Offering HIV Testing Routinely in Family Practice

Programming Connection

Case Study

**Organization:** Vancouver STOP Project  
**Region:** Vancouver, British Columbia  
**Prepared:** 2013

### Quick Facts

<table>
<thead>
<tr>
<th>Goal (immediate)</th>
<th>To increase the routine offer of HIV testing in family practice to adult patients who have not had an HIV test in the last year</th>
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<tbody>
<tr>
<td>Goal (ultimate)</td>
<td>To make the offer of HIV testing routine in family practice settings for all adult patients who have not had an HIV test in the last year</td>
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<tr>
<td>Participants</td>
<td>Family physicians</td>
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<tr>
<td>Type of Program</td>
<td>Testing</td>
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<tr>
<td>Setting</td>
<td>Clinic</td>
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</table>
| Required Resources | 1. Medical health officer  
|                  | 2. Family physicians with experience of HIV  
|                  | 3. Nurse educator  
|                  | 4. Trusted physician education organizations  
|                  | 5. Project manager and project assistant  
|                  | 6. An existing and responsive infrastructure that can support effectively and appropriately family physicians when they diagnose a patient with HIV  
|                  | 7. Varied educational modalities that meet the needs of most family practitioners  
|                  | 8. Tools and resources that lower barriers to integrating the routine offer of HIV testing into family practice |
| Scope and Duration | All family practitioners practising in the City of Vancouver. Ongoing. |
| Date Started     | 2011 |
Introduction

“We made HIV testing more like other tests”

If you live in Vancouver and you’ve had an appointment with your family doctor in the last couple of years, you may have been offered an HIV test during your visit.

As part of a wider shift in Vancouver from risk-based HIV testing alone to a combination of risk-based and routine HIV testing, the Vancouver STOP Project, a collaboration between Providence Health Care and Vancouver Coastal Health, has been training and supporting family physicians to routinely offer HIV testing to all their patients. Dr. Réka Gustafson, Vancouver’s medical health officer for communicable diseases, recommends that all adults who haven’t been tested in the last year be offered the test. “Offering an HIV test has become more like offering other tests,” she adds.

In Canada, approximately 25 percent of people who are HIV-positive don’t know their status. In Vancouver, research from 2012 shows that 39 percent of people are diagnosed with HIV at the time of their first HIV test and that 60 percent of people are diagnosed with HIV so late that treatment is already indicated both of which suggest that there are not enough acceptable opportunities for testing. Roughly 20 percent of them are diagnosed with such advanced infection that they are already at risk for AIDS-defining infections like Kaposi’s sarcoma and oral thrush.

Late diagnosis is not entirely caused by avoidance of healthcare. Research demonstrates that it is common for multiple missed opportunities for diagnosis to be recorded in people’s medical histories before an HIV diagnosis is made. A missed opportunity is an instance in which an HIV test could have been offered or requested along with other blood tests during a patient’s visit to a healthcare setting, but it wasn’t. Often these opportunities are missed because doctors don’t consider HIV when a patient presents with symptoms consistent with HIV, unless they know the patient engages in behaviours that might put them at high risk.

Integrating the routine offer of HIV testing into family practice aims to remove barriers preventing people from receiving an early diagnosis by normalizing HIV testing for everyone. The Vancouver STOP Project has striven to ensure that family physicians have the tools, skills and support to routinely offer testing to patients.

According to Dr. Gurdeep Parhar, a family physician involved in the project, training family doctors to offer testing is key because they are “unlikely to become HIV experts and yet it’s people like me who will have to introduce HIV testing.”

What is the STOP HIV AIDS Project?

Seek and Treat for Optimal Prevention of HIV/AIDS (STOP) was a $48 million, four-year (2010-2013) pilot project funded by the government of British Columbia. This project aimed to increase the quality of life of people living with HIV and reduce the number of new HIV infections by taking a proactive public health approach to finding people living with HIV, linking them to HIV care and treatment programs and supporting them to stay in care. STOP aimed
to improve the experience of people living with HIV or AIDS in every health and social service interaction and significantly improve linkage and engagement across the full continuum of services in HIV prevention, testing and diagnosis, treatment, care and support.

STOP was rolled out in Vancouver and Prince George. It was made up of numerous interconnected and discrete clinic-based, hospital-based, community-based and policy-focused programs implemented through the collaboration of a significant number of stakeholders. In Vancouver, Vancouver Coastal Health and Providence Health Care partnered to form the Vancouver Project. Through this partnership, these two organizations shared governance, funding and reporting for most of the initiatives that took place in Vancouver between 2011 and 2013.

The family practice testing initiative of the Vancouver STOP Project seeks to expand HIV testing in Vancouver by encouraging all family physicians to make the offer of HIV testing routine for all adult patients who have not had an HIV test in the last year. This recommendation aims to ensure that HIV is considered a possibility when patients present with symptoms consistent with a possible HIV diagnosis. The recommendation also adds the opportunity to screen individuals who wouldn’t otherwise be tested. To prepare for this practice change, the Vancouver STOP Project partnered with University of British Columbia Continuing Professional Development (UBC CPD) to offer education and training to physicians.

**What is the program?**

In 2011, the Vancouver STOP Project launched an initiative to implement the routine offer of HIV testing in family practices across the city. The central component of this effort is the training and ongoing support of family practitioners on how to integrate a routine offer of HIV testing in their practices.

This initiative is led by an interdisciplinary team of professionals, including a medical health officer, physician leaders, a nurse educator, a project manager, project assistant and staff from University of British Columbia Continuing Professional Development (UBC CPD). For the purpose of this case study, they will be referred to as the family practice team.

The goal of this initiative is to expand opportunities for HIV testing by making the offer of an HIV test routine for most patients. Implementing the routine offer of HIV testing is recommended by one of Vancouver’s medical health officers. Although the offer of a test is routine practice in Vancouver, testing is not mandatory or automatic and the test must be ordered with the verbal consent of patients.

The recommendation to physicians from Vancouver Coastal Health is to:

- offer an HIV test to all adults who have not had one in the past year
  - in acute and community care
  - as part of blood work for any other reason
  - every time a test is ordered for sexually transmitted infections, hepatitis C, tuberculosis

Physicians aware of a specific risk should recommend an HIV test during the appointment, and more often:

- when clinical symptoms are present
- every time they diagnose another sexually transmitted infection
- every three to six months if they are aware of ongoing high risk

The family practice team held consultations with family practitioners and the bodies that represent them (such as the British Columbia College of Family Physicians) to determine the most appropriate content and means of offering education on this topic. They developed three main accredited educational options and various supplementary educational opportunities, and they adapted or created tools and resources intended to lower barriers for physicians to adopt the practice of offering of an HIV test routinely.

**Why Was the Program Developed?**

The initiative to routinely offer HIV testing in family practice was developed in response to the provincial STOP Project’s goal to expand access to HIV testing. Three complementary approaches have been used to expand access to testing. First, longer hours at community clinics and a greater presence of nurses offering outreach testing increased opportunities for testing among populations at highest risk. Second, routine HIV testing has been
introduced into clinical services that serve clients who experience ongoing high risk of HIV infection, such as clinics serving men who have sex with men and addictions services. Finally, the routine offer of an HIV test is being recommended in general medical settings such as hospitals and family practices.

For more information on the expansion of testing in hospitals and in high-risk settings, please see the Routine HIV Testing in Acute Care Case Study and the Targeted Testing Initiative Case Study.

Building the rationale for the routine offer of HIV testing has been critical to the success of this initiative, because routine testing represents a major change in the HIV testing practice of family practitioners. It was developed by physician leaders at Vancouver Coastal Health and the Vancouver STOP Project through extensive research into HIV testing patterns and effective practices and policies in other jurisdictions.

The general rationale for the routine offer of HIV testing rests on seven key points:

1. Early diagnosis and treatment can lead to a near-normal life expectancy with a good quality of life. The overall goal of any testing strategy is diagnosis of HIV at the earliest possible time during the course of infection.
2. With early diagnosis and treatment, the likelihood of onward transmission of HIV is significantly reduced.
3. Despite the goal of early diagnosis, late diagnosis is the norm, rather than the exception. Sixty percent of people diagnosed with HIV in Vancouver are diagnosed when they are already eligible for HIV treatment. Twenty percent are diagnosed very late in the course of infection, when significant damage to the immune system has already occurred.
4. Routine HIV testing increases opportunities for early detection. There is evidence that the healthcare system misses opportunities to diagnose people with HIV. Often people who are diagnosed with HIV have had other blood tests as a consequence of visiting a healthcare provider in the past year but had not been offered an HIV test with that blood work.
5. Routine HIV testing is acceptable to patients. When HIV testing is offered as part of routine care to all patients, the stigma associated with the offer of an HIV test diminishes.
6. Routine screening for HIV is already being done for pregnant women, largely by family doctors.
7. HIV infection meets all of the World Health Organization’s guidelines for conditions for which routine screening should be considered. Routine testing is cost-effective: with a diagnosed prevalence of 12.1/1000 (for every 1000 people in Vancouver, 12 are HIV-positive), Vancouver is well above the diagnosed prevalence threshold used by the United Kingdom to determine whether HIV testing should be offered routinely. Estimates of the return on investment in routine testing indicate that at Vancouver’s prevalence, routine HIV testing is likely to be not only cost-effective but also cost saving.

This rationale was presented to family practice leadership and shared with family physicians in letters from the relevant medical health officer, in an article in the British Columbia Medical Journal, at multiple family practice rounds and at several conferences. After this introduction, a comprehensive education and support program was developed, as outlined below.

How Does the Program Work?

Policy development

Before 2011, most HIV testing guidelines indicated that pre-test counselling was required for anyone seeking or being offered an HIV test. This counselling was offered verbally and, if performed according to the guidelines, could take considerable time with each patient.

The requirement of pre-and post-test counselling has been demonstrated to be a barrier to routinely offering an HIV test in family practice settings, both for the practitioner and for the patient. In consultations, clinicians cited the time and knowledge needed to offer pre-test counselling as among the most important barriers to implementing the routine offer of HIV testing in their practice. The pre-test conversation may also be a barrier for some patients who do not want to discuss their risk behaviour with their healthcare provider or who are not aware of their risks.

Therefore, in 2011, the BC Centre for Disease Control updated its HIV Test Pre and Post Test Guidelines, in consultation with the Vancouver STOP Project, the B.C. Centre for Excellence in HIV/AIDS, Positive Women’s Network and Positive Living BC. These guidelines no longer require physicians to provide verbal pre- and post-test counselling. The new guidelines state that, in the course of routine clinical care, providing written information to patients about HIV and HIV testing is sufficient for informed consent. Patients should always be offered the test and
those who request more information from their physicians should receive it, as with any other diagnostic test.

This policy change has not been without controversy. A small number of community groups have voiced concern that the end of the requirement of mandatory verbal pre-test counselling infringes on the rights of people to understand the intricacies of an HIV diagnosis. Although strides have been made to normalize testing and to des-stigmatize HIV in Vancouver, HIV is still stigmatized and HIV non-disclosure is criminalized. These groups argue that people could be providing consent for an HIV test before they are adequately informed, since many may not read the patient FAQ until after the blood test has been ordered or the blood has been drawn.

Despite this concern, the leaders of the Vancouver STOP Project and the clinicians who are providing the routine offer of HIV tests under these guidelines believe that the benefits of early diagnosis are so clear that streamlining pre-test counselling to promote early diagnosis is essential. In settings where the likelihood of a positive diagnosis is high and patients wish it, clinicians should continue to offer more in-depth pre-test counselling.

Implementation

Initial engagement: Contracting a respected physician education organization

The Vancouver STOP Project needed the expertise of a trusted educational organization to coordinate and deliver effective educational opportunities for clinicians to learn about the introduction of routine HIV testing.

University of British Columbia Continuing Professional Development (UBC CPD), which is a division of the Faculty of Medicine, was chosen in a competitive process because they are a well-regarded organization that already delivers a large portion of the continuing professional development opportunities for family practitioners in British Columbia. UBC CPD also has experience with developing and delivering education and with continuing medical education accreditation processes. It was believed that family practitioners would be receptive to education and training offered by UBC CPD because of this reputation and the organization’s ability to engage busy family physicians in quality education that leads to practice improvement.

A physician lead who is a family physician with a background in physician education and public health was also contracted by the Vancouver STOP Project to work with UBC CPD and explore the learning and practice needs of the family physicians representing the target audience.

Continuing medical education credits

Physicians in Canada are required to accrue a certain number of continuing medical education (CME) credits every five years to keep their medical licence. Critically, the Vancouver STOP Project’s partnership with UBC CPD allowed it to offer CME credits to participants for attending training. This included the highest level MAINPRO-C credits, which are only granted through programs that have been approved by the College of Family Physicians of Canada. For educational opportunities to qualify for MAINPRO-C credits, they must place an emphasis on interactive learning, small group discussions and critical reflection.

If it had not been possible to provide study credits for the training, it would have been more challenging to attract physicians to attend these learning sessions.

Initial engagement: Consulting with family practitioners

The family practice team consulted family practitioners, nurses involved in primary care, and office managers and medical office assistants, ensuring that representatives from a range of primary care practice types were involved. Consultations were intended to identify process barriers and facilitators for physicians to integrate a routine offer of HIV testing in their practices.

Feedback was solicited through meetings and individual interviews. Through this process, the family practice team gathered information about integrating a routine offer of testing in family practice. Some family practitioners who were initially resistant to the concept of routine HIV testing came to support the initiative as a result of their participation in the consultation process.

Once this initial part of the discovery process was complete, the family practice team began to engage family
practice leadership through the development of a leadership advisory group. Representatives from the British Columbia Medical Association, the British Columbia College of Family Physicians, the Society of General Practitioners of British Columbia and the Department of Family Practice at the University of British Columbia and others all sat on the advisory committee.

The purpose of this group was to solicit perspectives on the initiative, to shape the initiative’s rollout, to confirm or identify additional barriers and facilitators to integration and to engage the leads of these physician organizations early in the initiative. The experience and guidance from the initial consultations and from subsequent meetings with these family practice leaders allowed the team to firmly ground its engagement strategy, educational programming and language in the daily experience of family physicians.

An educational reference group was then formed, consisting of family practitioners from a range of practice types and who have considerable experience with physician education and continuing professional development programming and represent the target audience. This group advised the family practice team on the specific structure and content of educational and promotional materials and has continued to review all educational content that is developed for the initiative.

Through this process, the team learned that among the barriers to implementation in family practice were time constraints, lack of training on how to counsel patients, considerable confusion about the British Columbia-specific laboratory forms with nominal and non-nominal testing options, presumption and concern that patients would react negatively to being offered a test, and some fears about giving and managing a positive diagnosis. With this knowledge, the family practice team developed training and materials to reduce these barriers for family practitioners and produced tools to encourage and enable expanded and routine HIV testing.

**Family practitioner education and training**

Family physicians in private practice are not required to implement routine HIV testing in their practice. However, public health authorities recommend routine HIV testing. Participation in training and subsequent implementation is completely voluntary.

**Recruitment**

The family practice team uses multiple methods of recruitment: visiting offices, capitalizing on existing professional relationships within the team, and using various electronic communications. UBC CPD’s existing communications infrastructure is used to recruit family physicians to participate in the educational training.

The team produces monthly e-blasts about all of UBC CPD’s educational opportunities, conducts postal mail-outs and hands out flyers at conferences. In addition to these methods, the project team relies on word of mouth from one educational stream to the others. The team also engages community groups to gain support within communities before scaling up testing in certain geographical areas. The team also places advertisements in physician organization newsletters and publications and in community media outlets.

**Educational program**

The education and training are designed to answer physicians’ questions about HIV testing and to give them the competency they need to offer an HIV test routinely, answer any patient questions related to HIV testing, and deliver a new HIV diagnosis and linkage to care services in the rare cases where an HIV-positive result occurs. Physicians can choose to participate in whichever form of training is best suited to their needs and learning style.

Family physicians have three options to receive education on HIV testing: they can participate in a webinar, they can participate in workshops or they can receive in-practice support. Physicians can access multiple options if they wish. The team also developed additional educational opportunities, including an online [This Changed My Practice](#) article that was distributed to a mailing list of 10,000. Physicians can earn credits for reflecting and posting a comment. A guided [Linking Learning to Practice](#) exercise was also developed, and presentations and booths at conferences also provide educational opportunities.

**“HIV Testing: What’s Different Now?” webinar**
A 90-minute live webinar entitled *HIV Testing: What’s Different Now* is being offered, which is moderated by a family physician who has been involved in the development and design of the initiative. A recorded webinar presentation is archived on the UBC CPD website so that physicians can view the recording at their convenience. As of January 2013, 128 participants have attended live webinars.

The webinar is delivered by the relevant medical health officer, a physician who has and treats HIV-positive patients and has integrated the routine offer of HIV testing in his own practice, and a family physician who has a general practice with a few HIV-positive patients. This mix of presenters was chosen to ensure that participants understand that the routine offer of HIV testing is a regional recommendation from public health, is endorsed by physicians who treat patients with HIV and is realistic to implement in a truly general primary care setting.

In the first part of the webinar, a medical health officer covers the clinical and public health rationales for routine HIV testing. In the second, the family practitioners lead participants through a presentation on the adjustments that need to be made in a practice when offering an HIV test, and the challenges and facilitators.

Attendance at the webinar earns participants a certificate for 1.5 MAINPRO-M1 CME credits. Participants are also provided with an option to engage in a critical reflection of their experience of integrating the routine offer of HIV testing in their practices after they attend the webinar, whereby they may earn higher level MAINPRO-C credits. This can be done by completing a self-guided exercise called *Linking to Learning Practice* and submitting it for credit to the College of Family Physicians of Canada.

To support physicians to participate in the practice reflection, a guided *Linking to Learning Practice* tool was developed by a family physician. The guide presents a case example of Dr. X who has attended HIV testing education and has then applied what she learned in her practice, indicating how she self-evaluated and reflected upon her experience. The case study reviews some of the challenging learning areas for implementing routine HIV screening, including the differences between case finding and screening, between pre- and post-test processes, and between nominal and non-nominal testing.

**Workshops**

Group workshops are also offered in locations throughout Vancouver that correspond to the local health areas defined by Vancouver Coastal Health. The workshop is divided into two parts (workshop A and workshop B). Typically, 20 participants have attended each of these sessions. Participants complete an online needs assessment before attending the first workshop to allow facilitators to tailor the session to their needs and areas of interest. Workshops are facilitated by family physicians who have already introduced routine testing in their practices and family physicians with HIV-focused practices. As of January 2013, 74 participants have attended these workshops.

**Workshop A**

Workshop A typically runs for three hours. The learning objectives for workshop A are to:

- consider the clinical rationale and evidence for routine HIV testing, early treatment and treatment-as-prevention
- interpret HIV testing recommendations from public health
- identify and employ resources to facilitate routine HIV testing
- enable participants to design a plan for integration and evaluation of routine HIV testing in their practices

These objectives are achieved through small group discussion, brainstorming and role-play.

**Workshop B**

Workshop B typically runs for two hours. The learning objectives for workshop B are to:

- identify and employ resources to facilitate connecting HIV-positive patients to care
- encourage participants to self-appraise and reflect upon routine HIV testing in their practices

These objectives are achieved through small group discussion, brainstorming and individual reflection exercises.

The workshops have been accredited by the College of Family Physicians of Canada for up to five MAINPRO-C credits. As with all MAINPRO-C accreditation, physicians receive an equivalent number of M1 credits. Physicians must
attend both workshops and complete the reflective exercise at the end of workshop B to receive their MAINPRO-C certificate.

**In-practice support**

Through the in-practice support option, a combination of a family physician, a registered nurse and occasionally a medical health officer go to group practices to provide tailored support. The content of the initial hour-long presentation is tailored to the community in which clinicians practise. The in-practice support option, unlike the webinar or workshop options, allows clinicians from the same practice to attend a training tailored to their clinic’s specific needs.

Flexibility in timing is offered and the session can be held before the work day, over lunch, at the end of the day or over dinner. The in-practice team provides ongoing support and quick follow-up with customized resources for the physicians’ office. Nursing support is ongoing, and follow-up visits to review testing trends and troubleshoot any issues are available. Participants are encouraged to identify a site champion, with whom the nurse will follow up.

The in-practice support program has been accredited for up to five MAINPRO-M1 credits. Additionally, physicians may take advantage of the guided *Linking Learning to Practice* exercise, including reminders to complete and submit.

**Resource development to support implementation**

The family practice team, in consultation with family physicians and Positive Living BC, developed resources to support physicians to implement the routine offer of HIV testing in their practices, answer any questions a patient or a colleague may have, deliver a positive diagnosis and connect those who receive a positive test result to specialized care and support.

This includes resources and tools for family practitioners wanting to implement routine testing in their practices, such as an integration checklist, a one-page summary of the evidence and rationale for the routine offer of HIV testing, and a tabulation sheet to track test offers and acceptances; patient resources such as handouts, posters and pamphlets to be displayed in clinics; and handouts on Vancouver-specific services and resources available to family practitioners who are preparing to deliver a diagnosis to a patient with HIV, including a laminated card with the telephone numbers of services dedicated to supporting physicians in providing an HIV diagnosis. The in-practice support team also supports integration of resources into office clinical management and electronic medical record software.

The testing initiative also developed an HIV testing report that is offered to all physicians participating in routine HIV testing education. With a physician’s informed consent, their personalized test order history – before and after they receive education – is summarized for them numerically and graphically. Physicians in British Columbia are accustomed to similar reports, which they receive from the mammography and the cervical cancer screening programs. Participation in the HIV testing report program is voluntary. Physicians who choose the in-support education option can have a nurse return to their offices in person to go over the report.

One early concern expressed by physicians was that if patients are not expecting the offer of an HIV test, the process of explaining the rationale would be prohibitively long. A social marketing campaign called It’s Different Now was developed to prepare the general public for the routine offer of HIV testing, both in family practice and in hospitals. For more information on this social marketing campaign, please see the [It’s Different Now Case Study](#).

**Integrating a routine offer of HIV testing in family practice**

Although the integration of the routine offer of HIV testing will differ in each practice setting, each family physician is encouraged to do the following things.

**Choose the approach that is right for them:** The timeline and intensity with which each clinic integrates this practice change will differ. Some practices, if several physicians are participating, stagger the dates on which clinicians begin offering tests to patients, while others have all clinicians start on the same day. Physicians are also supported to identify whether they want to have a testing blitz, where all patients visiting the clinic over a period of a few weeks are offered a test, or if they prefer to increase their numbers incrementally over several weeks. All
physicians are encouraged to set realistic and achievable testing targets, to keep track of the number of tests they order and to evaluate their progress.

**Establish a reminder system:** Individual physicians and clinics are encouraged to choose the reminder systems that work best in their practice. This can include using requisition forms where HIV is highlighted, using requisitions where HIV is pre-checked or inserting reminders into electronic or paper patient charts. Tally sheets, HIV testing posters in the physician’s line of sight and click-counters (which are provided at workshops) have all been reported to be useful.

**Communicate the practice change to patients:** Patient materials developed by the Vancouver STOP Project are distributed for display in clinics so that patients are prepared when their physician offers them a test.

**Linkage to care**

It is unlikely that family practitioners who routinely offer HIV testing will encounter many positive results. Therefore, a robust system of support needed to be in place to facilitate disclosing the diagnosis and ensuring a strong linkage to HIV care. Preparation included testing existing elements of the system and developing new mechanisms for strong linkages to HIV care and support.

A Routine HIV Testing Resource Card (available in the Program materials section of this case study) was developed for practitioners routinely offering HIV testing. It lists the contact information for public health nurses trained to disclose HIV diagnoses and offer partner notification; for the STOP Outreach Team, an interdisciplinary clinical team responsible for improving engagement and linkage for people with the most complex barriers to care; and for the REACH Line, a telephone line that allows physicians to connect to other physicians experienced in HIV care, 24 hours a day.

**Next steps**

Data collected from this initiative will inform the development of more specific provincial guidelines for routine HIV testing that will include lower and upper age limits for testing and recommend a frequency of testing for those with no known risk. It is hoped that these guidelines will be available by the mid-2013. Please contact Dr. Réka Gustafson, Vancouver’s medical health officer for communicable diseases, for more information.

**Required Resources**

**Human resources**

- **Medical health officer:** provides and presents clinical and public health rationale.
- **Family physician leaders with HIV expertise:** develop and facilitate educational opportunities.
- **Family physicians with education expertise and communication expertise:** facilitate webinars and workshops.
- **Nurse educator:** provides follow-up support to practices using the in-practice support option.
- **UBC CPD staff:** coordinates and supports delivery of education. Coordinates communications and CME accreditation.
- **Project administrator:** provides administrative support to the project team.
- **Project manager:** coordinates the project components of the initiative including engagement, timelines, budgets, tracking, issue management and reporting.

**Program materials**

Most of the materials related to the implementation of the routine offer of HIV testing in family practice in Vancouver can be found on the UBC CPD website.

This includes resources and tools for family practitioners wanting to implement routine testing in their practices; patient resources to be displayed and offered in clinics; handouts on Vancouver-specific services and resources available to family practitioners who are preparing to diagnose a patient with HIV; and the entire HIV Testing: What’s Different Now? webinar.
Materials from the It’s Different Now social marketing campaign can be viewed on the It’s Different Now website.

Barriers to Implementation

1. **Recruitment and engagement of family practitioners.** Not all family practitioners are engaging in training and education on routine HIV testing. The in-practice support program, for example, receives responses from 50 percent of practices approached to participate and it is a challenge to determine why the other 50 percent are not participating. Multiple strategies are being used to reach physicians who have yet to participate. For example, practices in one neighbourhood in Vancouver with a large Asian and South Asian patient population have the lowest testing rate in the city, so the in-practice support team has partnered with a local nurse and community leader to engage practitioners.

2. **Competing priorities.** Family practitioners are busy, and HIV competes with many other important medical issues for their attention.

Evaluation

**Effectiveness and efficiency**

The family practice initiative will be evaluated for effectiveness and efficiency and in the context of using multiple testing strategies at the same time. The effectiveness of a testing initiative can be assessed by determining whether earlier diagnoses have the desired outcome. The desired outcome is monitored by analyzing the stage of disease at diagnosis at the population level. Data from the first year of expanded testing indicated that a greater proportion of patients were diagnosed later in their infection. It is probable that the expanded testing in hospitals and primary care meant that individuals who had long been missed were now being diagnosed. Over time, as these individuals are diagnosed and linked to care, it is expected that the proportion of late diagnoses will decline.

Efficiency will be evaluated on the basis of yield. The cost-effectiveness threshold for routine testing in the United States is one diagnosis per 1,000 tests. An equivalent cost-effectiveness threshold for Canada has not been established. So although yield will be monitored, the threshold for discontinuing routine testing has not yet been established.

**Education**

All three of the main education delivery methods are evaluated by participant satisfaction surveys. Participants complete feedback forms to evaluate the strengths of the session, suggest what could be improved, indicate their intent to change their testing practices and assess whether the educational sessions met the learning objectives. Workshops are evaluated with a suite of evaluation tools: a pre-workshop needs assessment, post-workshop surveys, a commitment-to-change exercise, and a reflective exercise completed after workshop A and workshop B respectively. In-practice support sessions and webinars are evaluated using a survey completed immediately after the sessions. Observational field notes, input from the faculty and facilitators and demographic data are also collected to inform ongoing program improvement.

**Impact**

It is clear that the implementation of routine testing in family practice has begun to change both practitioners’ and patients’ perceptions of HIV and HIV testing. Survey data collected to date indicate that physicians intend to increase the routine offer of HIV testing in their practice following education: 80 percent of survey respondents stated that they intend to increase or start routine HIV testing following an educational session (13 percent stated they were already testing routinely). Workshop participants reported increasing their HIV testing rate between workshop A and workshop B: 92 percent of survey respondents stated they were offering HIV testing routinely or had started to offer tests more often during the integration period. This was supported by qualitative data obtained from the reflective exercise and verbal reports.

As of March 2013, data are being collected to determine the increase in testing volumes as a result of education and the diagnostic yield from expanded testing.

**Learned and Confirmed**

1. **Build a compelling rationale.** The relevant medical health officer and her staff developed a compelling
rationale for the routine offer of HIV testing in family practice. The rationale provides a strong case for testing that speaks to healthcare providers effectively.

2. **Involve the bodies that represent family physicians.** Having the support and early engagement of the various associations and colleges that represent family doctors in Vancouver and British Columbia allowed the integration of routine HIV testing to be owned and led by family physicians.

3. **Deliver the education via family practitioners in current practice:** Having the educational sessions delivered by family practitioners in current practice means that participants can receive peer-to-peer education and have issues addressed as they arise by a colleague who has been there.

4. **Validate and address concerns and barriers:** Each interactive educational session provides an opportunity for the educators to improve the educational materials and address the specific concerns of the participating physicians. This iterative process has meant that the education delivered now has benefited from the input of previous participants and is a much improved product as a result.

5. **Partner with a leader in physician education.** A partnership with a reputable educational organization with strong networks with family practitioners facilitates uptake and delivery of training. UBC CPD provided the Vancouver STOP Project with the expertise to recruit, coordinate and deliver high-quality, accredited education to family practitioners.

6. **Provide multiple avenues for education.** By providing at least three different ways in which physicians could receive information and support to introduce the routine offer of HIV testing in their practices, the Vancouver STOP Project and UBC CPD were able to reach out to physicians and meet their different learning needs and schedules through the multi-modal educational strategy.

7. **Provide strong follow-up support.** Through all three educational modalities, participants are encouraged to seek additional help as they implement routine testing. Emails and calls are returned, and in the case of in-practice support, a nurse returns to practices with resources and tools to reduce barriers that clinicians are experiencing and to offer an opportunity for further discussion about implementation.

8. **Create a variety of support and educational tools.** Project staff developed strategies and tools to overcome clinicians’ perceived barriers, including adapting electronic medical record systems and offering different types of laboratory requisition forms, knowing that physicians would not all experience the same barriers or need the same resources.

**Other Useful Materials**

**Information found on the CATIE website**

- [Testing and diagnosis fact sheet](http://www.catie.ca/en/prevention/testing-and-diagnosis#hiv-testing)
- [CATIE Ordering Centre testing and diagnosis materials](http://orders.catie.ca/index.php?lang=e&cPath=10_25&language=en)

**Contact Information**

For more information, please contact:

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Disclaimer

Decisions about particular medical treatments should always be made in consultation with a qualified medical practitioner knowledgeable about HIV- and hepatitis C-related illness and the treatments in question.

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