

Opt-Out Strategies and Experience

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"I have no real or perceived vested interests that relate to this presentation nor do I have any relationships with pharmaceutical companies, biomedical device manufacturers, and/or other corporations whose products or services are related to pertinent therapeutic areas."

Learning Objectives



- Define rationale for HIV opt-out testing integration process
- Identify practice model and patient flow challenges to implementation of opt-out testing
- Analyze staff readiness and identify support strategies

Rationale for Integration



- CDC Recommendation
- Focus of PPGNNJ and PPMNJ OPA/HIV Prevention Project
- Agency commitment to provide routine testing
- Provide continuity of care for patients
- Already doing HIV Rapid Testing

Date Initiated



- Opt-out testing began in the first of 8 centers in August 2006
- Opt-out testing offered to all Initial and Annual Patients in all clinic centers by January 2008

Staffing Issues



- Demystifying HIV Testing
- Staff buy-in
- Cross training HIV counselors to perform other clinical duties
- Training additional staff
- Fear of giving a preliminary positive result

Training



- Combined HIV Counselor training by Cicatelli Associates & NJDHSS Div. of HIV/AIDS
- OraQuick Rapid Test and Controls training by Medical Director
- Paperwork training
- Updating Lab Manual resource
- Brainstorming in each Center and at Supervisors' Meeting as how to proceed

Changes in Practice Model



- HIV testing offered routinely to all Initial and Annual Visits
- There is no "one size fits all" approach
- Trial and Error to see what approach works best in a particular Center
- Way of offering: "Today we will be doing a pap, chlamydia test and an HIV test."

Reimbursement



- Four centers receive OraQuick kits and controls for rapid testing at no charge from the state of New Jersey
- Four centers purchase rapid testing kits
- Insurance companies do reimburse for HIV testing

Lessons Learned: Successes



- Testing twice as many patients
- Identified 25 confirmed positives compared to 10 in same time frame the year before
- Increasing staff buy-in
- Numbers continue to increase
- Modified Visit form to include routine HIV testing

Lessons Learned: Challenges



- Buy-in of long-time HIV counselors
- Streamlining counseling message
- Increased paperwork
- Turnover of staff
- Fear of getting a Preliminary Positive result and disruption of clinic flow
- Training additional staff
- Cost

Lessons Learned: Changes in Approach



- Encouraging staff to do finger stick blood testing instead of oral swab in attempt to decrease number of discordant results
- If one patient flow model doesn't work, try another
- Providing "Step by Step" instructions in a flip chart format
- Appoint a staff member to oversee program in each Center

Table 1: Testing/Tracking/Linkage to Care

Number HIV tests <i>prior</i> to implementing integrated model	6548 10 (+)
Number HIV tests <i>after</i> implementing integrated model	11344 25 (+)
Is Routine HIV testing offered to all clients	Yes
Number "opting out" of testing & why	Data being collected
# referrals for Follow-up care	100%



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