POLICY AND GUIDELINES FOR PUBLIC HEALTH OUTREACH AFTER NEW HIV DIAGNOSIS IS REPORTED

Policy Unanimously Approved by Beyond AIDS Foundation Board, March 2023

INTRODUCTION:

The Beyond AIDS Foundation recommends that the following services be routinely and consistently provided by public health departments upon receipt of a new HIV diagnosis (a positive laboratory test report or a report by a provider). These recommendations are consistent with CDC surveillance and prevention grant expectations, but currently adherence is not monitored as a condition for continued CDC funding.

A published survey of state and territorial HIV/AIDS directors conducted by our Foundation (https://guilfordjournals.com/doi/abs/10.1521/aeap.2019.31.1.82) demonstrated wide discrepancies in actual practices among U.S. states and territories. We encourage concurrence with this policy by state and territorial HIV/AIDS directors and epidemiologists, city and county public health officials, federal, state, and local communicable disease-related agencies, local HIV/AIDS projects, state conferences of local health officers and of communicable disease controllers, and others.

Below our policy statement, we have provided more detailed guidelines as a reference to public health departments for developing their HIV outreach services after new HIV diagnoses are reported.

POLICY:

When a new HIV diagnosis is reported by a laboratory or a provider, surveillance by public health departments should either include or be seamlessly integrated with outreach and "case management" services to prevent further transmission:

- Initiation and facilitation of the HIV Care Continuum (linkage to care, and encouragement of maintenance of treatment to reach undetectable viral loads). The achievement of undetectable viral loads both eliminates sexual transmission and achieves the best clinical outcomes, and is therefore a major public health objective.
- Partner services (contact tracing and partner notification) with referrals of contacts for testing and counseling; best conducted by public health personnel

with or without the presence of the patient. Trusting the patient to notify partners is not consistently reliable, and should only be used as a last resort and when adherence can be verified

- Referrals to other needed services (substance abuse or mental health treatment, housing, etc.)
- Counseling/education on HIV infection and its prevention and treatment. This should include information that the patient does not yet have and is interested in receiving. Safe behaviors, protection of partners (e.g., condoms and PrEP), and the benefits of rapid treatment initiation are priority topics.
- Obtaining information to accurately complete the morbidity reporting form. This is important to the local jurisdiction, state, and CDC for monitoring the epidemic, but does not in itself interrupt transmission or result in treatment, and therefore should not be the sole objective when following up on new reported diagnoses.

These services can be provided by communicable disease investigators if they receive adequate training. Some jurisdictions may assign other staff, such as public health nurses or health educators. These staff may be assigned as case managers, so that there is consistent follow-up by a worker who has already established rapport and knows the patient.

When a public health department receives a new positive HIV test result, there should be immediate outreach. If the test was ordered by a medical provider, there are advantages to contacting the provider first. The provider's office can frequently provide information regarding reaching the patient, completing the morbidity reporting form, known partners, acute transmission risks such as history of needle sharing, comorbidities including mental illness and substance abuse, homelessness, and whether the provider can offer immediate initiation of therapy, has already made arrangements for referral or consultation regarding HIV care, or is willing to delegate referral for treatment initiation to the public health department or designee.

Following the communication with the provider, or if there is no provider associated with the test, the public health department should make every possible effort to contact the patient directly. In-person meetings have the advantage of establishing trust and rapport. Virtual meetings may be next best, and in some cases, the only opportunity to see each other. The same four bulleted priorities listed above should be discussed with the patient, emphasizing rapid linkage to care and partner services. A follow-up contact a few weeks later, should help verify that linkage actually occurred. Subsequently, monitoring of periodic lab reports, particularly of viral load, should be done to determine whether the patient is maintaining treatment and that the viral load is approaching undetectable levels. The patient,

medical provider, and in some cases the laboratory should be contacted if these test results are not being regularly reported.

If a patient is found to live outside of the jurisdiction of the public health department, the appropriate department in the jurisdiction of residence should be informed of the case, so that services can be initiated.

GUIDELINES FOR PUBLIC HEALTH DEPARTMENTS:*

The following more detailed guidelines are provided as a reference for public health departments in implementing the services recommended in the above policy. They depend in part on various contingencies, such as whether the patient lives within the jurisdiction. These guidelines may be adapted for differing available capacities, within the department or in its external referral practices. The services should be provided by trained public health staff, who may function as case managers.

High priority topics are in italics.

I. Report received from lab with provider identified, and/or report from provider has been received

A. ***Contact provider*** *or nursing staff in provider's office:*

1. *Obtain data to complete confidential morbidity reporting form, including best contact information to reach patient.*
2. *Determine whether provider has informed patient of result, and if not, whether provider wants to be the one to inform patient, to be rapidly followed up by public health contact.*
3. *Determine whether provider has made arrangements or has plans re who will treat and follow patient.*
    a. If provider will be initiating treatment, would slides or an outline be welcome re what baseline tests and what medications are currently recommended by HHS, and a standing offer for public health consultation or referral?
    b. If referral to an HIV or ID specialist is planned or has already been requested, is there likely to be a delay, and if so, would it be OK for public health to offer to immediately initiate treatment pending that referral and to refer back (assuming these services are available)?
    c. If no plans yet for treatment, would it be OK for public health to invite the patient for both initiation and ongoing HIV treatment (assuming these

services are available)? Will provider want to continue the primary care (the usual arrangement) or to refer total care of the patient?

4. *Does provider have any info regarding whether patient is homeless, has mental illness, or substance abuse, or is at risk for domestic abuse?*
5. *Does provider know of any likely sexual or needle-sharing partners, e.g., spouse or significant other? (This information can legally be shared with public health by provider's office in conjunction with the case reporting process; at a later time it would require patient's signed release.)*
6. *What health insurance does patient have?*

B. **Contact patient**; see II. below.

II. <u>Outreach to patient after provider has been contacted</u> *<u>(per section I above)</u>.* <u>Patient's HIV test was ordered by a provider.</u> ***<u>In-person meeting is recommended, because a phone call may be distrusted</u>.*** *Virtual meeting may be second best.*

A. Patient is in jurisdiction:

1. *If necessary, more than one communication may be conducted to cover all the topics below. In-person meetings are best for at least the first contact; phone or virtual meetings and emails may be utilized in follow-up. At conclusion, repeat and summarize to be sure messages are captured and recalled; keep in mind that patient learning of diagnosis may be anxious and distracted and have difficulty recalling messages; email to summarize key points in writing may be helpful.*
2. *Contact patient unless multiple efforts fail; determine whether s/he has received test result and whether HIV status was already known. If status was known but not in care, discuss and offer linkage consistent with section II.A.6 below and other relevant portions of this outline.*
3. *Establish rapport; inform patient of result if not already received, and explain significance.*
4. Explain that provider and public health are working together to assure best services.
5. Reassure patient that help is available; *offer virtual or in-person follow-up meetings if anxiety evident and/or if insufficient time to discuss everything below in one contact.*
6. *Obtain data from patient to complete confidential morbidity reporting form, if information is missing.*
7. ***Linkage to care:*** *If provider invited public health to arrange for initiation of treatment or to follow and treat patient for HIV , provide details to patient and arrange appointment.*

a. *If no provider for HIV care has been arranged by the primary care provider, offer urgent referral for immediate initiation of treatment.*
b. *If services are available directly from public health (treatment initiation with or without ongoing care), offer that as an option.*
c. *Inform patient of importance of rapid and maintained treatment and suppression of virus, for best health outcome and to prevent sexual transmission.*
d. *If patient declines public health initiation of treatment, but does not have an alternative source of care without a delay, arrange rapid linkage to another source of HIV care.*

8. ***Partner services*** *with contact identification and tracing (followed later by confidential partner notification, which may be referred to a second communicable disease investigator (CDI).*
   a. *Public health departments increased their use of contact tracing during the COVID pandemic. However, partner services for HIV are more complex than contact tracing for COVID, in part because of stigma and social implications about sex or drug use. They are most similar to similar services for syphilis, gonorrhea, and chlamydia. Extra training is suggested for all staff participating.*
   b. *Explain importance of partner notification, for testing and possibly treatment if already infected (one of past partners was after all the source of this patient's infection)*
   c. *Provide a choice of two recommended types of partner notification:*
      - *1st option: Having DPH CDI notify partners; in this option patient's identity will not be revealed (and the law actually requires that when performed by public health).*
      - *2nd option: Having DPH CDI join with patient in notifying each partner; this is not anonymous of course, but CDI can reduce chances of domestic abuse or relationship conflict by pointing out that we do not know who infected whom, that condoms can be used, that PrEP is available if partner tests negative, and that patient will be non-infectious once reaching viral suppression with treatment.*
      - *3rd option: Having patient inform his/her own partners. This is listed as an option by CDC, but is not recommended, and should be done only the first two options are not feasible and if adherence can be verified. Without anonymous notification or participation by a public health representative, the patient may be more likely to face the risks of breakup of or damage to the relationship or domestic abuse. Literature and human nature suggest that patients may fear such outcomes, and*

often do not inform their partners, and even if they do, that the partners may not get tested and may not receive the same preventive messages and follow-up as recommended in these guidelines.

- *In all cases, partners should be urgently referred for testing at a public health facility that will follow up and perform the same procedures as in this outline.*

d. *Inquire whether there is a risk of domestic abuse after partner is notified, even though source of partner's exposure will not be identified (and in spite of the fact that the partner may actually be the source of infection and will be so informed. I****f there is a perceived risk of domestic abuse, partner notification should be delayed until protective precautions are in place. If the patient feels secure enough to proceed, precautions should be discussed first, and the 2nd option above will be best for notification.***

e. Address any concerns about damage to relationship; offer to suggest to partners possible exposure to infected fluid without confirming sexual exposure.

f. Partner information shared by provider may be raised in the discussion.

g. Non-judgmental approach; may help to suggest that it is very common for people to have more than one partner.

h. Under some circumstances, entrusting the patient to inform his/her own contacts may be appropriate, but does not always result in referral for testing and provision of HIV education, which are mandated when a provider performs partner services; partner services are best performed by public health.

9. Prevention of transmission:

a. Needles and "works" must not be shared.

b. Condoms should be used, to prevent HIV transmission until virus is undetectable, and beyond that to prevent other STDs that can be more damaging in persons with HIV.

c. Regular partners, and friends who are subject to HIV exposure, can take PrEP, which helps prevent HIV but not other STDs so best to use as adjunct to condom use.

10. Ask about housing insecurity, refer to emergency housing assistance, e.g., through Ryan White.
11. Ask about mental health issues, especially anxiety, depression, and refer as appropriate to Department of Behavioral Health or other resource.
12. Ask about substance abuse, and refer as appropriate.
13. Provide basic HIV education as appropriate, and offer referral for further education about HIV.

14. Offer referral for testing for other sexually transmitted and bloodborne infections, specifically including syphilis, hepatitis B, and hepatitis C, and gonorrhea and chlamydia if appropriate, if not already done, or encourage patient to promptly request this from primary care or HIV provider.
15. Ask about health insurance, and assist with or refer for Medicaid or Affordable Care Act applications. For services for which no other insurance coverage is available, refer for Ryan White eligibility and applications. Written information about Ryan White services including ADAP for medications may be provided by email or hardcopy handouts.
16. If food insecurity, refer to the state SNAP program if financially eligible.
17. *Offer a written copy of recommendation, referrals, and available services for HIV positive persons: can be email or hardcopy sheet or pamphlet including standard information, with individualized instructions re referrals/resources added. Such prepared handouts should also be made readily available and accessible to community medical providers who wish to assist their HIV positive patients.*

B. *There should be a **follow-up contact in about 2 weeks** to check on whether the patient has linked to care or has an appointment, and connected with other referrals, and to allow patient to ask further questions and provide more HIV education. The patient should have been informed at the end of the first meeting that this follow-up will occur, and urged to have made appointment(s) and hopefully to have been linked to care by that time. This is an important part of data to care and for the HIV Care Continuum. If first meeting was in person, this follow-up may be by phone, virtual meeting, or exchange of emails.*

C. ***Viral load and CD4 test results should be monitored and compared with diagnoses. About a year after the above services, if no viral load, CD4, and genotype results have been reported, further public health follow-up is needed**, because the patient is either out of care or has moved out of the jurisdiction, or a laboratory is not reporting results. If the patient is in the jurisdiction and not in care, outreach is an important part of data to care and retention in care for the HIV Care Continuum. If the patient insists that s/he is in care and taking medication, the provider needs to be contacted about ordering viral load tests every 3-4 months and CD4 counts every 3-6 months per HHS recommendations. If the provider has been ordering these tests, but they have not been reported to public health, the laboratory should be contacted about adhering to state reporting policy.* Some state public health departments cross-tabulate reported test results and diagnoses, and periodically notify local public health departments of reported cases with no recently reported laboratory results. This spares the local departments from the need to prepare such lists, and is recommended.

D. If the patient was diagnosed in but is now living outside of the public health jurisdiction
    1. Obtain contact information and notify appropriate public health jurisdiction.
    2. Contact patient if possible and emphasize importance of rapid initiation of treatment; discuss whether patient has a source of medical care in new location, and suggest a source of HIV care in patient's location if known; meanwhile offer to provide initiation of HIV treatment if patient can make it to one of the local HIV clinic sites.

III. Patient outreach re report received from lab, **no provider identified**

A. Establish rapport; reassure patient that help is available.

B. Obtain identification of primary care provider if any (even though test was not ordered by that provider), and ask whether patient would like public health to contact and inform him/her and to discuss treatment.

C. Continue with II.A -D (*linkage to care, partner services, prevention of transmission,* housing inquiry, mental health, substance abuse, HIV education, other STI screening, insurance, *written or emailed copy of information, and follow-up of whether viral load results are being received*).

IV. Counseling of person testing negative, but admitting to sexual or drug-related risk

(CDC is placing more emphasis on "status neutral" HIV testing, i.e., spending more time and attention to high-risk patients who test negative.)

A. Explain current "window" or delay until a negative test can reliably rule out about 99% of HIV infections: Rapid fingerstick test: 90 days; fourth-generation venous blood test: 45 days; nucleic acid test: 33 days.

B. If exposure was more recent, invite back for retests and further counseling at appropriate timing.

C. Discuss behavioral methods of reducing risk: no needle or works sharing, condoms, PrEP (should be used with condoms to prevent other STIs and to provide added HIV protection; needs follow-up including STI screening. Other methods: limit partners, assure partners also tested, monogamous relationship.

D. Ask about factors that may be contributing to risky behavior, e.g., depression/poor self esteem, stigma, substance addiction, pressure from partner, etc.; refer for services as appropriate.

E. Refer as appropriate for other STI and viral hepatitis tests not yet done, and for HIV/AIDS education.

F. *Offer a written copy of directions: can be email or hardcopy sheet or pamphlet including standard information, including standard text on prevention and PrEP, with individual instructions re referrals/resources added.*

*An early version of the guidelines was developed by Ronald P. Hattis, MD, MPH, while working as a consultant at the Department of Public Health, San Bernardino County, CA , May-September 2022. However, this document does not represent official policy or protocols of that department. The guidelines were revised with input from Beyond AIDS Foundation Board and Scientific Committee members, February-March 2023.