

Report on Findings from an Assessment of Health Department Efforts to Implement HIV Testing in Health Care Settings

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Executive Summary

In February 2010, the National Alliance of State and Territorial AIDS Directors (NASTAD) surveyed health departments in all 65 states, territories and cities funded by the U.S. Centers for Disease Control and Prevention (CDC) for HIV prevention efforts in order to update national data on their efforts to implement and support HIV testing in health care settings. The survey also examined the extent to which CDC's [*Revised Recommendations for HIV Testing of Adults, Adolescents and Pregnant Women in Health Care Settings*](#) (2006 CDC Recommendations) have influenced or will influence health department efforts to implement HIV testing in health care settings.

This report highlights the legal environment for HIV testing, implementing HIV testing in health care settings, reimbursement, barriers to HIV testing and evaluation. Data collected through this survey updates those collected through a similar survey in 2007. Findings will help identify priority areas for technical assistance and strategies for health departments to further support implementation of HIV screening efforts and will inform priorities for advocacy and education among key stakeholders and partners.

Legal Environment for HIV Testing¹

Since jurisdictions were surveyed in 2007, the state-level legal and state and local policy environment offers increased flexibility for HIV testing. Fewer health departments reported in 2010 that separate consent for HIV testing is required by statute or regulation and fewer reported that pre-test counseling is required prior to HIV testing. Substantially more health departments reported that routine offering of HIV testing in health care settings, with right of refusal, is allowed by statute, regulation or policy in their jurisdictions for any specific population(s).

The legal environment for HIV testing at the state-level is largely responsive to CDC's *Recommendations* and should be conducive to provision of HIV testing as a standard of medical care. At present, however, there is little evidence that changing consent and counseling requirements has resulted in an appreciable increase in the number of health care facilities providing HIV testing, in the number of tests conducted, or in the number of previously undiagnosed infections.

Implementing HIV Testing in Health Care Settings

State health departments have made substantial and increased investments in supporting HIV testing in a variety of health care settings. Nearly all health departments reported supporting HIV testing efforts in health care settings in 2010 while only 35 reported doing so in 2007. Three-fourths of health departments currently reported supporting the routine offering of HIV testing to all patients aged 13-64 years, without regard to clinical signs or symptoms or behavioral risk.²

1 The six directly-funded localities responding to the survey were excluded from analysis of the items related to the statutes and regulations as HIV testing in each of these cities is subject to the statutes and regulations of the states in which they are located. Responses provided by the responding cities were examined and found to be consistent with responses reported by the corresponding state. Responses from the cities related to policies were included, as policies may be under the purview of the local health department.

2 The 14 health departments that did not report supporting routine HIV testing were not funded under CDC's Expanded Testing Initiative, suggesting the importance of these resources in stimulating the implementation of routine HIV testing in health care settings.

Reimbursement for HIV testing continues to be a key concern for health departments. Publicly supported testing programs are extremely vulnerable due to their reliance on unstable public funding. Approximately one-fourth of health departments indicated that their state Medicaid program does not reimburse for routine HIV testing while an equal proportion reported having no knowledge of whether their state Medicaid program reimburses for routine HIV testing. Most health departments also reported having no knowledge about private insurer reimbursement for routine HIV testing. Much work still needs to be done to ensure sustainable financing of HIV testing, particularly through insurance reimbursement.

Health departments identified a lack of adequate funding, provider resistance and health facility resistance as the most important barriers to implementing HIV testing in health care settings. They reported viewing hospital emergency departments, correctional facilities and community health clinics as the most challenging environments in which to implement HIV testing.

These findings suggest that operational issues and provider attitudes are substantial barriers to implementing HIV testing in health care settings. This suggests a heightened need to develop, evaluate and make tools available to providers, including multiple test technologies, which will enable and support implementation of testing in a way that appropriately matches individual facility needs and capacities. Provider education and awareness efforts may be another important strategy for encouraging and supporting HIV testing in health care settings.

Health departments have been largely successful in implementing HIV testing, including routine testing, in health care settings. This illustrates that health departments appreciate the potential value that testing in these settings has relative to identifying previously undiagnosed infection and for providing access to testing for individuals who would not seek services through traditional public health venues or through community-based testing programs.

Background and Introduction

In February 2010, the National Alliance of State and Territorial AIDS Directors (NASTAD) conducted a survey of health departments in all 65 states, territories and cities funded for HIV prevention efforts by the U.S. Centers for Disease Control and Prevention (CDC). NASTAD conducted this assessment to update national data on health department efforts to implement and support HIV testing in health care settings. The survey was also intended to examine the extent to which CDC's [*Revised Recommendations for HIV Testing of Adults, Adolescents and Pregnant Women in Health Care Settings*](#) (2006 CDC Recommendations) have influenced or will influence health department efforts to implement HIV testing in health care settings.

Data collected through this survey provide an update to data collected through a similar survey conducted in 2007. Findings from the 2010 survey will help identify priority areas for technical assistance and strategies for health departments to further support implementation of HIV testing efforts. Findings will also inform priorities for advocacy and education among key stakeholders and partners.

Methodology

A 16 item, self-administered [survey](#) was conducted online via Survey Monkey™ to the AIDS program directors in each of the 65 jurisdictions funded for HIV prevention activities by CDC³. NASTAD staff conducted follow-up with health departments that did not complete the survey by the due date to encourage greater response. A total of 57 responses, representing an 88 percent response rate, were received from state and local health departments, including all 50 states, the District of Columbia and the six CDC directly-funded localities.

The questionnaire encompassed two major sections. The first section examined the legal environment for HIV testing within a jurisdiction. In particular, the survey sought to gather information about legal, regulatory and policy requirements related to informed consent and counseling associated with HIV testing. The responses from the six directly-funded localities were excluded from the analysis of the items related to statutes and regulations associated with HIV testing as each of these jurisdictions is subject to the statutes and regulations of the states in which they are located. Responses provided by the localities were examined and were found to be consistent with the responses reported by the corresponding state. Responses from the localities around questions related to policy were included, as policies may be under the purview of the local health department.

The second section addressed implementation of HIV testing in health care settings. Items in this section were intended to help better characterize the specific health care settings in which health departments currently support HIV testing, including routine HIV testing, and how such efforts are financed. In addition, the types and methods of consent and counseling were examined by setting.

3 CDC funds for HIV prevention each of the 50 states, six localities (Chicago, Houston, Los Angeles County, New York City, Philadelphia, and San Francisco), the District of Columbia and eight territories.

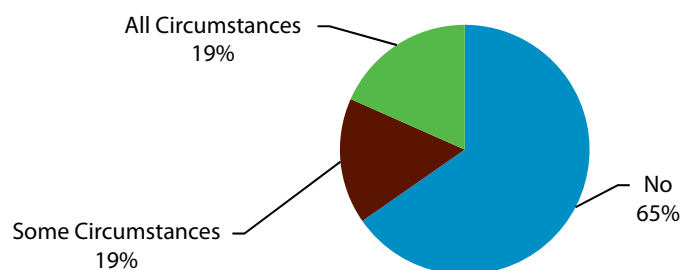
Findings

Legal Environment for HIV Testing

Health departments were asked to respond to a series of five questions related to the statutory and regulatory environment in which HIV testing is conducted in their jurisdictions.

Respondents were asked whether separate consent for HIV testing is required by statute or regulation within the jurisdiction. Forty-nine health departments responded to this item (Figure 1). Of these, nine (18 percent) reported that separate consent for HIV testing is required by statute and/ or regulation in all circumstances. Another eight (16 percent) reported that separate informed consent is required in some circumstances.

Figure 1: "Is separate consent for HIV testing required by statute of regulation in your jurisdiction?" (n=49)



In 2007, 34 of 50 responding health departments reported that specific consent for HIV testing is required by statute and/or regulation in some or all circumstances.

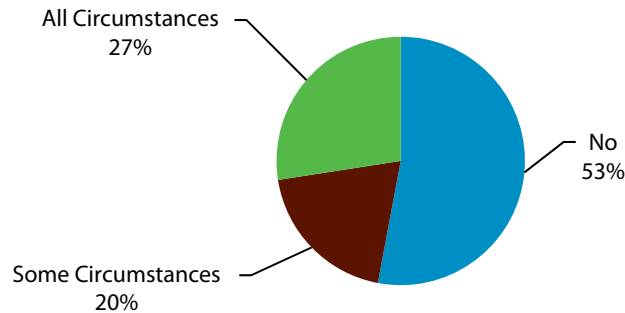
In the 2010 survey, health departments were asked to indicate if written consent for HIV testing is required by statute or regulation. Seventeen out of 23 health departments responding to this question reported a statute or regulation requiring that consent for HIV testing be obtained in writing, at least in some circumstances.⁴ Among the twelve jurisdictions reporting that written consent was required in at least some circumstances, testing conducted in publicly funded sites (e.g., county health departments), community-based organizations and other non-medical settings as well as for insurance purposes were identified as the circumstances requiring written consent.

Health departments were asked to indicate whether provision of pre-test information was required by statute or regulation. As illustrated in Figure 2, fourteen of 51 health departments (27 percent) indicated that provision of pre-test information is required by statute or regulation in all circumstances. An additional ten (20 percent) indicated that it is required in some circumstances. By comparison, in 2007, 42 percent of health departments responding indicated that HIV testing was prohibited by statute and/or regulation unless preceded by "pre-test counseling." For health departments that reported provision of pre-test information is required in some circumstances, testing conducted in publicly funded sites, community-based organizations and non-

4 The District of Columbia did not respond to this item and has no statute that addresses consent for HIV testing.

medical settings as well as for pregnant women were identified as circumstances requiring provision of pre-test information.

Figure 2: "Is provision of pre-test information required by statute or regulation in your jurisdiction?" (n=51)



Health departments were also asked whether provision of pre-test information is required by policy. Of the 57 responding health departments, 16 (28 percent) reported that pre-test information is not required by policy; 16 (28 percent) reported that provision of pre-test information is required by policy in all circumstances and 25 (44 percent) reported that provision of pre-test information is required by policy in some circumstances. Provision of pre-test information was reported as being required by policy in sites such as publicly funded sites, community-based organizations, non-medical settings and in venues serving high-risk populations (e.g., STD clinics).

Among the 27 state health departments and the District of Columbia that reported no statutory requirements for provision of pre-test information, 16 (59 percent) reported that provision of pre-test information is required by policy in at least some circumstances and four (15 percent) reported that provision of pre-test information is required by policy in all circumstances.

Health departments were asked to identify the kinds of information required to be provided prior to HIV testing. Twenty-four⁵ health departments reported either a statutory or regulatory requirement for provision of pre-test information. Responses regarding the components of provision of pre-test information are provided in Table 1.

Table 1: Required components of pre-test information	% Responding (n=24)
Information about the test	92% (22)
Meaning of test results	71% (17)
Benefits/drawbacks of the test	54% (13)
Legal rights of the test subject	46% (11)
People/entities to whom results must be disclosed	33%(8)
Risk reduction planning	33% (8)
Risk reduction counseling	33%(8)
Risk assessment	29% (7)

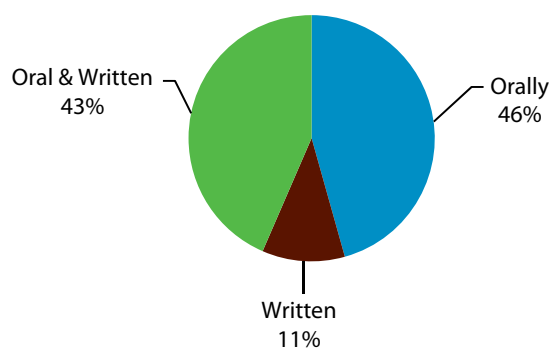
5 Eight jurisdictions reported having neither a statute nor policy mandate to provide pre-test information.

When compared with responses from the 2007 survey, no significant differences in response were noted.

Twenty state health departments reported policy requirements for provision of pre-test information but no statutory requirements. Among these jurisdictions, a larger proportion reported risk assessment, risk reduction and counseling among the required elements of information which precedes HIV testing when compared with jurisdictions that only have statutory requirements. Nearly two-thirds (63 percent) reported that risk assessment is required, 56 percent reported requirements regarding people/entities to whom results must be disclosed and 52 percent reported that risk reduction planning and counseling are required. Interestingly, a smaller proportion of “policy only” jurisdictions reported a requirement for provision of information about the test (67 percent), the benefits and drawbacks of the test (37 percent) and the legal rights of test subjects (37 percent).

Forty-six (81 percent) health departments responded to questions about how pre-test information is provided. As illustrated in Figure 3, 20 (43 percent) reported that pre-test information is required in either or both oral and written forms; 21 (46 percent) reported a requirement for provision of oral pre-test information and five (11 percent) reported a requirement for provision of pre-test information in written form.

Figure 3: "How is pre-test information required to be provided?" (n=46)



Fifty-five (96 percent) health departments responded to questions about disclosure of HIV test results by mail, telephone or similar means (not face-to-face). Of these, 41 state health departments (75 percent) reported no statutory or regulatory prohibitions regarding provision of HIV test results via telephone, mail or other similar means. When this question was asked in 2007, 30 jurisdictions reported no statutory or regulatory prohibitions regarding provision of HIV test results via telephone, mail or other similar means. Twenty-one (38 percent) health departments (state and local) reported that disclosure of HIV test results by mail, telephone or similar non face-to-face means was not prohibited by policy in their jurisdictions.

Health departments were asked whether the offering of HIV testing in health care settings with right of refusal (i.e., “opt-out”) was allowed by statute or regulation in jurisdictions for any specific population. Of the 47 state health departments that responded to this question, 34 (72 percent) reported that the routine offering of HIV testing in health care settings with right of refusal is allowed by statute or regulation in their jurisdictions for any specific population(s).

Fifty (88 percent) health departments⁶ responded to questions about whether the routine offering of HIV testing in health care settings is allowed by policy in their jurisdictions. Of these, 38 health departments (76 percent) reported that the routine offering of HIV testing in health care settings with right of refusal is allowed by policy.⁷ Thirty-nine health departments⁸ (70 percent) responded to questions regarding for which populations a routine offering of HIV testing is required by statute, regulation or policy. The findings are presented in Table 2.

Table 2: Populations for which routine offering of HIV testing is required by statute, regulation or policy	% Responding (n=39)
Pregnant women	59% (23)
STD clients	39% (15)
Delivering women	33% (13)
Incarcerated persons	28% (11)
Newborns	15% (6)
Substance abuse treatment clients	15% (6)
Persons ages 13–64	15% (6)

By comparison, in 2007, seven health departments reported a statute, regulation or policy that required the routine offering of HIV testing to pregnant women and two reported the same for incarcerated persons. Routine offering of HIV testing for incarcerated persons, newborns and STD clients was required each by one health department.

Fifty-six (98 percent) health departments responded to a question about whether there are efforts currently underway to change HIV testing statutes, regulations or policies. Of these, twenty-seven (48 percent) health departments reported that there are efforts currently underway to change HIV testing statutes, regulations or policies in their jurisdictions. In 2007, health departments were asked whether they planned to pursue legislative or regulatory changes to enable implementation of the CDC recommendations. At that time, 18 state health departments reported such plans.

Implementing HIV Testing in Health Care Settings

Health departments were asked to respond to a series of questions regarding current HIV testing efforts within health care settings. Fifty-five health departments (96 percent) reported supporting

6 Localities included.

7 Two state-locality pairs provided consistent responses to a statutory prohibition on opt out testing (“no”), but the local jurisdiction provided an affirmative response to local policies that allow for opt-out testing. For one of these pairs (NY/ NYC) New York State law requires a separate written consent for all voluntary HIV testing. This essentially precludes opt-out testing. However, the NYC DOHMH STD clinics, received exemption from the State which allowed for the incorporation of the HIV consent into the general medical consent, thus allowing opt-out testing. However, in September 1, 2010, a new law was enacted in New York State. Now, State law mandates the offer of an HIV test to all patients aged 13-64 seen in emergency departments, admitted as inpatient, and seen in primary care settings. The law also now allows for consent to be obtained in multiple ways, including documented oral consent for rapid tests (antibody tests that can produce a result in 60 minutes or less), HIV consent incorporated into a general medical consent, or a separate consent for HIV. Similarly, one state-locality pair (IL/CHI) provided consistent responses to a permissive statute, but the local jurisdiction reported no local level policy permitting opt-out testing. In this case, the State of Illinois has allowed for opt-out testing since June 1, 2008. However, each of the agencies that the City of Chicago worked with for the PS-07768 Expanded HIV Testing Initiative had internal policies that did not allow for this to occur. All clients were required to sign an additional consent form. This includes the Chicago Department of Public Health STI Specialty Clinics.

8 Localities included.

HIV testing efforts in health care settings. By comparison, 35 health departments reported providing HIV testing in health care settings when surveyed in 2007.

The types of settings in which health departments are supporting screening efforts are described in Table 3.

Table 3: Health care settings in which the health department is supporting HIV testing	% Responding (n=55)
STD clinics	93% (51)
Community health clinics	87% (48)
Substance abuse treatment centers	87% (48)
Corrections	82% (45)
Family planning clinics	80% (44)
Hospital emergency departments	64% (35)
TB clinics	55% (30)
Primary care clinics	40% (22)
Prenatal/obstetrical clinics	35% (19)
Labor and delivery	31% (17)
Hospital outpatient settings	27% (15)
Urgent care clinics	22% (12)
Hospital inpatient settings	20% (11)
Other (e.g., ASO, CBOs, mobile vans)	27% (15)

A majority of health departments reported continuing to support HIV testing in traditional public health settings such as STD, substance abuse treatment, family planning and correctional facility clinics. When compared with 2007, however, large gains were seen in the number of health departments reporting supporting HIV testing in health care settings, especially community health clinics (48 versus 21), emergency departments (35 versus 8), labor and delivery (17 versus 20) and hospital outpatient settings (15 versus 2).

Health departments were asked about their efforts to support routine HIV testing in health care settings. Forty-three health departments (75 percent) reported supporting the routine offering of HIV testing to all patients aged 13-64 years, without regard to clinical signs or symptoms or behavioral risk in at least one or more clinical venues.⁹

As illustrated in Table 4, a majority reported supporting the routine offering of HIV testing in the traditional public health venues of STD and substance abuse treatment clinics.

⁹ The 14 health departments that did not report supporting routine HIV testing anywhere were not funded under CDC's Expanded Testing Initiative, which may suggest the importance of these resources in stimulating the implementation of routine HIV testing in health care settings. Thirteen of these jurisdictions are low-prevalence jurisdictions.

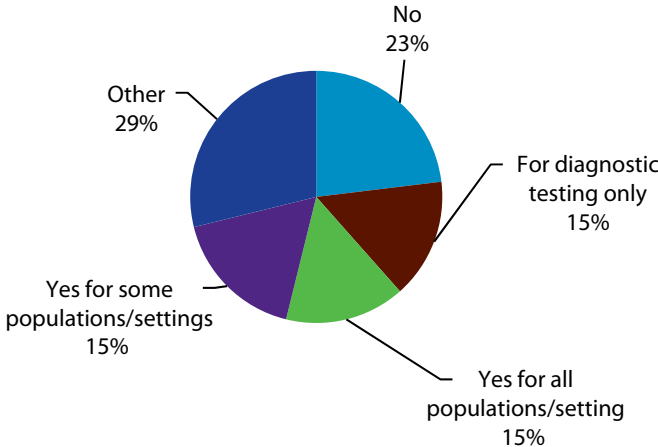
Table 4: Health care settings in which the health department reported supporting routine HIV testing	% Responding (n=43)
STD clinics	79% (34)
Hospital emergency departments	60%(26)
Community health clinics	60% (26)
Substance abuse treatment centers	51% (22)
Corrections	51% (22)
Family planning clinics	51% (22)
TB clinics	42% (18)
Prenatal/obstetrical clinics	35% (15)
Primary care clinics	28% (12)
Labor and delivery	28% (12)
Urgent care clinics	19% (8)
Hospital inpatient settings	19% (8)
Hospital outpatient settings	16% (7)
Other (e.g., ASO, CBOs)	30% (13)

A majority of respondents also reported the routine offering of HIV testing in hospital emergency departments and community health clinics. A substantial minority of respondents reported implementing the routine offering of HIV testing in labor and delivery settings, hospital inpatient, hospital outpatient and urgent care settings.

Reimbursement

One question assessed whether state Medicaid programs reimbursed for HIV screening. As illustrated in Figure 4, eight health departments (15 percent) reported that their state Medicaid program reimburses for routine HIV testing in all settings and populations. Nine reported reimbursement in some settings and populations (15 percent) and eight (15 percent)¹⁰ reported reimbursement for diagnostic testing only. Twelve health departments (23 percent) reported

Figure 4: "Does your state Medicaid program reimburse for routine offering of HIV testing?" (n=52)



10 Due to rounding, both nine and eight equal 15 percent.

that their state Medicaid programs do not reimburse for routine HIV testing. Of the 15 health departments reporting “other,” 12 indicated that they did not know or were unsure whether their state Medicaid programs provided reimbursement for routine HIV testing.

Thirteen jurisdictions responded to a question regarding the Medicaid reimbursement rate, per test, for an HIV test performed as a screening test (i.e., not for diagnostic purposes). Ten jurisdictions were able to provide figures, of which four provided estimates only. The minimum reported was \$5.98 and the maximum was \$105 (estimate). Of those respondents that were able to provide a specific dollar figure, most reported a reimbursement rate of under \$20.

Health departments were asked whether any private insurers provided reimbursement for routine HIV testing. Of the 55 responding, 42 (74 percent) did not know if any private insurers in their jurisdictions reimbursed for routine HIV testing; three (five percent) knew that they did not; four (seven percent) reported that private insurers provide reimbursement for routinely offered HIV tests in all settings and populations and six (11 percent) reported that in their jurisdictions, private insurance will provide reimbursement in some settings and/or for some populations.

Barriers to HIV Testing

Health departments were asked to respond to questions about barriers to implementing HIV testing in health care settings (both in terms of HIV testing in general as well as in the context of routine HIV testing). As illustrated in Table 5, the vast majority of health departments (53, or 92 percent) identified one or more barriers. Lack of funding and insurance reimbursement were identified as the most important barriers to implementing HIV testing in health care settings. Resistance of health care providers and health care facilities also featured prominently.

Table 5: Barriers to implementation of HIV testing in health care settings?	% Responding (n=53)
Lack of adequate funding to support implementation	89% (47)
Health care provider resistance	66% (35)
Health care facility resistance	60% (32)
Lack of reimbursement from Medicaid or other insurers	53% (28)
Inadequate reimbursement from Medicaid/other insurers	40% (21)
Lack of training/technical assistance	34% (18)
Lack of models for operationalizing HIV testing	25% (13)
Lack of data to identify appropriate facilities	23% (12)
Access to care/treatment for HIV-infected persons	19% (10)
Consent requirements	15% (8)
Community resistance	11% (6)

Health departments were asked about barriers to implementing routine¹¹ HIV testing and were specifically asked to rank the top five barriers to implementing routine testing in health care settings. Fifty-two (91 percent) health departments responded to the question. Thirty-eight health departments ranked “lack of adequate funding” among the top three barriers, with 21 (40 percent)

11 For the purposes of this survey, “routine” is defined as HIV testing conducted without regard to clinical symptoms and/or behavioral risk.

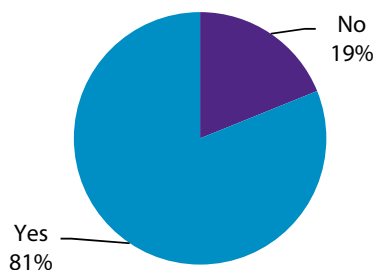
ranking it as the number one barrier. “Health care provider resistance” was ranked by 25 health departments as one of the top three barriers, with 13 (25 percent) identifying it as the second most important barrier. “Health care facility resistance” was ranked by 22 health departments as one of the top three barriers, with eight (15 percent) identifying it as the third most important barrier.

Health departments were asked to identify which settings have been the most challenging in which to implement routine HIV testing. Forty-eight health departments (84 percent) responded to the question. Thirty health departments ranked emergency departments among the top three most challenging environments in which to implement HIV testing, of which, 22 (46 percent) reported that they were the most challenging. Correctional facilities were ranked by 16 health departments as one of the top three most challenging environments while community health clinics were ranked among the top three by 15 health departments.

Health departments were asked to indicate whether they had experienced resistance from health care providers in implementing routine HIV testing. Fifty-three health departments (92 percent) responded to the question. As illustrated in Figure 5, the vast majority of health departments (43, or 81 percent) reported that they had experienced resistance from health care providers in implementing routine HIV testing, while only ten (19 percent) reported that they had not.

In contrast, when questioned about provider resistance in 2007, 21 (64 percent) health departments responded affirmatively that they had experienced provider resistance to implementing routine HIV testing.

Figure 5: "Have you experienced resistance from health care providers in implementing routine HIV testing?" (n=53)



Forty-two (73 percent) health departments responded to the question about what providers most commonly cited as reasons for not wanting to implement routine HIV testing. Responses are presented in Table 6. Competing priorities and the potential for disruption of clinic flow were among the most frequently cited reasons for providers not wanting to implement routine HIV testing. Provider perception of patients not being at risk and the lack of reimbursement for testing were also equally important reasons for providers not wanting to implement routine HIV testing.

Table 6: Reasons most commonly cited by providers for not wanting to implement routine HIV testing	% Responding (n=42)
Competing priorities	69% (29)
Potential for disruption in clinic flow	69% (29)
Patients not at risk	52% (22)
Lack of reimbursement for testing	52% (22)
Cost	50% (21)
Lack of comfort in addressing HIV	33% (17)
Lack of comfort in addressing sexual issues	33% (17)
Counseling requirements	29% (12)
Consent requirements	17% (7)
Lack of access to care and treatment	14% (6)

Consent requirements were cited by a minority of respondents as a reason for provider resistance in implementing routine HIV testing. In comparison, in 2007, 53 percent of health departments identified this as a commonly cited reason for provider resistance to routine HIV testing. Counseling requirements were cited by 19 percent of respondents and lack of reimbursement by 38 percent.

In the 2010 survey, 54 (95 percent) health departments responded to the question: “In the next 12 months, does the health department plan to expand implementation of routine HIV testing in your jurisdiction?” Of these respondents, 32 (59 percent) responded affirmatively. Of the 32 that intend to expand routine HIV testing, 24 (75 percent) named hospital emergency departments and 19 (59 percent) named community health clinics as their top priorities for expansion. Another 14 (44 percent) reported plans to expand in correctional facilities, 13 (41 percent) in primary care clinics and 11 (34 percent) in each of STD and dental clinics.

Evaluation

Health departments were asked whether an evaluation of efforts to implement HIV testing in health care settings, including routine approaches, had been conducted. Fifty-five jurisdictions (96 percent) responded to this question, of which 13 (24 percent) reported that an evaluation had been conducted.

Discussion

Legal Environment for HIV Testing

CDC's *Revised Recommendations for HIV Testing of Adults, Adolescents and Pregnant Women in Health Care Settings* (2006 CDC Recommendations) suggested that specific, written consent is a barrier to HIV testing in health care settings and therefore recommended that consent for HIV testing be incorporated into general consent for medical care. Similarly, CDC's *Recommendations* suggested that counseling is a barrier to HIV testing in health care settings and therefore recommended that HIV testing be performed in clinical settings without such counseling.

Since NASTAD conducted its 2007 survey, significant changes have been made to state laws and regulations associated with HIV testing, particularly regarding informed consent and counseling requirements. This has resulted in a legal environment that is largely responsive to the CDC recommendations and should be conducive to provision of HIV testing as a standard of medical care. In addition, findings from the 2010 survey indicate that efforts are under way in nearly one-half of states to further change statutes, regulations or policies associated with HIV testing.

Based on the findings of this survey, it appears that the number of states that require specific consent for HIV testing has decreased by one-half, from 34 states in 2007 to 17 in 2010. Many have eliminated the requirement to obtain written consent for HIV testing, at least in health care settings. Interestingly, many states have retained requirements, either by statute and/or by policy, applicable to publicly funded providers, to obtain written consent for HIV testing.

Similarly, legal requirements associated with “pre-test counseling” have eased significantly with 27 percent of health departments reporting a legal mandate to provide some type of information and/or counseling prior to HIV testing compared to 42 percent in 2007. Again, many states have retained requirements either by statute and/or by policy, applicable to publicly funded providers, to provide pre-test information and/or counseling.

State-level statutory reform has addressed key barriers to implementing HIV testing in health care settings identified by providers. With these barriers removed, one could reasonably expect to see an increase in HIV testing conducted in health care settings. In the report based on the 2007 survey data, NASTAD raised the question of whether consent and counseling requirements were actual or perceived barriers, particularly in light of the fact that many jurisdictions had been able to implement routine HIV testing in health care settings while maintaining requirements for written informed consent. At present, there is little evidence that changing consent and counseling requirements has resulted in an appreciable increase in the number of health care facilities providing HIV testing, in the number of tests conducted, or in the number of previously undiagnosed infections.¹²

In fact, the 2010 survey suggests that operational concerns, coupled with provider attitudes and skills, are more important barriers to the implementation of HIV testing in health care settings. Additionally, the most important policy barrier was, and continues to be, financing. Little progress has been made nationally since the 2007 survey was conducted in persuading state Medicaid

¹² Institute of Medicine Committee on HIV Screening and Access to Care. *HIV Screening and Access to Care: Exploring Barriers and Facilitators to Expanding HIV Testing*.

programs to reimburse routine HIV testing and/or to do so at an acceptable rate. Similarly, it appears that there are still few private insurers who will provide reimbursement for screening. This may be an important area to prioritize for legal or policy reform.

Implementing HIV Testing in Health Care Settings

Fifty-five health departments (96 percent) reported supporting HIV testing efforts in health care settings, compared with 35 in 2007. Many health departments appear to have been relatively successful in implementing HIV testing, including routine testing in health care settings, particularly in STD clinics. A majority of health departments also reported successfully implementing HIV testing in emergency departments and community health clinics. This illustrates that health departments appreciate the potential value that programming in these settings has relative to identifying previously undiagnosed infection and for providing access to testing for individuals who would not seek services through traditional public health venues or through community-based testing programs.

Health departments have been an important source of support for HIV testing efforts in health care settings, especially in stimulating uptake in emergency departments and community health centers through the Expanded Testing Initiative resources. While health departments have contributed considerable state and local funding to these efforts, federal funding has also been critical. The findings of this survey highlight that financing HIV testing is a critical issue both in terms of further expanding HIV testing, but also in terms of sustaining current efforts. Reliance on public funding, whether federal, state or local, makes HIV testing in health care settings extremely vulnerable. Relatively few jurisdictions indicated that Medicaid or other insurers reimburse routine HIV testing.

Health departments appear to have relatively limited knowledge of health insurance as it relates to reimbursement of HIV testing. In fact, a fair number of respondents reported that they knew very little about their own state Medicaid program as it relates to reimbursement of HIV testing services. This suggests a need to support health departments in building relationships with the insurance industry and working collaboratively with other partners to positively influence insurers' practices around reimbursement, including reimbursement rates. Learning from states that have forged partnerships with insurers and that have been successful in working with their state Medicaid programs around these issues may be an important strategy for addressing this critical financing issue.

These survey results suggest that operational concerns, coupled with provider attitudes and skills, are important barriers to implementing HIV testing in health care settings. The vast majority (81 percent) of health departments indicated that they had encountered provider resistance in implementing routine HIV testing, compared with 64 percent in 2007. The nature of the resistance relates to operational issues such as the potential for disruption of clinic flow and experiencing competing priorities.

This suggests a need to develop, evaluate and make available to providers and facility administrators multiple implementation models and tools that will support implementation of HIV testing in a way that matches individual facility needs and capacities. Additionally, it should be recognized that expanded testing efforts supported by the CDC have heavily emphasized use of rapid HIV tests at the point of care. The use of conventional technologies in a centralized laboratory may make HIV testing more feasible in some settings, such as emergency rooms. Emerging technologies and associated testing algorithms should be examined and included among tools available for implementation planning as this may facilitate implementation of HIV testing by addressing

operational barriers.¹³

Provider attitudes about HIV and sexual health also appear to be significant barriers. A majority of health departments reported that provider perception that their patients are not at risk for HIV is a barrier to implementing HIV testing. A substantial majority of health departments also indicated that providers are resistant to implementing HIV testing due to their own lack of comfort with HIV specifically, and with sexual health issues, more generally. This suggests that provider education and awareness efforts may be an important strategy for encouraging and supporting HIV testing in health care settings.

Finally, CDC recommends routine HIV testing in populations/settings where prevalence is one per 1,000. At present, there is little evidence that a screening approach, compared to testing using a diagnostic approach, will result in an appreciable increase in the number of previously undiagnosed infections or in linking with care earlier in the course of infection.¹⁴ Given the operational challenges, coupled with the fiscal realities, it is important to carefully examine and evaluate the relative effectiveness of this approach. Health departments can and should play a central role in such evaluation efforts, given the range of facilities in which they support HIV testing, as well as the diversity of implementation models.

13 For more information, see NASTAD's report: *HIV Testing in Hospital Emergency Departments*.

14 Haukoss, J. et al. Routine Opt-Out Rapid HIV Screening and Detection of HIV Infection in Emergency Department Patients. *JAMA*. 2010; 304 (3):284-292.

Issues for Consideration

The findings from this survey demonstrate clearly that health departments continue to value HIV testing in health care settings, including routine approaches, and are committed to continuing to support these efforts. Based on the findings of this survey, the following recommendations should be considered priorities to support health departments in implementing and/or expanding HIV testing in health care settings:

1. Continue to support and encourage health departments in implementing HIV testing in health care settings. However, such efforts must not be at the expense of other critical primary prevention efforts, including targeted HIV testing programs.
2. Collaborate with professional organizations at the state and national levels to develop education and training opportunities supporting HIV testing to facilitate buy-in from providers. Training and education must address not only provider awareness of patient risk for HIV, but also build their skills and comfort in addressing HIV and sexual health issues with their patients.
3. Collaborate with professional organizations, CDC, AIDS Education Training Centers (AETCs) and others to continue providing peer-mediated technical assistance and education to support the implementation of HIV testing. Opportunities must address the key operational challenges identified by providers in order to identify strategies to successfully integrate HIV testing into existing clinic flow.
4. Collaborate with CDC, the Association for Public Health Laboratories (APHL) and others to identify and support technology transfer for emerging testing technologies. Point-of-care rapid testing, which has been emphasized in conjunction with federally supported expanded testing activities, may not be feasible or appropriate for all settings and populations. Conventional and emerging technologies may help to address provider concerns about point-of-care rapid testing disrupting clinic flow.
5. Collaborate with professional organizations, CDC and others to provide peer-mediated technical assistance to health departments and their implementing partners to make data-driven decisions regarding implementing HIV testing in health care settings, including routine approaches, in order to optimize resources.
6. Continue to support and engage in state and national/federal-level advocacy to require Medicaid and other third-party payers to reimburse health care providers for routine HIV testing and to do so at adequate rates. Health departments and their implementing partners require assistance and support in identifying effective advocacy strategies.

Limitations

There are a number of limitations to these findings. All data were self-reported and are subject to the knowledge and interpretation of the individual(s) who completed the questionnaire. Furthermore, responses provided, particularly as they relate to explanation of statutes and regulations, may be incomplete or may not completely and accurately represent those statutes and regulations, which are often complex and nuanced. Additionally, there was variation between some of the questions asked in the 2007 survey and the 2010 survey; therefore some of the responses are not directly comparable.

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National Alliance of State and Territorial AIDS Directors (NASTAD)
444 North Capitol Street, NW, Suite 339
Washington, DC 20001-1512
(202) 434-8090 (phone)
(202) 434-8092 (fax)
www.NASTAD.org

Julie M. Scofield, Executive Director
Ann Robbins (Texas), Chair



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& TERRITORIAL AIDS DIRECTORS