Selecting an Opt-Out HIV Testing Model

TOUCH POINTS IN PAN-VIRAL TESTING AND LINKAGE TO CARE

Choosing the right opt-out testing model helps emergency departments (EDs) maximize screening while minimizing workflow disruptions. The structure of the model affects the reliability, efficiency, and sustainability of opt-out HIV testing. Because EDs vary widely in staffing, patient populations, and workflows, these models should be tailored to fit the specific needs of your organization.

Opt-out HIV testing in the ED can be implemented using parallel staffing or integrated staffing.

- **Parallel Staffing Models** uses a dedicated team that operates alongside standard ED workflows to identify and coordinate the testing of eligible patients, minimizing the burden on frontline staff.
- **Integrated Staffing Models** embeds testing directly into the routine ED care, making HIV screening a standard part of patient evaluation and management by existing ED personnel.

Either approach may be implemented with or without electronic medical record (EMR) support and may be protocolized or non-protocolized.

PARALLEL STAFFING

Screening and testing done by separate staff co-located in ED.

Options:

- *EMR-Assisted:* EMR prompts identifies eligible patients while the parallel team handles coordination
- *Non-EMR:* The parallel team manually identifies eligible patients based on ED census, chief complaints, or clinical criteria
- *Protocolized:* All patients are approached by the parallel team
- *Non-Protocolized:* Decisions about offering testing are made on a case-by-case basis by ED staff or the parallel team.

INTEGRATED STAFFING

Testing embedded into routine ED provider workflows.

Options:

- *EMR-Assisted:* EMR alerts, order sets, or default lab panels ensure HIV testing is embedded in routine care
- *Non-EMR:* Implementation relies on staff education, clinical culture, and individual initiative
- *Protocolized:* HIV testing is automatically included through standing orders, triage protocols, or bundled lab panels
- *Non-Protocolized:* Clinicians independently determine when and how to offer testing

PARALLEL VS. INTEGRATED STAFFING MODELS

Feature	Parallel Staffing Model	Integrated Staffing Model
Staffing	Dedicated team manages testing; less burden on ED staff	ED providers manage testing; may add to workflow demands
Reliability	Variable. Improved with EMR-assistance	High. Increased with EMR-assisted and protocolized options
Implementation Complexity	Low. Little requirement for ED staff participation	High. Requires staff training and new workflow protocols
Cost	High. New staff required, typically needs separate funding	Low. Costs only associated with additional testing.
Testing Volume	Generally lower than integrated staffing.	Generally higher than parallel staffing.

The Core Elements of Opt-Out HIV Testing in Emergency Departments

TOUCH POINTS
IN PAN-VIRAL TESTING AND LINKAGE TO CARE

Opt-out HIV testing in the ED is shaped by a set of core program elements rather than a single policy decision. Decisions about who is offered testing, how consent is obtained, how testing is operationalized, and how patients are linked to care collectively determine program success. Although four elements are described separately below, they are interdependent in practice and must align with the realities of ED workflow.

1. Patient Selection

How patients are selected for HIV testing largely determines the reach and equity of ED-based screening. Terms like *routine* and *universal* are inconsistently defined leading to variable implementation. Establishing clear, operationalized patient selection criteria is essential for successful opt-out testing.

COMMON PATIENT SELECTION TERMS/OPTIONS

Term	Meaning	Key Limitation
Routine	HIV testing is part of usual care	Vague, used differently across institutions
Universal	Everyone in a defined setting is tested	Rarely achieved in practice
Non-Targeted	All eligible patients are offered testing	Misses patients when workflows break down
Targeted	Only patients with certain risks or indicators are tested	Hard to identify “high-risk” patients reliably
Diagnostic	Testing on patients with specific symptoms or conditions	Not a screening strategy

2. Consent

Consent processes are a major driver of variation in testing uptake across opt-out HIV programs. Although opt-out testing is designed to test patients unless they decline, many ED programs function in practice as opt-in systems, with staff asking patients whether they want an HIV test. This framing requires an active decision and is associated with lower testing rates.

Key consent design choices that influence uptake and ethical clarity include:

- *Wording:* Opt-in language reduces testing compared to opt-out framing.
- *Awareness of Refusal:* Explicitly informing patients of their right to decline supports informed consent, but may modestly reduce uptake.
- *Consent Method:* Verbal consent is faster and often more accepted by patients than signed consent.
- *Workflow Integration:* Incorporating HIV testing into general medical consent normalizes screening and reduces stigma, while separate consent increases visibility but adds steps that may discourage testing.

Differences in consent rates often reflect program design and staff communication more than patient reluctance. Well-designed consent processes can uphold patient autonomy while supporting high screening uptake and public health goals.

3. Assay

While HIV screening assays are largely standardized, their effectiveness in the ED depends on how well they are integrated into local laboratory and clinical workflows. Turnaround time, batching practices, staffing, and result reporting all influence whether opt-out testing can occur reliably within the ED.

Effective programs clearly define key operational details, including:

- Who is responsible for sample collection?
- When testing occurs during the ED visit?
- Where blood is drawn to minimize missed opportunities?
- How samples are collected and ordered (e.g. venipuncture, residual blood, point-of-care testing)?

Clear operational definitions allow opt-out HIV testing to function as a sustainable component of ED care rather than an ad hoc or fragile intervention.

4. Linkage to Care

Although no formal standards specify a required level of linkage support for ED-based opt-out HIV testing, every program needs a clear plan for managing positive results. Linkage models vary in both responsibility and intensity.

Responsibility for linkage to care may fall to:

- ED staff
- External partners (e.g. health departments or community-based organizations)
- The patient

The level of support may range from:

- Passive referral (information only)
- Active referral (help with scheduling or communication)
- Ongoing engagement to support continued care onsite

More robust linkage strategies improve patient outcomes, but even limited follow-up does not diminish the public health value of identifying HIV in the ED.

Key Considerations for Implementing Opt-Out HIV Testing

TOUCH POINTS IN PAN-VIRAL TESTING AND LINKAGE TO CARE

Successful implementation of an ED-based opt-out HIV testing program requires attention to operational, cultural, and organizational factors. Key considerations include securing staff and leadership buy-in, aligning testing with existing workflows, integrating with clinical and information systems, and planning for long-term sustainability. Implementation quality is as important as the policy intent. The gap between program design and day-to-day execution often determines actual testing coverage. Even small operational decisions can substantially influence an opt-out screening program.

Obtaining Buy-In

Meaningful progress is more often achieved through partial, well-executed implementation than through ambitious, full-scale rollouts that often fail to take hold. Building internal support requires addressing concerns directly, aligning the program with staff priorities, and demonstrating that HIV testing can be integrated without disrupting patient flow.

Embrace Incrementalism: Begin with low-burden, limited-scope approaches to generate early wins and build momentum among staff and leadership.

Roll with Resistance: Adapt implementation strategies to address the specific concerns raised by stakeholders rather than rigidly adhering to a predefined plan.

Concern	Practical Solution
The ED is too busy	Implement testing during historically slow shifts
Lab turnaround too slow/rooms needed before results available	Use delayed result notification or linkage via follow-up mechanisms
Can't test everyone	Start with high-yield patient groups (e.g. those with STIs or already receiving a blood draw)
"Not for us"	Make opt-out available to providers who wish to use it

Developing Motivation

Beyond logistics, implementation depends on motivation. Building motivation means helping staff understand the purpose of opt-out testing, validating their concerns, and connecting the program to values they already prioritize.

TOUCH POINTS IN PAN-VIRAL TESTING AND LINKAGE TO CARE

BUILD FAMILIARITY AND UNDERSTANDING

- Approach staff with a collaborative, problem-solving mindset
- Recognize that perceived barriers are real to staff
- Identify the specific operational or clinical pain points driving hesitation

ATTEND TO DOWNSTREAM ACTIONS

- Staff may question the value of testing if follow-up care for positive results is unclear or unreliable
- Provide ongoing feedback on both expected and actual program yield to demonstrate tangible impact

ALIGN ARGUMENTS WITH INTRINSIC MOTIVATION

- Emphasize shared values such as patient safety, equity, preventing missed diagnoses, and clinical excellence
- Highlight how opt-out testing supports comprehensive, patient-centered care

RELY ON CHAMPIONS

- Identify trusted and enthusiastic staff who can model participation and motivate peers

REFORMULATE THE TARGET

- If broad implementation meets resistance, focus on smaller, achievable goals, such as one shift, one area of the ED, or one patient group, to reduce psychological resistance and build confidence

ECONOMIC CONSIDERATIONS

- Emphasize that the cost of screening is typically small relative to the overall ED budget
- Highlight alignment with organizational mission, quality improvement initiatives, community health priorities, and potential public visibility

Incremental implementation demonstrates feasibility and minimizes perceived risk. Early successes provide concrete evidence that opt-out HIV testing can be integrated into routine ED care, helping shift perceptions and build durable, long-term buy-in.

Resources

Below are some resources you can access to further your understanding of opt-out HIV, STIs, viral hepatitis and latent TB infection in EDs and effective implementation models.

HealthHIV Touch Points in Pan-Viral Testing webinar series. March - November, 2025.
https://healthhiv.org/training_series/touch-points/

American Medical Association. *Routinely screen for HIV, STIs, viral hepatitis and latent TB infection: The AMA's toolkit for community health centers and emergency departments guides you from patient intake to linkage to care.* Accessed December 9, 2025.
https://www.ama-assn.org/public-health/prevention-wellness/routinely-screen-hiv-stis-viral-hepatitis-and-latent-tb-infection

American Medical Association. *Screening is the First Step to Treatment: Screen your patients for HIV, STIs, Viral Hepatitis, and LTBI*. Accessed December 9, 2025.
https://www.ama-assn.org/system/files/routine-screening-toolkit.pdf

U.S. Preventive Services Task Force. *Final Recommendation Statement: Human Immunodeficiency Virus (HIV) Infection: Screening.* June 11, 2019.
https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/human-immunodeficiency-virus-hiv-infection-screening

Bridge to Treatment. *Making the Case for Emergency Department Syphilis, HIV, and Hepatitis Screening—Sustainability Tool.* Accessed December 9, 2025.
https://bridgetotreatment.org/resource/making-the-case-for-emergency-department-syphilis-hiv-and-hepatitis-c-virus-hcv-screening-sustainability-tool/