Implementing HIV Testing in the Rhode Island TB Clinic

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- Rhode Island ~ 1 million people
- Capital city: Providence ~ 180,000 people
  - Large immigrant population (29.2% foreign born)
- Single TB clinic based at The Miriam Hospital
  - 25-50 cases of active TB annually
  - ~1000 cases of LTBI annually
- Estimate 4000-4500 prevalent HIV cases
  - 1400 patients in care at The Miriam Hospital HIV clinic
Case History

- 33 year old woman was referred to TB clinic for evaluation of TST (22x22mm) noted during pre-natal care
- She had been part of a contact investigation 14 years earlier, was found to be TST + and had initiated but not completed INH treatment
- At her TB clinic visit during pregnancy, she had no symptoms and a normal chest radiograph.
- Treatment for LTBI was deferred until post-partum

Case History (continued)

- Following her TB clinic appointment, she underwent HIV testing during her prenatal care and was found to be HIV +
- She was referred to HIV clinic for initiation of ARVs/PMTCT but her HIV status was not communicated to the TB clinic
- Following delivery, she defaulted from HIV care and did not keep her appointment in TB clinic
Case History (continued)

- Three years later, she developed GI symptoms associated with fever and was eventually diagnosed with abdominal TB (retroperitoneal lymph node biopsy smear and culture positive)

HIV testing in TB clinic

- Case prompted MDs to consider incorporating routine HIV testing of all new TB and LTBI patients
- Pilot trial was started at Tuesday evening clinic sessions
Barriers to starting HIV testing (1)

- Reluctance of staff to add one more task in a busy clinic setting
- Discomfort of staff members discussing HIV and offering testing
- Written consent forms were time consuming and only available in English and Spanish
  - RI changed law to require verbal consent only
- How to get testing kits, who pays?

Barriers to starting HIV testing (2)

- Lack of lab space for specimen
- Disruption of patient flow in clinic
- Would patients be driven away with the mention of HIV testing?
- Need for staff to be trained and certified in procedure
Pros for Starting Testing

- Important that individuals be screened and referred for HIV treatment if positive
- Important in stratifying patients’ risk of developing active TB
- Easy access to HIV care: Hospital immunology clinic right next door
- Compliance with CDC guidelines

Overcoming Barriers (1)

- Despite staff reluctance (myself included), we gave it a shot
- All nurses were trained and certified (1 hour training)
- After initially borrowing supplies left over from a research study, funding was built into the grant that supports TB care
- With practice, staff became proficient and more comfortable initiating testing
- Surprisingly, patients were not upset and were excited to be able to get immediate results
Overcoming Barriers (2)

- RI changed consent law and the hospital implemented verbal consent – this was a great help!
- Main obstacle for the staff was that we couldn’t spend 20 min in room waiting for test to run – disrupted flow
- Working with MDs, we set up a secure site in MD office where specimens could be labeled, test run with timer for each, and MDs or staff could check results when timer went off

Overcoming Barriers (3)

- Despite all the perceived barriers, we now have a smoothly running system
  - Testing initiated by RN
  - Post-test counseling done by MDs or RN
  - Patients with positive rapid test immediately seen by MD and staff from immunology clinic involved as soon as possible
Results to date

- Over 1000 patients tested
- Two patients newly diagnosed with HIV

Case 1

- Young, foreign-born (Eastern Europe) woman who had PPD done for employment
  - TST +, CXR normal
  - Single, monogamous with boyfriend of 3 yrs
  - HIV result from lab-based testing (not rapid)
- Shocked by her HIV diagnosis – not expected by patient or by staff
- Confirmatory testing performed and linked to HIV care (initial CD4 ~ 900)
- Successfully completed LTBI treatment
- Actively followed in HIV clinic, not yet on ARVs
Case 2

- Young woman from West Africa, recently immigrated
- Skin tested to begin work as volunteer nursing assistant
- TST +, CXR normal
- Rapid HIV +
- Immediately seen by TB clinic MD, and SW from HIV clinic
- Patient initially refused to believe the results
- HIV social worker continued engaging re. HIV while we focused only on her LTBI care
- Completed confirmatory testing at related hospital, CD4 ~ 300
- As of June, 2012, started anti-retroviral therapy
- Still receiving treatment for LTBI

Lessons Learned

- Universal opt-out HIV testing in the RITB Clinic is feasible, practical, and well-accepted by staff and patients
- Contrary to pre-implementation staff predictions, patient refusal rates were low
- Potential barriers can be overcome
- HIV testing in this setting may be an effective way of reaching populations that do not otherwise have access to testing
References

• Rhode Island Department of Health, Rhode Island STD and HIV Epidemiology Survey. December 2, 2011.