AMA
AMERICAN MEDICAL ASSOCIATION

Screening is the first step to treatment

Screen your patients for HIV, STIs, Viral Hepatitis and LTBI

→ GET STARTED NOW

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Disclaimer: The AMA HIV, STIs, Viral Hepatitis and LTBI Routine Screening Toolkit contains resources supplied by third party organizations. Inclusion of these materials in the toolkit does not imply endorsement of these resources or corresponding organization.

This effort is supported through a cooperative agreement with the Centers for Disease Control and Prevention's (CDC) National Center for HIV, Viral Hepatitis, STD, and TB Prevention (CDC-RFA-OT18-1802: *Strengthening Public Health Systems and Services through National Partnerships to Improve and Protect the Nation's Health*).

Land and Labor Acknowledgement

We acknowledge that we are all living off the stolen ancestral lands of Indigenous peoples, which they have cared for since time immemorial. We acknowledge the extraction of brilliance, energy and life for labor forced upon people of African descent for more than 400 years. We celebrate the resilience and strength that all Indigenous people and descendants of Africa have shown in this country and worldwide. We carry our ancestors in us, and we are continually called to be better as we lead this work.

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Table of Contents

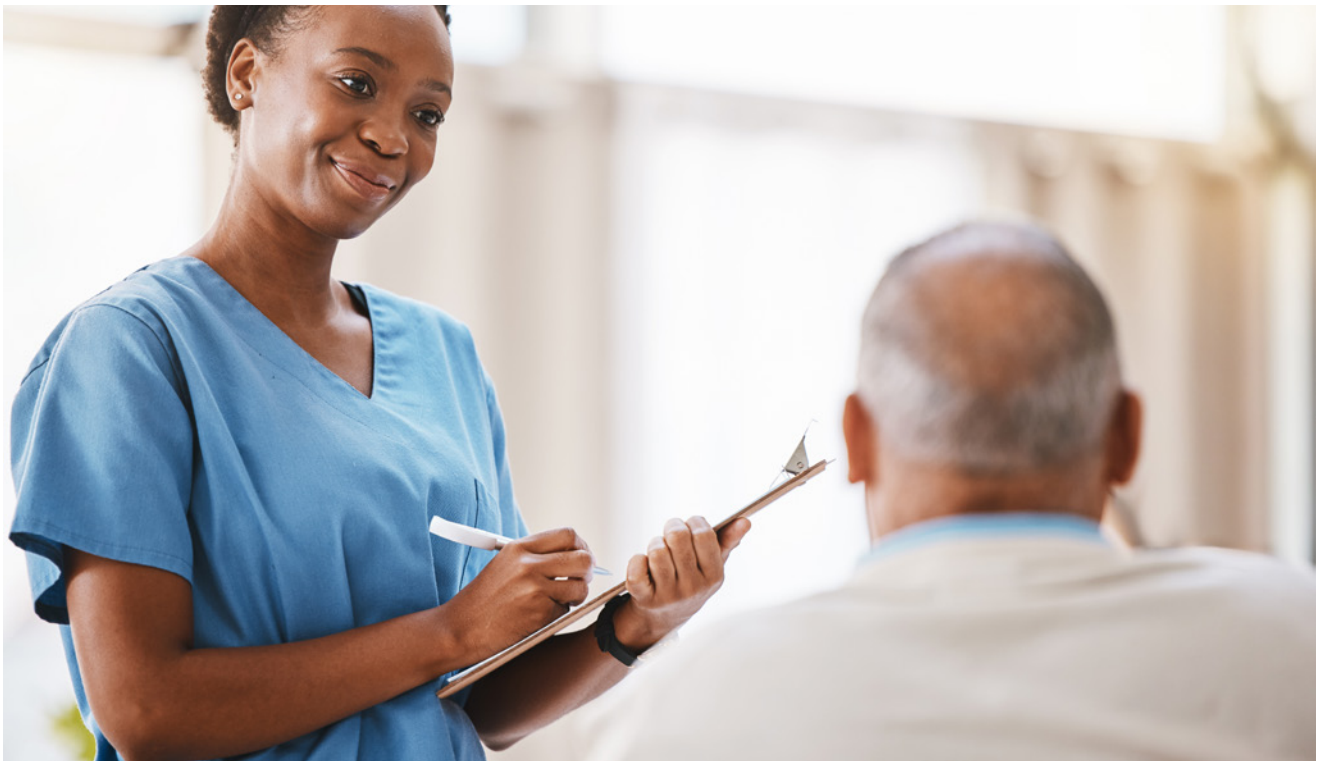
Introduction

Every year, millions of Americans are diagnosed with human immunodeficiency virus (HIV), sexually transmitted infections (STIs), viral hepatitis or tuberculosis (TB) and tens of thousands die from their infection. Guideline adherent screening programs can effectively identify these infections creating opportunities for treatment and prevention. Most of these infections share commonalities, from modes of transmission to demographic, social, and economic conditions that increase risk.

Routine screening and early detection of HIV, STIs, viral hepatitis and LTBI are critical for the health of our communities as these infections can have an asymptomatic stage which may prevent individuals from seeking the testing needed. For example, not everyone infected with TB bacteria becomes sick. As a result, two TB-related conditions exist: latent TB infection (LTBI) and TB disease. Persons unaware of their health status cannot take advantage of the treatment needed to improve their health and can unknowingly transmit the virus to other individuals.

The American Medical Association's (AMA) HIV, STIs, Viral Hepatitis and LTBI Routine Screening Toolkit for Community Health Centers and Emergency Departments is specifically designed to help clinicians overcome barriers and integrate screening into routine patient care.

The toolkit was vetted and reviewed by clinicians and physicians in community health centers and emergency departments nationwide, with a particular focus on practice leaders and champions who are looking to optimize routine screening practices. Its evidence-based approach walks through detailed, actionable steps for implementing routine screening to improve patient health outcomes.



What is routine screening?

By routine screening, we mean implementation of the Centers for Disease Control and Prevention (CDC) and U.S. Preventive Services Task Force (USPSTF) evidence-based preventive service guidelines and recommendations, including testing patients without symptoms based on patient characteristics or reported behaviors that would indicate screening is recommended. The AMA, as reflected in policy, supports the adoption and implementation of evidence-based preventive screening guidelines.

Implementing an effective routine screening program

Several critical considerations need to be understood and addressed to achieve successful routine screening practices.

- **Infectious disease testing is often considered separate from routine care.** Community health centers serve a variety of health needs. While screenings for blood pressure and cholesterol may be considered routine, screenings for infectious diseases may not. Infectious disease testing separate from regular routine care may reduce the likelihood people receive needed tests.
- **Care is often complaint-based.** A patient's most immediate complaints often drive appointments, due to pressures of time and patient satisfaction. Frequently, routine infectious disease screening is not front of mind unless their complaint is related to symptoms of HIV, STIs, viral hepatitis or LTBI.
- **Confusion over the definition of "routine" prevails.** Clinicians often undertake testing only when a patient presents with certain risk factors associated with HIV, STIs, viral hepatitis or LTBI. While these risk factors may be included in routine screening guidelines, others in need of routine screening are often overlooked, and not everyone recommended for routine screening is tested. Uncertainty or discomfort over how to link persons diagnosed with HIV and other conditions to care may also discourage clinicians from screening.
- **Stigma and fear persist.** HIV, STIs, viral hepatitis and LTBI carry stigmas, and screening for these conditions comes with a fear of knowing one's status—particularly with HIV. Clinicians sometimes need help working with patients to normalize screening and results counseling.

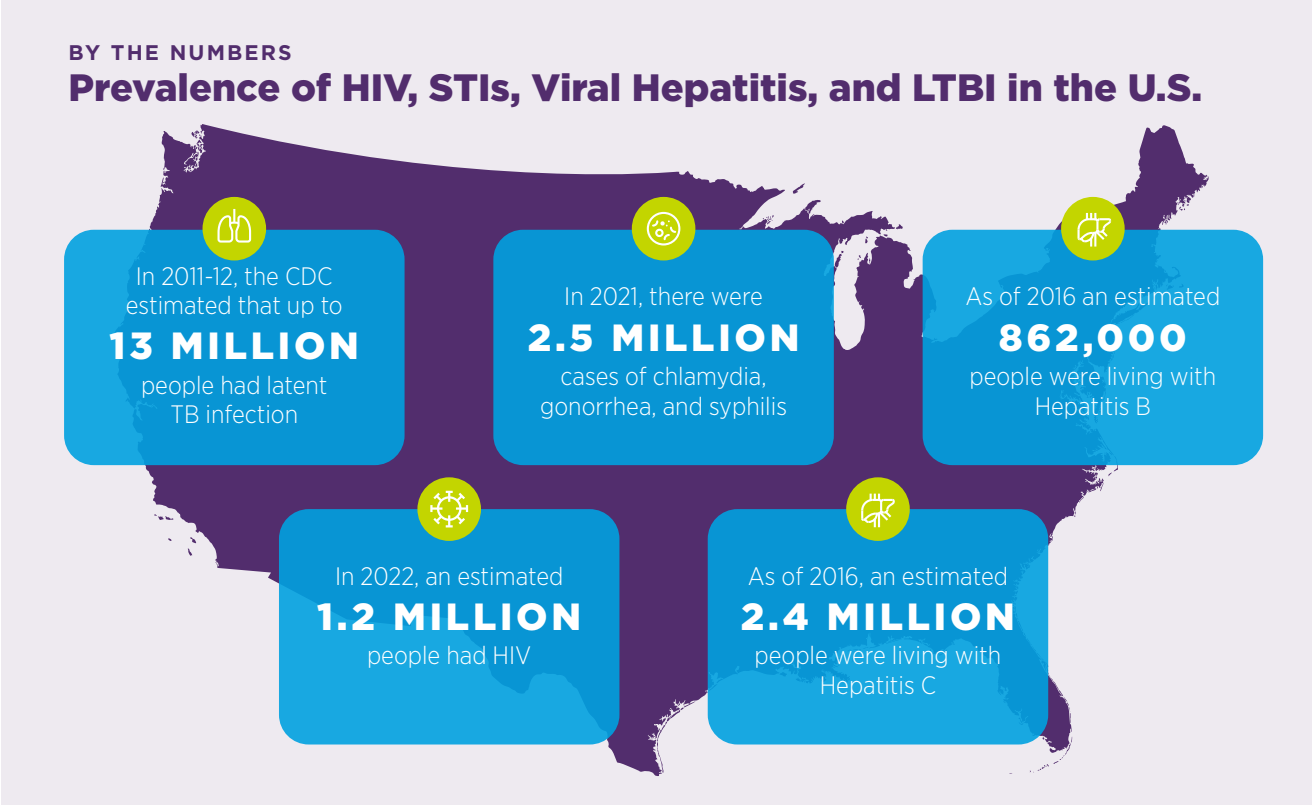
How to use the routine screening toolkit

The toolkit resources include a mix of both implementation and training-related materials for the care team. It is flexible, allowing you to follow along throughout the continuum to help improve your overall screening and testing approach or narrow in and focus on a specific stage. While not a specific stage, monitoring and evaluation along the screening continuum is critical and performance outcomes should inform continuous quality improvement efforts.

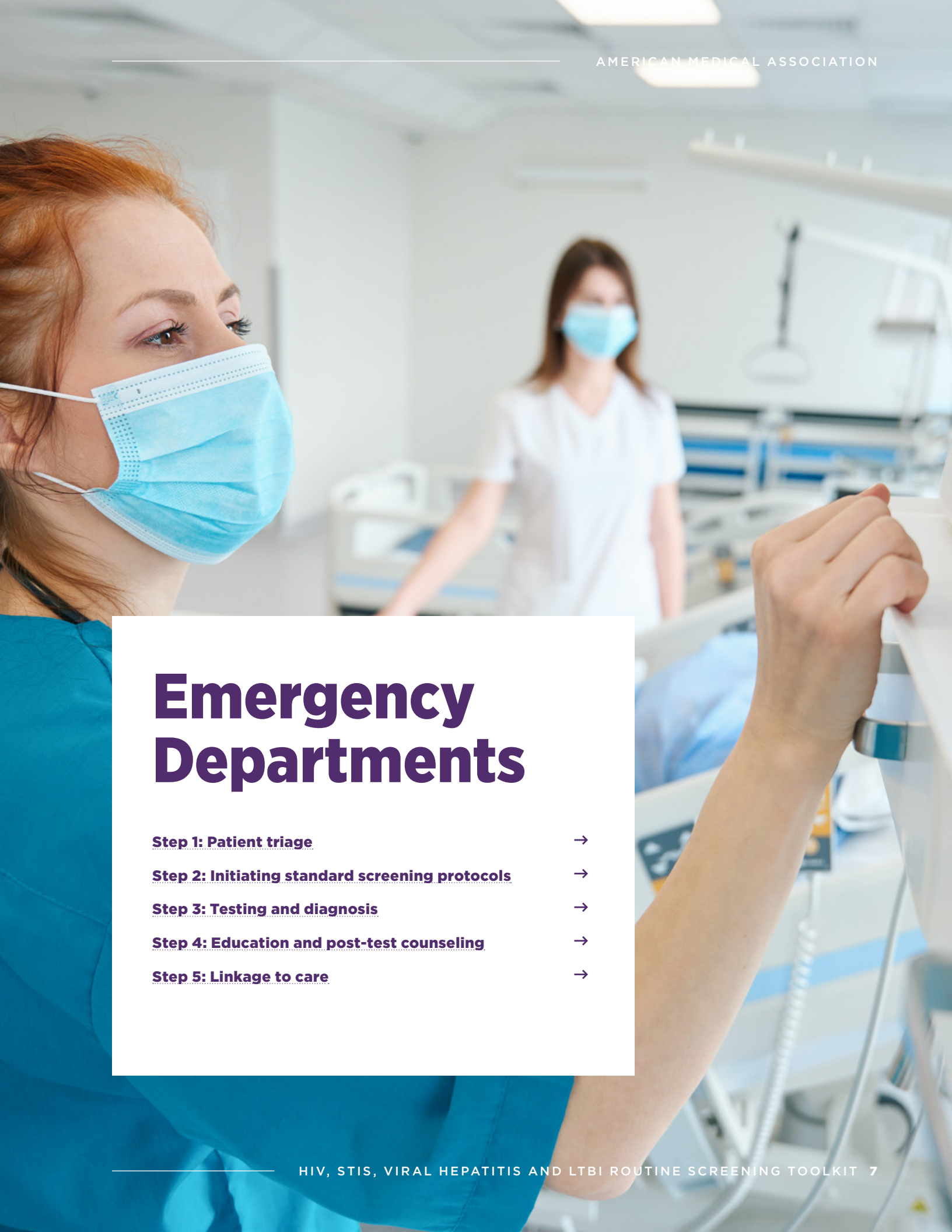
Given the specific populations recommended by CDC and USPSTF for LTBI screening in primary care settings, LTBI screening is not included in the routine screening strategies for emergency departments. Emergency departments should continue to consider TB disease in patients with risk factors or positive screening and diagnostic evaluations. For emergency departments who have strong active linkage to care systems established to support LTBI treatment, including staff dedicated to following up with the patient and facilitating confirmed linkage to treatment, and serve a patient population for whom LTBI screening is recommended, please refer to the community health center strategies for LTBI screening and treatment resources.

Impact by the numbers

Community health centers and emergency departments are uniquely positioned to screen for HIV, STIs, viral hepatitis, and LTBI among under-resourced and disproportionately affected populations. Together we can increase screening and reduce the number of new infections, but first we must understand the scale of the problem.



"For the most recent data, please visit CDC's National Center for HIV, Viral Hepatitis, STD, and TB Prevention AtlasPlus, HIV Data | CDC, STI Statistics | CDC, Statistics & Surveillance of Viral Hepatitis | CDC, and TB Data & Statistics | CDC.



Emergency Departments

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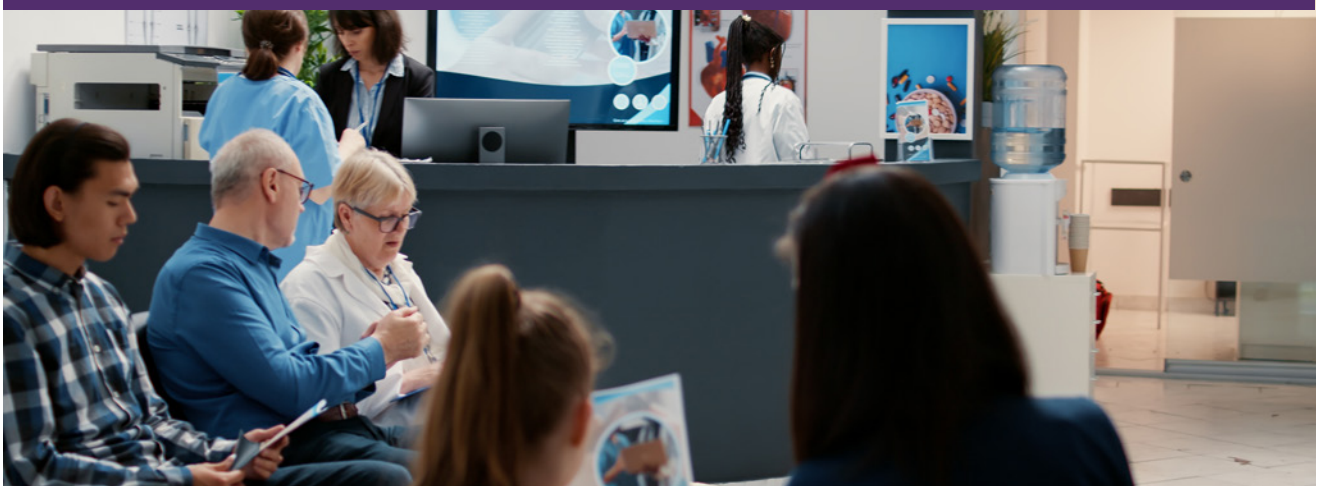

STEP 1:
Patient triage

Frequently, sporadic visits to the emergency department might be a patient's only interaction with the health care system and can lead to challenges in health record traceability and continuity of care. Obtaining medical records to guide the clinical decision-making process can pose a challenge, especially among patients who are uninsured and underinsured.

Additionally, patient discomfort with discussing sexual history negatively impacts access to care, disrupts important risk assessment conversations and often prevents test consent. Creating a trusted and welcoming environment for the patient and letting them play a larger role in the screening process by actively engaging them in the intake process in conjunction with automated support, can help give a better view of the patient's screening needs and ultimately increase screening.

Critical considerations at this stage

- Incomplete medical history stored across multiple care locations
- EHR excludes patient records from other health care systems
- Inconsistent demographic information
- Lack of space to ensure patient privacy
- Patient discomfort in discussing personal sexual history
- Distrust of institutional health
- Staff discomfort in discussing personal sexual history with patients
- Lack of awareness in the community about the need for screening
- Lack of knowledge on costs and affordability of screening
- Misconceptions about disease transmission
- Fear about finding out one's status and the associated stigma in the community

Step 1: Patient Triage (cont)

Strategies you can implement

1. Create a trusted and welcoming environment

Trust is earned through creating an environment and care team that is understanding of the patient's needs: hire from the community, keep the screening team small and personal, and offer options to self-report. Concerns of privacy and patient comfort with discussing sexual health history can be particularly challenging in emergency departments where physical space presents a challenge, with emergency triage areas lacking the appropriate privacy for conversations about sexual history or consent. Hiring administrative and clinical staff that reflect the language, culture, race, sexuality and socio-economic status of communities that health settings intend to serve helps bridge gaps in communication at patient intake and helps "catch" opportunities for screening.

Related resources

- Tools to Create a Welcoming Environment: Included as a subset of resources in the National Coalition of Sexual Health's Compendium of Sexual & Reproductive Health Resources for Healthcare Providers, users can find examples and resources on how to create a welcoming and safe environment for both teen and LGBTQ patients.
- Target HIV Cultural Competency Resources: This webpage includes a collection of guidance, tools and trainings that clinicians can use to identify and address bias to improve communication with diverse patients.
- Cultural Competence in Health and Human Services: This resource from the National Prevention Information Network defines what cultural competence is and how it applies to HIV, viral hepatitis, STI and TB prevention.

2. Involve patients in the screening process

Proactive engagement with patients at intake, through written or tablet surveys, allows emergency departments to gather information that will expedite the screening workflow, enable privacy and help form a more robust patient record. Front desk staff should be trained to provide patients with self-assessments. Patient navigators can assist with self-assessments, if available. Enabling self- or automated risk assessment saves time in the workflow and prevents physician fatigue. Further assessment of clinical risk factors can be conducted by the physician at a later point, if the patient tests positive.

Related resources

Self or risk assessment templates: The following links provide you with examples of self or risk assessment templates that you can leverage in your practice.

- HIV: Learn the HIV risk of different sexual activities when one partner is HIV positive and one partner is HIV negative (a discordant partnership).
- STIs: Assess your risk with the CDC's Prepare Before You're There STI self-risk assessment quiz.
- Viral hepatitis: Assess your risk with this Hepatitis Risk Assessment Tool from the CDC.

3. Collect comprehensive patient demographics and sexual history

Developing a standardized method to collect patient demographics, including race and ethnicity data, and sexual history can not only help you understand the screening needs for your patient, but can also be a mechanism to help identify quality improvement initiatives related to population health and improve health equity at your organization. Patient discomfort and stigma surrounding sexual history negatively impacts access to care and oftentimes disrupts screening consent. Equipping clinicians in your organization with tools and resources to routinely capture this information in an accurate and sensitive manner will help increase screening.

Step 1: Patient Triage (cont)

Related resources

- Discussing Sexual Health with Your Patients: The resource from the CDC outlines strategies and tips for facilitating discussions with and asking patients sensitive questions related to sexual health.
- A Guide to Taking a Sexual History: This CDC resource offers a framework for discussing sexual health issues to help clinicians complete the overall picture of their patient's health.
- GOALS Framework for Sexual History Taking in Primary Care: The GOALS Framework resource from the Clinical Guidelines Program of the New York State Department of Health AIDS Institute is designed to streamline sexual history conversations and elicit information most useful for identifying an appropriate clinical course of action.
- Sexual Health and Your Patients: A Provider's Guide: The resource from the National Coalition for Sexual Health was developed to help health care professionals better integrate sexual health conversations and recommended preventive services into routine visits with adolescents and adults.
- AMA STEPS Forward: Collecting Patient Data – Improving Health Equity in Your Practice: This training module from AMA STEPS Forward highlights why it is important to collect patient race and ethnicity data and how you can establish standards for and train your staff to collect this data.

4. Define clear approach and team member roles for routine screening

A lack of a clear protocol for routine screening, compounded by an overwhelming demand for care, causes staff roles to blur. A clear routine screening plan, streamlined by EHR support, can help clarify care team member roles. If it is feasible, having dedicated staff or volunteers to initiate point of care testing, allows clinicians to focus on confirmatory screening, treatment, and the chief reason for the visit.

Related resources

- Clinical algorithm flowcharts for screening: This set of documents translates screening guidance and clinical considerations from the USPSTF and CDC into a decision tree format to guide implementation.
  - Clinical algorithm flowchart for HIV screening (PDF)
  - Clinical algorithm flowchart for Chlamydia and Gonorrhea screening (PDF)
  - Clinical algorithm flowchart for Syphilis screening (PDF)
  - Clinical algorithm flowchart for HBV screening (PDF)
  - Clinical algorithm flowchart for HCV screening (PDF)
- Streamlined testing cascade: This set of infographics outlines the testing cascade for infectious diseases covered in this toolkit, including opportunities to optimize screening, and can be used to help clarify care team member roles at each step as well as define a clear post-test protocol.
  - Streamlined testing cascade for HIV in Emergency Departments (PDF)
  - Streamlined testing cascade for STIs in Emergency Departments (PDF)
  - Streamlined testing cascade for HCV in Emergency Departments (PDF)

VIEW THIS STEP AND ADDITIONAL VIDEO CONTENT ONLINE →

STEP 2:

Initiating standard screening protocols

Identifying who to screen for what infection(s) and when is a critical consideration for how to implement an effective routine screening program. Emergency departments continue to face challenges with individual biases about sexual health and infectious disease, both from patients and the clinical staff. This sense of vulnerability, compounded by socialized stereotypes and stigma, makes testing consent conversations emotional and complex. Implementing an opt-out approach to screening can help simplify these conversations and normalize screening as a standard of care.

Guidance from the EHR, including automated orders and reminders, as well as straightforward, demographic-based routine screening criterion have proven to be effective tools for increasing screening and are time and energy savers for a busy care team. Patients feel more comfortable if routine screening is offered as a clinical standard of care, and they feel seen and heard by health care professionals.

CRITICAL CONSIDERATIONS AT THIS STAGE

- The more complex the criteria, the harder it is to reliably execute routine screening
- Screening conversations can take time while moving through the EHR, making the interaction less personal and more transactional
- Implicit bias carried by care team staff members
- Lack of EHR support and optimized structure for routine screening
- Relying on clinicians to remember to screen for all diseases without alerts or reminders
- Testing is seen as a financial liability, at odds with the emergency department's business model
- Time constraint of patient encounters

Strategies you can implement

1. Implement the "opt-out" approach

Training health care professionals and appropriate staff to implement opt-out language helps normalize routine screening as standard of care. Opt-out screening reduces the subjectivity of the decision on behalf of the patient where consent is not legally required.

Related resources

- Explanation of opt-out screening approach for HIV: This resource link from the CDC provides an explanation of an opt-out approach to screening and why it is effective at increasing screening.
- Sample opt out script for clinicians during HIV screening encounter: Pages 4-5 of the Guidance for Delivering HIV Pre-Test and Post-Test Results resource from the Reproductive Health National Training Center outlines samples scripts that clinicians can use when conducting an opt-out approach to HIV screening.
- Discussion Guide: Using normalizing and opt-out language for chlamydia and gonorrhea: This resource from the Reproductive Health National Training Center is designed to build the confidence of clinic staff to use normalizing and opt-out language for chlamydia and gonorrhea screening.
- State Laws that address High-Impact HIV Prevention Efforts: This resource from the CDC is a summary of state specific laws on a minor's autonomous consent for HIV and/STI services, and laws that address HIV prevention efforts.

2. Stick to sex-positive messaging

Equipping care team members with training and resources on sex-positive and non-judgmental messaging about risk, transmission, treatment, outcomes, and benefits of screening can help overcome initial patient refusal.

Related resources

Care team resources to help health care providers educate patients on the importance of sexual health: These tools from the National Coalition for Sexual Health can help health care providers and clinical staff cultivate a clinical environment that delivers inclusive, patient-centered, and accessible sexual health services for all patients.

- Inclusive Sexual Health Services: Practical Guidelines for Providers & Clinics
- Sexual Health and Your Patients: A Provider's Guide
- Compendium of Sexual & Reproductive Health Resources for Healthcare Providers

Care team training on LGBTQ, transgender and gender nonconforming essentials: The AMA Ed Hub offers a series of training modules developed by Howard Brown Health, SAGECare, The Fenway Institute and more that can help provide education to your care team on sex-positive and gender appropriate language and methods to incorporate best practices into your organization.

- Patient Care Education from Howard Brown Health
- SAGECare Education
- LGBTQIA+ Health Education from The Fenway Institute
- AMA Ed Hub CME Course: LGTBQ Health, Diversity & Inclusion

3. Implement automated EHR reminders, prompts & orders to increase screening

EHRs that automatically flag patients in need of screening as well as EHR reminders to initiate screening takes the pressure off the health care professional to remember who to screen. Alerts can automatically prepopulate test orders,

further reducing the clinician's responsibilities. Auto-orders in the EHR that are connected to the patient identification algorithms for routine screening will reduce time in the EHR and additional steps for clinicians. Positive and indeterminant results can also be linked to auto-orders for confirmatory testing.

Related resources

- Clinical Decision Support System to Increase HIV Screening: This webpage outlines Community Preventative Services Task Force (CPSTF) recommendations and considerations for implementation of clinical decision support systems, which evidence shows increases HIV screening both for the general population as well as those at higher risk for HIV infection.
- Tips to Leverage Your Electronic Health Record to Implement Opt-Out HIV: This resource from Health Information Technology Evaluation and Quality Center outlines best practices and strategies for implementing opt-out HIV screening in your organization using the electronic health record.
- EHR Case Study from the University of Colorado ED: This case study highlights work undertaken by the the University of Colorado Emergency Department to incorporate screening for HIV into their EHR workflow.

4. Align infectious disease control with organization's goals

Presenting the health and cost-benefit analysis of diagnosing diseases early versus treating disease progression can help establish infectious disease control as a strategic imperative in a health setting and gain access to timesaving resources.

Related resources

- HIV Cost-effectiveness: This resource from the CDC provides a basic guide to the cost-effectiveness analysis of prevention interventions for HIV infection and AIDS and help prevention program staff and planners become more familiar with potential uses of economic evaluation.
- Integrating Routine HIV Screening Into Clinical Practice (PDF): This resource from the CDC outlines the clinical benefits of early HIV diagnosis and treatment.
- Overview of Cost, Reimbursement, and Cost-Effectiveness Considerations for Hepatitis C Treatment Regimens: This webpage outlines the cost-effectiveness of HCV treatment and care with a section specifically dedicated to the cost effectiveness of screening for HCV.

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STEP 3:

Testing and diagnosis

A lack of a clear protocol for testing, compounded by an overwhelming demand for care, causes staff roles to blur and leaves the bulk of the workflow on the clinician's shoulders, including obtaining consent, disclosing results, counseling, and coordinating follow-up care.

Defining a routine testing plan streamlined by EHR support, outlining a clear post-test protocol, and clarifying team member roles can help incorporate routine screening more seamlessly into standard workflows.

Some clinicians and staff may also feel intimidated by interpreting results and next steps for the inconclusive test results. For HIV, clinicians are often unaware what the next step is upon a positive diagnosis. Providing education on the latest evidence-based guidance for screening, testing and treatment can instill confidence in the care team and provide a more personal approach to address the patient's needs.

Critical considerations at this stage

- Screening guideline ambiguity and the need for clarity for all test result scenarios and who to notify and when to notify them
- Knowing they have the responsibility to check results and make follow-up calls, clinicians are hesitant to screen in addition to urgent clinical duties
- Education on interpreting results and next steps for inconclusive/indeterminate results
- Lack of on-site equipment and reliance on external labs thus clinicians are hesitant to order initial test if the patient will need to be referred out to a clinic and pay twice for testing
- Desire from patients to know results right away is at odds with testing logistics and can lead to loss of contact with the patient before results are complete
- Pressure to meet other funder-driven requirements in addition to patient's chief reason for visit
- Knowledge and awareness of the appropriate CPT codes
- Lack of payer coverage for routine screening for HCV
- STD tests sometimes run into insurance denials based on diagnostic codes

Step 3: Testing and Diagnosis (cont)

Strategies you can implement

1. Streamline the testing cascade

Optimizing the clinical workflow can help to streamline testing, clarify roles and ensure emergency department staff know what happens at each step along the way. Also, leveraging testing innovations like rapid antibody test technology or Reflex RNA for HCV, which allows for faster detection through the ability to immediately run another lab test on the same blood draw so that patients do not have to return for additional testing, allows for quicker delivery of results to patients. Clear guidance on testing interpretation and result sharing, in accordance with applicable privacy laws, will help reduce the cognitive load for health care professionals who are juggling a positive diagnosis with other immediate clinical needs. Strong relationships with local health departments (in particular, disease surveillance units) can also enable clinical staff members to rapidly identify which patients are experiencing a diagnosis for the first time, or who need reengagement in medical care.

Related resources

- Clinical algorithm flowcharts for screening: This set of documents translates screening guidance and clinical considerations from the USPSTF and CDC into a decision tree format to help outline steps in the testing continuum from beginning to end.
  - Clinical algorithm flowchart for HIV screening (PDF)
  - Clinical algorithm flowchart for Chlamydia and Gonorrhea screening (PDF)
  - Clinical algorithm flowchart for Syphilis screening (PDF)
  - Clinical algorithm flowchart for HBV screening (PDF)
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  - Streamlined testing cascade for HIV in Emergency Departments (PDF)
  - Streamlined testing cascade for STI testing in Emergency Departments (PDF)
  - Streamlined testing cascade for HCV in Emergency Departments (PDF)
- Screening guidelines form the CDC and USPSTF:
  - CDC Guidelines and Recommendations: Find information on guidelines and recommendations for delivering HIV, viral hepatitis, STD, and TB care.
  - USPSTF A&B Recommendations: This page outlines all of the USPSTF recommendations with a grade of either A or B including screening for HIV, chlamydia and gonorrhea, syphilis, hepatitis B, hepatitis C and latent tuberculosis infection.
- Health Department directories: This resource from the CDC outlines who is working to protect the public's health in your area, including senior health officials, state, local, and territorial health departments, and tribes and Indian organizations. Clinical staff may need to develop relationships with staff in various sections of health departments in order to facilitate reporting, linkage to care or prevention, and other critical services.

2. Outline funding and reimbursement strategies

Breaking down direct and indirect costs for each element of routine screening and testing, across the health setting's payer mix, will help identify gaps in funding and reimbursement and uncover opportunities for negotiation. Budgeting EHR development, equipment, the cost of tests, and staff time for routine screenings will eliminate unknowns and inspire

confidence. Additionally, ensuring you are coding services properly for eligible patients will ensure you are reimbursed for the cost of the service and that the patient will not have any out-of-pocket costs.

Related resources

- Routine screening coding quick guide: This coding guide outlines a list of procedural codes related to HIV, STI and viral hepatitis screening for both private payer insurance and Medicare and helps you ensure that you are coding services correctly for eligible patient populations to cover the cost of the service, with the patient having no cost-sharing responsibility.
  - Routine screening Medicare coding quick guide (PDF)
  - Routine Screening Toolkit: Private payer coding guide (PDF)
- Potential resources to cover direct and indirect costs: The following links are listings of available funding opportunities that could help to cover screening related initiatives and associated costs at your clinic.
  - CDC's National Prevention Information Network – Funding Opportunities
  - CDC HIV Funding and Budget resource
  - Rural Health Information Hub – HIV and AIDS Funding Opportunities
  - Grant funding through your state and local health department

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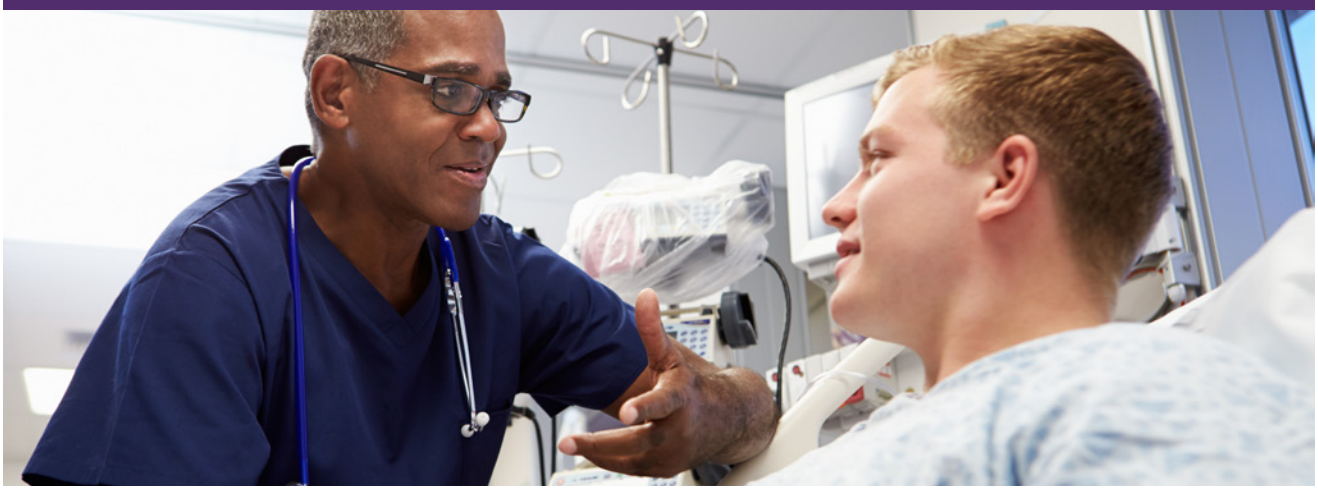

STEP 4:

Education and post-test counseling

Educating and engaging patients in their care is a critical consideration for how to implement an effective routine screening program. However, lack of care team training or knowledge on infectious disease control contributes to the uneven division of labor, reducing the likelihood of routine screening and causing missteps in follow up and linkage to care.

Some clinicians or staff members who lack counseling skills may be intimidated by sharing positive results and thus may skip routine screening all together. When rapid testing is performed in the emergency department, both lack of time and lack of space for privacy to provide education or in-person counseling can also be a challenge. Empowering every member of the care team with education and equipping the care team with counseling training can help overcome these concerns. Additionally, having patient friendly education materials can help improve discharge communications.

Critical considerations at this stage

- Knowledge gaps exist across members of the care team who may not know the steps to take or the latest HIV or STI treatments
- Access to patient-centric material to distribute is needed
- Patients do not understand the behaviors associated with HIV, STIs or viral hepatitis, especially if they do not identify with the stereotypical population disproportionately affected
- Additional training on how to provide sensitive counseling of post-test results is needed
- Time for clinicians and staff members to effectively communicate results and counsel with respect to the patient's privacy needs to be allocated

Strategies you can implement

1. Empower every member of the care team with education and training

Providing in-depth, disease-specific education sessions for every member of the care team on the need for routine screening and how to conduct it, engenders greater empathy for the patient and boosts confidence to answer questions rather than deferring to the lead clinician.

Related resources

Training and education for the care team on HIV, STIs, viral hepatitis, and TB essentials: The following links are a compilation of education and training resources from the CDC targeted to health care professionals. STD and STI testing training materials can be leveraged to equip your care team members with the latest information to help boost the confidence of any member of the care team in answering patient questions.

- HIV/ AIDS Training for Public Health Professionals from the National Prevention Information Network
- HIV Training Resources
- Hepatitis Training resources from the National Prevention Information Network
- Viral Hepatitis Training Resources
- STD Prevention Training from the National Prevention Information Network
- STD Training Resources

County-level Syphilis Rates to Direct Screening Efforts: Health care professionals can use this county-level map from the CDC that visualizes primary & secondary syphilis rates as they consider their syphilis screening efforts.

Compendium of Evidence-Based Interventions and Best Practices for HIV Prevention: This webpage from the CDC outlines a collection of HIV interventions in the form of evidence-based and evidence-informed info sheets.

2. Have patient education materials available at visit completion

Having patient friendly education materials at discharge is an important piece of patient care. Emergency departments can improve discharge communication through educating patients and providing resources about their institution's options or other community-based health clinics for routine care.

Related resources

Patient Education Materials from the CDC: These links compile downloadable patient education materials from the CDC with resources targeted to different patient demographics and available in multiple languages. Patients should be provided with information about the communicable nature of these infections and consider options for notifying others that were potentially exposed.

- HIV Consumer Info Sheets
- Viral Hepatitis Patient Education Materials
- STI Patient Resources from the CDC
  - CDC Fact Sheets
  - Next steps after testing positive for gonorrhea or chlamydia
  - Getting Tested for STIs
  - How to Prevent STIs

Step 4: Education and Post-Test Counseling (cont)

Patient Pages from the JAMA Network: JAMA Patient Pages are free patient resources designed to distill high-quality evidence and updated guidance from USPSTF into a more accessible patient friendly format to help guide patient decisions.

- HIV
  - Human Immunodeficiency Virus
  - Who Should Be Screened for HIV Infection?
  - Can HIV Infection Be Prevented With Medication?
  - HIV Infection: The Basics
- Viral hepatitis
  - Screening for Hepatitis B in Nonpregnant Adolescents and Adults
  - Screening for Hepatitis B in Pregnant Women
  - Screening for Hepatitis C Virus Infection
  - Treating Hepatitis C
- STIs
  - What is Syphilis?
  - Screening for Syphilis in Pregnant Women
  - Screening for Syphilis
  - Screening for Chlamydia and Gonorrhea

3. Equip staff with skills to communicate more effectively with patients

In the absence of patient navigators, investing in training for the care team on counseling and cultural safety or structural competence can help staff develop skills to communicate more effectively with patients, leading to increased comfort with counseling patients on results. Especially in the emergency department, dedicated counseling at the point of discharge can help to emphasize the importance of routine screening, promote health literacy, and link patients to the resources they need to access routine screening in the future.

Related resources

- AMA STEPS Forward: Health Coaching: This learning module from AMA STEPS Forward outlines steps to help you develop and implement a health coaching model in your practice.
- Target HIV Cultural Competency Resources; This webpage includes a collection of guidance, tools and trainings that clinicians can use to identify and address bias to improve communication with diverse patients.
- Cultural Competence in Health and Human Services: This resource from the National Prevention Information Network defines what cultural competence is and how it applies to HIV, viral hepatitis, STI and TB prevention.

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STEP 5:

Linkage to care

The routine screening process does not simply end with diagnosis. Care team members must be confident and clear on next steps after result notification. Inadequate linkage to care processes and procedures in emergency departments prevents clinicians from initiating routine screening. Emergency departments are often reluctant to conduct routine screening if they cannot guarantee appropriate follow up and linkage to care. It can also be a struggle to obtain reliable patient contact information to follow up with result disclosure.

Without a strong linkage to care infrastructure, positive results fall in the patient's hands, leaving a huge responsibility on the individual to seek and manage treatment, often resulting in the patient being lost to care. Routine screening is also critical for re-linking people previously diagnosed back to care.

Critical considerations at this stage

- Day-to-day unpredictability with patients in precarious situations
- Inconsistent patient contact information
- Multiple follow-ups needed to bring patients back into care
- Patient resistance to initiating long term treatment

Strategies you can implement

1. Form a strong referral network

A robust referral list can help connect patients with linkage venues that meet their needs including both treatment for a positive diagnosis as well as support for other wrap around services. For emergency departments struggling with confirmatory testing or linkage to care, developing in-hospital, public health department or specialty clinic partnerships can help bridge the gap to care. Building strong relationships with other medical and social service organizations in your

community will help connect patients with linkage venues that meet their needs including both treatment for a positive HIV, STIs and viral hepatitis diagnosis as well as support for other wrap around services.

Related resources

- Partnership Mapping Template (PDF): This template provides a framework to help your organization keep track of relationships with local community health centers and other non-clinical services that will support a sustainable linkage to care program.
- Tool for Tracking Partners and Partnership Activities: Pages 81-88 from HRSA's Integrating HIV Care, Treatment & Prevention Services into Primary Care – A Toolkit for Health Centers guide includes a Partnership Toolkit that provides a comprehensive list of key considerations, steps, and Partnership-Focused Templates to help guide organizations' relationship building and tracking.
- Health Department directories: This resource from the CDC outlines who is working to protect the public's health in your area, including senior health officials, state, local, and territorial health departments, and tribes and Indian organizations. Clinical staff may need to develop relationships with staff in various sections of health departments in order to facilitate reporting, linkage to care or prevention, and other critical services.
- Clinical Guidance for PrEP: This resource from the CDC outlines recommendations, treatment options and considerations for managing patients on PrEP.
- Preventing new HIV Infections: This webpage from the CDC includes both the latest Clinical Practice Guidelines and Clinical Providers' Supplement for using PrEP for the prevention of HIV infection.
- National HIV PrEP Curriculum: This free resource was developed at the University of Washington for health care professionals who want to learn about HIV PrEP.
- CDC Guidelines on the use of doxy PEP: This report outlines CDC's recommendation for the use of doxycycline postexposure prophylaxis (doxy PEP) for bacterial sexually transmitted infection prevention.

2. Hire or assign current staff as patient navigators

Emergency departments primarily serve vulnerable populations, who may be facing a host of non-clinical challenges in addition to a positive diagnosis. Patient navigators take on the labor-intensive responsibility of delivering patient education following a positive diagnosis, making multiple follow-up calls and arranging treatment appointments so health care professionals can focus on clinical duties.

Related resources

- HIV Navigation Services – STEPS to Care: This resource from the CDC provides links to trainings designed to improve navigation skills for those delivering prevention services to persons with HIV and HIV-negative persons at risk.
- STEPS to Care: Staffing and Supervision: This resource from the CDC outlines key roles and responsibilities for the patient navigation team including adaptable job description templates and videos that discuss key skills and strengths needed to be a patient navigator.
- HIV Navigation Services Section of the Rapid Antiretroviral Therapy Toolkit: Section 2 (beginning on page 19) of this toolkit developed in partnership by Primary Care Development Corporation, My Brother's Keeper, the San Francisco Community Health Center, and the Denver Prevention Training Center provides an overview of the essential role of HIV navigation services in rapid ART services. It also includes a review of staffing needs and considerations for resource-limited settings, suggested protocols, and real-world examples of how to provide services in resource variable settings.

Implementation Resources

- Care Team Member Roles And Responsibilities →
- Clinical Workflow Algorithms →
- Streamlined Testing Cascades →
- EHR Case Study from University of Colorado ED →
- Medicare Coding Guide →
- Private Payer Coding Guide →
- Partnership Mapping Template →

Care Team Member Roles and Responsibilities

All members of a care team have a crucial role to play in navigating patients through the routine screening workflow. This can include pre-test counseling; patient education; and linkage to care and prevention.

BILLING

BENEFITS NAVIGATION

Navigates insurance for routine screening (note: many clinics provide routine screenings free of charge using grant funding to pay for specific tests).

Emergency departments especially may need to assess coverage or refer a patient to a clinic for screening.

NON-CLINICAL

FRONT DESK

Registers patient and provides patient information to triage nurse or patient navigator.

Provides a friendly, welcoming environment and is representative of the community being served. This is especially crucial in clinic settings.

PATIENT NAVIGATION

Meets patient at reception and stays connected with them throughout their care.

Typically, closer to patient's age, representative of patient population.

Takes on nonclinical tasks to relieve providers, including pre-test counseling, patient education and linkage to care; also can provide results.

SOCIAL WORKER

Links patients to support services, as needed, including domestic violence and mental health.

Key to ensuring patients stay in care. Often, patients need help meeting basic needs that allow them to remain connected to care.

CLINICAL

NURSE

May meet with patient in room first and may obtain screening consent.

Provides post-screening treatment or vaccinations.

May provide results

PROVIDER (NP/PHYSICIAN)

Offers screening and obtains patient consent/opt-out.

Conducts necessary physical examinations, orders screening.

Typically provides results

MEDICAL ASSISTANT

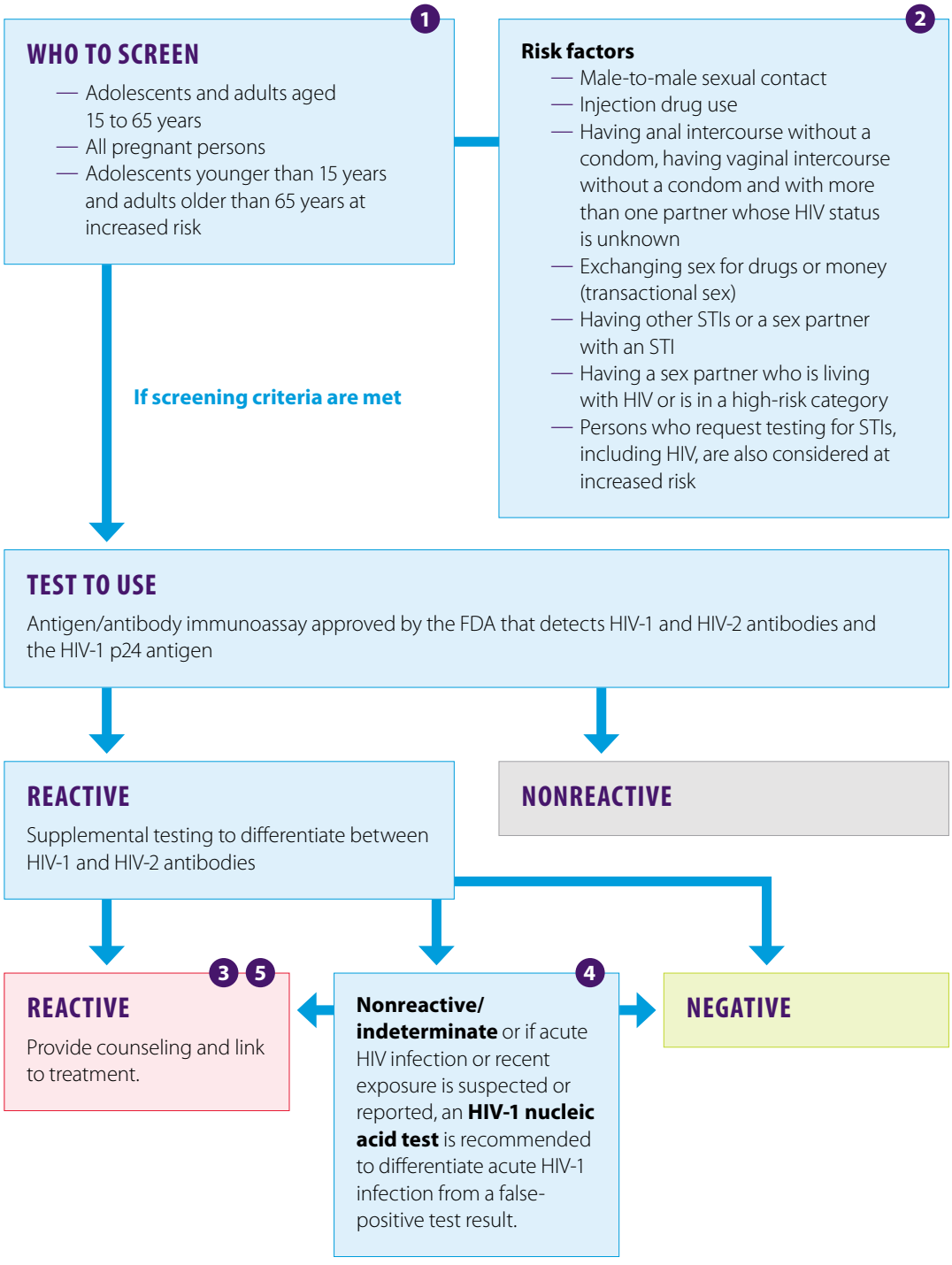
Draws blood to complete screening process.

May provide results

Clinical Workflow Algorithm

HIV Screening

This document translates screening guidance and clinical considerations from the USPSTF and CDC into a decision tree format to guide implementation.



IMPLEMENTATION CONSIDERATIONS

1 Test frequency

At least once as a part of routine care. Repeat screening is reasonable for persons known to be at increased risk of HIV infection.

Pregnant people may be tested twice, once when they first present to care and a second time in the third trimester.

2 Risk assessment

Needed for those outside the universal screening age of 15 to 65 and to determine ongoing risk.

3 Link to treatment

Early initiation of antiretroviral therapy (ART) and other interventions effectively reduce the risk of clinical progression to AIDS.

4 Equivocal results

Consider using a different validated supplemental HIV-1 or HIV-2 test (antibody test and/or NAT) if available. Alternatively, redraw and repeat algorithm in two to four weeks.

5 Case reporting

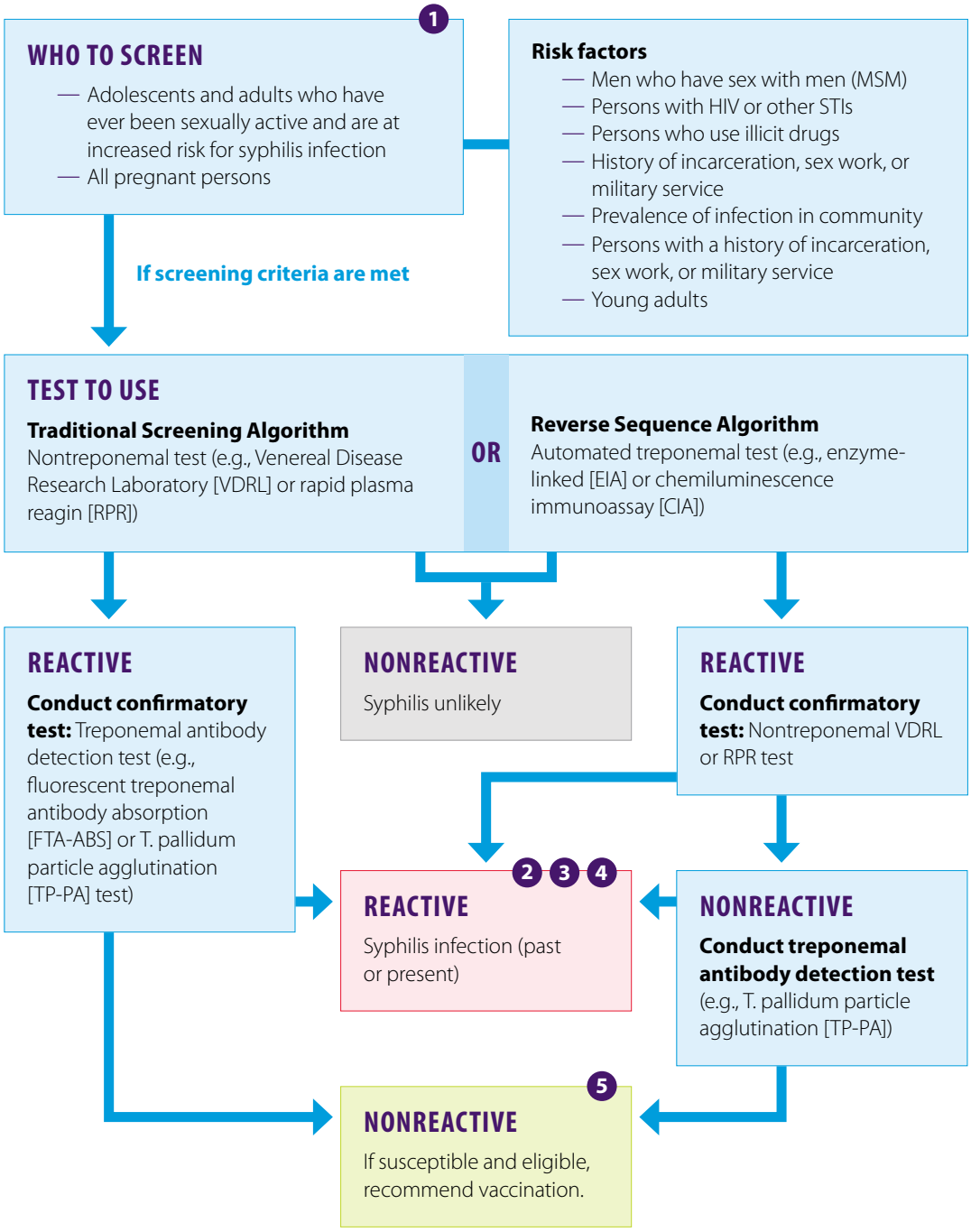
Report positive case to state or local health department.

Last updated 10/31/2024

Clinical Workflow Algorithm

Syphilis Screening

This document translates screening guidance and clinical considerations from the USPSTF and CDC into a decision tree format to guide implementation.



IMPLEMENTATION CONSIDERATIONS

1 Test frequency

MSM or persons with HIV may benefit from screening at least annually or more frequently (e.g., every 3 to 6 months) if they continue to be at high risk.

For pregnant persons, screen at first prenatal visit. Individuals who have not received prenatal care should be tested at the time they present for delivery.

2 Case reporting

Report positive case to state or local health department.

3 Past infection

An RPR comparison to former values may be needed if there's a history of prior disease.

4 Treatment

Penicillin G, administered parenterally, is the preferred drug for treating patients in all stages of syphilis.

See: https://www.cdc.gov/std/treatment-guidelines/syphilis.htm

5 Further evaluation

If at risk of infection, repeat RPR in several weeks.

If epidemiologic risk and clinical probability for syphilis are low, further evaluation or treatment is not indicated.

Last updated 10/31/2024

Clinical Workflow Algorithm

Chlamydia and Gonorrhea Screening

This document translates screening guidance and clinical considerations from the USPSTF and CDC into a decision tree format to guide implementation.

WHO TO SCREEN [1] [2]

Sexually active women, including pregnant persons:

- 24 years or younger
- 25 years or older and at increased risk for infection

Risk factors

- Previous or coexisting STI
- New or more than 1 sex partner
- Sex partner having sex with other partners at the same time
- Sex partner with an STI
- Inconsistent condom use when not in a mutually monogamous relationship
- Exchanging sex for money or drugs
- History of incarceration
- Clinicians should consider the communities they serve and may want to consult local public health authorities about local epidemiology and guidance on who is at increased risk.

If screening criteria are met

TEST TO USE

NAATs can test for infection at urogenital and extragenital sites, including urine, endocervical, vaginal, male urethral, rectal, and pharynx. Chlamydia and gonorrhea can be tested at the same time with the same specimen.

POSITIVE [3] [4]

Chlamydial and gonococcal infections respond to treatment with antibiotics.

See:
https://www.cdc.gov/std/treatment-guidelines/chlamydia.htm

https://www.cdc.gov/std/treatment-guidelines/gonorrhea.htm

NEGATIVE

Evaluation complete, no infection

IMPLEMENTATION CONSIDERATIONS

1 Evidence is insufficient to assess the balance of benefits and harms of screening for chlamydia and gonorrhea in men. The net benefit estimates for screening are driven by biological sex rather than gender identity.

2 Test frequency

Screen patients whose sexual history reveals new or persistent risk factors since the last negative test result.

For pregnant persons, screen at first prenatal visit and in the 3rd trimester for those who remain at high risk of infection.

3 Case reporting

Report positive case to state or local health department.

4 Partner notification

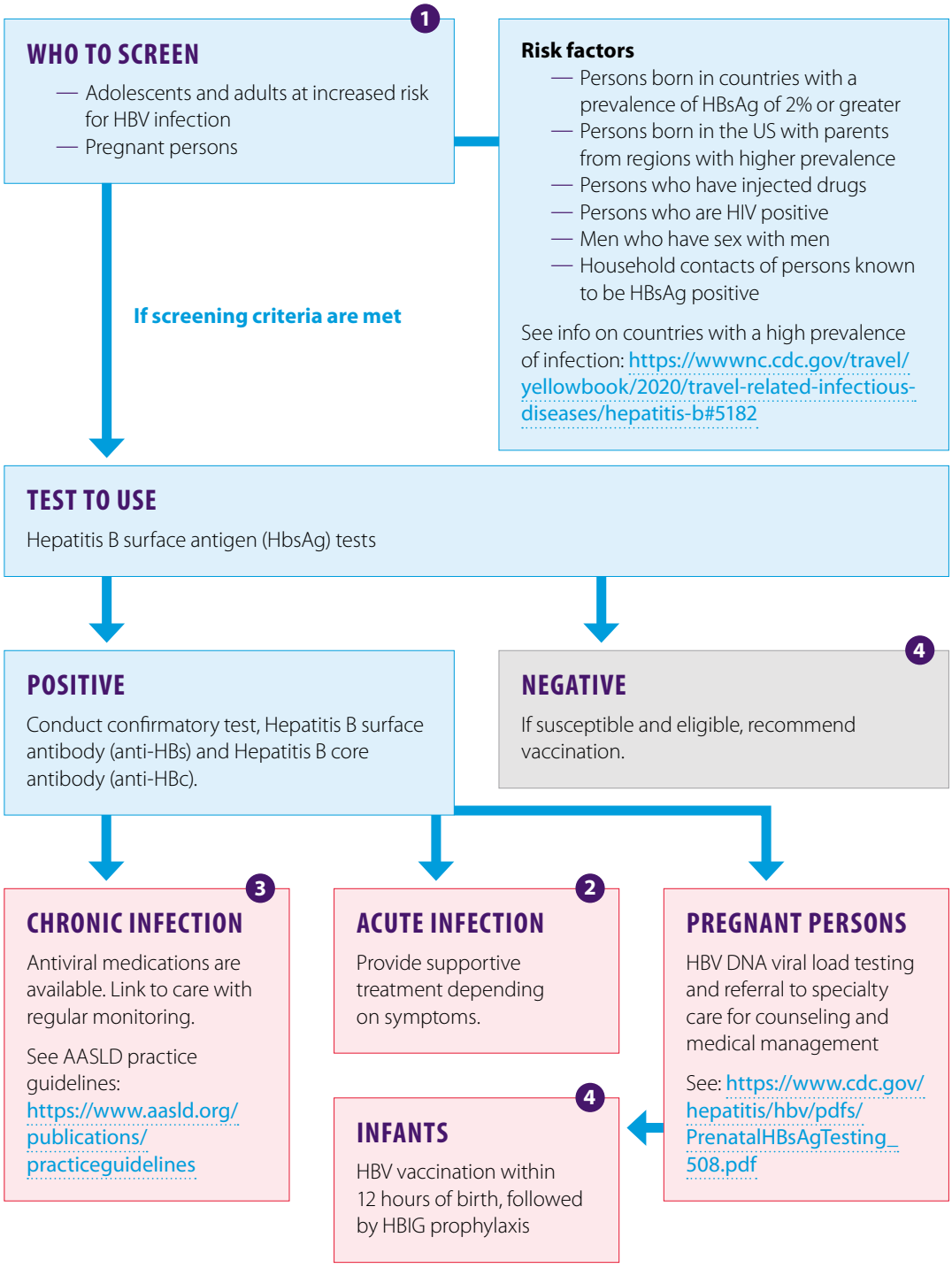
is important to reduce the chance or reinfection.

Last updated 10/31/2024

Clinical Workflow Algorithm

Hepatitis B (HBV) Screening

This document translates screening guidance and clinical considerations from the USPSTF and CDC into a decision tree format to guide implementation.



IMPLEMENTATION CONSIDERATIONS

1 Test frequency

Periodically screen persons with continued risk for HBV infection.

Pregnant persons should be tested at first prenatal visit, for each pregnancy, and those with unknown HBsAg status or risk factors for HBV infection should be screened at admission for delivery.

2 Acute infection

- HBsAg positive
- Anti-HBc positive
- IgM anti-HBc positive
- Anti-HBs negative.

3 Chronic infection

- HBsAg positive
- Anti-HBc positive
- IgM anti-HBc negative
- Anti-HBs negative

4 ACIP HBV vaccine recommendations

The HBV vaccine is recommended for all infants, all children or adolescents younger than 19 who have not been vaccinated, all adults age 19 through 59 years, and adults age 60 years or older with risk factors for infection.

Adults who are 60+ without known risk factors may also receive the vaccine.

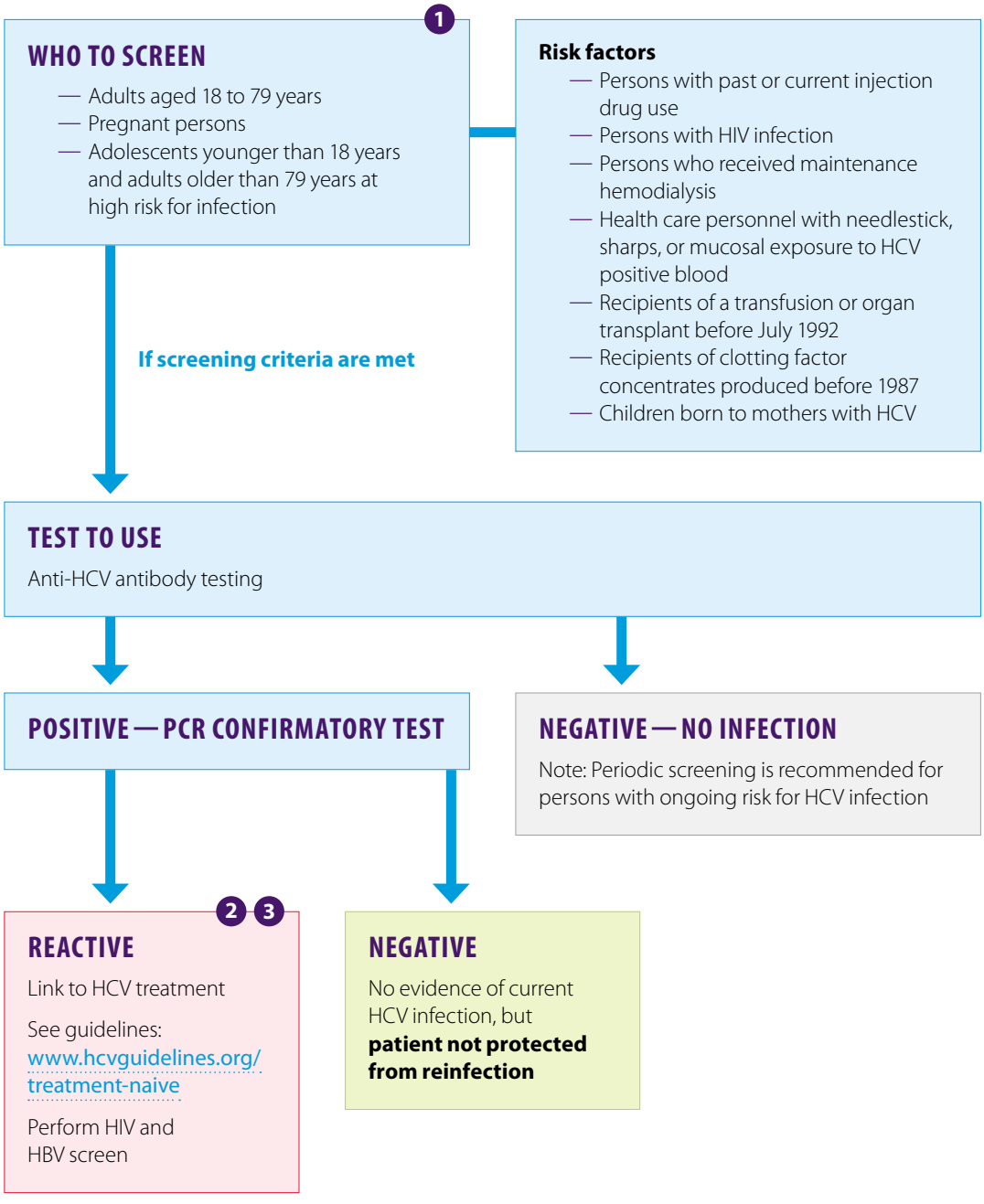
See: https://www.cdc.gov/mmwr/volumes/67/rr/rr6701a1.htm

Last updated 10/31/2024

Clinical Workflow Algorithm

Hepatitis C (HCV) Screening

This document translates screening guidance and clinical considerations from the USPSTF and CDC into a decision tree format to guide implementation.



IMPLEMENTATION CONSIDERATIONS

1 Test frequency

One-time screening for most adults and for each pregnancy. Periodic screening for persons with continued risk for HCV infection.

2 Treatment

Ensure patient knows that safe and highly effective treatment is available for hepatitis C.

3 Case reporting

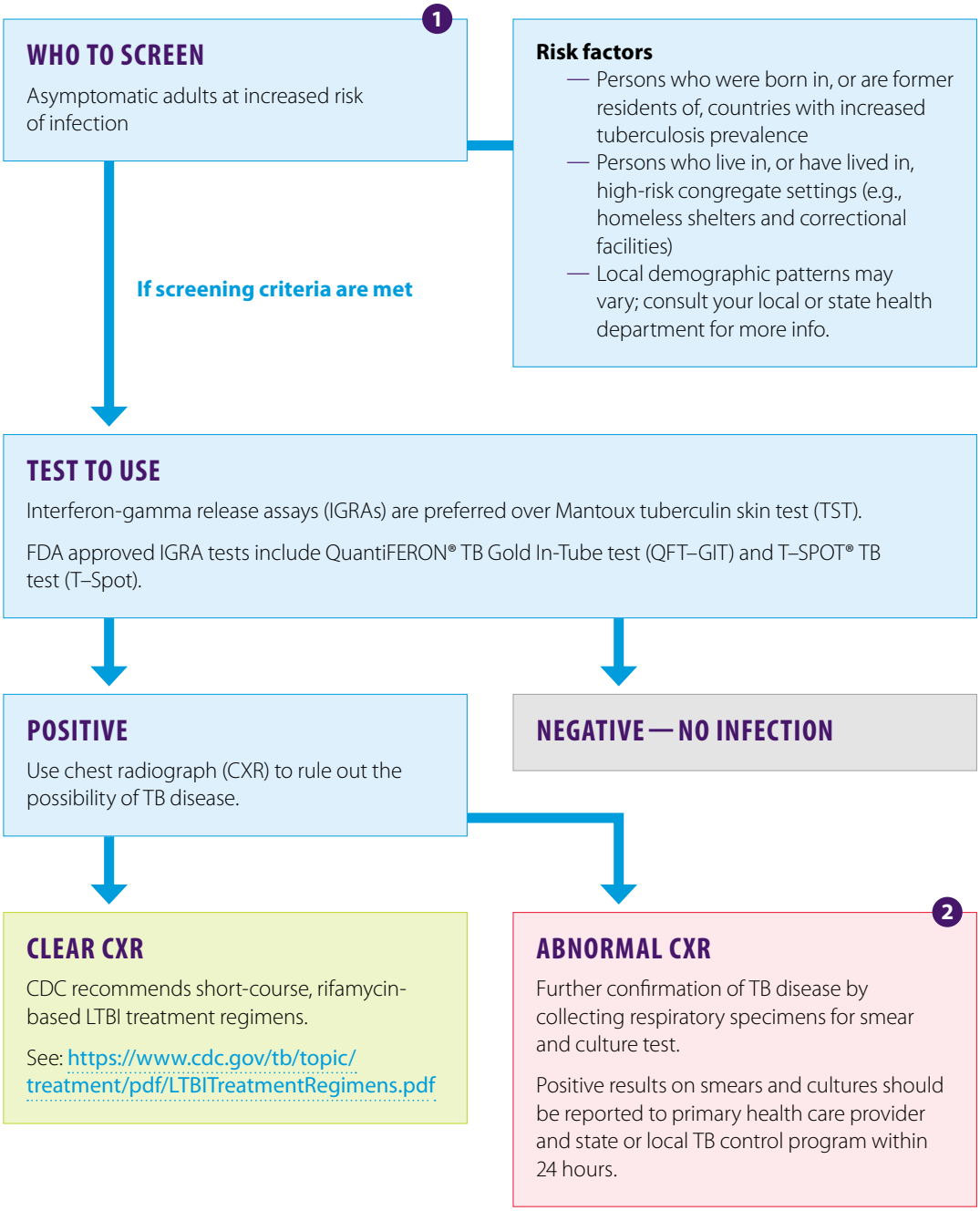
Report positive cases to public health agency.

Last updated 10/31/2024

Clinical Workflow Algorithm

Latent Tuberculosis Infection (LTBI) Screening

This document translates screening guidance and clinical considerations from the USPSTF and CDC into a decision tree format to guide implementation.



IMPLEMENTATION CONSIDERATIONS

1 Test frequency

One time testing for those with risk factors for infection. At clinician discretion, more frequent testing may be recommended based on known continuous or new exposures.

2 Connect with local health department

for guidance on additional testing to confirm diagnosis, when referral to an ID provider should take place, and when reporting of a positive test result should be made in your jurisdiction.

Last updated 10/31/2024

Emergency Department HIV Workflow Solutions

PRE-ROUTINE SCREENING — Patient engagement and screening preparedness

- Patient intake 1
- Test ordered 2
- Patient triaged 3
- Opt-out test offered 4

OPPORTUNITIES TO OPTIMIZE

1. **Automate EHR algorithms** which can identify patients who qualify for routine screening, eliminating the need for clinicians to remember to conduct risk assessment.
2. **Bundle test orders.** The EHR alert can automatically populate an order, such as bundling with HCV or other recommended tests, for a physician to accept order if patient is getting blood drawn.
4. **Conduct opt-out testing with verbal notification.** Led by the triage nurse at point of blood draw, opt out testing alleviates stigma-related barriers and reduces the counseling burden.

ROUTINE SCREENING — Test performed and results communicated

- Rapid testing 5
- Patient informed of results 6

OPPORTUNITIES TO OPTIMIZE

5. **Make routine screening packets available** for nurses to obtain from phlebotomy stations. These should include patient identification cards, requisite screening tubes to draw for screening test, and an additional non-standard 6 mL lavender tube to be filled for every rapid test. In the event that the preliminary result is positive, the patient will not have to have their blood drawn again.
6. **Disclose rapid test results before patient leaves setting** to minimize loss in follow-up. Clinicians should be trained to disclose results so they are confident to follow through.

FOLLOWING UP — Confirmatory testing and linkage to care, treatment and prevention

POSITIVE RESULT

- Risk stratify 7
- Confirmatory testing 8+
- Report result to local health department 9
- Linked to care 10

NEGATIVE RESULT

- Linked to prevention 8-

OPPORTUNITIES TO OPTIMIZE

7. **Use risk stratification,** based on lab interpretation and chart review, to identify acute infection and likelihood of confirmation, to determine how quickly a patient needs to be linked to care and started on ARTAS.

8+. **Link confirmatory testing orders automatically** to rapid positive results via an EHR reflex, saving time for the clinician.

10. **Leverage patient navigators** to review patient records, make sure confirmatory test is being done in timely manner, disclose confirmatory test to patient (2–10 days later), and work with community clinic partner as liaison to get client into care as soon as possible.

Emergency Department STI Workflow Solutions

PRE-ROUTINE SCREENING — Patient engagement and screening preparedness

- Patient intake 1
- Patient triaged 2
- Opt-out test offered 3

OPPORTUNITIES TO OPTIMIZE

1. **Use a self-risk assessment at intake,** integrated with the EHR, to expedite the test order process and reduce burden for the triage clinician. Alternatively, a demographic-based criteria for STI testing would be easier to code in EHRs to auto-flag patients without a self-risk assessment.
2. **Leverage a pre-populated EHR screening tool,** if self-risk assessment is not possible, to help standardize the process and link to automatic orders for patients who are eligible for routine screening.
3. **Implement opt-out testing,** which when allowed by state statutes, makes screening a routine part of clinical services, saving time as well as patient or clinician discomfort.

ROUTINE SCREENING — Test performed and results communicated

- Tests ordered 4
- Test performed 5
- Patient counseled 6

OPPORTUNITIES TO OPTIMIZE

4. **Bundle panels to co-test** with HIV and HCV (or other recommended tests depending on what the patient qualifies for) at blood draw to save time for clinicians and help reduce transmission of undiagnosed, untreated infection.
6. **Disclose rapid test results before patient leaves setting** to minimize loss in follow-up. If a rapid test is positive, an automatic EHR order for confirmatory testing can reduce that need for a follow-up visit. Clinicians should be trained to disclose STI testing results so they are confident to follow through.

FOLLOWING UP — Confirmatory testing and linkage to care, treatment and prevention

POSITIVE RESULT

- Report result to local health department 7
- Patient informed of result 8+
- Prescription administered 9
- Linkage to care/ treatment 10

NEGATIVE RESULT

- Notified in portal 8-

OPPORTUNITIES TO OPTIMIZE

8+. **Inform patients of results** via their patient portal or the phone. There should be clear delineation of care team roles in delivering results. Locations where clinicians lack time can have patient navigators take on this role.

9. **Establish a protocol for administering prescription orders** for STIs that does not require confirmatory testing.

10. **Link positive patients to care,** which may require multiple follow ups to be located. Hiring a patient navigator can unburden clinicians from non-clinical follow up work and effectively get patients into care.

Emergency Department HCV Workflow Solutions

PRE-ROUTINE SCREENING — Patient engagement and screening preparedness

- Patient intake 1
- Test ordered 2
- Patient triaged 3
- Opt-out test offered 4

OPPORTUNITIES TO OPTIMIZE

1. **Leverage an automated EHR algorithm** which can identify patients who qualify for routine screening, eliminating the need for clinicians to remember to conduct risk assessment.
2. **Bundle test orders.** The EHR alert can automatically populate an order, such as bundling with HIV or other recommended tests, for a physician to accept order if patient is getting blood drawn.
4. **Conduct opt-out testing with verbal notification.** Led by the triage nurse at point of blood draw, opt out testing alleviates stigma-related barriers and reduces the counseling burden.

ROUTINE SCREENING — Test performed and results communicated

- Rapid testing 5
- Patient informed of results 6

OPPORTUNITIES TO OPTIMIZE

5. **Explore rapid testing order sets for HCV that include a single tube** of blood for rapid antibody and reflex RNA testing. Two-tube storage can be a barrier at many health settings. To overcome this, labs can conduct validation studies to see if antibody testing and Reflex RNA testing can be done on the same tube. This will save storage space and time so that the patient does not return for a second blood draw.
6. **Disclose rapid test results before patient leaves setting** to minimize loss in follow-up. Patient navigators can be trained to disclose results at bedside.

FOLLOWING UP — Confirmatory testing and linkage to care, treatment and prevention

POSITIVE RESULT

- Risk stratify 7
- Confirmatory testing 8
- Report result to local health department 9
- Linked to care 10

OPPORTUNITIES TO OPTIMIZE

7. **Conduct risk stratification.** Further assessment of clinical risk factors can be done once the patient tests positive.
8. **Link confirmatory Reflex RNA testing** automatically to rapid positive results via the EHR, saving time for the clinician.
10. **Leverage patient navigators** to review patient records, make sure confirmatory test is being done in timely manner, disclose confirmatory tests to patients within 2 weeks, share educational materials and work with community clinic partner as liaison to get client into care.

Electronic Health Record Case Study

University of Colorado's HIV Routine Screening EHR Program

AMA
AMERICAN MEDICAL ASSOCIATION

Introduction

In recent years, the importance of routine HIV screening in health care settings has become increasingly evident.

Early detection and diagnosis are crucial in managing HIV, improving patient outcomes and reducing transmission rates. As of 2022 there were an estimated 15,700 people in the state of Colorado living with HIV, and only about 55.5% had achieved successful viral suppression.[1]

Additionally, approximately 13.2% of people living in Colorado with HIV are unaware of an active infection and can transmit the virus to others without knowing.[1]

Over recent decades, people with HIV have been increasingly able to live long, healthy lives due to improvements in antiretroviral therapy. However, meaningful discrepancies exist in who benefits from the advancements in HIV care, with ethnic and racial minorities being disproportionately affected.[2]

HIV screening and linkage to care are critical services that we have the opportunity to provide to patients in Emergency Departments (ED).

Frequently, ED visits serve as touch points for patients who may not otherwise interact with the medical system. The University of Colorado Emergency Department cares for over 110,000 individual patients per year presenting a significant opportunity to offer services that these individuals might otherwise be unable to access due to limited health care availability.

Historically, HIV screening tests were only ordered by the ED providers*. However, we felt there was an opportunity to expand screening to a large population by leveraging various strategies outlined in the **AMA's HIV, STIs, Viral Hepatitis and LTBI Routine Screening Toolkit**, specifically implementation of various clinical decision support tools.

*Providers, according to the University of Colorado for the purposes of this case study, refers to MDs, DO, NPs and PAs.

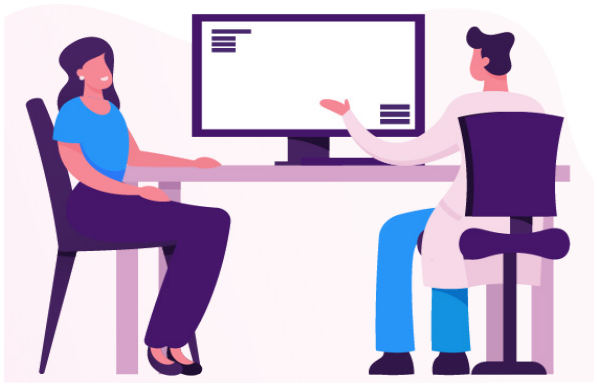
Problem

Historically, HIV testing was only offered if the patient requested a test or had a relevant chief complaint that prompted the provider to offer screening.

However, there was variability in the process and screening was ultimately at the provider's discretion which led to missed opportunities for increased testing. During our participation as a member of the **AMA's HIV, STIs, Viral Hepatitis and LTBI Routine Screening Toolkit** pilot from October 2023 – March 2024, we set out to increase our departmental HIV testing by automating the ordering process, revamping the HIV pathway, and providing comprehensive education to staff.

Approach

We utilized various strategies of the AMA toolkit to facilitate our approach.



The first strategy was designing a flowsheet in the Electronic Health Record (EHR) with question logic. Our idea was to incorporate the Denver HIV Risk Score Tool[3] as the basis for the flowsheet logic. This is an externally validated scoring system that considers various demographic, clinical and social factors to estimate the risk of HIV infection.[2, 4] A higher score indicates a patient may be at a higher risk of HIV infection, and as a result, should be tested. We chose the BPA to fire at moderate or high to increase the number of patients screened.

During initial screening a nurse asks a variety of questions to the patient and captures their response in the EHR's flowsheet section **(Figure 1)**. Each question is assigned a value which is summed to give a total score. The next step involves a Best Practice Advisory (BPA) alert that triggers if patient scores moderate or high on the flowsheet **(Figure 2)**. This BPA directs the nurse to the HIV pathway where they are given a reference on the next steps of patient care related to HIV concerns **(Figure 3)**. Pathways are standard tools we utilize in our organization in order to decrease provider variability and serve as an evidence-based guide for managing a variety of scenarios. The HIV pathway can be directly opened from the BPA or is accessible through the main screen of the EHR. This allows our HIV pathway to serve as a central resource for providers and nurses to access and streamline patient care.

The first part of the pathway from the BPA explains why consent is not explicitly needed but the patient must still agree to testing. The order for the test is linked directly in the pathway and once clicked populates in the order section of the EHR.

This allows for ease of ordering and limiting the number of clicks. After the nurse agrees to order the test, it describes the next steps which includes informing the provider. This gives the provider the chance to counsel the patient about the test and its potential results. If the test is negative the patient can be given resources for the PrEP clinic as well as access to the patient navigator whose role is to facilitate appointment scheduling and ensure follow up if the patient wishes.

If the patient has a positive test, confirmatory testing is ordered in addition to a consult with the HIV linkage to care coordinator. This consult order is directly embedded into the pathway and links to the EHR. In addition, there is a newly built direct link for a group chat function in the EHR. During normal business hours the primary RN will utilize this link to message the active linkage to care coordinator to facilitate follow up. Overall, the pathway is diverse and serves as a central hub for the team to provide the best HIV care by seamlessly interacting with the EHR, including order placement.

Figure 1: Initial Screening Questions

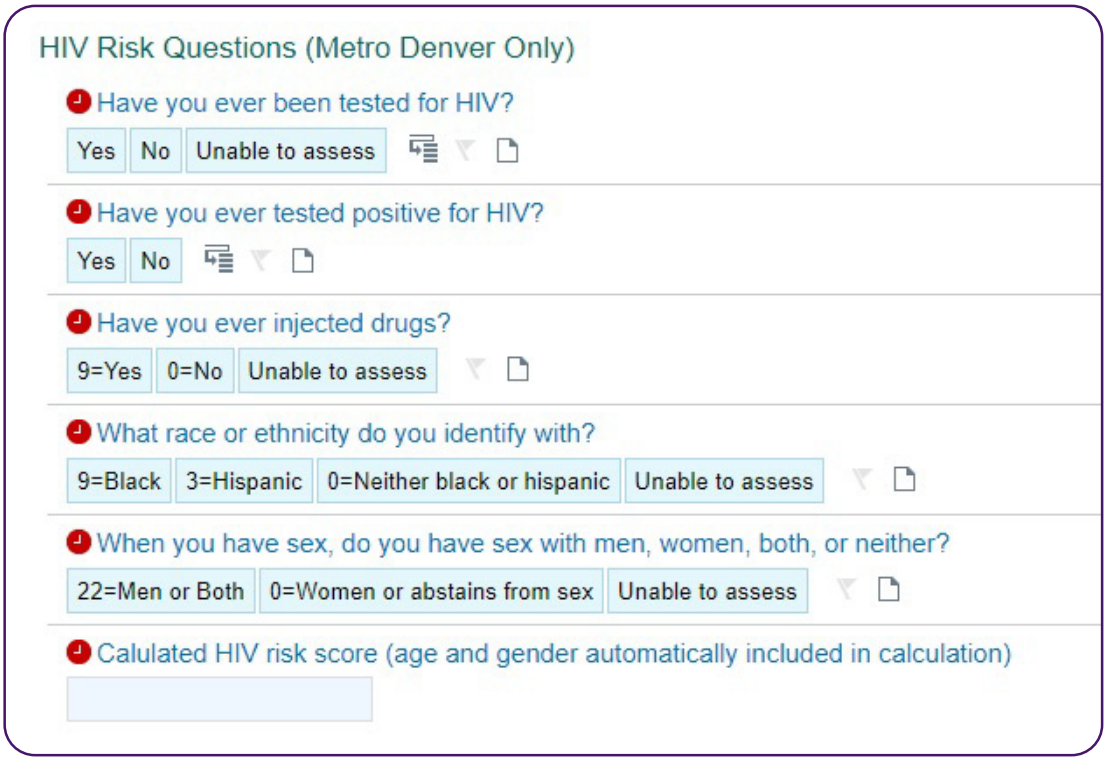


Figure 2: Best Practice Advisory (BPA) Alert

BestPractice Advisory - Sepsis, Testamc

Attention (1)

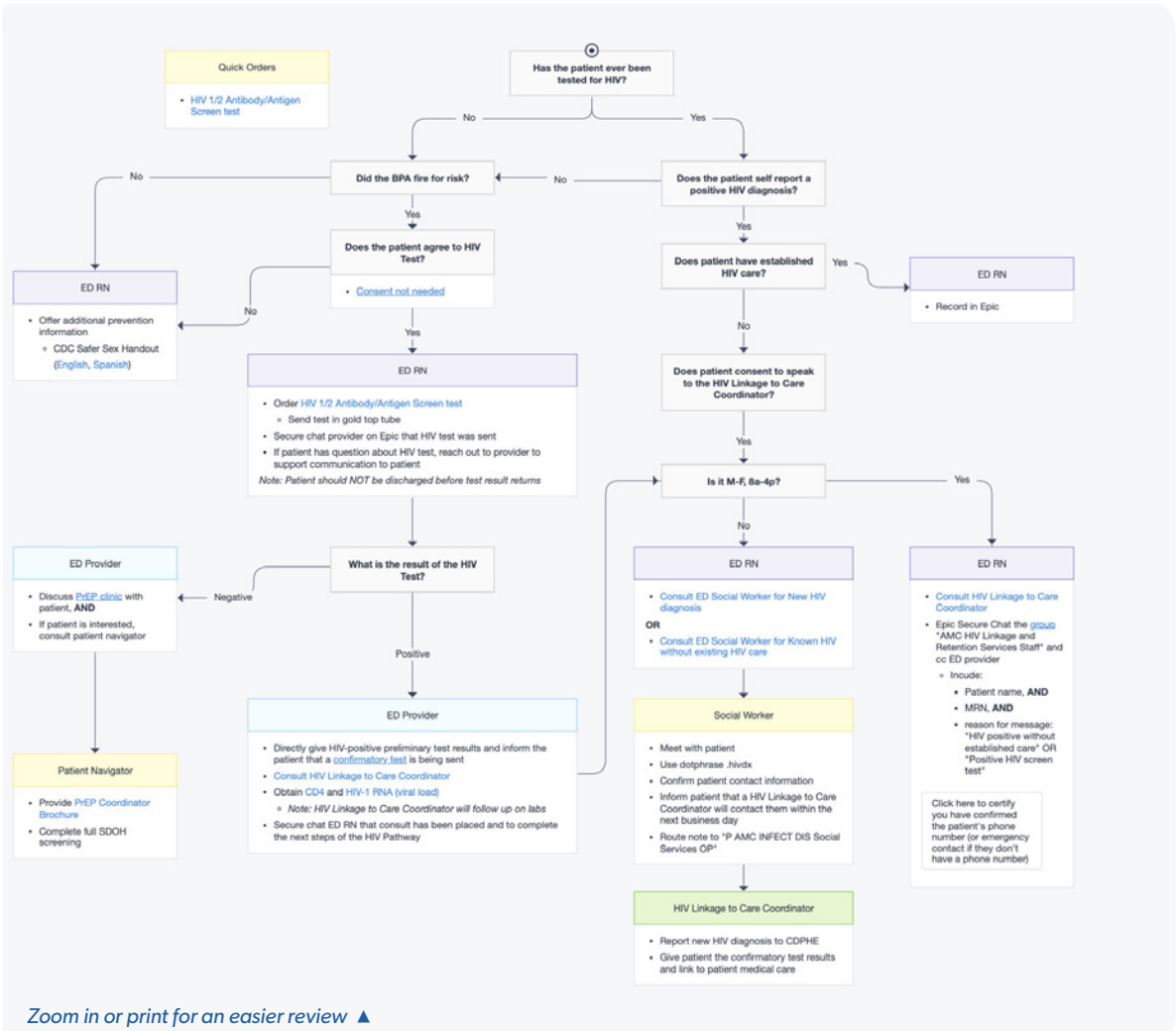
HIV Screening Pathway (# 2524)

This patient has a moderate to high Denver HIV risk score or qualifies for other resources. Open the HIV Screening Pathway below to order the HIV screening test and access other resources for patients. No additional consent is required.

Tell the patient: "We are an HIV testing site. Based on screening questions we ask all of our patients, I recommend we add the HIV screen test to your workup today."

Open HIV Screening Pathway

Figure 3: Reference on the next steps of patient care



Zoom in or print for an easier review ▲

Challenges & Solutions

We faced a number of challenges during implementation ranging from care team discomfort with screening to ongoing monitoring and editing of our EHR tools.

At the University of Colorado Emergency Department, patients go through an intake process and, as a result, not every patient receives all screening questions. This limits the number of patients who are receiving the Denver HIV Risk Score Tool questions. However, providers are still free to order HIV testing on anyone interested in the ED.

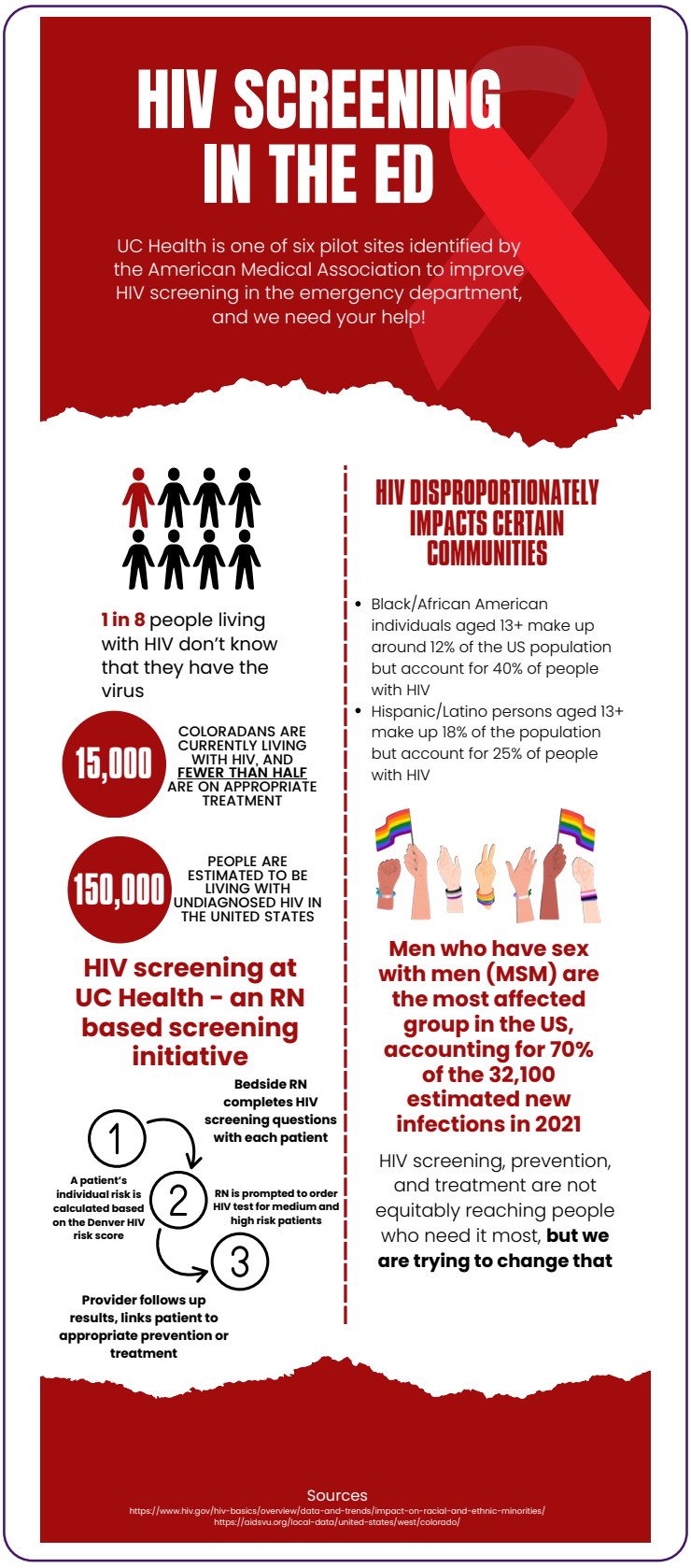
Another challenge we faced was continued nursing engagement. Our screening method relies on the nursing staff to ask sensitive questions regarding sexual practices and racial/ethnic background. A survey was given to nursing staff who ask the risk assessment questions and it was noted that 27% of respondents felt uncomfortable asking questions around sexual practices. Specifically, it was noted that they did not always see the relevance of sexual history to the patient's overall ED care. They also did not want patients to feel discriminated against or fear that their care may change based on their answers. It was also noted that 47% of nurses felt uncomfortable asking about race or ethnicity. They cited similar reasons including not seeing the relevance to patient care.

Our solution to these concerns was focused on improving nurse comfort in asking these questions. We were able to utilize a toolkit strategy of utilizing sex positive messaging. The language that accompanies the BPA was updated after receiving frontline staff input. Another concern noted was around requiring additional consent.

By directly calling out this concern in the pathway and explaining the "why" we were able to decrease apprehension from staff. By providing this to staff they have noted feeling more comfortable when asking sensitive questions around HIV. We had interdisciplinary champions attend nurse huddles to provide reminders on the importance of this process as well. In addition, we created educational flyers **(Figure 4)** that provided more context to the process.

The flowsheet, BPA, and pathway all require consistent monitoring and edits. Initially, the nursing flowsheet logic did not include an area for free text. We felt this was an important area that we wanted to track and determine specific reasons in real time as to why they may not be able to assess an answer. In addition, there are regular updates to the pathway to ensure the most up to date information is provided.

Figure 4: Educational Flyer



Results

After implementing strategies outlined in the AMA's HIV, STIs, Viral Hepatitis and LTBI Routine Screening Toolkit at the University of Colorado, we noted a variety of improvements to our HIV screening process.

First, there was an increase in the number of patients screened for HIV after presenting to the ED. Compared to the pre-pilot data there was a 20% increase in the number of patients screened. In addition, we had 100% success in linkage to care as defined in the AMA's HIV, STIs, Viral Hepatitis and LTBI Routine Screening Toolkit. Finally, 90% of the nurses surveyed were in support of the additions to the BPA language and pathway.

Next Steps

During the pilot, we noted a high number of patients with moderate or higher risk for HIV infection.

Building upon this work, the next logical step is augmenting our prevention efforts by offering patients PrEP in the ED. Being able to offer PrEP in the ED for those patients who scored moderate or higher on the scoring tool and are at a higher risk for infection would not only enhance patient care but also continue to broaden our public health initiative by attempting to reduce the overall incidence and transmission of HIV in our community.

References

1. About AtlasPlus. National Center for HIV, Viral Hepatitis, STD, and Tuberculosis Prevention Published May 21, 2024. Accessed July 12 2024. https://www.cdc.gov/nchhstp/about/atlasplus.html?CDC_AAref_Val=https://www.cdc.gov/nchhstp/atlas/index.htm

2. Jason S. Haukoos, Michael S. Lyons, Christopher J. Lindsell, Emily Hopkins, Brooke Bender, Richard E. Rothman, Yu-Hsiang Hsieh, Lynsay A. MacLaren, Mark W. Thrun, Comilla Sasson, Richard L. Byyny, Derivation and Validation of the Denver Human Immunodeficiency Virus (HIV) Risk Score for Targeted HIV Screening, American Journal of Epidemiology, Volume 175, Issue 8, 15 April 2012, Pages 838–846

3. Denver HIV Risk Score Tool. Denver Prevention Training Center. Accessed July 12 2024. https://courses.denverptc.org/x/Denver_HIV_Risk_Score_Tool.pdf.

4. Haukoos JS, Hopkins E, Bucossi MM, Lyons MS, Rothman RE, White DA, Al-Tayyib AA, Bradley-Springer L, Campbell JD, Sabel AL, Thrun MW; Denver Emergency Department HIV Research Consortium. Brief report: Validation of a quantitative HIV risk prediction tool using a national HIV testing cohort. J Acquir Immune Defic Syndr. 2015 Apr 15;68(5):599-603. doi: 10.1097/QAI.0000000000000518. PMID: 25585300; PMCID: PMC4357562.

Medicare Coding Guide

Due to the Affordable Care Act (ACA), when physicians order certain evidence-based preventive services for patients, the insurance company may cover the cost of the service, with the patient having no cost-sharing responsibility (zero-dollar). The ACA requires that most private insurance plans provide zero-dollar coverage for the preventive services recommended by four ACA designated organizations (the U.S. Preventive Services Task Force [USPSTF], the Advisory Committee on Immunization Practices [ACIP], Women's Preventive Services Initiative, and Bright Futures).

As coverage is directly aligned with these evidence-based recommendations, it is important to recognize which patient populations are eligible for each preventive service without cost-sharing and which patients may require cost-sharing for the same services. This "Medicare coding guide" helps physicians ensure that they are coding services correctly to be eligible for zero-dollar coverage. **Click here for more information.**

Below is a list of procedural codes related to HIV, STIs, viral hepatitis and latent tuberculosis infection screening that may be applicable in your clinical practice. The information provided does not make recommendations for the specific tests that need to be ordered.

HIV

HIV screening

Coverage guidance: Certain Medicare beneficiaries without regard to perceived risk or who are at increased risk for HIV infection, including anyone who asks for the test, or pregnant persons.

CPT® code	Code descriptor	Co-pay/ coinsurance waived (Yes/No)?	Deductible waived (Yes/No)?
80081	Obstetric panel (includes HIV testing) This panel must include the following: Blood count, complete (CBC), and automated differential WBC count (85025 or 85027 and 85004) OR Blood count, complete (CBC), automated (85027) and appropriate manual differential WBC count (85007 or 85009) Hepatitis B surface antigen (HBsAg) (87340) HIV-1 antigen(s), with HIV-1 and HIV-2 antibodies, single result (87389) Antibody, rubella (86762) Syphilis test, non-treponemal antibody; qualitative (e.g., VDRL, RPR, ART) (86592) Antibody screen, RBC, each serum technique (86850) Blood typing, ABO (86900) AND Blood typing, Rh (D) (86901)	**YES**	**YES**

HCPCS code	Code descriptor	Co-pay/ coinsurance waived (Yes/No)?	Deductible waived (Yes/No)?
G0432	Infectious agent antibody detection by enzyme immunoassay (eia) technique, HIV-1 and/or HIV-2, screening	**YES**	**YES**
G0433	Infectious agent antibody detection by enzyme-linked immunosorbent assay (elisa) technique, HIV-1 and/or HIV-2, screening	**YES**	**YES**
G0435	Infectious agent antibody detection by rapid antibody test, HIV-1 and/or HIV-2, screening	**YES**	**YES**
G0475	HIV antigen/antibody, combination assay, screening	**YES**	**YES**

Medicare Coding Guide

Screening for STIs and high intensity behavioral counseling to prevent STIs

Coverage guidance: Certain Medicare beneficiaries when all of the following are true:

- Sexually active adolescents and adults at increased risk for STIs
- Referred for this service by a primary care provider and provided by a Medicare-eligible primary care provider in a primary care setting

CPT® code	Code descriptor	Co-pay/ coinsurance waived (Yes/No)?	Deductible waived (Yes/No)?
86631	Antibody; Chlamydia	**YES**	**YES**
86632	Antibody; Chlamydia, IgM	**YES**	**YES**
87110	Culture, chlamydia, any source	**YES**	**YES**
87270	Infectious agent antigen detection by immunofluorescent technique; Chlamydia trachomatis	**YES**	**YES**
87320	Infectious agent antigen detection by immunoassay technique, (e.g., enzyme immunoassay [EIA], enzymelinked immunosorbent assay [ELISA], fluorescence immunoassay [FIA], immunochemiluminometric assay [IMCA]) qualitative or semiquantitative; Chlamydia trachomatis	**YES**	**YES**
87490	Infectious agent detection by nucleic acid (DNA or RNA); Chlamydia trachomatis, direct probe technique	**YES**	**YES**
87491	Infectious agent detection by nucleic acid (DNA or RNA); Chlamydia trachomatis, amplified probe technique	**YES**	**YES**
87810	Infectious agent antigen detection by immunoassay with direct optical (i.e., visual) observation; Chlamydia trachomatis	**YES**	**YES**
87800	Infectious agent detection by nucleic acid (DNA or RNA), multiple organisms; direct probe(s) technique	**YES**	**YES**
87590	Infectious agent detection by nucleic acid (DNA or RNA); Neisseria gonorrhoeae, direct probe technique	**YES**	**YES**
87591	Infectious agent detection by nucleic acid (DNA or RNA); Neisseria gonorrhoeae, amplified probe technique	**YES**	**YES**
87850	Infectious agent antigen detection by immunoassay with direct optical (i.e., visual) observation; Neisseria gonorrhoeae	**YES**	**YES**
86592	Syphilis test, non-treponemal antibody; qualitative (e.g., VDRL, RPR, ART)	**YES**	**YES**
86593	Syphilis test, non-treponemal antibody; quantitative	**YES**	**YES**
86780	Antibody; Treponema pallidum	**YES**	**YES**
87340	Infectious agent antigen detection by immunoassay technique, (e.g., enzyme immunoassay [EIA], enzymelinked immunosorbent assay [ELISA], fluorescence immunoassay [FIA], immunochemiluminometric assay [IMCA]) qualitative or semiquantitative; hepatitis B surface antigen (HBsAg)	**YES**	**YES**
87341	Infectious agent antigen detection by immunoassay technique, (e.g., enzyme immunoassay [EIA], enzymelinked immunosorbent assay [ELISA], fluorescence immunoassay [FIA], immunochemiluminometric assay [IMCA]) qualitative or semiquantitative; hepatitis B surface antigen (HBsAg) neutralization	**YES**	**YES**

Screening for STIs and high intensity behavioral counseling to prevent STIs (continued)

HCPCS code	Code descriptor	Co-pay/ coinsurance waived (Yes/No)?	Deductible waived (Yes/No)?
G0445	High intensity behavioral counseling to prevent sexually transmitted infection; face-to-face, individual, includes: education, skills training and guidance on how to change sexual behavior; performed semiannually, 30 minutes	**YES**	**YES**

VIRAL HEPATITIS

Hepatitis B virus (HBV) screening

Coverage guidance: Certain Medicare beneficiaries who fall into any of the following categories:

- Asymptomatic, nonpregnant adolescents and adults at high risk for HBV infection
- Pregnant persons

CPT® code	Code descriptor	Co-pay/ coinsurance waived (Yes/No)?	Deductible waived (Yes/No)?
86704, pregnant female	Hepatitis B core antibody (HBcAb); total	**YES**	**YES**
86706, pregnant female	Hepatitis B surface antibody (HBsAb)	**YES**	**YES**
87340, pregnant female	Infectious agent antigen detection by immunoassay technique, (e.g., enzyme immunoassay [EIA], enzymelinked immunosorbent assay [ELISA], fluorescence immunoassay [FIA], immunochemiluminometric assay [IMCA]) qualitative or semiquantitative; hepatitis B surface antigen (HBsAg)	**YES**	**YES**
87341, pregnant female	Infectious agent antigen detection by immunoassay technique, (e.g., enzyme immunoassay [EIA], enzymelinked immunosorbent assay [ELISA], fluorescence immunoassay [FIA], immunochemiluminometric assay [IMCA]) qualitative or semiquantitative; hepatitis B surface antigen (HBsAg) neutralization	**YES**	**YES**

HCPCS code	Code descriptor	Co-pay/ coinsurance waived (Yes/No)?	Deductible waived (Yes/No)?
G0499, Asymptomatic, Nonpregnant, High Risk	Hepatitis B screening in non-pregnant, high risk individual includes hepatitis b surface antigen (hbsag), antibodies to hbsag (anti-hbs) and antibodies to hepatitis B core antigen (anti-hbc), and is followed by a neutralizing confirmatory test, when performed, only for an initially reactive hbsag result	**YES**	**YES**

Medicare Coding Guide

Hepatitis C virus (HCV) screening

Coverage guidance: Certain adult Medicare beneficiaries who fall into at least one of the following categories:

- High risk for HCV infection
- Born between 1945 and 1965
- Had a blood transfusion before 1992

CPT® code	Code descriptor	Co-pay/ coinsurance waived (Yes/No)?	Deductible waived (Yes/No)?
G0472	Hepatitis C antibody screening, for individual at high risk and other covered indication(s)	**YES**	**YES**

Private Payer Coding Guide

Due to the Affordable Care Act (ACA), when physicians order certain evidence-based preventive services for patients, the insurance company may cover the cost of the service, with the patient having no cost-sharing responsibility (zero-dollar). The ACA requires that most private insurance plans provide zero-dollar coverage for the preventive services recommended by four ACA designated organizations (the U.S. Preventive Services Task Force [USPSTF], the Advisory Committee on Immunization Practices [ACIP], Women's Preventive Services Initiative, and Bright Futures).

As coverage is directly aligned with these evidence-based recommendations, it is important to recognize which patient populations are eligible for each preventive service without cost-sharing and which patients may require cost-sharing for the same services. This "Private payer coding guide" helps physicians ensure that they are coding services correctly to be eligible for zero-dollar coverage. **Click here for more information.**

Below is a list of procedural codes related to HIV, STIs, viral hepatitis and latent tuberculosis infection screening that may be applicable in your clinical practice. The information provided does not make recommendations for the specific tests that need to be ordered.

HIV

HIV screening: Pregnant persons

Applicable patient population: The USPSTF recommends that clinicians screen all pregnant persons for HIV, including those who present in labor who are untested and whose HIV status is unknown.

CPT® code	Code descriptor	Use Modifier 33 (Yes/No)?
86689	Antibody; HTLV or HIV antibody, confirmatory test (e.g., Western Blot).	**YES**
86701	Antibody; HIV-1	**YES**
86702	Antibody; HIV-2	**YES**
86703	Antibody; HIV-1 and HIV-2, single result	**YES**
87389	Infectious agent antigen detection by immunoassay technique, (e.g., enzyme immunoassay [EIA], enzyme-linked immunosorbent assay [ELISA], fluorescence immunoassay [FIA], immunochemiluminometric assay [IMCA]) qualitative or semiquantitative; HIV-1 antigen(s), with HIV-1 and HIV-2 antibodies, single result	**YES**
87390	Infectious agent antigen detection by immunoassay technique, (e.g., enzyme immunoassay [EIA], enzyme-linked immunosorbent assay [ELISA], fluorescence immunoassay [FIA], immunochemiluminometric assay [IMCA]) qualitative or semiquantitative; HIV-1	**YES**
87391	Infectious agent antigen detection by immunoassay technique, (e.g., enzyme immunoassay [EIA], enzyme-linked immunosorbent assay [ELISA], fluorescence immunoassay [FIA], immunochemiluminometric assay [IMCA]) qualitative or semiquantitative; HIV-2	**YES**

This table continues on the next page.

Private Payer Coding Guide

HIV screening: Pregnant persons (continued)

CPT® code	Code descriptor	Use Modifier 33 (Yes/No)?
87534	Infectious agent detection by nucleic acid (DNA or RNA); HIV-1, direct probe technique	**YES**
87535	Infectious agent detection by nucleic acid (DNA or RNA); HIV-1, amplified probe technique, includes reverse transcription when performed	**YES**
87536	Infectious agent detection by nucleic acid (DNA or RNA); HIV-1, quantification, includes reverse transcription when performed	**YES**
87537	Infectious agent detection by nucleic acid (DNA or RNA); HIV-2, direct probe technique	**YES**
87538	Infectious agent detection by nucleic acid (DNA or RNA); HIV-2, amplified probe technique, includes reverse transcription when performed	**YES**
87539	Infectious agent detection by nucleic acid (DNA or RNA); HIV-2, quantification, includes reverse transcription when performed	**YES**
87806	Infectious agent antigen detection by immunoassay with direct optical (i.e., visual) observation; HIV-1 antigen(s), with HIV-1 and HIV-2 antibodies	**YES**

HIV screening: Nonpregnant adolescents and adults

Applicable patient population: The USPSTF recommends that clinicians screen for HIV infection in adolescents and adults ages 15 to 65 years. Younger adolescents and older adults who are at increased risk should also be screened.

CPT® code	Code descriptor	Use Modifier 33 (Yes/No)?
86701	Antibody; HIV-1	**YES**
86702	Antibody; HIV-2	**YES**
86703	Antibody; HIV-1 and HIV-2, single result	**YES**
87389	Infectious agent antigen detection by immunoassay technique, (e.g., enzyme immunoassay [EIA], enzyme-linked immunosorbent assay [ELISA], fluorescence immunoassay [FIA], immunochemiluminometric assay [IMCA]) qualitative or semiquantitative; HIV-1 antigen(s), with HIV-1 and HIV-2 antibodies, single result	**YES**
87390	Infectious agent antigen detection by immunoassay technique, (e.g., enzyme immunoassay [EIA], enzyme-linked immunosorbent assay [ELISA], fluorescence immunoassay [FIA], immunochemiluminometric assay [IMCA]) qualitative or semiquantitative; HIV-1	**YES**

This table continues on the next page.

HIV screening: Nonpregnant adolescents and adults (continued)

CPT® code	Code descriptor	Use Modifier 33 (Yes/No)?
87391	Infectious agent antigen detection by immunoassay technique, (e.g., enzyme immunoassay [EIA], enzyme-linked immunosorbent assay [ELISA], fluorescence immunoassay [FIA], immunochemiluminometric assay [IMCA]) qualitative or semiquantitative; HIV-2	**YES**
87534	Infectious agent detection by nucleic acid (DNA or RNA); HIV-1, direct probe technique	**YES**
87535	Infectious agent detection by nucleic acid (DNA or RNA); HIV-1, amplified probe technique, includes reverse transcription when performed	**YES**
87536	Infectious agent detection by nucleic acid (DNA or RNA); HIV-1, quantification, includes reverse transcription when performed	**YES**
87537	Infectious agent detection by nucleic acid (DNA or RNA); HIV-2, direct probe technique	**YES**
87538	Infectious agent detection by nucleic acid (DNA or RNA); HIV-2, amplified probe technique, includes reverse transcription when performed	**YES**
87539	Infectious agent detection by nucleic acid (DNA or RNA); HIV-2, quantification, includes reverse transcription when performed	**YES**
87806	Infectious agent antigen detection by immunoassay with direct optical (i.e., visual) observation; HIV-1 antigen(s), with HIV-1 and HIV-2 antibodies	**YES**

STIs

Chlamydia screening: Sexually active women, including pregnant persons

Applicable patient population: The USPSTF recommends screening for chlamydia in all sexually active women 24 years or younger and in women 25 years or older who are at increased risk for infection.

CPT® code	Code descriptor	Use Modifier 33 (Yes/No)?
86631	Antibody; Chlamydia	**YES**
86632	Antibody; Chlamydia, IgM	**YES**
87110	Culture, chlamydia, any source	**YES**
87270	Infectious agent antigen detection by immunofluorescent technique; Chlamydia trachomatis	**YES**
87320	Infectious agent antigen detection by immunoassay technique, (e.g., enzyme immunoassay [EIA], enzyme-linked immunosorbent assay [ELISA], fluorescence immunoassay [FIA], immunochemiluminometric assay [IMCA]) qualitative or semiquantitative; Chlamydia trachomatis	**YES**
87490	Infectious agent detection by nucleic acid (DNA or RNA); Chlamydia trachomatis, direct probe technique	**YES**
87491	Infectious agent detection by nucleic acid (DNA or RNA); Chlamydia trachomatis, amplified probe technique	**YES**
87810	Infectious agent antigen detection by immunoassay with direct optical (i.e., visual) observation; Chlamydia trachomatis	**YES**

Private Payer Coding Guide

Gonorrhea screening: Sexually active women, including pregnant persons

Applicable patient population: The USPSTF recommends screening for gonorrhea in all sexually active women 24 years or younger and in women 25 years or older who are at increased risk for infection.

CPT® code	Code descriptor	Use Modifier 33 (Yes/No)?
87590	Infectious agent detection by nucleic acid (DNA or RNA); Neisseria gonorrhoeae, direct probe technique	**YES**
87591	Infectious agent detection by nucleic acid (DNA or RNA); Neisseria gonorrhoeae, amplified probe technique	**YES**
87592	Infectious agent detection by nucleic acid (DNA or RNA); Neisseria gonorrhoeae, quantification	**YES**
87850	Infectious agent antigen detection by immunoassay with direct optical (i.e., visual) observation; Neisseria gonorrhoeae	**YES**

Syphilis screening: Pregnant persons

Applicable patient population: The USPSTF recommends early screening for syphilis infection in all pregnant persons.

CPT® code	Code descriptor	Use Modifier 33 (Yes/No)?
80055	Obstetric panel This panel must include the following: Blood count, complete (CBC), automated and automated differential WBC count (85025 or 85027 and 85004) OR Blood count, complete (CBC), automated (85027) and appropriate manual differential WBC count (85007 or 85009) Hepatitis B surface antigen (HBsAg) (87340) Antibody, rubella (86762) Syphilis test, non-treponemal antibody; qualitative (e.g., VDRL, RPR, ART) (86592) Antibody screen, RBC, each serum technique (86850) Blood typing, ABO (86900) AND Blood typing, Rh (D) (86901)	**YES**
80081	Obstetric panel (includes HIV testing) This panel must include the following: Blood count, complete (CBC), and automated differential WBC count (85025 or 85027 and 85004) OR Blood count, complete (CBC), automated (85027) and appropriate manual differential WBC count (85007 or 85009) Hepatitis B surface antigen (HBsAg) (87340) HIV-1 antigen(s), with HIV-1 and HIV-2 antibodies, single result (87389) Antibody, rubella (86762) Syphilis test, non-treponemal antibody; qualitative (e.g., VDRL, RPR, ART) (86592) Antibody screen, RBC, each serum technique (86850) Blood typing, ABO (86900) AND Blood typing, Rh (D) (86901)	**YES**
86592	Syphilis test, non-treponemal antibody; qualitative (e.g., VDRL, RPR, ART)	**YES**
86593	Syphilis test, non-treponemal antibody; quantitative	**YES**
86780	Antibody; Treponema pallidum	**YES**

Syphilis screening: Asymptomatic, nonpregnant adolescents and adults

Applicable patient population: The USPSTF recommends screening for syphilis infection in persons who are at increased risk for infection.

CPT® code	Code descriptor	Use Modifier 33 (Yes/No)?
86592	Syphilis test, non-treponemal antibody; qualitative (e.g., VDRL, RPR, ART)	**YES**
86593	Syphilis test, non-treponemal antibody; quantitative	**YES**
86780	Antibody; Treponema pallidum	**YES**

VIRAL HEPATITIS

Hepatitis B screening: Pregnant persons

Applicable patient population: The USPSTF strongly recommends screening for hepatitis B virus infection in pregnant persons at their first prenatal visit.

CPT® code	Code descriptor	Use Modifier 33 (Yes/No)?
80055	Obstetric panel This panel must include the following: Blood count, complete (CBC), automated and automated differential WBC count (85025 or 85027 and 85004) OR Blood count, complete (CBC), automated (85027) and appropriate manual differential WBC count (85007 or 85009) Hepatitis B surface antigen (HBsAg) (87340) Antibody, rubella (86762) Syphilis test, non-treponemal antibody; qualitative (e.g., VDRL, RPR, ART) (86592) Antibody screen, RBC, each serum technique (86850) Blood typing, ABO (86900) AND Blood typing, Rh (D) (86901)	**YES**
80081	Obstetric panel (includes HIV testing) This panel must include the following: Blood count, complete (CBC), and automated differential WBC count (85025 or 85027 and 85004) OR Blood count, complete (CBC), automated (85027) and appropriate manual differential WBC count (85007 or 85009) Hepatitis B surface antigen (HBsAg) (87340) HIV-1 antigen(s), with HIV-1 and HIV-2 antibodies, single result (87389) Antibody, rubella (86762) Syphilis test, non-treponemal antibody; qualitative (e.g., VDRL, RPR, ART) (86592) Antibody screen, RBC, each serum technique (86850) Blood typing, ABO (86900) AND Blood typing, Rh (D) (86901)	**YES**

Private Payer Coding Guide

Hepatitis B screening: Nonpregnant adolescents and adults

Applicable patient population: The USPSTF recommends screening for hepatitis B virus infection in persons at high risk for infection.

CPT® code	Code descriptor	Use Modifier 33 (Yes/No)?
86704	Hepatitis B core antibody (HBcAb); total	**YES**
86705	Hepatitis B core antibody (HBcAb); IgM antibody	**YES**
86706	Hepatitis B surface antibody (HBsAb)	**YES**
86707	Hepatitis Be antibody (HBeAb)	**YES**
87340	Infectious agent antigen detection by immunoassay technique, (e.g., enzyme immunoassay [EIA], enzyme-linked immunosorbent assay [ELISA], fluorescence immunoassay [FIA], immunochemiluminometric assay [IMCA]) qualitative or semiquantitative; hepatitis B surface antigen (HBsAg)	
87341	Infectious agent antigen detection by immunoassay technique, (e.g., enzyme immunoassay [EIA], enzyme-linked immunosorbent assay [ELISA], fluorescence immunoassay [FIA], immunochemiluminometric assay [IMCA]) qualitative or semiquantitative; hepatitis B surface antigen (HBsAg) neutralization	

Hepatitis C screening: Adults

Applicable patient population: The USPSTF recommends screening for hepatitis C virus infection in adults aged 18 to 79 years.

CPT® code	Code descriptor	Use Modifier 33 (Yes/No)?
86803	Hepatitis C antibody	**YES**
87520	Infectious agent detection by nucleic acid (DNA or RNA); hepatitis C, direct probe technique	**YES**
87521	Infectious agent detection by nucleic acid (DNA or RNA); hepatitis C, amplified probe technique, includes reverse transcription when performed	**YES**
87522	Infectious agent detection by nucleic acid (DNA or RNA); hepatitis C, quantification, includes reverse transcription when performed	**YES**

LATENT TUBERCULOSIS INFECTION

Latent Tuberculosis Infection Screening: Asymptomatic adults at increased risk for infection

Applicable patient population: The USPSTF recommends screening for latent tuberculosis infection in populations at increased risk.

CPT® code	Code descriptor	Use Modifier 33 (Yes/No)?
86480	Tuberculosis test, cell mediated immunity antigen response measurement; gamma interferon	**YES**
86481	Tuberculosis test, cell mediated immunity antigen response measurement; enumeration of gamma interferon-producing T-cells in cell suspension	**YES**
86580	Skin test; tuberculosis, intradermal	

Partner Mapping Template

Community Health Centers

ORGANIZATION NAME

PRIMARY CONTACT

PHONE NUMBER

EMAIL ADDRESS

LOCATION

NOTES

ORGANIZATION NAME

PRIMARY CONTACT

PHONE NUMBER

EMAIL ADDRESS

LOCATION

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ORGANIZATION NAME

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PHONE NUMBER

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ORGANIZATION NAME

PRIMARY CONTACT

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EMAIL ADDRESS

LOCATION

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Partner Mapping Template

Domestic Violence Centers

ORGANIZATION NAME

PRIMARY CONTACT

PHONE NUMBER

EMAIL ADDRESS

LOCATION

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ORGANIZATION NAME

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ORGANIZATION NAME

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Partner Mapping Template

Employment Services

ORGANIZATION NAME

PRIMARY CONTACT

PHONE NUMBER

EMAIL ADDRESS

LOCATION

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ORGANIZATION NAME

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Partner Mapping Template

Food Insecurity Services

ORGANIZATION NAME

PRIMARY CONTACT

PHONE NUMBER

EMAIL ADDRESS

LOCATION

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ORGANIZATION NAME

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Partner Mapping Template

Housing Services

ORGANIZATION NAME

PRIMARY CONTACT

PHONE NUMBER

EMAIL ADDRESS

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ORGANIZATION NAME

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Partner Mapping Template

Infectious Disease Clinics

ORGANIZATION NAME

PRIMARY CONTACT

PHONE NUMBER

EMAIL ADDRESS

LOCATION

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ORGANIZATION NAME

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Partner Mapping Template

LGBTQ Support Services

ORGANIZATION NAME

PRIMARY CONTACT

PHONE NUMBER

EMAIL ADDRESS

LOCATION

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ORGANIZATION NAME

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Partner Mapping Template

Mental Health Support Services

ORGANIZATION NAME

PRIMARY CONTACT

PHONE NUMBER

EMAIL ADDRESS

LOCATION

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ORGANIZATION NAME

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Partner Mapping Template

Substance Use Disorder Support Services

ORGANIZATION NAME

PRIMARY CONTACT

PHONE NUMBER

EMAIL ADDRESS

LOCATION

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ORGANIZATION NAME

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PHONE NUMBER

EMAIL ADDRESS

LOCATION

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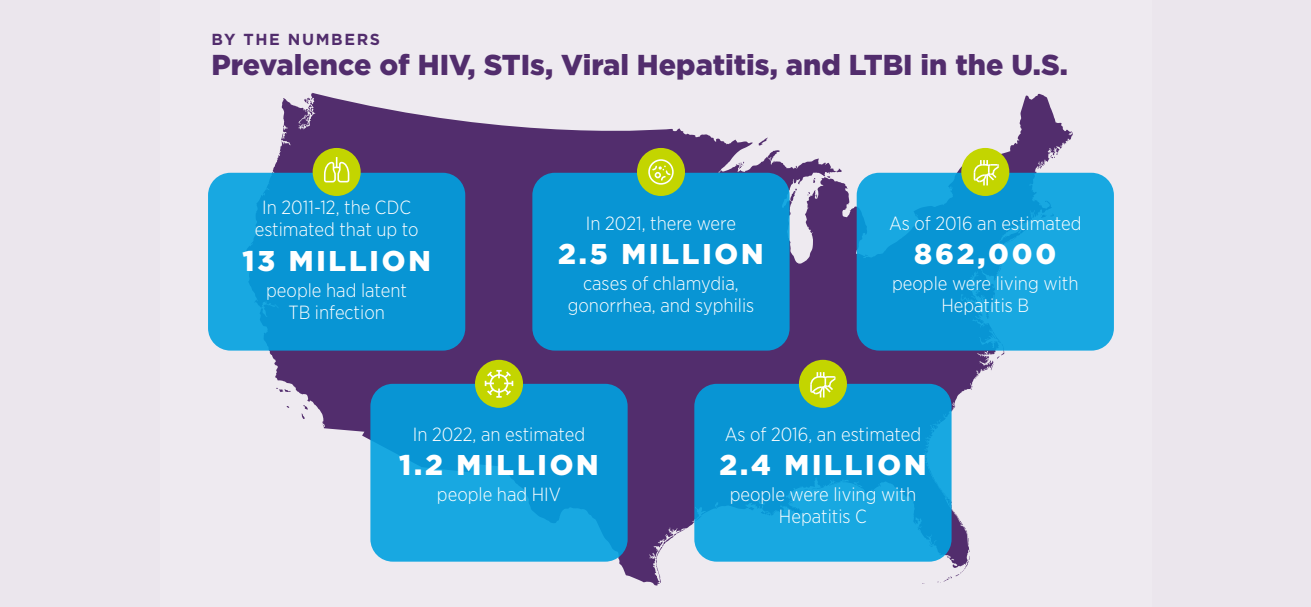
Resource Library

The HIV, STIs, Viral Hepatitis and Routine Screening Toolkit was developed with input from health care professionals and was designed for clinicians working in community health centers and emergency departments. Access the library of resources available from the toolkit for use in your practice.

Jump to:



Impact by the numbers

To access interactive maps and charts on number of reported cases by state, race/ethnicity and sex, visit the CDC's National Center for HIV, Viral Hepatitis, STD, and TB Prevention Atlas Plus resource.

HIV

In 2022, an estimated 1.2 million people aged 13 and older had HIV in the United States, including an estimated 153,500 (13%) people whose were not aware of their HIV-positive status (CDC).

For the latest in HIV surveillance from the CDC you can visit the HIV Data webpage.

STIS

Data published by the Centers for Disease Control and Prevention (CDC) show that reported annual cases of STIs in the United States continued to climb in 2021, reaching an all-time high for the sixth consecutive year.

The 2021 STI Surveillance Report found:

- 2.5 million cases of chlamydia, gonorrhea, and syphilis, the three most reported STIs in 2021.

- Congenital syphilis continues to surge, increasing 203 percent in the past five years. In 2021, 38 jurisdictions, including 37 states and the District of Columbia, reported an increase in congenital syphilis cases.

For the latest in STI surveillance from the CDC you can visit the About STI Statistics webpage.

VIRAL HEPATITIS

- As of 2016, nearly 3.3 million people in the United States were living with chronic viral hepatitis—an estimated 862,000 with hepatitis B and 2.4 million with hepatitis C.
- Hepatitis B: In 2019, a total of 3,192 acute hepatitis B cases were reported to CDC, resulting in 20,700 estimated infections after adjusting for case under-ascertainment and under-reporting
- Hepatitis C: In 2019, 4,136 acute hepatitis C cases were reported to CDC, resulting in 57,500 estimated infections after adjusting for case under ascertainment and under-reporting. The number of cases reported during 2019 corresponds to a 133% increase from the 1,778 cases reported during 2012.

For the latest in viral hepatitis surveillance from the CDC you can visit the Viral Hepatitis Statistics and Surveillance webpage.

LATENT TUBERCULOSIS INFECTION (LTBI)

- During 2019, the United States reported the lowest number of TB cases (8,916) and lowest incidence rate (2.7 cases per 100,000 persons) since individual TB case reporting began in 1953.
- This represents a 1.2% decrease in TB cases and 1.7% decrease in the incidence rate from 2018.
- However, CDC estimated in 2011-2012 up to 13 million people in the United States had LTBI who could benefit from testing and treatment to prevent reactivation to TB disease.

For the latest in Tuberculosis surveillance from the CDC you can visit the Tuberculosis Data and Statistics webpage.

Summary of action items

WHAT CAN YOU DO?

- Couple screenings for HIV, STIs, viral hepatitis and LTBI with screenings for chronic conditions or care for everyday concerns
- Understand what comprehensive care looks like and feels like to the community being served and place routine screening in that context
- Implement patient self-assessment screening in waiting room and address during visit as needed
- Make sure all staff are up to date on screening recommendations
- Identify opportunities for clinical decision support tools that provide reminders or support automatic laboratory orders
- Ensure staff are trained in patient counseling and can deliver news in a clear, culturally sensitive, and effective way
- Have patient education materials available at visit completion
- Have resources to aid patients with disclosing their status to partners
- Have strong linkage to care and follow up protocols for patients in place
- Discuss accessible preventive measures

Implementation materials

RESOURCES TO HELP BUILD STRONG COMMUNITY PARTNERSHIPS

- Tool for Tracking Partners and Partnership Activities: Pages 81-88 from HSA's Integrating HIV Care, Treatment & Prevention Services into Primary Care–A Toolkit for Health Centers guide includes a Partnership Toolkit that

provides a comprehensive list of key considerations, steps, and templates to help guide your organizations' community relationship building and tracking.

- Partnership Mapping Template (PDF): This template provides a framework to help your organization keep track of relationships with non-clinical services and outpatient clinics that will support both community outreach and a sustainable linkage to care program.

SOCIAL AND DIGITAL MARKETING MATERIAL AND CAMPAIGN EXAMPLES

The CDC's National Prevention Information Network includes information and links to digital marketing examples and marketing campaigns executed by a variety of organizations.

- CDC's Let's Stop HIV Together Campaign
- CDC's National Prevention Information Network Digital Media Tools for HIV
- CDC's Let's Stop HIV Together Social Media Toolkit
- CDC's National Prevention Information Network Digital Media Tools for hepatitis
- CDC's National Prevention Information Network Digital Media Tools for STDs
- CDC's Think. Test. Treat TB Campaign
- CDC's Latent TB Infection Online Resource Hub

SOCIAL DETERMINANTS OF HEALTH RESOURCES

- Tools for Putting Social Determinants of Health into Action: This CDC resource compiles a series of tools and resources that health care practitioners can review in order to embed strategies to address social determinants of health in their organization.
- Health-Related Social Needs Screening Tool: This resource from the Centers for Medicare and Medicaid Services can help clinicians find out patients' needs in 5 core domains including housing instability, food insecurity, transportation problems, utility help needs and interpersonal safety.
- PRAPARE Screening Tool and Implementation Toolkit: Developed in partnership between the National Association of Community Health Centers, the Association of Asian Pacific Community Health Organizations, and the Oregon Primary Care Association the Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences (PRAPARE) is a national standardized patient risk assessment protocol designed to engage patients in assessing and addressing social determinants of health.

MEET PATIENTS WHERE THEY ARE RESOURCES

- HIV Testing in Non-Clinical Settings: This CDC webpage compiles a series of guidelines, recommendations and job aids that supports HIV testing in non-clinical settings.
- Implementing HIV Testing in Nonclinical Settings: A Guide for HIV Testing Providers: The purpose of this guide from the CDC is to familiarize health care professionals with key programmatic issues that impact delivery of HIV testing services in nonclinical settings.

Patient education materials

PATIENT EDUCATION MATERIALS FROM THE CDC

These links compile downloadable patient education materials from the CDC with resources targeted to different patient demographics and available in multiple languages. Patients should be provided with information about the communicable nature of these infections and consider options for notifying others that were potentially exposed.

- HIV Consumer Info Sheets
- Viral Hepatitis Patient Education Materials

- STI Patient Resources from the CDC
  - CDC Fact Sheets
  - Next steps after testing positive for gonorrhea or chlamydia
  - Getting Tested for STIs
  - How to Prevent STIs
- LTBI and TB disease resources
  - Find TB Resources: TB Education & Training from the CDC
  - Tuberculosis Patient & General Public Materials

PATIENT PAGES FROM THE JAMA NETWORK™

JAMA Patient Pages are free patient resources designed to distill high-quality evidence and updated guidance from USPSTF into a more accessible patient friendly format to help guide patient decisions. These resources can also be helpful to reference as your clinic or institution develops their own patient-friendly educational resources.

HIV

- Human Immunodeficiency Virus
- Who Should Be Screened for HIV Infection?
- Can HIV Infection Be Prevented With Medication?
- HIV Infection: The Basics

Viral hepatitis

- Screening for Hepatitis B in Nonpregnant Adolescents and Adults
- Screening for Hepatitis B in Pregnant Women
- Screening for Hepatitis C Virus Infection
- Treating Hepatitis C

STIs

- What is Syphilis?
- Screening for Syphilis in Pregnant Women
- Screening for Syphilis
- Screening for Chlamydia and Gonorrhea

LTBI

- Screening for Latent Tuberculosis

SELF OR RISK ASSESSMENT TEMPLATES

The following links provide you with examples of self or risk assessment templates that you can leverage in your practice.

- HIV: Learn the HIV risk of different sexual activities when one partner is HIV positive and one partner is HIV negative (a discordant partnership).
- STIs: Link to the CDC's Prepare Before You're There STI self-risk assessment quiz.
- Viral hepatitis: Assess your risk with this Hepatitis Risk Assessment Tool from the CDC.
- LTBI
  - This CDC resource is an LTBI guide booklet for primary care clinicians. Appendix A of this resource is a sample

risk assessment that can be leveraged when screening for LTBI.

RESOURCES ON COLLECTING COMPREHENSIVE PATIENT DEMOGRAPHICS AND SEXUAL HISTORY

- Discussing Sexual Health with Your Patients: The resource from the CDC outlines strategies and tips for facilitating discussions with and asking patients sensitive questions related to sexual health.
- A Guide to Taking a Sexual History (PDF): This CDC resource offers a framework for discussing sexual health issues to help health care professionals complete the overall picture of their patient's health.
- GOALS Framework for Sexual History Taking in Primary Care: The GOALS Framework resource from the Clinical Guidelines Program of the New York State Department of Health AIDS Institute is designed to streamline sexual history conversations and elicit information most useful for identifying an appropriate clinical course of action.
- Sexual Health and Your Patients: A Provider's Guide: The resource from the National Coalition for Sexual Health was developed to help health care professionals better integrate sexual health conversations and recommended preventive services into routine visits with adolescents and adults.

SCREENING GUIDELINES FROM THE CDC AND USPSTF

- CDC Guidelines and Recommendations
- USPSTF A&B Recommendations
- Clinical algorithm flowcharts for screening: This set of documents translates screening guidance and clinical considerations from the USPSTF into a decision tree format to help outline steps in the testing continuum from beginning to end and allow you to help clarify team member roles at each step of the process.
  - Clinical algorithm flowchart for HIV screening (PDF)
  - Clinical algorithm flowchart for Chlamydia and Gonorrhea screening (PDF)
  - Clinical algorithm flowchart for Syphilis screening (PDF)
  - Clinical algorithm flowchart for HBV screening (PDF)
  - Clinical algorithm flowchart for HCV screening (PDF)

RESOURCES TO STREAMLINE THE TESTING CASCADE

- Streamlined testing cascade: This set of infographics outlines the testing cascade for each infectious disease in this toolkit for both community health centers and emergency departments, including opportunities to optimize screening, and can be used to help clarify care team member roles at each step as well as define a clear post-test protocol.
  - **Community Health Center:**
    - Routine Screening Toolkit: Streamlined Testing Cascade, HCV (PDF)
    - Routine Screening Toolkit: Streamlined Testing Cascade, HIV (PDF)
    - Routine Screening Toolkit: Streamlined Testing Cascade, LTBI (PDF)
    - Routine Screening Toolkit: Streamlined Testing Cascade, STI (PDF)
  - **Emergency Department:**
    - Routine Screening Toolkit: Streamlined Testing Cascade, HIV (PDF)
    - Routine Screening Toolkit: Streamlined Testing Cascade, STI (PDF)
    - Routine Screening Toolkit: Streamlined Testing Cascade, HCV (PDF)
- Care team members roles and responsibilities (PDF): This resource outlines potential care team member roles in your organization and the part that they play in the routine screening process.
- Recommendations for Providing Quality STD Clinical Services: This resource from the CDC highlights the services

health care settings can offer to provide the highest-quality STI care to their patients.

- Health Department directories: This resource from the CDC outlines who is working to protect the public's health in your area, including senior health officials, state, local, and territorial health departments, and tribes and Indian organizations. Clinical staff may need to develop relationships with staff in various sections of health departments in order to facilitate reporting, linkage to care or prevention, and other critical services.

IMPLEMENT THE "OPT-OUT" APPROACH

Training clinicians to implement opt-out language helps normalize routine screening as standard of care. Opt-out screening reduces the subjectivity of the decision on behalf of the patient where consent is not legally required.

- Explanation of opt-out screening approach for HIV: This resource link from the CDC provides an explanation of an opt-out approach to screening and why it is effective at increasing screening.
- Sample opt out script for providers during HIV screening encounter: Pages 4-5 of the Guidance for Delivering HIV Pre-Test and Post-Test Results resource from the Reproductive Health National Training Centers outlines samples scripts that clinicians can use when conducting an opt-out approach to HIV screening.
- Discussion Guide: Using normalizing and opt-out language for chlamydia and gonorrhea: This resource from the Reproductive Health National Training Centers is designed to build the confidence of clinic staff to use normalizing and opt-out language for chlamydia and gonorrhea screening.
- State Laws that address High-Impact HIV Prevention Efforts: This resource from the CDC is a summary of state specific laws on a minor's autonomous consent for HIV and/STI services, and laws that address HIV prevention efforts.

RESOURCES TO SUPPORT SEX-POSITIVE, STATUS-NEUTRAL MESSAGING ABOUT THE BENEFITS OF ROUTINE SCREENING

- Care team resources to help health care providers educate patients on the importance of sexual health: These tools from the National Coalition for Sexual Health can help health care providers and clinical staff cultivate a clinical environment that delivers inclusive, patient-centered, and accessible sexual health services for all patients.
  - Inclusive Sexual Health Services: Practical Guidelines for Providers & Clinics
  - Sexual Health and Your Patients: A Provider's Guide
  - Compendium of Sexual & Reproductive Health Resources for Healthcare Providers

CLINICAL DECISION SUPPORT SYSTEM RESOURCES

- Clinical Decision Support System to Increase HIV Screening: The webpage outlines new recommendations and considerations for implementation from the CPSTF that the use of clinical decision support systems increases HIV screening both for the general population as well as those at higher risk for HIV infection.
- Tips to Leverage Your Electronic Health Record to Implement Opt-Out HIV: This resource from Health Information Technology Evaluation and Quality Center outlines best practices and strategies for implementing opt-out HIV screening in your organization using the electronic health record.

TASK SHIFTING RESOURCES

- Sharing and Shifting Tasks to Maintain Essential Healthcare During COVID-19 in Low Resource, non-US settings resource from the CDC: This resource developed by the CDC specifically for maintaining health care during COVID-19 outlines many of the basics of task shifting and task sharing that can be applied across many health care delivery situations.
- Task Shifting: Global Recommendations and Guidelines from the World Health Organization: This resource from provides recommendation and guidance from the World Health Organization on how to redistribute tasks among the health care team in order to make more efficient use of available human resources, especially in workforce

shortages, in order to reach more patients with care.

RESOURCES TO CREATE A TRUSTED AND WELCOMING ENVIRONMENT

- Tools to Create a Welcoming Environment: Included as a subset of resources in the National Coalition of Sexual Health's Compendium of Sexual & Reproductive Health Resources for Healthcare Providers, users can find examples and resources on how to create a welcoming and safe environment for both teen and LGBTQ patients.
- Target HIV Cultural Competency Resources: This webpage includes a collection of guidance, tools and trainings that clinicians can use to identify and address bias to improve communication with diverse patients.
- Cultural Competence in Health and Human Services: This resource from the National Prevention Information Network defines what cultural competence is and how it applies to HIV, viral hepatitis, STI and TB prevention.

COST EFFECTIVENESS RESOURCES

Presenting the cost-benefit analysis of catching diseases early versus treating disease progression can help establish infectious disease control as a strategic imperative in a health setting and gain access to timesaving resources.

- HIV Cost-effectiveness resource: This resource from the CDC provides a basic guide to the cost-effectiveness analysis of prevention interventions for HIV infection and AIDS and help prevention program staff and planners become more familiar with potential uses of economic evaluation.
- Integrating Routine HIV Screening Into Clinical Practice (PDF): This resource from the CDC outlines the clinical benefits of early HIV diagnosis and treatment.
- Overview of Cost, Reimbursement, and Cost-Effectiveness Considerations for Hepatitis C Treatment Regimens: This webpage outlines the cost-effectiveness of HCV treatment and care with a section specifically dedicated to the cost effectiveness of screening for HCV.
- Cost-effectiveness of testing and treatment for Latent Tuberculosis Infection: This original investigation published in JAMA Internal Medicine aimed to estimate health outcomes, costs, and cost-effectiveness of LTBI testing and treatment among non-US born residents with and without medical comorbidities.

FUNDING AND REIMBURSEMENT STRATEGY RESOURCES

Routine screening coding quick guide: This coding guide outlines a list of procedural codes related to HIV, STI, viral hepatitis and tuberculosis screening for both private payer insurance and Medicare and helps you ensure that you are coding services correctly for eligible patient populations to cover the cost of the service, with the patient having no cost-sharing responsibility.

- Routine screening Medicare coding quick guide (PDF)
- Routine Screening Toolkit: Private payer coding guide (PDF)
- ICD-10-CM Codes for Tuberculosis (TB)
- Screening, Diagnosis, and Treatment of Latent Tuberculosis Infection (LTBI) in Primary Care Settings: Tips for Coding and Billing (PDF)

POTENTIAL RESOURCES TO COVER DIRECT AND INDIRECT COSTS

The following links are listings of available funding opportunities that could help to cover screening related initiatives and associated costs at your clinic.

- CDC's National Prevention Information Network–Funding Opportunities
- CDC HIV Funding and Budget resource
- Rural Health Information Hub–HIV and AIDS Funding Opportunities

RESOURCES TO HELP FORM A STRONG REFERRAL NETWORK

- **Linkage to care administrative resources:**
  - Tool for Tracking Partners and Partnership Activities (PDF): Pages 81-88 from HRSA's Integrating HIV Care, Treatment & Prevention Services into Primary Care–A Toolkit for Health Centers guide includes a Partnership Toolkit that provides a comprehensive list of key considerations, steps, and Partnership-Focused Templates to help guide organizations' relationship building and tracking.
  - Partnership Mapping Template (PDF): This template provides a framework to help your organization keep track of relationships with non-clinical services and outpatient clinics that will support both community outreach and a sustainable linkage to care program.
- **Providing or linking to care treatment and prevention resources:**
  - Effective Interventions to Treat HIV: This webpage from the CDC outlines resources that are available for the HIV prevention workforce to increase their capacity to link, retain, and re-engage people for HIV care and treatment.
  - Ready, Set, PrEP: Health care professionals and individuals can use this website to learn more about the the Ready, Set, PrEP program which provides free PrEP HIV-prevention medications to thousands of people living in the United States, including tribal lands and territories, who qualify.
  - Clinical Guidance for PrEP: This resource from the CDC outlines recommendations, treatment options and considerations for managing patients on PrEP.
  - Sexually Transmitted Infections Treatment Guidelines: CDC's Sexually Transmitted Infections (STI) Treatment Guidelines, 2021 provides current evidence-based prevention, diagnostic and treatment recommendations that replace the 2015 guidance.
  - CDC Guidelines on the use of doxy PEP: This report outlines CDC's recommendation for the use of doxycycline postexposure prophylaxis (doxy PEP) for bacterial sexually transmitted infection prevention.
  - HCV Guidance: Recommendations for Testing, Managing, and Treating Hepatitis C: To provide healthcare professionals with timely guidance, the American Association for the Study of Liver Diseases (AASLD) and the Infectious Diseases Society of America (IDSA) developed this website to facilitate the dissemination of evidence-based, expert-developed recommendations for hepatitis C management.
  - Behavioral Health Treatment Services Locator: This resource from SAHMSA helps connect persons seeking treatment facilities in the United States for substance use and addiction as well as mental health problems.

RESOURCES RELATED TO LEVERAGING PATIENT NAVIGATORS AS MEMBERS OF THE CARE TEAM

- HIV Navigation Services – STEPS to Care: This resource from the CDC provides links to trainings designed to improve navigation skills for those delivering prevention services to persons with HIV and HIV-negative persons at risk.
- STEPS to Care: Staffing and Supervision: This resource from the CDC outlines key roles and responsibilities for the patient navigation team including adaptable job description templates and videos that discuss key skills and strengths needed to be a patient navigator.
- HIV Navigation Services Section of the Rapid Antiretroviral Therapy Toolkit: Section 2 (beginning on page 19) of this toolkit developed in partnership by Primary Care Development Corporation, My Brother's Keeper, the San Francisco Community Health Center, and the Denver Prevention Training Center provides an overview of the essential role of HIV navigation services in rapid ART services. It also includes a review of staffing needs and considerations for resource-limited settings, suggested protocols, and real-world examples of how to provide services in resource variable settings.

Care team training

TRAINING ON HOW TO ASSESS SOCIAL DETERMINANTS OF HEALTH

- AMA STEPS Forward® Module: Addressing Social Determinants of Health: This learning module from AMA STEPS

Forward® outlines how to identify methods to understand the unique health needs of your community and formulate a plan to help your organization begin to address social determinants of health.

- Social Determinants of Health foundational course: This case-based virtual course from Aquifer provides foundational knowledge and a framework for building skills that minimize the effects of social determinants of health on health outcomes.
- Training Primary Care Residents on the Social Determinants of Health: This resource from the Greater New York Hospital Association includes foundational content that can be used when teaching social determinants of health concepts to both primary care residents as well as other care team members involved in the routine screening process.

CARE TEAM TRAINING ON LGBTQ, TRANSGENDER AND GENDER NONCONFORMING ESSENTIALS

The AMA Ed Hub offers a series of training modules developed by Howard Brown Health, SAGECare, The Fenway Institute and more that can help provide education to your care team on sex-positive and gender appropriate language and methods to incorporate best practices into your organization.

- Patient Care Education from Howard Brown Health
- SAGECare Education
- LGBTQIA+ Health Education from The Fenway Institute
- AMA Ed Hub CME Course: LGTBQ Health, Diversity & Inclusion

TRAINING TO HELP STAFF DEVELOP SKILLS TO COMMUNICATE WITH PATIENTS MORE EFFECTIVELY

- AMA STEPS Forward®: Health Coaching: This learning module from AMA STEPS Forward® outlines steps to help you develop and implement a health coaching model in your practice.
- Self-Study Modules on Tuberculosis: Patient Rights and Confidentiality in Tuberculosis Control (PDF): Patient Rights and Confidentiality in Tuberculosis Control: This resource from the CDC discusses patient rights and general recommendations for developing trust and maintaining confidentiality in the context of TB control.
- Talking with Your Patients about Latent Tuberculosis (TB) Infection: A conversation guide for health care providers about how to talk to patients about latent TB infection.

LONG FORM COURSES WITH BACKGROUND EDUCATION ON HIV, STIS, VIRAL HEPATITIS, AND LTBI ESSENTIALS

The following links are a compilation of education and training resources from the CDC targeted to health care professionals. These training materials can be leveraged to equip your care team members with the latest information to help boost the confidence of any member of the care team in answering patient questions.

HIV:

- HIV/ AIDS Training For Public Health Professionals from the National Prevention Information Network
- HIV Training Resources
- Compendium of Evidence-Based Interventions and Best Practices for HIV Prevention: This webpage from the CDC outlines a collection of HIV interventions in the form of evidence-based and evidence-informed info sheets.
- Preventing new HIV Infections: This webpage from the CDC includes both the latest Clinical Practice Guidelines and Clinical Providers' Supplement for using PrEP for the prevention of HIV infection.
- National HIV PrEP Curriculum: This free resource was developed at the University of Washington for health care professionals who want to learn about HIV PrEP.

Viral hepatitis:

- Hepatitis Training resources from the National Prevention Information Network
- Viral Hepatitis Training Resources

STIs:

- STD Prevention Training from the National Prevention Information Network
- STD Training Resources
- County-level Syphilis Rates to Direct Screening Efforts: Health care professionals can use this county-level map from the CDC that visualizes primary & secondary syphilis rates as they consider their syphilis screening efforts.

LTBI and TB:

- TB 101 for Health Care Workers
- Core Curriculum on Tuberculosis: What the Clinician Should Know
- TB Centers of Excellence for Training, Education, and Medical Consultation
- LTBI Online Resource Hub
- Find TB Resources
- Tuberculosis Testing and Latent Tuberculosis Infection Treatment Practices Among Health Care Providers — United States, 2020–2022

TRAINING ON THE PDSA APPROACH TO QUALITY IMPROVEMENT INITIATIVES

- AMA STEPS Forward Plan-Do-Study-Act (PDSA): This learning module provides an overview of the PDSA approach to quality improvement in your clinic as well as a process mapping toolkit.

TRAINING ON PATIENT PORTAL OPTIMIZATION

- AMA STEPS Forward®: Patient Portal Optimization: This training module from AMA STEPS Forward® outlines how patient portals can help both the care team and patients and how you can encourage your patients to enroll.

TRAINING ON COLLECTING COMPREHENSIVE PATIENT DEMOGRAPHICS AND SEXUAL HISTORY

- AMA STEPS Forward®: Collecting Patient Data–Improving Health Equity in Your Practice: This training module from AMA STEPS Forward® highlights why it is important to collect patient race and ethnicity data and how you can establish standards for and train your staff to collect this data.

Video Clips from Telementoring Session Series for Community Health Centers

Building strong community partnerships:

- During this telementoring session focused on building strong community partnerships, Jennifer Brumfield, RN shares how Express Personal Health in Jackson, MS built relationships with other providers to improve patient experiences and outcomes.

Establishing an integrated approach to care:

- During this telementoring session focused on establishing an integrated approach to care, Jacky Bickham describes how the Louisiana Department of Health's STD, HIV, and Hepatitis Program approaches addressing the needs of community members.

Meet patients where they are:

- During this telementoring session focused on meeting patients where they are, Jacky Bickham shares examples and an approach to how the Louisiana Department of Health's STD, HIV, and Hepatitis Program provides testing outside of the clinic.

Registering patients in EHR portals:

- During this telementoring session focused on registering patients into EHR portals, Jennifer Brumfield, RN describes how patients at Express Personal Health in Jackson, MS benefited from being enrolled in their EHR portal.

Collecting comprehensive patient data:

- During this telementoring session focused on collecting comprehensive patient demographics and sexual history, Kara Green, MHA, MSN, APRN, FNP-BC shares how the HOPE Clinic in Houston, TX improved their patient data collection processes and improved their screening procedures.
- During this telementoring session focused on collecting comprehensive patient demographics and sexual history, Jason Zucker, MD, discusses sex-positive strategies for taking a sexual history and the importance of collecting SOGI data.

Sex-positive, status-neutral messaging about the benefits of routine screening:

- During this telementoring session focused on sex-positive, status neutral messaging, Jason Zucker, MD talks about the many benefits of sex-positive, status-neutral messaging in HIV care.

Streamline the testing cascade:

- During this telementoring session focused on approaches to streamline the testing cascade, Lesley Miller, MD describes how the Grady Liver Clinic uses their EHR system to streamline testing and follow-up.

Patient education materials at conclusion of the visit:

- During this telementoring session focused on patient education materials at the conclusion of the visit, Cabell Jonas, PhD shares how the Mid-Atlantic Permanente Medical Group has improved patient education around HCV.

Linkage to care:

- During this telementoring session focused on linkage to care, Katie Conner, MPH discusses key facilitators success for CrescentCare's rapid linkage to care program for HIV.

Video Clips from Telementoring Session Series for Emergency Departments

- **Create a trusted and welcoming environment:**
  - During this telementoring session, Fahd Ahmad, MD from the St. Louis Children's Hospital discusses the importance of establishing a trusted and welcoming environment for adolescents in order to increase screening opportunities.
- **Involve patients in the screening process:**
  - During this telementoring session, Fahd Ahmad, MD shares the St. Louis Children's Hospital's approach to screening asymptomatic adolescent patients for STIs in the emergency department.
- **Collect comprehensive patient demographics and sexual history:**
  - During this telementoring session, Jason Zucker, MD provides some best practices for taking a sexual history by applying the GOALS Framework for Sexual History taking to an emergency department setting.
- **Implement an opt-out approach:**
  - During this telementoring session, Douglas White, MD provides an overview of the history of the opt-out approach for HIV screening and why it is recommended.
  - During this telementoring session, Douglas White, MD from Alameda Health System's Highland Hospital shares tips on implementing opt-out notifications in an emergency department setting.
- **Stick to sex-positive messaging about the benefits of screening:**

- During this telementoring session, Jason Zucker, MD provides an overview of the importance of using sex-positive messaging to help increase screening for HIV and STIs.

- **Implement automated EHR reminders, prompts and orders to increase screening:**
  - During this telementoring session, Carmen Burrell, DO shares West Virginia University's approach to optimizing EHR alerts when implementing opt-out screening in the emergency department.
  - During this telementoring session, Lesley Miller, MD outlines the way that they implemented changes to their EHR in the Grady Hospital emergency department in order to increase routine screening for HCV.
- **Align infectious disease control with organization's goals:**
  - During this telementoring session, Jason Zucker, MD shares studies that show how universal screening has been shown to be cost effective in numerous settings and models, while also removing stigma associated with HIV testing and contributing to earlier diagnosis and treatment, leading to reduced transmission.
- **Empower every member of the team with education and training:**
  - During this telementoring session, Lesley Miller, MD outlines trends in hepatitis C, why screening is important and the path to achieve elimination.
- **Form a strong referral network:**
  - During this telementoring session, Alex McIntosh-Ogunfolu from CCI Health Services discuss the importance of building strong community partnerships in order to create trusted, warm handoffs for a patient seeking treatment or additional services following a visit in the ED.
- Hire or assign current staff as patient navigators:
  - During this telementoring session, Carmen Burrell, DO describes how her institution, University of West Virginia, approaches linking patients to care after a positive diagnosis in the emergency department.
  - During this telementoring session, Lesley Miller, MD reviews the pros and cons of two different approaches to patient navigation that the Grady Liver Clinic has used with patients after a positive diagnosis in the Grady Health System emergency department--bedside navigation and traditional navigation.

Implementing Routine Screening Webinar Series

- The Importance of Routinely Screening for HIV, STIs, Viral Hepatitis and LTBI: AMA Past President, Jesse Ehrenfeld, MD, MPH, and Jonathan Mermin, MD, MPH, Director of CDC's National Center for HIV, Viral Hepatitis, STD and TB Prevention introduce AMA's toolkit designed for community health centers and emergency departments to integrate routine screening of infectious diseases into patient care. Gain insights on implementing opt-out screening and empowering every member of the care team with training.
- Improve Your Screening Process for HIV, STIs, Viral Hepatitis & LTBI: AMA Past President, Jesse Ehrenfeld, MD, MPH, and a panel of experts share real life experiences and effective routine screening strategies for HIV, STIs, viral hepatitis and LTBI, focusing on sticking to sex-positive, status neutral messaging and streamlining the testing cascade.
- Connecting Patients to Treatment for HIV, STI, Viral Hepatitis & LTBI: AMA Past President, Jesse Ehrenfeld, MD, MPH, and a panel of experts explore two of the strategies related to connecting patients to treatment: forming a strong referral network and hiring or assigning current staff as patient navigators.

ama-assn.org/RoutineScreeningToolkit

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