Prenatal HIV Screening

Preliminary Results

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HIV Screening

- 1985: protect blood supply
- 1987: high risk groups
- 1993: voluntary counseling/testing encouraged in patients 15-54 years
- 1995: prenatal testing
- 2001: opt-out for prenatal testing
- 2006: routine opt-out for all

Main Modes of Transmission: Women

- Heterosexual: 69%
- Injecting Drug Use (IDU): 29%

Prenatal HIV Screening Rates

2006 (GPRA FY 2006)

- Nationwide IHS, approx 65%
- California Area 34%

Opt-out Changes Everything

Reduces stigma, saves time, increases rates

- “opt-out” initiated in 2001
  - “ . . .the average annual percent increase in the number of HIV tests among females was 1.4%. In the month immediately following the adoption of opt-out testing, the rate increased by 28%.”

Opt-out

- Inform patient (instead of asking permission)
- Makes HIV screening same as other infectious diseases such as syphilis
- Get rid of the consent form
- Some Service Units have a form for woman to ‘actively decline’

Why Test?

- Earliest possible detection and intervention prevents mother-to-child transmission
- Early detection gets mother on tx immediately
- National standard
- Legal exposure of provider/unit if they do not test

Transmission Rates

- Studies have shown transmission rates of less than 2% among HIV infected mothers who started antiretroviral treatment during pregnancy
- Those who did not begin treatment until labor or after birth had transmission rates of 12-13%
- Infants whose mothers receive no preventive treatment contract HIV at a rate of 25%

When Do I Screen?

- As early as possible in pregnancy with other routine blood tests
- Should be done a second time in 3rd trimester if risk factors and in ‘jurisdictions’ with higher prevalence
- Rapid test for late presenters

Prenatal HIV Testing/GPRA

Preliminary field results based on
7 sites

Diagnosing Problem

- All sites believed they have excellent screening
- Wide variety of screening problems, often 1-2 “main” reasons
- First step is to diagnose by running a CRS program (patient list)

CRS program

- Very simple, steps can be emailed to facility
- Can pull sample of charts of patients who are entered in RPMS as:

1) pregnant (in 2005)

2) not tested for HIV

Findings

- 2 types of problems
  - Clinical (not testing)
  - Data (testing not recorded in RPMS)

Clinical problems

Not screening:

1) Not using opt-out
2) Transfer patients to other facility, not include HIV in early bloodwork
3) Patient considered to not have risk factors

Clinical problems (con't)

4) "Carrying over" HIV test from last pregnancy

5) Women decline test: often provider-specific

Data Problems

Women screened, but not recorded:

1) Lack of data entry (HIV test in chart)
2) No historical data entered if tested at other facility
3) Lab not linked to RPMS

Data problems (con't)

4) Miscoding:
    1) women declined test
    2) problems in change to EHR
    3) woman not pregnant

Large vs. Small Facilities

- Small clinics tended to have women transfer out, lost to follow up, or assumed that larger clinic would test
- Small clinic primary providers reluctant to test:

  -what if it is positive?

  -I'm not a counselor! No Time!

  -assumptions on patient confidentiality

  -patient transferred out anyway

  -no treatment here

Large vs. Small Clinics

- Larger service units assumed field clinics did the test
- Received women at last minute (but still should have tested)

Generalizing Problems by GPRA rate

- Clinics <80% have a systemic clinical and/or informational gap.
- Clinics with >80% have misses that are more difficult to solve (for example, women that never return after initial HCG+)

Misses in Other ID Tests

-Most misses in Hep B and RPR

-More reliable for G/C

-Reasons not clear, possibly linked to transfers or low disease prevalence

-Nearly all had basic bloodwork done, misses limited mainly to ID

Recommendations: Identifying the problem

- Have service unit run CRS to identify non-screened prenatal women
- Perform chart review
- Give prompt feedback, “blame the system” not the individual

Recommendations: Clinical

- HIV Test as soon as possible
- Ensure opt-out understood
- Overcome primary providers ‘not my job’ sentiment if it is present

Recommendations: Clinical

- Follow up defaulter cases as these likely to be at highest risk
- Rapid tests for late presenters
- Providers have HIV support: referral and consultation help is available for persons who test positive

Recommendations: Data

- Historical data must be entered, cannot refer out data responsibility with the patient. No reason for 0% screening.

- Not large additional workload for small clinic (<50 prenatal patients/yr)