDs is a key concern for health departments.

Health departments and their ED partners have experience with and presented a number of models for implementing HIV testing. None of the programs presented at the meeting, however, represented a “true” screening approach (i.e., all patients are tested for HIV unless they decline). Those which most closely approximated a screening approach might best be characterized as a “test as many as possible” approach, while other programs used a risk-based approach, wherein patients were screened for HIV-related behavioral and/or clinical “risks” and recommended HIV testing on the basis of risk.

While health departments and their ED partners have implemented a variety of models of testing, all expressed the desire to have access to “good” evaluation data about the effectiveness of various models and approaches to guide program planning and refinement. There is currently little in the published literature which addresses this gap in knowledge.

As mentioned previously, CDC and others have advanced screening, especially screening which utilizes an "opt-out" approach, as the ideal for EDs. Health departments and their ED partners identified a number of operational challenges which have precluded implementing HIV screening.

Health departments and their ED partners also expressed concern over the lack of substantial evidence to support screening approaches as the "ideal" for ED-based HIV testing. In particular:

- Health departments are skeptical about the cost-effectiveness of screening approaches, particularly as implemented in EDs. Screening approaches have been promoted as cost-effective based on a limited number of studies, none of which are based on "real world" costs.
- Health departments expressed an urgent need for information about the costs associated with ED-based HIV testing. Currently, there is very limited information readily available regarding the cost of ED-based testing programs and this information is needed to guide program planning, decision-making about resource allocation, as well as policy advocacy and education efforts.
- There is little published evidence that supports that "opt-out"

testing in EDs or other clinical settings improves entry to care or that it will successfully address the "problem" of late entry to care. This evidence is critical to helping health departments make decisions about prioritizing services within their overall prevention portfolios.

- Programs reported mixed results with regard to successful linkages to care. It is unclear, however, to what extent and in what ways the lack of success can be attributed to structural factors (e.g., processes for making referrals), providers (e.g., how referral information is presented to patients), or the patient (e.g., whether or not he/she shows up for an appointment). Information to help understand strategies by which to ensure successful referrals into care is essential and urgently needed.
- Importantly, health departments expressed concern about a lack of compelling evidence for the feasibility of operationalizing screening in an ED. Risk-based models of HIV testing may miss some patients who are HIV infected, but they may be more feasible to implement in EDs and may be more manageable in terms of ensuring that newly diagnosed patients access needed care and treatment services.

Recommendations:

- There are many gaps in knowledge about HIV testing in EDs in terms of models for delivery of testing, screening versus targeted approaches, cost-effectiveness, and overall effectiveness in identifying new positives and successfully linking these individuals to care. Until and unless this gap in knowledge is addressed, health departments and their ED partners should implement a model and approach to testing which makes the most sense for a particular facility in terms of operational issues, which is feasible within the context of available human and fiscal resources, and which is most likely to successfully achieve programmatic objectives related to helping patients learn their HIV status and to link them with needed prevention and care services. Health departments considering implementing or expanding ED-based testing efforts should seek the advice and consultation of their peers who are similarly engaged in supporting ED-based testing. Ongoing peer-to-peer consultation and technical assistance is likely to facilitate a rapid diffusion of current practices and strategies.
- Health departments and their ED partners should collaborate in operational research to identify the approaches and strategies

that facilitate implementation of HIV testing in EDs, optimize the effectiveness of ED-based testing programs, and ensure successful linkages to care and prevention services. Health departments and their ED partners should also advocate for resources to support such research.

Financing HIV testing activities in EDs is a critical concern for health departments and their ED partners.

Health departments have financially invested in implementing HIV testing in EDs, ranging from purchasing HIV test devices to providing grants that fund staff and laboratory services. Health departments expressed serious concern, however, about their capacity to continue to support ED-based programs and to expand such services, as health departments have to address multiple, competing priorities within increasingly constrained resources. Sustainability of ED-based HIV testing, particularly if delivered through a screening approach, was expressed as a critical concern for health departments and their ED partners.

Obtaining reimbursement for screening from Medicaid and other insurers was identified as essential to facilitating implementation and expansion of HIV testing in EDs (as well as other clinical settings) and, more importantly, sustainability of these services. At the time of the meeting, only one state, New York, had successfully negotiated with its state Medicaid program to

cover HIV screening in EDs. Even if public and private insurers move toward covering HIV screening, EDs will continue to require additional resources to support HIV testing for under- and uninsured populations.

ED partners also indicated that financing is the most important challenge associated with implementation of HIV testing in EDs. Many EDs face serious financial challenges today, particularly as they serve greater numbers of under- and uninsured individuals while simultaneously dealing with decreased reimbursement from insurers and increasing costs of health care. Some EDs report that all ED services are included in a "global" charge to insurers which is insufficient to cover additional costs associated with implementation of HIV screening. Global charges either need to be increased to cover the cost of HIV screening or EDs need to be allowed to charge insurers separately for it.

Recommendations:

- Health department HIV/AIDS programs should engage state Medicaid programs regarding obtaining reimbursement for HIV screening in EDs. Collaboration with provider organizations, such as state hospital associations and professional provider organizations, may be beneficial in facilitating these discussions.
- Health departments, EDs, and professional organizations

representing EDs and clinicians should engage in state-level advocacy and education to encourage third-party payers to reimburse health care providers for HIV screening in EDs.

- Health departments and provider organizations should collaborate, when feasible, in state-level advocacy for additional resources to support expansion of HIV testing in EDs.

Data and reporting requirements associated with federally-funded HIV testing efforts were identified as an important barrier to ED-based testing.

Health departments and ED partners expressed a serious concern with the data collection and reporting requirements associated with publicly-supported HIV testing efforts in EDs and other clinical settings. Meeting participants raised repeated concerns regarding the burden of collecting and reporting client-level data, particularly as related to CDC's Program Evaluation and Monitoring System (PEMS). Many of the variables currently required by PEMS are not routinely collected from patients in association with health services provided by the ED. Data that are routinely collected in association with ED services are often compiled in clinical information systems (CIS) or electronic medical record (EMR) systems from which data extraction may not be possible due to incompatibility of file formats, lack of capacity/technical expertise to do so,

or because of confidentiality protections associated with patient information (e.g., HIPAA).

Data collection and reporting requirements were identified as a barrier to ED-based testing because the necessity of collecting such data can interfere with provision of services and interrupt patient flow. Busy clinicians have insufficient time to attend to data collection. Data collection, entry, and management can require dedicated staff to deal with either/both a large volume of data or duplicate entry of data, since

data reporting requirements associated with federal funding have necessitated development of "parallel" data systems in order to satisfy reporting requirements. This diverts resources away from program services.

Recommendation:

- Health departments must continue to advocate for scaled-back reporting requirements associated with publicly-supported HIV testing efforts provided in clinical settings,

NOTES

APPENDIX A STATE PROFILES OF HIV TESTING IN EDs

Colorado

Implementation: Beginning in 2004 in the Denver Health Medical Center. The University of Colorado Hospital also recently implemented HIV testing in its ED.

Approach: Physician-based, risk-targeted, "opt-in." Beginning in February 2007, Colorado planned to initiate a trial to evaluate "opt-out" rapid testing in the Denver Health Medical Center, supported with funding from the CDC. Risk assessment/risk reduction counseling is provided to patients.

Consent: Colorado statutes do not require specific consent for HIV testing. Verbal consent is permissible.

Testing: Rapid tests are processed in the hospital's central "core" laboratory.

Staffing Model and Flow: Physicians recommend HIV testing to patients, based on risk and/or clinical symptoms, and obtain verbal consent to test. An ED-based social worker obtains written informed consent and provides pre-test counseling. Nurses or health care technicians obtain blood specimens. Specimens are tested by the hospital's core laboratory. Clinical social workers provide negative results and post-test counseling. The physician, along with a clinical social worker, reports positive results.

Linkages for HIV Positive Patients: Clinical social workers facilitate linkage to care. Newly-diagnosed patients are "walked" to specialty care at one of four facilities (depending on patient needs and eligibility) during business hours. If patients are diagnosed at night or weekends they are followed-up on next business day.

Financing: Grant from the Colorado Department of Public Health and Environment (CDPHE) and, recently, a grant from the CDC.

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District of Columbia

Implementation: Beginning in September of 2006 in the ED of the George Washington University Hospital.

Approach: Population-based screening (patients 13-64 years old), using "opt-in" approach using trained "screeners" to approach patients.

Consent: District of Columbia does not require specific consent for HIV testing.

Testing: Point-of-care rapid testing.

Staffing Model and Flow: All patients who are not known to be HIV-infected and who are between the ages of 13 and 64 years are provided with an information sheet about HIV testing by a triage nurse. One or two staff specifically trained to perform HIV testing (i.e., "screeners") is available from 8am to 12am every day and approach patients in the ED to offer testing. If patients have a reactive result, the attending physician is notified of the result to support appropriate clinical decision-making and to order confirmatory testing.

Linkages for HIV Positive Patients: Patient discharge instructions include referral information. Infectious disease fellows are notified via page or email to arrange for initial follow-up of newly identified HIV-infected patients at the George Washington Infectious Disease Clinic.

Financing: District of Columbia Department of Health provided HIV rapid test kits at no charge.

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Florida

Implementation: Beginning in May 2006 at Jackson Memorial Hospitals (JMH) in Miami.

Approach: Population-based "opt-in" approach. Risk assessment/risk reduction counseling is provided to patients.

Consent: Patients provide specific consent for HIV testing.

Testing: Point-of-care rapid testing.

Staffing Model and Flow: Dedicated staff provides HIV testing services from 7:30am to 9:00pm, Monday-Saturday. Plans are underway to expand further into the evening and on Sundays. Dedicated testing staff approach patients who are already in beds and offer them HIV testing, obtain consent, provide counseling, perform HIV testing, and provide test results. Pre- and post-test counseling are provided to all patients in accordance with Florida statute.

Linkages for HIV Positive Patients: Patients found to be HIV-infected are immediately linked into the South Florida AIDS Network (SFAN) system. Patients are walked, by the HIV testing staff, to the SFAN office to facilitate linkage to clinical evaluation and care and engagement in case management services either at JMH or other services, depending on patient needs and eligibility. Plans are underway for the JMH to incorporate ARTAS Linkage to Care to strengthen linkages to care and prevention services for patients diagnosed in the JMH ED.

Financing: Grants from the Miami-Dade Department of Health and Gilead Foundation.

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Louisiana

Implementation: Beginning in August of 2005 at the ED of Earl K. Long Hospital, a public not-for-profit ED in Baton Rouge.

Approach: Risk-based opt-in testing utilizing HIV test counselors, trained by the Louisiana Department of Health. Risk assessment/risk reduction counseling is provided to patients.

Consent: Louisiana, by statute, requires written informed consent for HIV testing.

Testing: Point-of-care rapid testing.

Staffing Model and Flow: Staffing for this program relied on a single dedicated "tester." Testing is offered to patients with identified risk for hepatitis B (HBV) in order to minimize stigma and awkwardness of HIV testing. Testing for HBV and hepatitis A (HAV), hepatitis C (HCV), and syphilis are offered along with HIV testing. HIV counselors obtain consent, provide counseling, and conduct point-of-care rapid tests. Confirmatory testing for reactive rapid tests is offered in the ED.

Linkages for HIV Positive Patients: Linkage Coordinators are immediately paged to the ED for patients with reactive test results. Linkage Coordinators meet with clients and assist them with making appointments for medical evaluation/treatment, prevention, and other support services.

Financing: Louisiana Department of Health provided staff and HIV rapid test kits.

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Maryland

Implementation: HIV testing has been performed in the ED for over 15 years, initially for epidemiologic studies, but over the past five years, HIV testing has been conducted in the Johns Hopkins University (JHU) ED as part of demonstration projects related to understanding operationalization of HIV testing in ED settings.

Approach: Population-based opt-in testing.

Consent: Maryland statute requires written consent specific for HIV testing.

Testing: Rapid tests are processed in the ED satellite laboratory.

Staffing Model and Flow: The JHU utilizes a combination of provider driven testing combined with dedicated HIV testing staff, referred to as "facilitators." The first staffing model is a health care worker (HCW) initiated model. In this model, the HCW (e.g., physician, nurse) approaches a patient to ascertain interest. Physicians provide pre-test information, primarily in the form of a written brochure, and obtain consent to test. Nurses or ancillary staff collect samples, which are processed in the ED laboratory. Physicians deliver test results and arrange for follow-up and referrals. JHU also uses dedicated "facilitators" to conduct HIV counseling and testing. Facilitators approach patients, provide them with information/pre-test counseling, and obtain consent. Nurses or other staff obtain samples which are processed in the ED laboratory. Physicians deliver test results and provide post-test counseling and referrals. Facilitators work with clinical staff to ensure that test results are delivered and to ensure referrals to care and treatment. The facilitator-led approach appears to increase the number of patients who consent to testing and thus JHU plans to expand the hours during which facilitated testing is available.

Linkages for HIV Positive Patients: Clinical staff and "facilitators" provide referrals for medical evaluation and follow-up. Facilitators also provide assistance to patients to ensure follow-up with referrals. The HIV specialty clinic of the JHU provides dedicated appointment "slots" for follow-up of patients with reactive rapid test results.

Financing: Grant from the Maryland Department of Health.

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Massachusetts

Implementation: Beginning in 2002, the Massachusetts Department of Health initiated efforts to implement routine offering of HIV testing to all patients in multiple Urgent Care Centers in Boston, Cambridge, Everett, Worcester, and Springfield under a research protocol. The HIV testing program run by the Boston University Medical Center was presented.

Approach: Hierarchical routine screening on an "opt-in" basis. Risk assessment/risk reduction counseling is provided to patients.

Consent: Massachusetts requires written consent for HIV testing.

Testing: Point-of-care rapid testing.

Staffing Model and Flow: The program at Boston University Medical Center utilizes dedicated HIV counselors. Nurse managers work with HIV counselors to identify highest risk patients on the basis of behavioral risk and presenting symptoms. HIV counselors approach patients in the exam room, after triage has been completed, but prior to clinical consultation with a physician. Approximately ten percent of patients are referred to counselors by physicians. Counselors conduct pre-test counseling, obtain consent, conduct tests, provide results, and facilitate needed referrals.

Linkages for HIV Positive Patients: HIV counselors walk patients to the HIV clinic during regular hours of operation; appointments for next business day.

Financing: Grant from the Massachusetts Department of Public Health.

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Michigan

Implementation: Beginning in 2004 in two EDs in Detroit: Detroit Receiving Hospital (DRH) and Henry Ford Health Systems (HFHS).

Approach: Detroit Receiving Hospitals: population-based, "opt-in" testing. Henry Ford Health Systems: risk-based targeted testing.

Consent: Michigan requires written consent for HIV testing. Counseling requirements have been streamlined.

Testing: Point-of-care rapid testing.

Staffing Model and Flow: DRH utilizes dedicated staff (i.e., "testers") to perform all aspects of HIV testing. HIV testing is available 24/7. Testers approach patients to offer HIV testing. If patients agree to HIV testing, testers provide pre-test information, utilizing a "script," obtain written consent to test, conduct HIV rapid testing at point-of-care, provide test results, and make referrals to care.

HFHS uses a "counselor on call" model. A nurse (employed by the Infectious Disease Clinic) utilizes an electronic patient information system to identify patients at high risk for HIV based on behavior or presenting symptoms. This nurse approaches these patients, offers them HIV testing, obtains consent to test, provides test results and makes referrals to care.

Linkages for HIV Positive Patients: DRH: During regular business hours staff from the Infectious Disease Clinic (ID) co-located in the building escort patients to their first appointment. Patients who are preliminary positive during evening and weekend hours are provided with an appointment on the next business day. Staff of the ID clinic conduct follow-up with patients who fail to make their first appointment.

HFHS: Same or next day appointments are provided for patients with preliminary positive results with the HFHS HIV Clinic, located in an adjacent building. Depending on insurance eligibility, patients are also referred to other HIV clinics. HIV clinic staff conduct follow-up on patients who fail to make their first appointment.

Financing: Grant from the Michigan Department of Community Health.

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New Jersey

Implementation: As a result of a statewide initiative to expand access to HIV testing, by March 2004, 21 EDs in New Jersey offered rapid HIV testing. The program at the ED of the University of Medicine and Dentistry of New Jersey (UMDNJ), Newark was highlighted (initiated in February 2005).

Approach: All facilities conduct risk-based, "opt-in" testing. Risk assessment/risk reduction counseling is provided in conjunction with HIV testing. UMDNJ uses a risk-based, opt-out approach to HIV testing.

Consent: New Jersey requires written consent for HIV testing.

Testing: Point-of-care rapid testing.

Staffing Model and Flow: Multiple models of testing are used across EDs including dedicated HIV counselors housed in the ED to specifically offer HIV counseling and testing; support of satellite services associated with EDs; and paging HIV counselors to the ED when HIV counseling/testing services are needed.

At UMDNJ, providers identify patients for whom HIV testing is recommended on the basis of risk and refer these patients to dedicated HIV counselors housed in the ED. Counselors provide pre-test counseling, obtain consent to test, perform rapid HIV testing, and deliver test results. Counselors arrange for confirmatory testing and provide linkage to care and other needed prevention and support services. HIV-negative patients receive referrals to prevention services.

Linkages for HIV Positive Patients: At UMDNJ, patients with confirmed positive results are provided with same or next-day medical appointments in the UMDNJ Infectious Disease Practice. ED-based HIV counselors walk patients to the Infectious Disease Practice. Vouchers (\$10) are provided to patients as incentive to return for confirmatory test results. Patients who fail to return for confirmatory results are referred to partner services. HIV-positive patients also have access to mental health services and prevention services through the ID Practice.

Financing: New Jersey Department of Health awarded grants to hospitals to fund counselors, supplies, and test and control kits.

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New York State

Implementation: New York State initiated HIV testing in EDs, on a pilot basis, beginning in mid-2004. The pilot project was designed to assess the feasibility and effectiveness of HIV testing in EDs. In 2005, the New York AIDS Institute embarked on a statewide initiative to encourage adoption of routine HIV testing in medical care settings. The program at the Metropolitan Hospital Center, New York City, was highlighted (initiated in July 2004).

Approach: Population-based, opt-in testing.

Consent: New York requires written informed consent for HIV testing. Counseling requirements have been streamlined; print and audio-visual materials can be used.

Testing: Rapid tests conducted and analyzed at point-of-care or via central laboratory. Most facilities provide point-of care testing.

Staffing Model and Flow: Among the six EDs supported by the New York Department of Health to provide HIV testing, three models for providing testing are utilized. The first is a clinician-driven model, used in low-volume settings. A triage nurse offers testing. Clinical staff (including physicians) conduct testing, point-of-care, and provide results. The second, known as a "counselor on call" model, is used primarily in medium volume ED settings. In this model, HIV counselors are called to the ED to assist clinical staff in delivering HIV positive results, facilitate linkage to care, and to otherwise support ED staff in provision of HIV testing. The third is a dedicated counselor model, used primarily in high volume EDs. In this model, dedicated HIV counselors perform all aspects of HIV testing, particularly related to delivery of HIV positive test results and facilitating entry to care, instead of, or along with, physicians.

Metropolitan Hospital Center (MHC) uses a clinician-based model for HIV testing. Triage nurses screen all patients and offer HIV testing and document test acceptance in the patients' electronic medical record (EMR). All patients interested in HIV testing are provided with a packet of written materials, including pre-test counseling information and consent forms. A staff nurse obtains signed consent from the patient and a sample for testing. Specimens are processed in the central lab. Physicians provide patients with test results and post-test counseling. Physicians refer patients with reactive rapid test results to the HIV clinic.

Linkages for HIV Positive Patients: Physicians make referrals to the MHC HIV clinic. HIV clinic staff follow up with patients to ensure linkage to care.

Financing: Grants from the New York Department of Health and the New York City Department of Health and Hygiene; Reimbursement via Medicaid (November 2006).

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New York City

Implementation: The New York City Department of Health and Mental Hygiene (NYCDHMH) funded nine EDs to provide HIV testing, beginning in January of 2006. The program at the ED of St. Luke's Roosevelt Hospital was highlighted.

Approach: Population-based, opt-in testing. All patients are provided with streamlined counseling, pursuant to state law. Most facilities offer risk assessment and risk reduction counseling.

Consent: New York requires written informed consent for HIV testing.

Testing: Rapid tests conducted and analyzed at point-of-care or via central laboratory. Most facilities provide point-of care testing.

Staffing Model and Flow: Multiple models of testing are used across EDs. In a "counselor model" all patients are offered of HIV testing at triage and dedicated HIV counselors consent patients, conduct rapid testing and provide results. In a "provider model," all patients are offered HIV testing at triage and clinical staff obtain consent from patients, order specimens, and deliver test results. Specimens are processed in a central laboratory. Hybrid models are also used. In one such model, Public Health Educators (PHEs) approach patients, obtain consent, and deliver test results. Physicians order tests and laboratory technicians conduct and read test results. In another hybrid model, physicians obtain consent and order HIV tests. HIV counselors obtain specimens and delivers results. Specimens are processed in a central laboratory.

St. Luke's Roosevelt Hospitals uses a physician-based model for HIV testing. Triage nurses provide patients with information about HIV testing. ED physicians offer HIV testing to all medically-stable patients, conduct pre-test counseling, obtain consent, and order HIV testing. If a patient requires blood work for other purposes, the sample for HIV testing is sent to the central laboratory and results are returned within one hour. If a patient does not require blood work for other purposes, dedicated HIV counselors performs rapid testing point-of-care. Physicians and/or HIV counselors provide test results to patients, including preliminary positives. Confirmatory testing is automatically ordered for all reactive rapid tests, without an additional order. HIV counselors provide post-test counseling, ensure that confirmatory test results are received, and facilitate linkages to care for all HIV-positive patients. Dedicated counselors are also available to provide HIV negative results to patients if physicians are not available.

Linkages for HIV Positive Patients: For patients receiving a reactive test result during regular business hours, HIV counselors are typically available to provide prevention counseling. Referrals are usually made to HIV clinics within the individual hospital's system.

Financing: NYCDHMH supports nine EDs through a fee-for-service arrangement, based on the actual number of HIV tests conducted. New York City Health and Hospital Corporation (NYCHHC) provides grants to 11 EDs. The New York AIDS Institute supports at least one ED and the CDC also supports at least one ED. New York State has changed Medicaid billing to allow EDs to seek reimbursement for HIV screening.

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New York City (Jacobi Medical Center)

Implementation: Project BRIEF was initiated at Jacobi Medical Center (North Bronx) beginning in 2003.

Approach: Population-based opt-in testing utilizing video-assisted risk assessment and counseling.

Consent: New York requires written informed consent for HIV testing.

Testing: Point-of-care rapid testing.

Staffing Model and Flow: Public health advocates (PHA) approach patients in the ED to be recruited for HIV testing. Patients who agree are set up with a computer which plays a brief (approximately 1.5 minutes) video that covers information about HIV and testing required by state law. Patients are then asked to answer a series of questions designed to assess risk for HIV and guide PHAs in providing focused risk reduction counseling. The risk assessment takes about 15 minutes to complete. Patients indicate their interest in HIV testing as part of the computerized questionnaire. PHAs obtain written consent from each patient, conduct rapid HIV testing, and provide test results and referral to care.

Linkages for HIV Positive Patients: For patients receiving a reactive test result during regular business hours, PHAs provide immediate, escorted referrals to Jacobi's AIDS specialty clinic. Same day appointments are available. PHAs send secure emails on patients newly diagnosed to the AIDS specialty clinic to help initiate treatment planning. Patients receiving reactive results in the evenings and on weekends are provided with appointments for the next business day.

Financing: Grants from Gilead and New York City Health and Hospital Corporation

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