Improving Adolescent HIV Testing Rates in the General Pediatrics Clinic

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HIV Testing

- In the United States, over one million adolescents and adults are currently living with human immunodeficiency virus (HIV).
- Around 50% of undiagnosed infections were amongst those aged 13–24 years old, the largest percentage of all age groups.
- The American Academy of Pediatrics recommends HIV testing for all sexually active adolescents, and HIV screening at least once by age 16 to 18 years old regardless of sexual activity if the prevalence in a community is greater than 0.1%. The prevalence in Greenville, NC is 0.35%.
Why Adolescents?

- Most sexually active adolescents and young adults do not feel that they are at risk of HIV infection and do not get tested.
- This sense of invulnerability is, in part, attributable to the adolescent’s physical, psychological, and social development— factors that contribute to low testing rates.
- Adolescents also cite concerns about confidentiality, access to testing, and invasive blood procedures as barriers to testing.
Current Gaps

- In our clinic:
  - There is no formal process in our clinic to check HIV levels. It is up to the discretion of the resident attending to offer screening to eligible patients.
  - One of the major gaps is the lack of knowledge about the current AAP guidelines about HIV screening and to do so for 16-18 year olds, regardless of whether they are sexually active.
  - Additionally, another gap is the way we communicate/offer the screening tests to our patients, which may result in more patients declining the screening, if offered.
  - Baseline data collection was performed, and the percentage of adolescents screened was **27.5%**.
Low HIV screening rates in ECU Pediatric clinic among 16-18-year-olds

Environment
- Slow clinic flow
- Separation of clinic rooms and lab
- Residents not aware of guidelines
- Stigma associated with test
- Low HIV risk perception
- Fear of parent's reaction

People

Environment
- Not enough time in clinic visit
- Fewer doctors visits among older patients

Policies
- Patient unaware of confidentiality policy
- No established clinic policy on HIV testing

Equipment/Test
- Anxiety waiting for results
- Type of test (blood test)
- Provider bias or prescription of importance
- Way in which test is presented
Our aim was to increase the rate of HIV testing in 16-18 year old adolescent patients in the general pediatrics clinic to 50% by February 2022.
Measures

- Residents conducted retrospective data collection by manual chart review of 16–18-year-old clinic visits to assess whether HIV screening was completed. We measured the rate of 16-18 year old males and females who have received an HIV screening test.
  - Patients who received a prior HIV test or patients who had a virtual visit were excluded.

- Baseline Measurement - Forty patients were reviewed during our baseline data collection the week of September 27th, 2021

- Outcome measurement - The percentage of adolescent patients who were tested for HIV

- Disparity measure:
  - Gender screening rate disparity
Measures

- **First intervention**: completed 10/15-10/19
  - Data was obtained from 10/20-11/19
- **Second intervention**: completed on 11/20/21,
  - Data was obtained from 11/21/21-1/14/22
- Forty patients were chart reviewed following each of the PDSA cycles
- A total of **120 encounters** were analyzed and organized in a shared Google document
First Intervention

1. Education for all clinic providers of the importance of HIV screening for 16-18 year olds
2. Attaching a reminder to all clinic computers that our physicians use

After our first intervention HIV screening rate increased from 27.5% (baseline) to 35%

After our first intervention, we found the most common reason for a patient to reject HIV testing was sexual activity status
Second Intervention

- Based on results from our first intervention, we created an educational video that demonstrated a mock patient encounter on how to approach the HIV screening conversation and the importance for all adolescents, regardless of sexual activity.

- After our second intervention, screening rate was further improved to 45%.
Outcomes

- After our first intervention HIV screening rate **increased from 27.5% (baseline) to 35%**. After our second intervention, screening rate **was further improved to 45%**.
- We also found a gender disparity in the HIV screening rate:
  - Baseline HIV screening was 22% in females and 35% in males.
  - After two PDSA cycles:
    - Female HIV screening rate increased to 40%.
    - Male HIV screening rate increased to 50%.
Challenges

- Rejection to HIV testing due to sexual inactivity
- Low adolescent visit compliance rate
- Rejection to HIV screening due to fear of parental retaliation
- Stigma by providers and communities remains an important obstacle
Areas for Future Improvement

- Identify approaches tailored to increase the access to and acceptance of HIV-testing among the adolescent populations.
- Continuing to educate providers on the AAP screening recommendation.
- Free testing services.
- Increase availability of rapid antigen/antibody testing methods.
Questions?