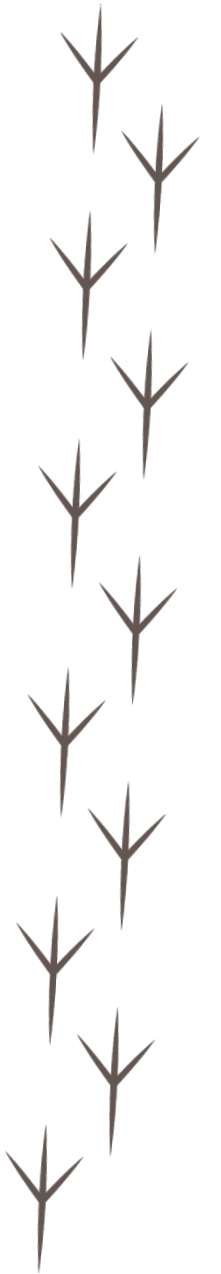


Screening in the ER

Rationale and Workflows from I/T/U facilities

Brigg Reilley MPH





One more thing? Don't say do one more thing.



THE RAVEN COLLECTIVE



HCV, HIV, and Syphilis in the U.S.

HCV

- 2.4 million people living with chronic infection
- 60,000–70,000 new infections annually

HIV

- 1.2 million people living with HIV
- 30,000–35,000 new diagnoses annually

Syphilis

- 200,000 total cases annually (all stages combined)
- Congenital syphilis >3,000 cases/year — highest rates in decades



Outcomes with Treatment

HCV—Cure in 8-12 weeks

HIV—Normal life expectancy

Syphilis--prevent long term sequelae, congenital infection

For all 3: interrupt ongoing disease transmission in community



Worse outcomes for AI/AN people

- HCV-related mortality is >3x the overall U.S. rate
- AI/AN people with HIV are less likely to know their status and achieve viral suppression
- Congenital syphilis rate nearly 12× higher than White infants

<https://minorityhealth.hhs.gov/hepatitis-and-american-indiansalaska-natives>

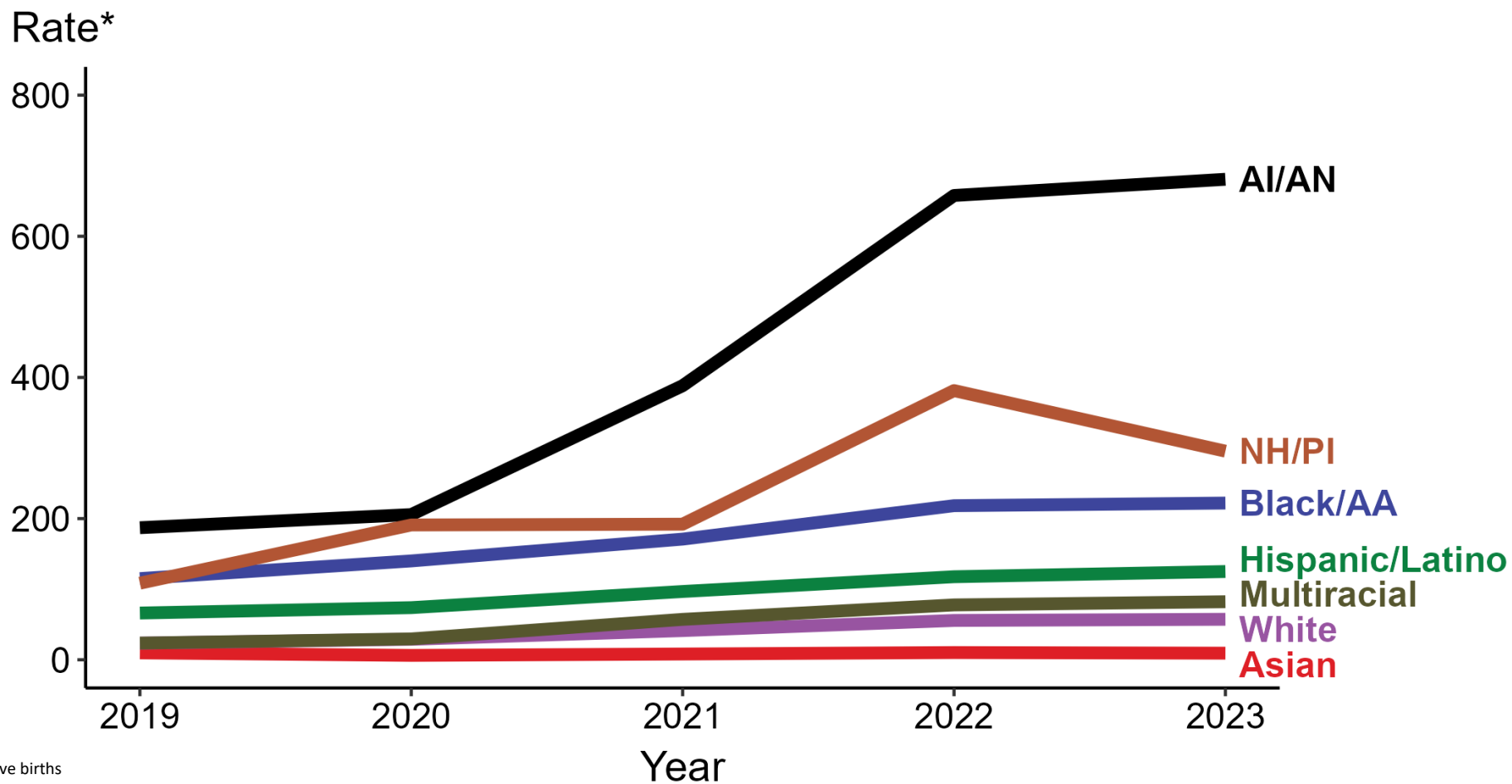
<https://www.cdc.gov/health-disparities-hiv-std-tb-hepatitis/populations/american-indian-alaska-native.html>

<https://www.cdc.gov/sti-statistics/annual/index.html>



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Congenital Syphilis — Rates of Reported Cases by Race/Hispanic Ethnicity of Birth Parent and Year of Birth, United States, 2019–2023



* Per 100,000 live births

ACRONYMS: AI/AN = American Indian or Alaska Native; Black/AA = Black or African American; NH/PI = Native Hawaiian or other Pacific Islander

NOTE: During 2019 to 2023, the percentage of all congenital syphilis cases with missing, unknown, or other race and not reported to be of Hispanic ethnicity was 5.2%, from a low of 5.0% (n = 193) in 2023 and 2019 to a high of 5.5% (n = 119) in 2020. These cases are not shown in this figure.



THE RAVEN COLLECTIVE



Screening?
Or testing?

And what is the
difference?

When to screen for anything?

- Asymptomatic
- Highly actionable diagnosis
- Test is reliable, non-invasive, not expensive



Syndemic Screening

- USPSTF has issued screening recommendations on HIV, HCV, STIs
- IHS-specific recommendation on syphilis

Facility level screening coverage tends to plateau at 55%-65%



Recommended by:

- **Centers for Disease Control and Prevention (CDC)** — opt-out HIV screening in all healthcare settings including EDs
- **American College of Emergency Physicians (ACEP)** — policy statements on HIV testing and screening
- **American Medical Association (AMA)** — guidance on routine screening for HIV, STIs, and viral hepatitis in EDs



Is it worth it?

Higher yielding studies in ER:

- HCV: >3% confirmed
- Syphilis 1.1% presumed active infection
- HIV: 0.5% prevalence

White DA et al. Ann Emerg Med. 2016

Haukoos JS et al. JAMA Netw Open. 2021.

Bristow CC et al. Sex Transm Dis. 2018



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You've lost it.

We can't screen
everyone.



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Simple but Not Easy

Integrated care pathways with dedicated coordinators substantially improve outcomes.

A London ED achieved 93% HBsAg linkage and 78% HCV linkage by offering immediate clinic appointments and using patient navigators to facilitate the first visit.

[An innovative approach to increase viral hepatitis diagnoses and linkage to care using opt-out testing and an integrated care pathway in a London Emergency Department - PubMed](#)



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Some Perspective

- Screening was not 100% in any study, often closer to about 25%
- Patients who dropped treatment were re-engaged in care
- Linkage to treatment often <50%, not part of the study intervention





I'm intrigued.

How are other
ERs doing
this?



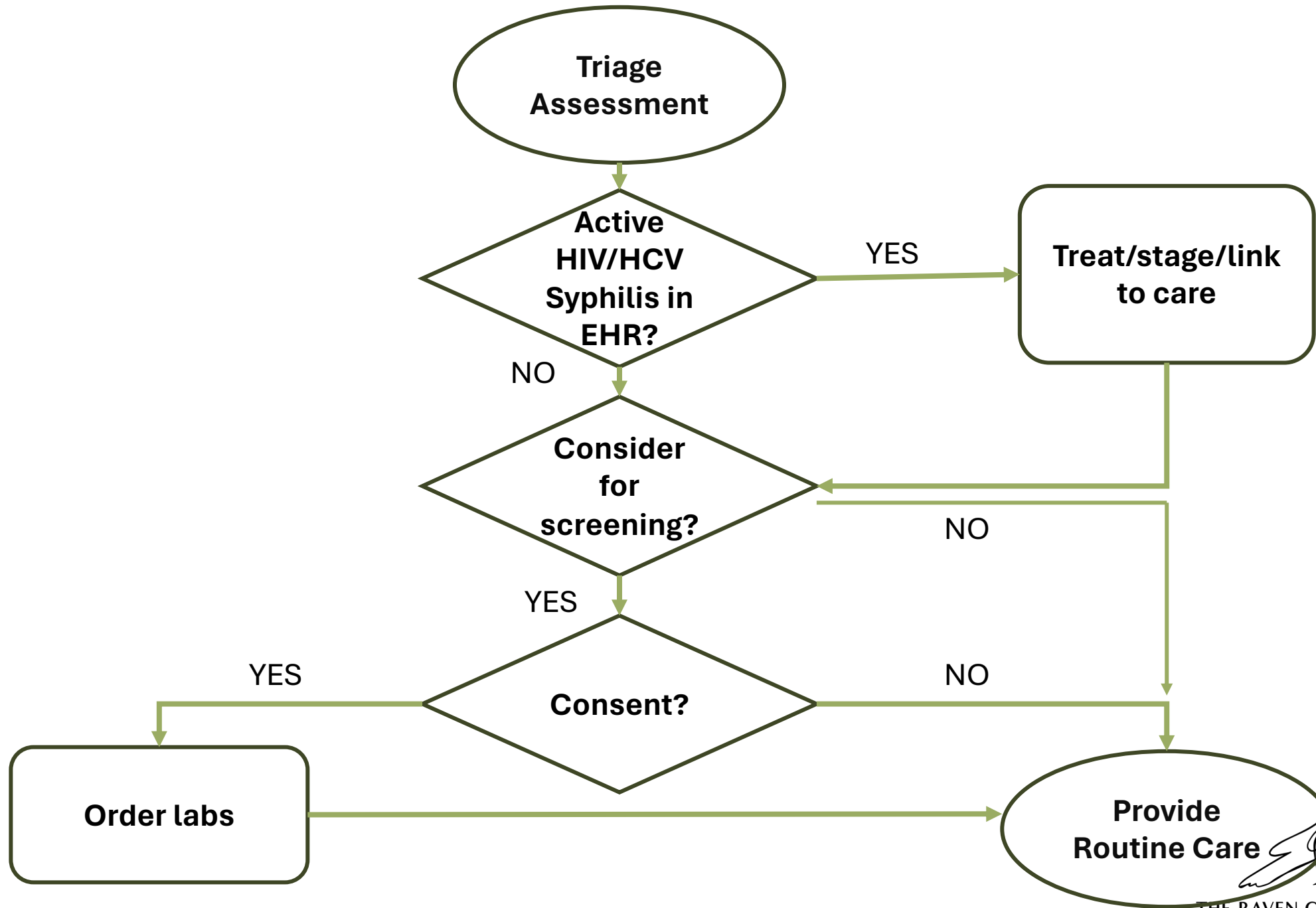
THE RAVEN COLLECTIVE



Partnerships are Critical

- Results and follow up must be referred to non-ER partners, usually primary care team or PHNs
- Detention systems





**Active
HIV/HCV
Syphilis in
EHR?**

Syphilis Patient Summary Tab in
RPMS

Link with PHN or PCP via EHR
and partnerships

Stage or Treat

This step often does not happen



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**Consider for
Screening?**

Local preconditions

(e.g if tests already ordered for PoV)

Presenting conditions (trauma,
ETOH, SUD)

EHR reminder



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Consent?

Opt-Out

Opt-in
(e.g. Express Testing Service)



Order Tests

- Often piggyback on existing labs (urine or blood)
- One click order or quickpick by provider, nurse, or lab
- Results policy to non-ER counterpart must be in place with clear roles



• **Refer Results/Follow Up**

- PHNs
- HIV/HCV/STI point person
- Tribal Public Health
- Care coordinators/Navigators





Okay. Maybe.

But can we get a little help?

We can

- Share criteria, consent forms, other policies and templates
- RPMS/EHR reminders
- Inservice for ER to onboard staff
- **Get your non-ER partners on board**
- Provide patient facing posters

- Learn from your program and PDSAs



Sexually Transmitted Infections (STIs) Are Common – and Often Silent

Most people with an STI feel completely fine.
That's why testing matters.

Free STI Screening Available Today



Confidential



Quick & Easy



No Symptoms
Needed



Just Ask.




Getting Tested is Routine Health Care.

- All ages & relationships.
- No judgment.

Should I get an STI screening today?"

Just ask.
Your provider can help.
No pressure.

• Why It Matters:

-  **Protect Your Health**
-  **Protect Your Partners**
-  **Prevent Future Problems**

Ask Today. It's Free. It's Routine. It's Your Health.

Posted information

Encourages patients

Reminds clinicians

Indigenous
Syndemic
Pathway
for Community Health Professionals

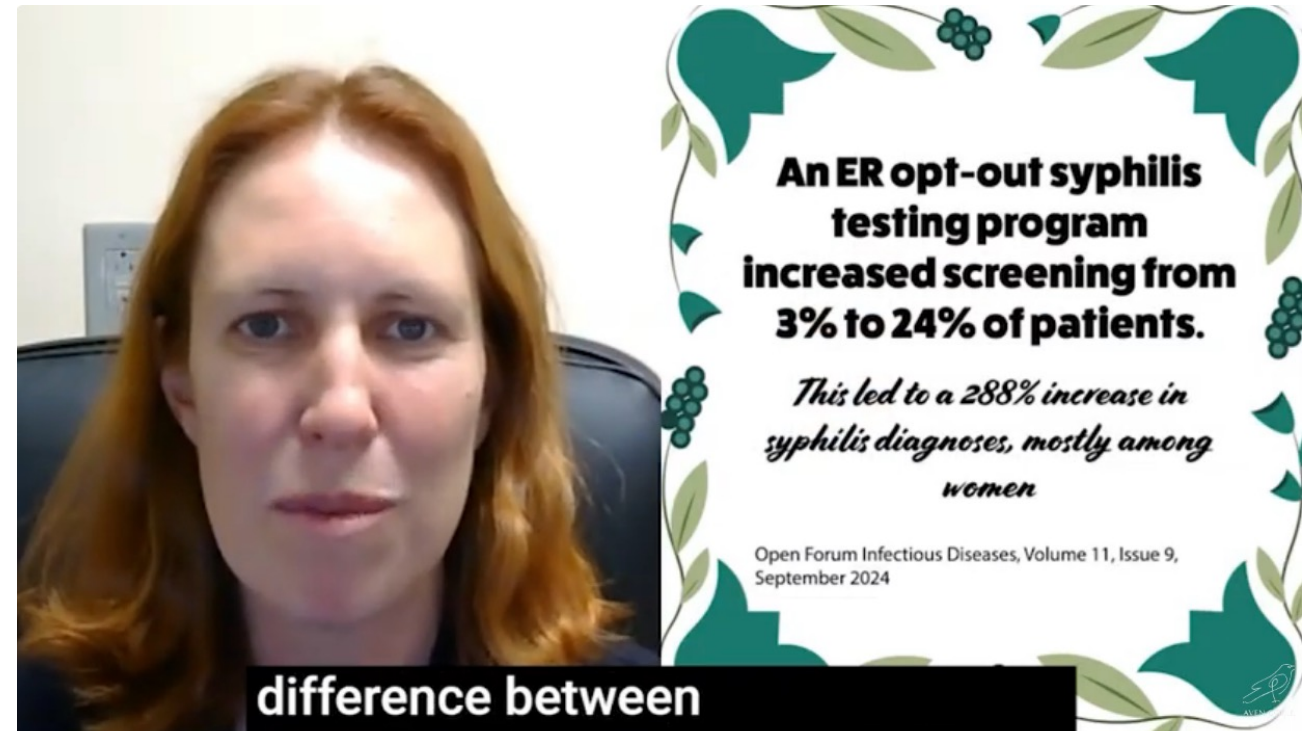


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The Raven Collective on Youtube

two minute videos for ER + longer lentocilin how-to

- https://www.youtube.com/@The_Raven_Collective





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More and More ERs screening

- Tuba City
- Whiteriver
- Tsehootshoi
- Cherokee Nation
- PIMC
- GIMC
- Others





Opt-Out Testing in the Emergency Department

Tony Nazario, STI NP, Phoenix Indian Medical Center,
Phoenix, AZ

Mary E. Coon, M.D., Chief of Emergency Medicine,
Phoenix Indian Medical Center, Phoenix, AZ



This material is the result of work supported with resources and the use of facilities at the Phoenix Indian Medical Center, located in the Phoenix Area of the Indian Health Service



Objectives

- What is Opt-Out Testing?
- Why is the Emergency Department an ideal place for this?
- Development of Opt-Out Testing at PIMC.
- Workflow for Opt-Out testing at PIMC
- What are the results?



What is Opt-Out Testing?

- Universal opt-out testing is a testing strategy used to increase the detection of certain infectious diseases within the public when presenting for care (*Opt-out Hepatitis c Testing, 2023*)
- The strategy incorporates HIV, Hepatitis C, and Syphilis testing into the routine testing bundle for patients that require lab studies



What is Opt-Out Testing?

- In opt-out testing patients are given the option to decline, or opt-out, of these tests when they complete the Consent for Treatment (Lyon, 2021)
- With this approach, we eliminate the healthcare providers subjective decisions from testing only those who might be at risk as this plan ensures everyone is screened (Lyon, 2021)



What is Opt-out Testing?

Goals

- Reduced stigma associated with testing for HIV, Hepatitis C, and Syphilis (*Opt-out Hepatitis c Testing, 2023*)
- Increases screening opportunities for high-risk populations that often use the Emergency Department for Primary Care services (Soh et al., 2022)
- Early detection of infection and linkage to care (Vliegenthart-Jongbloed et al., 2024)

Why the Emergency Department?

- The Emergency Department is the primary source of healthcare in many communities with limited access to healthcare (Vogel, 2019)
- Emergency Departments are frequently the primary source of access to health care resources, particularly with Health-related social needs such as housing instability, food insecurity, and physical abuse (McCarthy,2021)
- With decreased access to health insurance, many patient are left with the ED as their only access to health care (O'Lawrence, 2024)



Barriers to Opt-Out Testing

- Staff hesitancy
- Who are we going to test?
- Consent?
- EHR challenges
- Who is going to follow-up the results?



ED Nurses and Providers

- Already feeling overwhelmed and burdened by demands placed upon them.
- Discomfort with discussions about these diseases.
- Historically, ED providers were told NOT to order HIV testing.



Solutions

- Education about the disease prevalence in the community and risks with going undiagnosed (congenital syphilis, in particular)
- Create processes that limit additional work on the staff being asked to do this.



Who Are We Going to Test?

- 13-64 y/o with capacity to sign the ED treatment form
- Patients already getting blood work done
- No risk stratification required by ED provider



Do we need consent?

- Opt-out testing incorporates this into the ED workup and treatment
- Patients ALWAYS have the right not decline this testing when signing into the ED
- ED provider is responsible to check if the patient “opted-out”

Opt-out

Consent for treatment

Phoenix Indian Medical Center Emergency Department



1st visit to hospital? Date of Birth: _____ Phone #: _____

Last Name: _____	First Name: _____	M. I.: _____
REASON FOR VISIT (What do you want to be seen for in the E.R.?): _____		
FOR FEMALES ONLY: PREGNANT? <input type="checkbox"/> Yes <input type="checkbox"/> No If YES, How many weeks? Have you been pregnant in the last 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No	First day of your last period (LMP)? (please enter here): _____	
Any allergies to medications? <input type="checkbox"/> Yes <input type="checkbox"/> No List (if yes): _____	Do you smoke cigarettes? <input type="checkbox"/> Yes <input type="checkbox"/> No How many packs a day? _____	Do you consume any alcohol? <input type="checkbox"/> Yes <input type="checkbox"/> No How much per week? _____
Authorization for Treatment (Sign & date following statement): I, the patient or parent/legal guardian of patient named above, request and do authorize the Indian Health Service and the agency's authorized medical providers to render emergency medical care to the named patient. I agree and authorize that the physician, or other professional medical personnel in charge, will decide the care needed, and provided, which may include testing for HIV, syphilis and hepatitis C infection. I understand and authorize that students may provide my care as part of their medical training under the supervision of professional medical personnel.		
<input type="checkbox"/> I do not consent to HIV, syphilis or hepatitis C infection testing.		
Sign Here: _____ Date _____		
IF PATIENT IS MINOR>>>>>>> <small>(Less than 18 years old)</small>	Relationship to Patient: _____	Print Full Name of Parent or Guardian: _____ <small>**If patient is minor, parent/guardian must remain with patient at all times**</small>
<small>This information given to the Provider/Nurse/Admitting Clerk is confidential and will not be released unless required by law and/or your written request to inform third party.</small>		

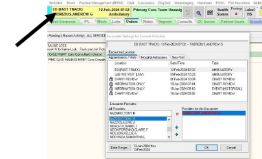
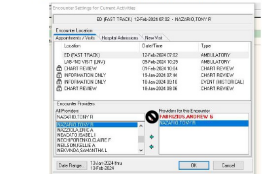
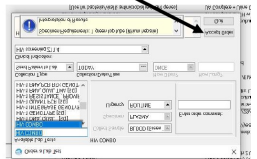
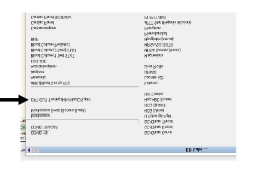
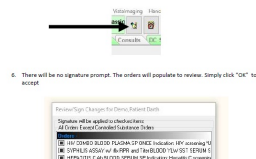
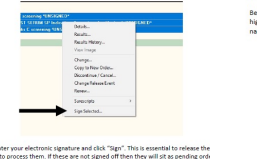
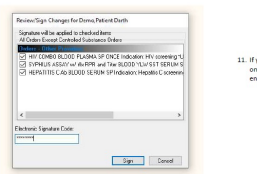
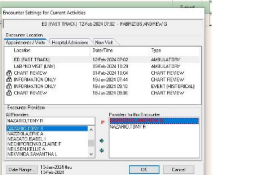




***** STOP HERE BELOW IS FOR HOSPITAL USE. *****

EHR Challenges

Entering Orders

- Lack of ease entering orders under another provider

1. While under the orders tab, click on the yellow box at the top of the chart to select the visit.
 
2. Here add "Nasario, Tony B" to the visit. Do not click "P" for primary provider, but you will want to leave it with "Nasario, Tony B" highlighted in blue and then click "OK".
 
3. Once the order is complete, then click the "signature/review orders" icon to review.
 
4. There will be no signature prompt. The orders will populate to review. Simply click "OK" to accept.
 
5. Then highlight the OPT OUT orders. Press and hold the "Ctrl" button while clicking the OPT OUT orders (BY COMBO/SYPHLS ASGAY/HEPATITIS C TAB).
 
6. Right-click over the highlighted orders and click "Sign Selected..."
 
7. Then enter your electronic signature and click "Sign". This is essential to release the the lab to process them. If these are not signed off then they will sit as pending order lab will not see them.
 
8. You have completed OPT OUT ordering under another provider. When these labs result they will be reviewed and followed up by "Nasario, Tony B" the STI NP.
 
9. Be sure to return to the yellow visit box on the top of the chart and select your name to highlight in blue and then click "OK" to return to ordering additional labs or tests under your name.
 
10. If you want to verify the orders placed for OPT-OUT. Under the order tab you may double-click on the OPT-OUT order and in the pop-up window you should see your name as "New Order entered by..." and "Nasario, Tony B" will appear next to "Electronic Signature".
 

- Approximately 10 steps to enter testing orders under another provider
- Provider entering order must remember to change ordering provider name back to their name for remainder of visit AFTER entering opt-out labs



Who is going to follow up the results?

- Ordering labs under designated HCP to shift follow-up burden and liability away from the Emergency Department providers
- Close collaboration with the Public Health Nursing Department and HIV/HCV Clinic for laboratory surveillance and linkage to care



Who is going to follow up the results?

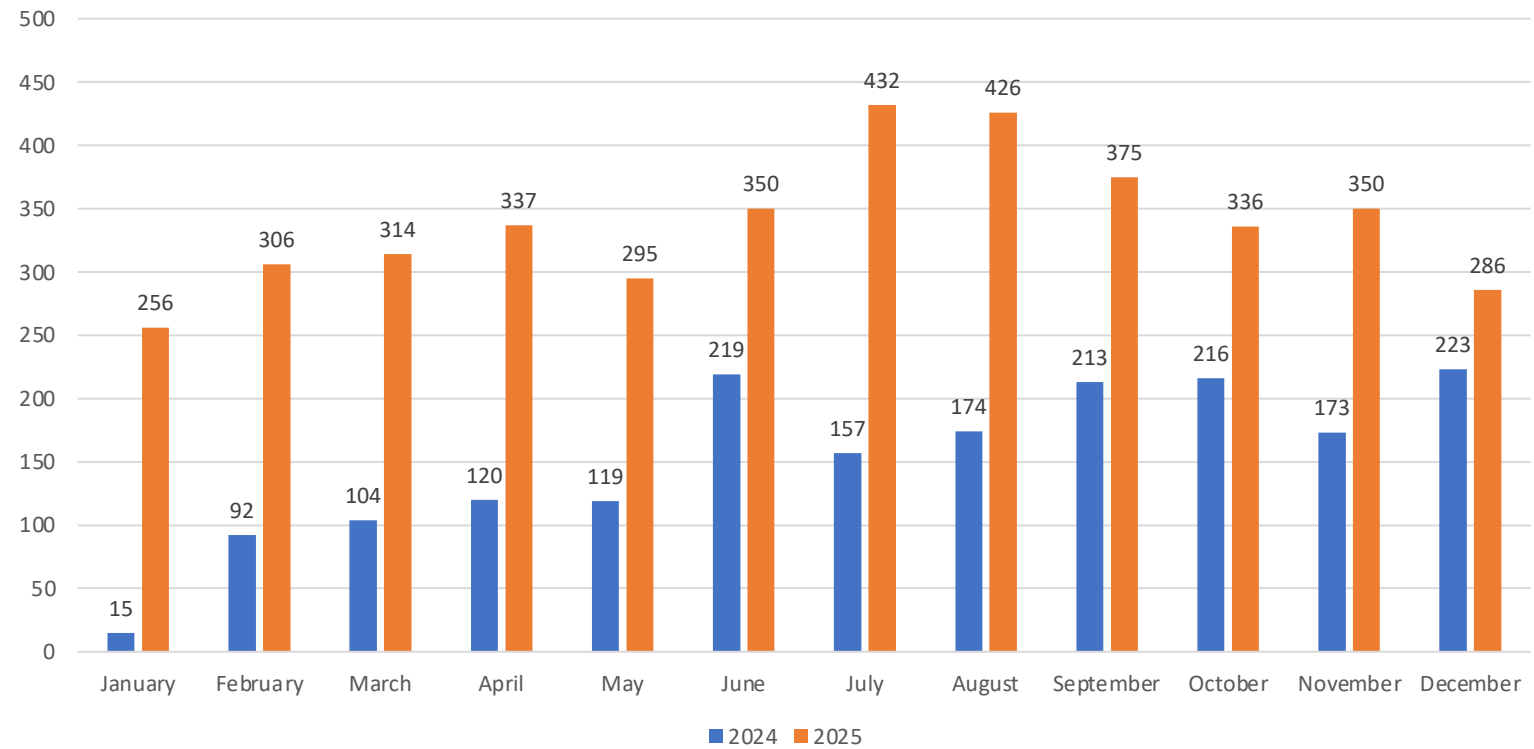
- Facility Public Health Department collaborates with local, tribal, and state health departments on cases
- A Memorandum of Understanding (MOU) was established with the state health department to provide support with additional communicable disease investigators



Results

Monthly Opt-out Tests in ED

Opt-out Tests 2024 v 2025

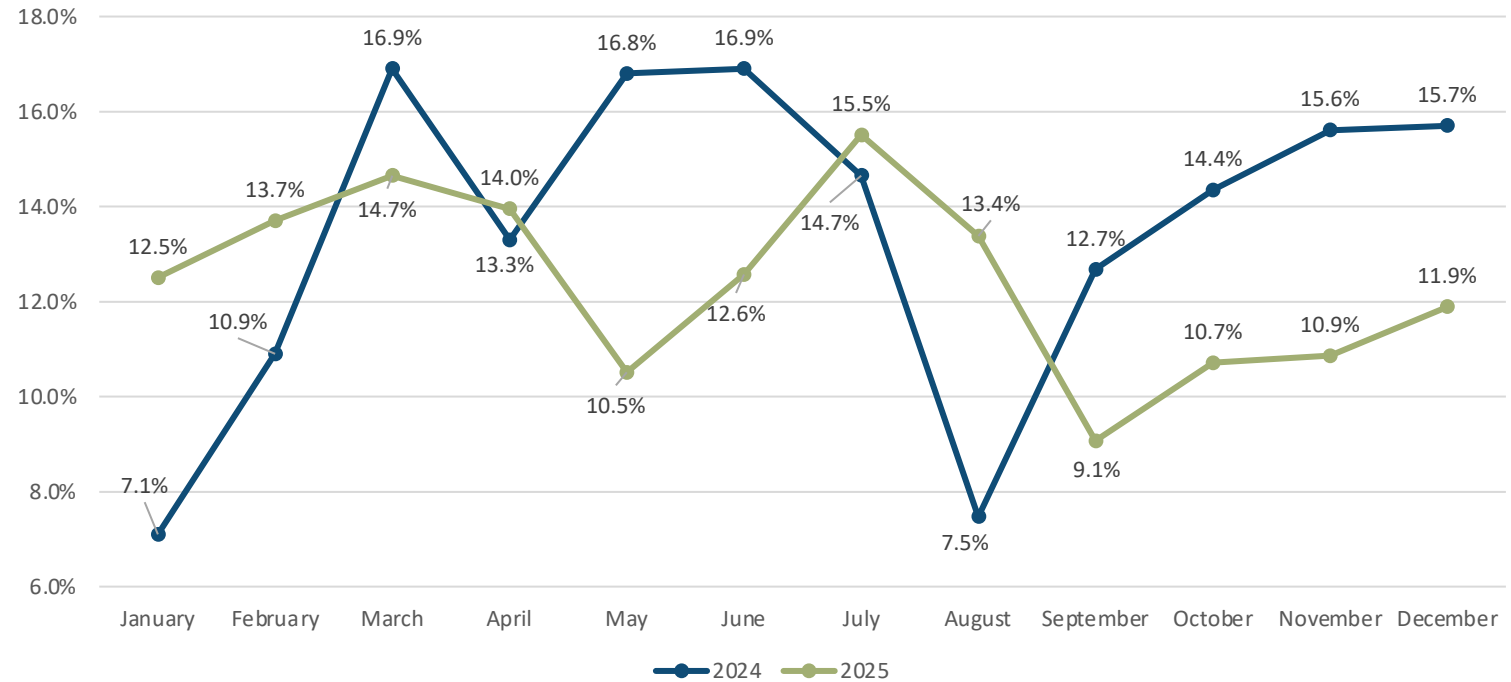




Results

Positivity 2024 v 2025

Positivity Rates





Case Study

Let's call him "Fred"

59 y/o male presents to ED

CC: back pain and frequent urination

PMHx: DMII, seizure disorder, HCV w/hx of tx

Vital signs unremarkable except for HR 106

Consent for treatment completed.

Pt did NOT opt-out of testing

Physical Exam: NL except +left CVA tenderness

Case Study

“Fred”



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UA

Test	Result
UA COLOR	YELLOW
UA CLARITY	TURBID
UA SPECIFIC GRAVITY	1.0220
_pH, Urine	5.5
UA PROTEIN SCREEN	20
UA GLUCOSE	NORMAL
UA KETONES	NEGATIVE
UA BILIRUBIN	NEGATIVE
UA BLOOD	2+
UA UROBILINOGEN	NORMAL
UA NITRITE	2+
UA LEU ESTERASE	500
WBC/HPF	182
RBC/HPF	25
BACTERIA	MOD
SQUAMOUS EPITHELIAL	<1
MUCOUS	MANY

CT Kidneys

Impression:

No urolithiasis or hydronephrosis. Urinary bladder is decompressed with diffuse wall thickening, nonspecific.

Case Study

“Fred”

Labs reviewed WBC 10, UA shows +leuk est and 2+ blood and nitrites

Patient dx: acute urinary tract infection

Opt-out labs:

Test	Result
_Anti-HCV Interpretation	Reactive
_Anti-HCV Index	>11.00
_Syphilis Interpretation	Reactive
_Syphilis Index	>45.00

Test	Result
_HIV Interpretation	Reactive
_HIV Index	1.579

Test	Result
HIV-1	Negative
_HIV-2	Negative



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Case Study

“Fred”

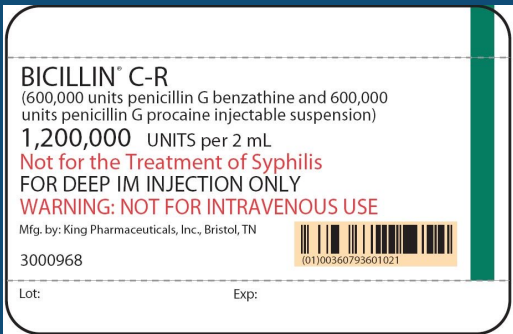
Additional hx obtained: Pt reports msm-vers with new partner, denies prior hx of STI. ED dx primary syphilis based and treated prior to discharge

Tx: Bicillin 2.4 MU IM x 1 (advised f/u STI Clinic)
Cipro 500 mg PO BID x 10 days for UTI

Patient discharged home and advised f/u STI Clinic



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Case Study

“Fred”

Additional labs returned and chart review completed by STI Clinic

Pt with prior hx syphilis without documented treatment from 2020

Pt chart shows history HCV and IVDU, was treated previously with Mavyret and achieved SVR

HIV neg previously in 2023

CONFIRMATION

Test	Result
RPR Screen	Non-Reactive
_RPR Titer	Non-Reactive

Test	Result
TREPONEMA PALLIDUM PA [SQ]	Reactive

Test	Result
HEP C QT RT PCR (IU/mL) [SQ]	446
_HEP C QT PCR (LogIU/mL) [SQ]	2.65

Test	Result
HIV-1 RNA, QUAL TMA [SQ]	DETECTED



Case Study

“Fred” follow-up

Based on ED note and labs STI Clinic attempted to link patient to care, with coordination with PIMC HIV Clinic, additional attempts were made and PHN consulted to assist in notification. State health department also notified to assist in locating patient.

Patient received letters and was notified by State two weeks after initial visit to return to facility for follow-up care. Patient was advised of diagnosis and need for treatment.



Case Study

“Fred” follow-up

Patient established care and completed treatment for late latent syphilis, initiated treatment for HIV and connected to HIV resources, and patient was monitored for HCV infection. Due to low viremia serial labs ordered and patient self-cleared newest infection.

Patient currently compliant with follow-up care and treatment plan and remains adequately treated for syphilis, HCV VL remain undetectable, and HIV VL also undetectable with a robust CD4 count.

Case Study

“Maybelle”

45-year-old female presents to ED for evaluation of stump infection

PMHx: Uncontrolled DMII, hx AUD, trichotillomania

Labs resulted: Syphilis -> non-reactive

HIV -> non-reactive

HCV Ab -> reactive → HCV-VL @ 1.78M



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Case Study

“Maybelle”

Patient transferred out for higher level of care due to osteomyelitis of stump

Patient was contact by STI Clinic and notified of HCV dx

Patient reports known history for 5+ years but reports not treated due to SUD at time of dx.

Patient would like treatment and reports sober for over 1 year. Linked to care with PIMC HIV Clinic and treatment initiated. SVR is pending.





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