Revised Recommendations for HIV Testing in Healthcare Settings in the U.S.

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National Center for HIV, STD, and TB Prevention
Centers for Disease Control and Prevention
Presentation Outline

- Where we are now –
  - HIV epidemic
  - Current testing
  - Previous recommendations and their effects
- The case for increased HIV testing
- Rationale for revised recommendations
- CDC’s New Recommendations
Estimated Number of AIDS Cases, Deaths, and Persons Living with AIDS, 1985-2004, United States

Note. Data adjusted for reporting delays.
Awareness of HIV Status among Persons with HIV, United States

Number HIV infected 1,039,000 – 1,185,000

Number unaware of their HIV infection 252,000 - 312,000 (24%-27%)

Estimated new infections annually 40,000

Glynn M, Rhodes P. 2005 HIV Prevention Conference
Awareness of Serostatus Among People with HIV and Estimates of Transmission

- ~25% Unaware of Infection
- ~75% Aware of Infection

People Living with HIV/AIDS: 1,039,000-1,185,000

New Sexual Infections Each Year: ~32,000

Accounting for:
- ~54% of New Infections
- ~46% of New Infections

Marks, et al
AIDS 2006;20:1447-50
HIV/AIDS Diagnoses among Adults and Adolescents, by Transmission Category — 33 States, 2001–2004

**Males (n ≈ 112,000)**
- MSM: 61%
- IDU: 16%
- Heterosexual: 17%
- MSM/IDU: 5%
- Other: 1%

**Females (n ≈ 45,000)**
- Heterosexual: 76%
- IDU: 21%
- Other: 3%

MMWR, Nov 18, 2005
HIV Prevalence, NHANES 1999-2002

- McQuillan et al, NCHS: JAIDS April 2006

In several U.S. cities, recent outbreaks of primary and secondary syphilis among men who have sex with men (MSM) (1) and increases in newly diagnosed human immunodeficiency virus (HIV) infections among MSM and among heterosexuals have created concern that HIV incidence might be increased rapidly during the 1980s. During 1981–2001, an estimated 1.3–1.4 million persons in the United States were infected with HIV (3), and 816,149 cases of AIDS and 467,910 deaths were reported to CDC (4). During the late 1990s, after the introduction of combination antiretroviral
Four priorities:

1. Make voluntary HIV testing a routine part of medical care
2. Implement new models for diagnosing HIV infections outside medical settings
3. Prevent new infections by working with persons diagnosed with HIV and their partners
4. Further decrease perinatal HIV transmission
Current Testing
Terminology - I

- **Diagnostic testing**: performing an HIV test based on clinical signs or symptoms
- **Screening**: performing an HIV test for all persons in a defined population
- **Targeted testing**: performing an HIV test on subpopulations of persons at higher risk based on behavioral, clinical or demographic characteristics
- **Opt-out screening**: performing an HIV test after notifying the patient that the test will be done; consent is inferred unless the patient declines
Terminology - II

- **Informed consent**: process of communication between patient and provider through which the patient can participate in choosing whether or not to undergo HIV testing.

- **HIV prevention counseling**: interactive process to assess risk, recognize risky behaviors, and develop a plan to take steps that will reduce risks.
Source of HIV Tests and Positive Tests

- 38% - 44% of adults age 18-64 have been tested
- 16-22 million persons age 18-64 tested annually in U.S.

<table>
<thead>
<tr>
<th>Source</th>
<th>HIV tests*</th>
<th>HIV+ tests**</th>
</tr>
</thead>
<tbody>
<tr>
<td>Private doctor/HMO</td>
<td>44%</td>
<td>17%</td>
</tr>
<tr>
<td>Hospital, ED, Outpatient</td>
<td>22%</td>
<td>27%</td>
</tr>
<tr>
<td>Community clinic (public)</td>
<td>9%</td>
<td>21%</td>
</tr>
<tr>
<td>HIV counseling/testing</td>
<td>5%</td>
<td>9%</td>
</tr>
<tr>
<td>Correctional facility</td>
<td>0.6%</td>
<td>5%</td>
</tr>
<tr>
<td>STD clinic</td>
<td>0.1%</td>
<td>6%</td>
</tr>
<tr>
<td>Drug treatment clinic</td>
<td>0.7%</td>
<td>2%</td>
</tr>
</tbody>
</table>

*National Health Interview Survey, 2002  
**Suppl. to HIV/AIDS surveillance, 2000-2003
Late HIV Testing is Common
Supplement to HIV/AIDS Surveillance, 2000-2003

Among 4,127 persons with AIDS*, 45% were first diagnosed HIV-positive within 12 months of AIDS diagnosis (“late testers”)

Late testers, compared to those tested early (>5 yrs before AIDS diagnosis) were more likely to be:
- Younger (18-29 yrs)
- Heterosexual
- Less educated
- African American or Hispanic

*16 states
Reasons for testing: late versus early testers
Supplement to HIV/AIDS Surveillance, 2000-2003

- **Illness**: Late ( Tested < 1 yr before AIDS dx )
- **Self/partner at risk**: Late ( Tested < 1 yr before AIDS dx )
- **Wanted to know**: Late ( Tested < 1 yr before AIDS dx )
- **Routine check up**: Late ( Tested < 1 yr before AIDS dx )
- **Required check up**: Early ( Tested > 5 yrs before AIDS dx )
- **Other**: Early ( Tested > 5 yrs before AIDS dx )
HIV Rapid Tests
Public Health Need for Rapid HIV Tests

- High rates of non-return for test results
  - *In 2000, 31% did not return for results of HIV-positive conventional tests at publicly funded sites*
- Need for immediate information or referral for treatment choices
  - Perinatal settings
  - Post-exposure treatment settings
- Screening in high-volume, high-prevalence settings
# Four FDA-approved Rapid HIV Tests

<table>
<thead>
<tr>
<th></th>
<th>Sensitivity (95% C.I.)</th>
<th>Specificity (95% C.I.)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>OraQuick Advance</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- whole blood</td>
<td>99.6 (98.5 – 99.9)</td>
<td>100 (99.7 – 100)</td>
</tr>
<tr>
<td>- oral fluid</td>
<td>99.3 (98.4 – 99.7)</td>
<td>99.8 (99.6 – 99.9)</td>
</tr>
<tr>
<td>- plasma</td>
<td>99.6 (98.5 – 99.9)</td>
<td>99.9 (99.6 – 99.9)</td>
</tr>
<tr>
<td><strong>Uni-Gold</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Recombigen</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- whole blood</td>
<td>100 (99.5 – 100)</td>
<td>99.7 (99.0 – 100)</td>
</tr>
<tr>
<td>- serum/plasma</td>
<td>100 (99.5 – 100)</td>
<td>99.8 (99.3 – 100)</td>
</tr>
</tbody>
</table>
## Four FDA-approved Rapid HIV Tests

<table>
<thead>
<tr>
<th>Test</th>
<th>Sensitivity (95% C.I.)</th>
<th>Specificity (95% C.I.)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Reveal G2</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>serum</td>
<td>99.8 (99.2 – 100)</td>
<td>99.1 (98.8 – 99.4)</td>
</tr>
<tr>
<td>plasma</td>
<td>99.8 (99.0 – 100)</td>
<td>98.6 (98.4 – 98.8)</td>
</tr>
<tr>
<td><strong>Multispot</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>serum/plasma</td>
<td>100 (99.9 – 100)</td>
<td>99.9 (99.8 – 100)</td>
</tr>
<tr>
<td>HIV-2</td>
<td>100 (99.7 – 100)</td>
<td></td>
</tr>
</tbody>
</table>
Additional Rapid Tests

- FDA approved – May 2006

Sure Check

Stat Pak
Confirmatory Testing

- Confirmatory test is essential (not just EIA)
- For Western blot:
  - Venipuncture for whole blood
  - Oral fluid specimen
- Follow-up testing of persons with negative or indeterminate Western blot results after 4 weeks
Postmarketing Surveillance: 2004-2005

Project-specific median (range) for confirmed HIV seropositivity, specificity and positive predictive value of OraQuick (347 testing sites, 14 project areas)

<table>
<thead>
<tr>
<th></th>
<th>No. of Tests</th>
<th>HIV Seropositive Median % (range)</th>
<th>Estimated Specificity Median % (range)</th>
<th>PPV Median % (range)</th>
</tr>
</thead>
<tbody>
<tr>
<td>RT whole blood</td>
<td>135,724</td>
<td>0.8 (0.1-2.6)</td>
<td>99.98 (99.7-100)</td>
<td>99.2 (66.7-100)</td>
</tr>
<tr>
<td>RT oral fluid</td>
<td>26,066</td>
<td>1.0 (0-4.0)</td>
<td>99.89 (99.4-100)</td>
<td>90.0 (50.0-100)</td>
</tr>
<tr>
<td>Conventional</td>
<td>31,811</td>
<td>1.5 (0.5-5.1)</td>
<td>---</td>
<td>---</td>
</tr>
</tbody>
</table>

Wesolowski et al, AIDS 2006
HIV Screening with OraQuick in MIRIAD
Mother Infant Rapid Intervention At Delivery

Testing of pregnant women in labor for whom no HIV test results are available; 12 hospitals in 5 cities

7680 women screened

- 54 (0.7%) new HIV infections identified
- 6 false positive OraQuick tests, no false negatives
- 15 false-positive EIAs

Specificity: OraQuick 99.92%; EIA 99.80%
Positive predictive value: OraQuick 90%; EIA 76%

Bultery et al, JAMA July 2004
Post-marketing Surveillance: 2004-2005

Project-area specific median (range) of clients who received test results
(368 testing sites in 17 project areas)

<table>
<thead>
<tr>
<th></th>
<th>Received Negative Results</th>
<th>Received Preliminary Positive Results</th>
<th>Received Confirmed Positive Results</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Median % (range)</td>
<td>Median % (range)</td>
<td>Median % (range)</td>
</tr>
<tr>
<td>Rapid</td>
<td>99.5 (93.7-100)</td>
<td>100 (89.8-100)</td>
<td>89.7 (49.4-100)</td>
</tr>
<tr>
<td>EIA*</td>
<td>77.3 (30.4-98.5)</td>
<td>---</td>
<td>81.0 (33.3-100)</td>
</tr>
</tbody>
</table>

*16 project areas
Role for Rapid HIV Tests

- Increase receipt of test results
- Increase identification of HIV-infected pregnant women so they can receive effective prophylaxis
- Increase feasibility of testing in acute-care settings with same-day results
- Increase number of venues where testing can be offered to high-risk persons
Previous Guidelines and their Effects
Previous Recommendations

Recommendations for HIV Testing Services for Inpatients and Outpatients in Acute-Care Hospital Settings

and

Technical Guidance on HIV Counseling

Revised Guidelines for HIV Counseling, Testing, and Referral

and

Revised Recommendations for HIV Screening of Pregnant Women
Previous CDC Recommendations
Adults and Adolescents

- Routinely recommend HIV screening in settings with high HIV prevalence (≥1%)
- Targeted testing based on risk assessment
- Routinely recommend HIV Testing seeking treatment for STDs
- Annual testing for sexually active MSM
Are Recommendations Having Their Intended Effect?

Advance Data
From Vital and Health Statistics

Number 340  ●  March 18, 2004

National Hospital Ambulatory Medical Care Survey:
2002 Emergency Department Summary

by Linda F. McCaig, M.P.H., and Catharine W. Burt, Ed.D., Division of Health Care Statistics
Recommendations Are Not Having Their Intended Effect in Acute Care Settings

- EDs account for 10% of all ambulatory care visits

<table>
<thead>
<tr>
<th></th>
<th>2000</th>
<th>2001</th>
<th>2002</th>
</tr>
</thead>
<tbody>
<tr>
<td>ED visits</td>
<td>108 million</td>
<td>107 million</td>
<td>110 million</td>
</tr>
<tr>
<td>Age 15-64</td>
<td>68.3 million</td>
<td>69.4 million</td>
<td>69.6 million</td>
</tr>
<tr>
<td>HIV serology</td>
<td>215,000</td>
<td>201,000</td>
<td>163,000</td>
</tr>
</tbody>
</table>

EDs account for 10% of all ambulatory care visits.
### Characteristics, Rapid Test Positive Patients Identified in ED Screening

<table>
<thead>
<tr>
<th>Risk Factor</th>
<th>Count (Percentage)</th>
</tr>
</thead>
<tbody>
<tr>
<td>No previous test</td>
<td>47 (57%)</td>
</tr>
<tr>
<td>Risk factors</td>
<td>N= 83</td>
</tr>
<tr>
<td>MSM</td>
<td>30 (34%)</td>
</tr>
<tr>
<td>IDU</td>
<td>8 (10%)</td>
</tr>
<tr>
<td>High risk hetero partner</td>
<td>3 (4%)</td>
</tr>
<tr>
<td>No identified risk</td>
<td>42 (51%)</td>
</tr>
</tbody>
</table>

- Cook County Bureau of Health Services, 2003
HIV Testing Practices in EDs

- Survey of 95 Academic EDs

- For patients with suspected STDs:
  - 93% screen for gonorrhea
  - 88% screen for chlamydia
  - 58% screen for syphilis
  - 3% screen for HIV

HIV Testing Practices in EDs

- Survey of 154 ED providers
  - Average: 13 STD patients per week
  - Only 10% always recommend HIV test

- Reasons for not testing for HIV:
  - 51% concerned about follow up
  - 45% not a “certified” counselor
  - 19% too time-consuming
  - 27% HIV testing not available

-Fincher-Mergi et al, 2002: AIDS Pat Care STDs
### HIV Prevalence and Proportion of Unrecognized HIV Infection Among 1,767 MSM, by Age Group and Race/Ethnicity

**NHBS, Baltimore, LA, Miami, NYC, San Francisco**

<table>
<thead>
<tr>
<th>Age Group (yrs)</th>
<th>Total Tested</th>
<th>HIV Prevalence</th>
<th>Unrecognized HIV Infection</th>
</tr>
</thead>
<tbody>
<tr>
<td>18-24</td>
<td>410</td>
<td>57 (14)</td>
<td>45 (79)</td>
</tr>
<tr>
<td>25-29</td>
<td>303</td>
<td>53 (17)</td>
<td>37 (70)</td>
</tr>
<tr>
<td>30-39</td>
<td>585</td>
<td>171 (29)</td>
<td>83 (49)</td>
</tr>
<tr>
<td>40-49</td>
<td>367</td>
<td>137 (37)</td>
<td>41 (30)</td>
</tr>
<tr>
<td>≥ 50</td>
<td>102</td>
<td>32 (31)</td>
<td>11 (34)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Race/Ethnicity</th>
<th>Total Tested</th>
<th>HIV Prevalence</th>
<th>Unrecognized HIV Infection</th>
</tr>
</thead>
<tbody>
<tr>
<td>White</td>
<td>616</td>
<td>127 (21)</td>
<td>23 (18)</td>
</tr>
<tr>
<td>Black</td>
<td>444</td>
<td>206 (46)</td>
<td>139 (67)</td>
</tr>
<tr>
<td>Hispanic</td>
<td>466</td>
<td>80 (17)</td>
<td>38 (48)</td>
</tr>
<tr>
<td>Multiracial</td>
<td>86</td>
<td>16 (19)</td>
<td>8 (50)</td>
</tr>
<tr>
<td>Other</td>
<td>139</td>
<td>18 (13)</td>
<td>9 (50)</td>
</tr>
</tbody>
</table>

**Total** 1,767 450 (25) 217 (48)

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*MMWR June 24, 2005*
Previous CDC Recommendations
Pregnant Women

- Routine, voluntary HIV testing as a part of prenatal care, as early as possible, for all pregnant women
- Simplified pretest counseling
- Flexible consent process
Estimated Number of Perinatally Acquired AIDS Cases, by Year of Diagnosis, 1985-2004 – United States

- PACTG 076 & USPHS ZDV Recs
- CDC HIV screening Recs

- ~95% reduction

Year of Diagnosis
The Case for HIV Screening
Criteria that Justify Routine Screening

1. Serious health disorder that can be detected before symptoms develop
2. Treatment is more beneficial when begun before symptoms develop
3. Reliable, inexpensive, acceptable screening test
4. Costs of screening are reasonable in relation to anticipated benefits

*Principles and Practice of Screening for Disease*
- WHO Public Health Paper, 1968
Example: Newborn Screening

Newborn screening results, 1994

- 3.7 million infants screened, twice

<table>
<thead>
<tr>
<th>Condition</th>
<th>Cases</th>
<th>Incidence</th>
<th>PPV</th>
</tr>
</thead>
<tbody>
<tr>
<td>PKU</td>
<td>289</td>
<td>1:13,050</td>
<td>2.65%</td>
</tr>
<tr>
<td>Galactosemia</td>
<td>54</td>
<td>1:62,800</td>
<td>0.57%</td>
</tr>
<tr>
<td>Hypothyroidism</td>
<td>1203</td>
<td>1:3,300</td>
<td>1.77%</td>
</tr>
<tr>
<td>Adrenal Hyperplasia</td>
<td>51</td>
<td>1:25,100</td>
<td>0.53%</td>
</tr>
</tbody>
</table>

-Arch Pediatr Adolesc Med, 2000
Example: Chlamydia Screening

- First recognized as major cause of STDs in 1970s (Schachter, 1975)
- Screening tests (other than culture) became available in the 1980’s – 1990’s
- Screening criteria developed based upon results of pilot screening programs
- Like HIV: Primary, community (eg, school) and health care provider prevention strategies
Recommendations for Prevention and Management of *Chlamydia Trachomatis* Infections, 1993

Health care provider strategies:

- Recognize and manage associated conditions
  - MPC, PID, *urethral syndrome*, *urethritis*
- Implement screening
  - *Sexually active women* < 20 years of age
  - *Women* 20-24 who meet either criteria or
    - Inconsistent use of barrier contraception
    - *New or more than one sex partner in the past 3 months*
Rapid HIV Screening in Acute Care Settings

<table>
<thead>
<tr>
<th>Study site</th>
<th>New HIV+</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cook County ED, Chicago</td>
<td>2.3%</td>
</tr>
<tr>
<td>Grady ED, Atlanta</td>
<td>2.7%</td>
</tr>
<tr>
<td>Johns Hopkins ED, Baltimore</td>
<td>3.2%</td>
</tr>
<tr>
<td>King-Drew Med Center ED, Los Angeles</td>
<td>1.3%</td>
</tr>
<tr>
<td>Inpatients, Boston Medical Center</td>
<td>3.8%</td>
</tr>
</tbody>
</table>
## Rapid HIV Screening in Medical Settings

<table>
<thead>
<tr>
<th>Demonstration Project</th>
<th>No. tested</th>
<th>No. (%) HIV+</th>
</tr>
</thead>
<tbody>
<tr>
<td>New York City</td>
<td>3,039</td>
<td>61 (2%)</td>
</tr>
<tr>
<td>Bronx- Lebanon: 2 clinics, 1 ED</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Los Angeles</td>
<td>6,909</td>
<td>75 (1.1%)</td>
</tr>
<tr>
<td>2 clinics, 1 ED</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Alameda County (Oakland)</td>
<td>6,283</td>
<td>84 (1.3%)</td>
</tr>
<tr>
<td>1 ED</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Massachusetts</td>
<td>5,994</td>
<td>45 (0.75%)</td>
</tr>
<tr>
<td>1 outpatient, 1 inpatient, 1 clinic</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Wisconsin</td>
<td>1,763</td>
<td>6 (0.34%)</td>
</tr>
<tr>
<td>3 clinics</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*CDC, preliminary data - Dec 2005*
Lessons Learned

• Difficult to obtain written consent and provide counseling, yet still screen the large numbers of patients in acute care settings.

• Sustainability will depend on streamlined systems, additional staff, or both.
Rationale for Revising Recommendations

- Many HIV-infected persons access health care but are not tested for HIV until symptomatic.
- Effective treatment available.
- Awareness of HIV infection leads to substantial reductions in high-risk sexual behavior.
- Inconclusive evidence about prevention benefits from typical counseling for persons who test negative.
- Great deal of experience with HIV testing, including rapid tests.
Mortality and HAART Use Over Time
HIV Outpatient Study, CDC, 1994-2003

<table>
<thead>
<tr>
<th>Year</th>
<th>Deaths per 100 PY</th>
<th>Patients on HAART</th>
</tr>
</thead>
<tbody>
<tr>
<td>1994</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>1995</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>1996</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>1997</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>1998</td>
<td>4</td>
<td>0.1</td>
</tr>
<tr>
<td>1999</td>
<td>6</td>
<td>0.2</td>
</tr>
<tr>
<td>2000</td>
<td>5</td>
<td>0.3</td>
</tr>
<tr>
<td>2001</td>
<td>4</td>
<td>0.4</td>
</tr>
<tr>
<td>2002</td>
<td>3</td>
<td>0.5</td>
</tr>
<tr>
<td>2003</td>
<td>2</td>
<td>0.6</td>
</tr>
</tbody>
</table>

“The cost-effectiveness of routine HIV screening in health care settings, even in relatively low-prevalence populations, is similar to that of commonly accepted interventions, and such programs should be expanded.”

1% HIV prevalence: $15,078 per QALY

>0.05% prevalence: <$50,000 per QALY
Cost Effectiveness


“In all but the lowest-risk populations, routine, voluntary screening for HIV once every 3 to 5 years is justified on both clinical and cost-effectiveness grounds. One-time screening in the general population may also be cost-effective.”
Knowledge of HIV Infection and Behavior

After people become aware they are HIV-positive, the prevalence of high-risk sexual behavior is reduced substantially.

Reduction in Unprotected Anal or Vaginal Intercourse with HIV-neg partners: 68%
HIV-pos Aware vs. HIV-pos Unaware

Meta-analysis of high-risk sexual behavior in persons aware and unaware they are infected with HIV in the U.S.
Effect of Counseling in Conjunction with HIV testing

Meta-analysis of 27 studies of HIV-CT:

- HIV-positive participants reduced unprotected intercourse and increased condom use.
- HIV-negative participants did not modify their behavior more than untested participants.

Opt-Out Screening

Prenatal HIV testing for pregnant women:
- RCT of 4 counseling models with opt-in consent:
  - 35% accepted testing
  - Some women felt accepting an HIV test indicated high risk behavior
- Testing offered as routine, opportunity to decline
  - 88% accepted testing
  - Significantly less anxious about testing

## Routine Opt-Out HIV Testing
### Texas STD Clinics, 1996-97

<table>
<thead>
<tr>
<th></th>
<th>Opt-In N (%)</th>
<th>Opt-Out N (%)</th>
<th>% change</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>STD Visits</strong></td>
<td>31,558 (61)</td>
<td>34,533 (69)</td>
<td>+9</td>
</tr>
<tr>
<td><strong>Eligible Clients</strong></td>
<td>19,184 (61)</td>
<td>23,686 (69)</td>
<td>+23</td>
</tr>
<tr>
<td><strong>Pre-test counsel</strong></td>
<td>15,038 (78)</td>
<td>11,466 (48)</td>
<td>-24</td>
</tr>
<tr>
<td><strong>Tested</strong></td>
<td>14,927 (78)</td>
<td>23,020 (97)</td>
<td>+54</td>
</tr>
<tr>
<td><strong>Post-test counsel</strong></td>
<td>6,014 (40)</td>
<td>4,406 (19)</td>
<td>-27</td>
</tr>
<tr>
<td><strong>HIV-positive</strong></td>
<td>168 (1.1)</td>
<td>268 (1.2)</td>
<td>+59</td>
</tr>
</tbody>
</table>

*Texas Department of State Health Services, 2005*
Eligible STD Clients
Percent Tested for HIV, 1997 - 2005

Semi-annual Period

STD Clients HIV Tested (Goal 95%)
Summary of Review of Evidence

- HIV meets the criteria for screening, and effective treatment is available
- Many patients with HIV visit healthcare providers but their infection goes undetected
- People decrease their risk behaviors when they find out they are infected with HIV
- HIV screening in healthcare settings is cost-effective
- Opt-out screening increases testing rates
Process for Revising Recommendations

- Consultation with providers, March 2004
- HIV Prevention Leadership Summit, San Francisco, August 2005
- Community consultation, Atlanta, September 2005
- Professional consultation, Atlanta, November 2005
- Peer review by recognized experts
- Public comment on revised draft, March 2006
- Final recommendations, September 2006
Revised Recommendations
Adults and Adolescents - I

- Routine, voluntary HIV screening for all persons 13-64 in health care settings, not based on risk
- Repeat HIV screening of persons with known risk at least annually
- Opt-out HIV screening with the opportunity to ask questions and the option to decline
- Include HIV consent with general consent for care; separate signed informed consent not recommended
- Prevention counseling in conjunctions with HIV screening in health care settings is not required
Revised Recommendations
Adults and Adolescents - II

- Intended for all health care settings, including inpatient services, EDs, urgent care clinics, STD clinics, TB clinics, public health clinics, community clinics, substance abuse treatment centers, correctional health facilities, primary care settings

- Communicate test results in same manner as other diagnostic/screening tests

- Provide clinical HIV care or establish reliable referral to qualified providers
Revised Recommendations
Adults and Adolescents - III

- Low prevalence settings:
  - Initiate screening
  - If yield from screening is less than 1 per 1000, continued screening is not warranted

- Steps should be considered to resolve conflicts between the recommendations and state or local regulations
Revised Recommendations
Pregnant Women - I

- Universal opt-out HIV screening
  - Include HIV in routine panel of prenatal screening tests
  - Consent for prenatal care includes HIV testing
  - Notification and option to decline

- Second test in 3rd trimester for pregnant women:
  - Known to be at risk for HIV
  - In jurisdictions with elevated HIV incidence
  - In high HIV prevalence health care facilities
Revised Recommendations
Pregnant Women - II

- Opt-out rapid testing with option to decline for women with undocumented HIV status in L&D
  - Initiate ARV prophylaxis on basis of rapid test result

- Rapid testing of newborn recommended if mother’s status unknown at delivery
  - Initiate ARV prophylaxis within 12 hours of birth on basis of rapid test result
Summary

- There is an urgent need to increase the proportion of persons who are aware of their HIV-infection status.
- Expanded, routine, voluntary, opt-out screening in health care settings is needed.
- Such screening is cost-effective.
- Several jurisdictions have already begun.