



Implementation of  
Routine HIV Testing in  
Health Care Settings:  
**Issues for  
Community  
Health Centers**

National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention  
Division of HIV/AIDS Prevention



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# Introduction

*“Health centers are in the best position to reach out in ways that other clinicians cannot, based on the populations we serve.”*

William Booker, MD, Medical Director at Aaron E. Henry Community Health Services Center, Clarksdale, MS

Community health centers (CHCs) are important facilities which implement routine HIV testing consistent with the 2006 recommendations issued by the Centers for Disease Control and Prevention (CDC). These CHCs serve as the primary care medical home and family physician for over 16 million people, in 6,000 sites, located in all 50 states, the District of Columbia, Puerto Rico, the U.S. Virgin Islands, and Guam. CHCs service patients who comprise some of the nation’s most vulnerable populations—people who, even if insured, remain isolated from traditional forms of medical care because of where they live, who they are, the language they speak, or their higher levels of complex health care needs. Patients who seek care in CHCs are disproportionately low income, uninsured or publicly insured, and members of minority races or ethnicities. For example:

- Ninety-two percent of health center patients are low income and 71% have family incomes at, or below, poverty level.
- Forty percent of patients are uninsured and another 36% depend on Medicaid.
- Approximately two-thirds of patients are members of racial or ethnic minority groups.
- About half of health center patients reside in rural areas and about half live in economically depressed, inner-city communities.

To better serve patients’ needs, CHCs provide health care services not normally found in primary

care settings, including dental care, behavioral health care, and pharmacy services. CHCs also offer important services such as transportation, case management, and home visits. Because of their understanding of the communities they serve, CHCs can customize and tailor their services and outreach to meet the specific linguistic, cultural, and literacy needs of their patients. CHCs provide continuous care regardless of patients’ ability to pay or of changes in insurance coverage or health status—a feature not found in most other health care settings. CHCs are community-owned and operated, and are fully committed to patient involvement in health care delivery.

The National Association of Community Health Centers, Inc. (NACHC), through funding from CDC’s Division of HIV/AIDS Prevention, completed a 1-year pilot initiative in six community health centers (19 delivery sites) to integrate HIV screening into routine primary care visits. The pilot program was launched within months of CDC’s 2006 revised recommendations and has resulted in a model, tools, and resources that health centers can use to rapidly launch routine HIV screening. The model and tools have been tested across the 19 clinical sites and can be applied to any health center or primary care entity during the planning and implementation stages. The pilot project found that integrating HIV screening into primary care visits was feasible and acceptable to patients, staff, and clinic leadership. Over the course of the pilot year, HIV testing was offered to over 17,000 non-pregnant patients (compared with fewer than 1,000 non-pregnant patients the previous year). Sixty-six percent of health centers’ patients accepted testing (range = 55–83%). For 56% of patients, this was their first HIV test.

# General Protocol Elements for Facility-based HIV Testing

Adding routine HIV testing to a primary care setting starts with identifying the flow of patients' visits. Each health center needs to map the current patient flow, identify where HIV testing is to occur, assign someone to administer the test, and determine who gives the results. In addition, documentation of results needs to be confirmed. In health centers without Ryan White funding, a tracking system needs to be developed to ensure both that results are documented and that a reminder/recall system is in place to contact persons with reactive HIV tests or those with indeterminate results.

## Why it is important that CHCs routinely offer HIV testing

CHCs are important places to offer HIV testing because the patients who receive medical care there are often members of groups that may be at high risk of HIV infection.

According to CDC's *2007 Surveillance Report*, blacks (including African Americans) account for more new HIV/AIDS diagnoses, AIDS cases, people estimated to be living with AIDS, and HIV related deaths than any other racial/ethnic group in the United States. While blacks currently comprise about 13% of the U.S. population, they account for half of all new AIDS cases. HIV death rates are still significantly higher for blacks than for other groups—this despite medical advances that have markedly reduced HIV related mortality rates for all racial/ethnic groups.

Similarly, Hispanics/Latinos in the United States are also disproportionately impacted by HIV/AIDS. They represent approximately 15% of the U.S. population, but account for 17% of the AIDS cases diagnosed in 2006.

Together, African Americans and Hispanics/Latinos comprise the overwhelming majority of CHC patients. Health centers serve 1 in 10

members of minority populations in the United States; nearly 65% of patients at CHCs are people of color. Additionally, many of the people living with HIV and AIDS live in communities served by CHCs. It is important to test CHC patients at these health centers because relationships have already been established with the community and the health center can provide a medical home.

Other populations are also at risk of HIV infection. Approximately 14% of new HIV/AIDS infections diagnosed in 2005, in 33 states with long-term, name-based HIV reporting were in persons under the age of 25. Persons who engage in high-risk, heterosexual contact make up nearly one third of all new HIV infections. Preventing new infections requires an understanding of these trends and the cultural context of HIV today, including knowledge of behavior patterns of HIV-infected and uninfected individuals. CHCs are uniquely qualified to explore and understand these trends due to the grassroots community involvement in their operations.

CDC data indicate that in 2006, roughly 21% of the estimated 1.1 million people living with HIV in the United States were unaware of being infected with HIV. CHCs have an important role to play in this public health crisis. In keeping with CDC's *2006 guidelines recommending routine HIV screening*, all patients seeking primary care services in health centers should be screened for HIV and STDs, assessed for behaviors that place them at risk, and referred to the appropriate prevention services.

Routine HIV and STD screenings not only provide the opportunity to educate patients about transmission of HIV and STDs, but also can allow people who are infected to receive care and services. Just as HIV testing of pregnant women has become a standard of care, so too should HIV and STD screening be included as a standard



of care along with cholesterol or blood sugar screenings.

Research shows that individuals who are aware of their HIV status are more likely to modify their behavior and take precautions to protect their health and to avoid infecting others. Yet it is also known that behavioral changes are not always maintained and that some persons continue to engage in risky behavior. Given these realities, it is clear that widespread use of HIV screening coupled with post-test counseling and treatment offer real potential for reducing the spread of HIV. CHCs can play a critical role in advancing these efforts.

More must be done in the ongoing HIV/AIDS epidemic than building more effective testing and service programs. What is now required is to adopt routine HIV screening of all patients as part of primary care services. The question is how the logistics of building HIV screening into the primary care program can be addressed and how to provide prevention, care services, and treatment for people infected with HIV.

## Ensuring confidentiality

Health center staff need to know: (1) the statutory and common laws of their state that relate to the confidentiality of HIV testing—in particular any state laws or regulations that require that the results of an HIV test be reported to government officials (city, county, or state health department); (2) the protections and limitations of the Health Insurance Portability and Accountability Act (HIPAA); and (3) any laws and regulations relating to partner notification and associated confidentiality protections.

Confidentiality of medical records is a major concern for many people, especially those newly diagnosed with HIV. The stigma associated with HIV/AIDS may make it difficult for people to disclose their HIV status to others. A patient may be forced from his or her home, a community might shut its doors, a boss may not understand, and an apartment lease may not be renewed.

Similar concerns about confidentiality may prevent a patient from consenting to an HIV test. CHC staff members can reassure patients that such information is held in strict confidence and that it will not be disclosed to others without informing or gaining approval from the patient. HIPAA provides patients with some legal rights concerning the privacy of health information, allowing the patient to set limits. Under most conditions, a patient can object to a health care provider sharing information with the patient's friends or family. Patients can ask to see their medical records and are allowed to make corrections.

Health centers are required to follow the law. Without patient authorization, medical information cannot be released to an employer. However, **HIPAA does not prohibit the disclosure of HIV test results to the public health department** as may be required by state law. In states that offer confidential HIV testing, it is important to explain to the patient that a person's name will be provided to health officials, along with information on the person's HIV status. In some situations, HIPAA also does not protect against disclosure in response to court subpoenas.

HIPAA provides patients with legal rights concerning the privacy of their health information and health center employees are well-schooled in informing patients of those rights; however, concerns about confidentiality of test results may still be a barrier to testing for some patients. The stigma associated with HIV and AIDS still exists in America. For some patients, there are worries about who in the community—in their place of worship, at their job, or in their family—might learn about an HIV test having been performed and/or the results.

It is the responsibility of each health center to create an environment in which patients feel emotionally safe and have confidence that HIV test results will remain confidential. Moreover, as routine HIV screening becomes the standard of care for all primary care patients, stigma around the actual testing will be greatly reduced.

Since this guide is intended for use throughout the country, it is not practical to attempt to discuss each state's laws. However, many states have specific laws imposing confidentiality requirements with respect to HIV test results and those laws vary in terms of who must keep information confidential and the circumstances under which confidentiality protections do not apply. Health centers should address the specifics of the laws of the state in which they operate in their procedures, protocols, and staff training related to HIV testing and should contact local legal organizations or the health department for guidance.

The *Compendium of State HIV Testing Laws* is a valuable resource that describes key state HIV testing laws and policies. Each state's HIV testing laws are unique and many have undergone revision or supplementation since the release of the CDC's 2006 HIV testing recommendations. The Compendium is designed to help clinicians understand HIV testing laws and to implement sound HIV testing policies. It should not, however, be used as an official legal document.

## Implementing alternatives to opt-out HIV testing

NACHC has not contemplated alternatives to opt-out testing but recognizes that the need may arise should routine HIV screening of all patients be financially unsustainable or prohibited by state law.

## Testing alternatives and procedures

Rapid HIV tests are essential to routine HIV screening in the primary care setting—especially in CHCs. From the perspective of a patient who has an appointment for a primary care visit, the test is quick and easy—a simple finger-stick that he or she might be getting anyway or an oral swab of the inside of the mouth, instead of blood drawn from the arm. Since the sample is easy to collect, the test fits easily into the visit. Also, the results are given to the patient when meeting in the exam room with the provider. For the patient,

there is no appreciable time added to the visit to the health center—nothing to make the patient late for work or make the patient's children impatient, and more importantly, if the result is non-reactive, the results are considered “negative.” If a rapid test is reactive, it is only considered “presumptively positive” and a confirmatory HIV test must be performed on a second specimen. HIV testing pilot projects have shown that the rapid test is one of the main reasons CHC patients agree to testing.

From the health center's perspective, the rapid HIV test facilitates the integration of testing into the primary care visit. This is an important benefit for CHC patients who are difficult to reach because of homelessness or migration or who do not have access to a telephone. Coming to the health center for results from conventional testing can be a challenge for some patients who have to travel long distances, who lack transportation or child care, or who work long hours. Adding the rapid HIV test to others at CHCs will not add to patients' transportation burdens since health centers that perform multiple laboratory functions will already have some of the skills and capacity necessary to perform HIV rapid tests. However, appropriate training is essential to achieving an increase in routine HIV testing as endorsed by CDC and CHCs should assess and address their staff training needs once an HIV testing modality is selected.

It should be recognized that, for some health centers, the use of conventional testing (ELISA and Western blot) through a reference lab or local health department may be the most appropriate option. This approach may work better when providers are already drawing blood for other diagnostic or screening tests and for patients that have an established relationship with the health center and can be easily located in the event of a positive result. One of the benefits of conventional testing is the lack of the need of a confirmatory test since this is already built into the testing panel. In some communities, health departments may provide testing supplies and/

or laboratory services free of charge. Also, some providers prefer conventional testing and find rapid testing stressful because they don't have a lot of time to prepare to deliver reactive results.

Before initiating a routine testing program, all health centers should explore the pros and cons of rapid testing versus conventional testing so that they may identify the option that best meets their needs and those of their patients.

## **Encouraging patients to return if a confirmatory HIV test is performed**

Once a CHC has established HIV screening as a routine part of medical care, initial post-test counseling will occur in the context of the visit in which the HIV rapid test was performed. The CHC staff person should talk to the patient regarding any anxieties about being tested or receiving the results. Discuss how the patient may feel during the waiting period, what the patient may need during that time, and how the health center can assist. How will the patient feel if the result is negative? How will the patient feel if the result is positive? Letting patients know there are options, support, and services available, regardless of the test results, might give them the resolve to have the test. Staff should explore the potential barriers, such as transportation, that might prevent patients from returning to the health center and work with them to solve those problems so the likelihood they will return for their results will increase.

If the rapid test is non-reactive, the result should be considered "negative" and the patient should be counseled accordingly.

If a rapid test is reactive, it is only considered "presumptively positive" and a confirmatory HIV test (generally Western blot) must be performed on a second specimen; a follow-up visit should be scheduled for the patient to receive the results. The patient should also be provided with information about risky behavior and strategies for prevention when the confirmatory test

specimen is collected, so that they will have that information before their follow-up appointment and even if they fail to return. A follow-up visit should be scheduled (whether for test results alone or in conjunction with a medical follow-up) before the patient leaves the clinic and the patient should receive an appointment card that includes the CHC's contact information. The follow-up visit can then become an opportunity to link the patient to care, or to psychosocial and other services if needed.

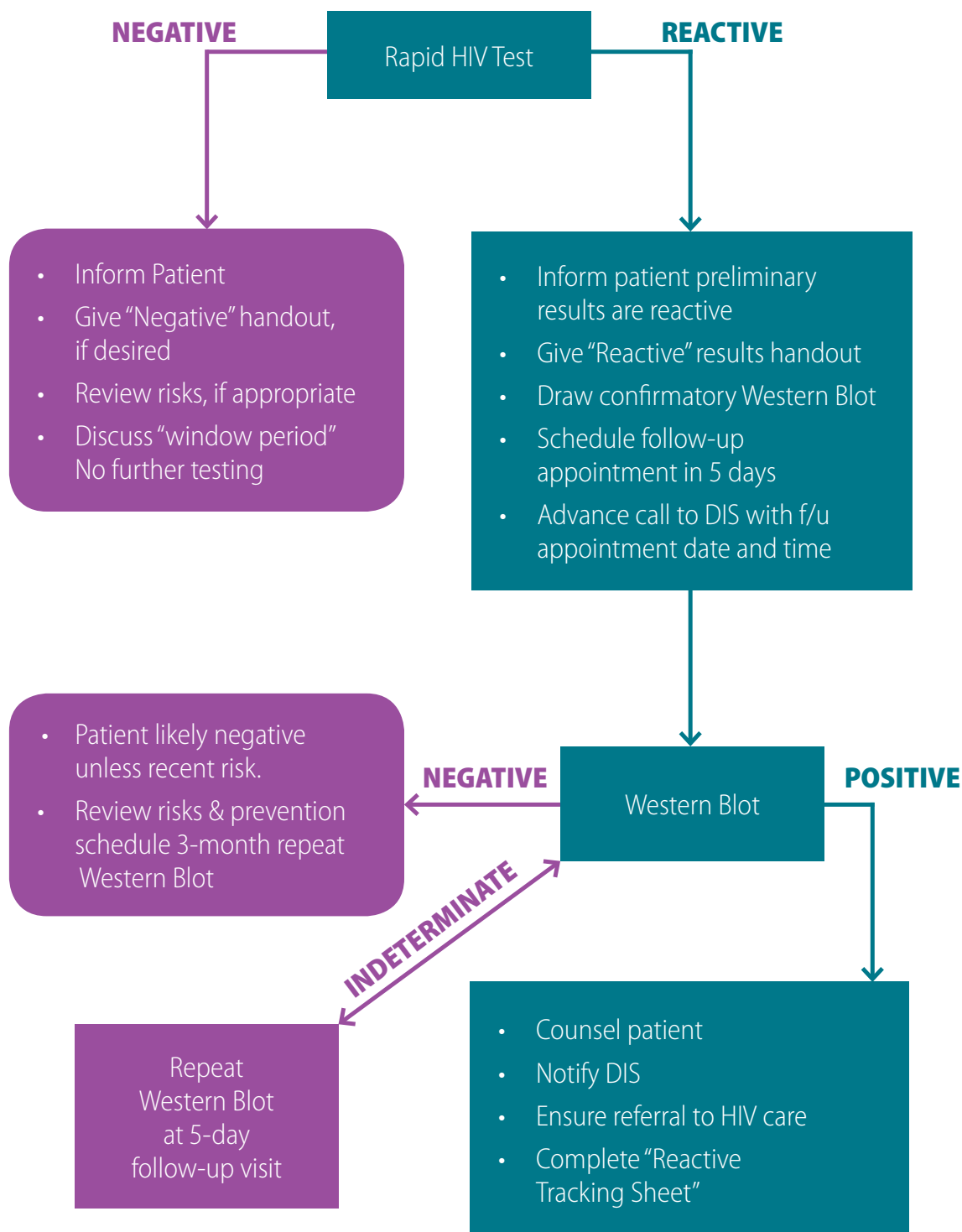
There are other confirmatory tests that can be used in instances where the Western blot results are uncertain: the Radioimmunoprecipitation assay, the Immunofluorescence assay, and the nucleic acid test. The polymerase chain reaction test is a specialized test that looks for the presence of the virus, not just for antibodies. It can detect HIV in someone who was recently infected, unlike the ELISA which may not detect HIV if the patient was infected 1 to 3 months prior to taking the test (a time known as the "window period").

All confirmatory tests can require days or weeks to get results back.

Patients who fail to return for their follow-up visit should be contacted regardless of whether the confirmatory test result is positive or negative so that they know their status and can be counseled accordingly. If the confirmatory test is positive and a patient fails to return to obtain the results, disease intervention specialists (DISs) from the local health department can be very helpful in locating and counseling him or her in a field setting.

# Routine HIV Screening

Interpreting preliminary and confirmatory test results





## Providing test results to patients

Patients receive the result of the rapid HIV test during the same primary care visit in which the test is performed. So for example, the test may be offered when the patient's vital signs are taken. By the time the patient is in the exam room with the provider, results are available for the provider to give to the patient. NACHC has created tools for providers to use when delivering results of the rapid HIV test (see item 1 in the technical assistance section at the end of this document).

In the event that the patient has a reactive rapid HIV test result and requires a confirmatory test, a blood draw will be required for the Western blot test and an appointment must be scheduled for the patient to return to the center to be given these test results.

## HIV Post-Test Counseling

If a rapid test has been used, the post-test counseling session occurs at the close of the primary care visit or, if a conventional test has been used, patients return to the CHC in about 1 week. This session provides both information and prevention counseling to patients.

### Delivering results to a person with a negative HIV test

It is important to let the patient who has tested negative for HIV know that this result does not mean immunity from infection. Nor does it mean that the patient is not engaging in activities that continue to put him or her at risk. For patients who continue to engage in risky behavior, it is important to identify barriers to risk reduction and to give information about steps patients can take to minimize or eliminate possible exposure to HIV. The provider should address the importance of being re-tested if the patient has engaged in unsafe behaviors during the “window period”—the time period after exposure during which an HIV test will be negative. Determine whether there is a need for referrals to other social service organizations that treat co-factors such as substance abuse, mental illness, or addictive sexual behaviors. Explore how friends and family can support behavior change or whether these people may apply pressure to continue

risky behavior. Identify how the health center can play a role in supporting positive behavior changes. Patients who indicate that they plan to continue risky behavior should leave the post-test counseling session with written materials on HIV prevention, condoms, and a referral to more intensive prevention counseling services from a community-based organization or the local health department. However, because HIV testing is a routine part of primary care and not based on assessed risk, many patients will not require these additional measures.

### Delivering results to an HIV-infected patient

As you prepare to tell a patient that the test result is preliminarily positive (rapid test) or confirmed as positive (conventional test), be sure that there are additional supportive resources available to the patient. This may mean a mental health counselor, social worker, or psychologist. If you are planning a post-test counseling session at the center, communicate with the appropriate staff in advance of the appointment so the time on the staff member's schedule is blocked out for when the patient may need that person's help. Remember, some patients might be better prepared to receive positive test results than others. The emotional impact of hearing

these results may prevent patients from clearly understanding information in the post-test counseling session.

If the tests are performed away from the primary care site, such as at a health fair or at a church, it is also important that a predetermined process for support and referral is in place. Names, telephone numbers, and transportation to counseling and supportive services, either at the health center or at a partner organization which provides these services, needs to be confirmed and available. Timeliness and efficiency are critical for these individuals to ensure that they are linked to care and are provided with a medical home.

Health centers should strongly consider partnering with the local health department DIS workers who may be able to assist with delivering results, with post-test counseling, and with partner services. These may be particularly important resources for sites that lack social workers or other staff trained in this area.

## Immediate clinical management issues

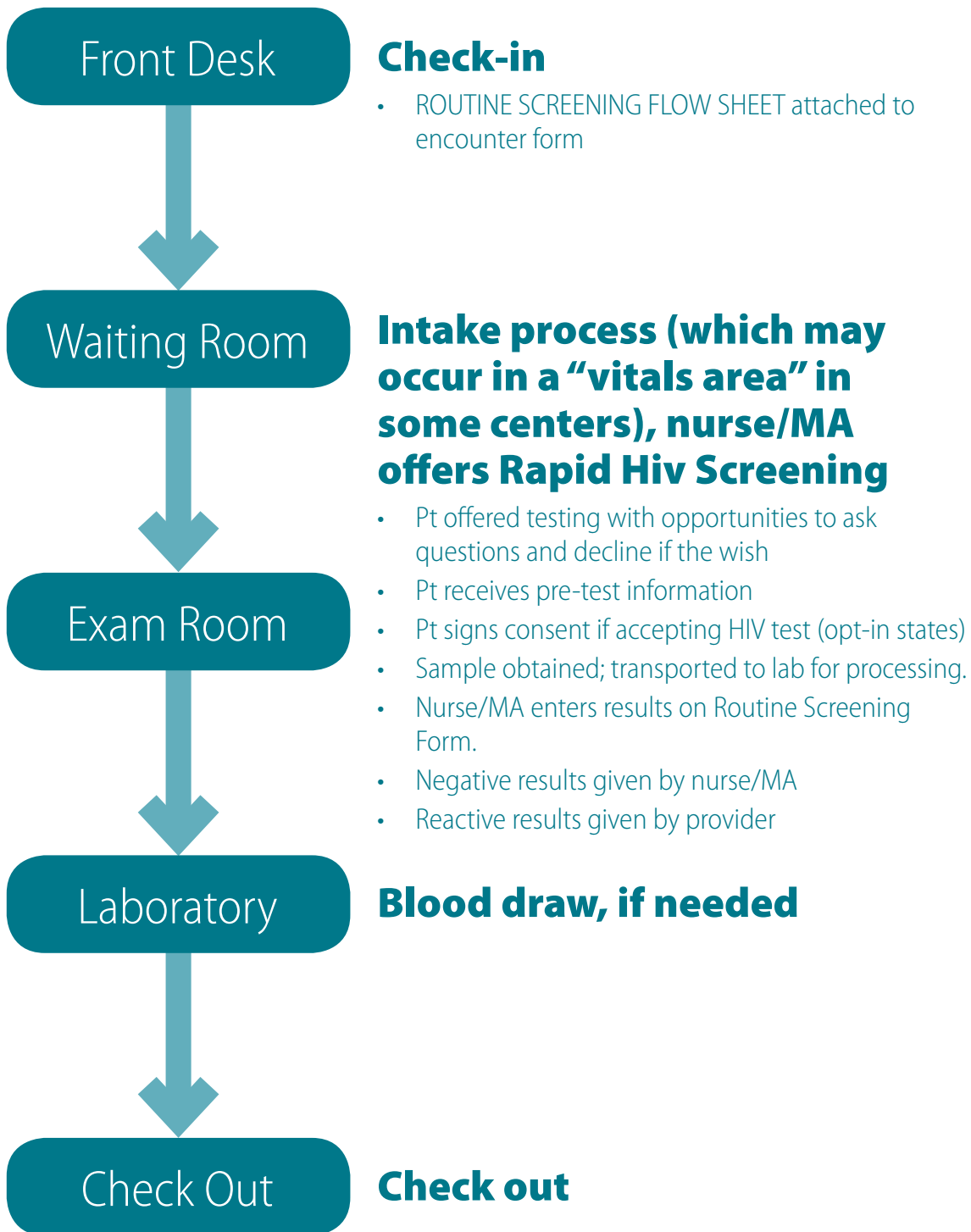
Depending on the patient's state of mind and behavior during the post-test counseling session, it might be appropriate to assess whether the patient is at risk of committing suicide or other violent behavior. If you have any concerns about the patient's safety or the safety of others (for example, a patient who may go after a partner whom he or she suspects of transmitting the virus), obtain the immediate assistance of a mental health counselor.

After patients receive their positive results, usually from a health center provider they trust, they need to be informed about taking precautions regarding risky behavior, given the name of their contact at the health center, and given ways to contact additional sources of information, such as the health department and CDC hotline numbers **(Call 1-800-CDC-INFO [1-800-232-4636], 24 hours a day, 7 days a week, or email [cdcinfo@cdc.gov](mailto:cdcinfo@cdc.gov). [For TTY, call 1-888-232-6348].**

All patients should be offered confidential partners' services through a health department DIS worker. Participation in partners' services should be voluntary and non-coercive.

Before beginning a routine testing program, health centers need to determine who should treat the newly diagnosed patient (e.g., an HIV care provider at the health center, a Ryan White-funded program, a local infectious disease provider, or another community resource that may be available) to support the complexities of care and treatment. If a health center plans to co-manage patients or refer them to a community HIV primary care provider, they need to establish these referral relationships in advance of initiating routine testing.

## Patient Care Model with Integrated Rapid HIV Testing



## Matching patients with appropriate medical care

Establishing a referral network of appropriate medical care is an issue specific to each health center. All centers have referral systems in place for many types of specialty medical care; community health centers are experienced in setting up these systems. The quality and efficiency of these systems depend on what services are offered locally and regionally. Patients at a rural health center may have to travel a long distance for specialty care or to the nearest Ryan White-funded organization or other HIV primary care program. Health centers should establish a referral system for their patients with HIV before launching routine HIV screening within their primary care program.

It is essential for the health center to maintain a referral system that is timely, patient-centered, and comprehensive. In some cases, patients with HIV may also be co-managed at the health center.

## Making referrals to support services

People newly diagnosed with HIV may have complex needs that extend beyond the infection. Many are poor, are without access to health care, or have other physical or mental issues. For example, according to CDC, 18% of people with HIV have substance abuse problems. It is estimated that more than half have mental health issues. The National Alliance to End Homelessness estimates that 3%–19.5% of the homeless population is infected with HIV, a rate much greater than the 1% seen in the general population.

In addition, a patient infected with HIV may have other needs that can impact his or her ability to seek and receive care. For example, the patient

may not own a car or have access to public transportation, or a parent may not come in for treatment at the required time if a sitter cannot be found. The patient may need additional support to maintain adherence or to avoid risky behaviors.

It is not necessary, or even realistic, to assume that the needs of all patients can be met by staff members alone, or even by the health center. Establishing communication links between staff in the health center and between the health center and other service agencies in the community will help ensure that patients get the support needed to stay in, and benefit from, care.

It may be useful to enlist the help of individuals whose work involves helping patients navigate the health care system and gain access to services, such as health department DIS workers, Ryan White or Medicaid case managers, care coordinators, social workers, or benefits counselors. If there is not such a person in your health center, check to see if the patient is eligible for those services from the local health department or another community-based agency. Many federal agencies fund these services for patients with HIV, so there is a good chance they will be available locally.

Where possible, communication links with other health centers, agencies, and clinics should be formally established and maintained through regular communication and ongoing contact. Periodic case conferences and written communications can be useful tools in coordinating patient care and services. These need to be done after obtaining appropriate documentation of patient consent.

## Disclosure and partner services

The function of partner services (PS) is to inform past and present sexual and/or needle-sharing partners of diagnosed individuals of their possible exposure to HIV. PS is a voluntary and confidential prevention activity with the following goals:

1. Provide culturally appropriate services to HIV-infected persons and to any sexual and needle-sharing partners in order to avoid infection or, in the case of the newly diagnosed health center patient, to prevent transmission to others and
2. Help partners gain earlier access to individualized counseling, HIV testing, medical evaluation, treatment, and other prevention services.

Health care providers should strongly encourage patients to disclose their HIV status to their spouses, current sex partners, and previous sex partners and to recommend that these partners be tested for HIV infection. Health centers are **strongly** encouraged to work with their local and state health departments to facilitate the PS process for **all HIV-positive patients**. Partner notification is an important component of PS and can aid in identifying persons who are potentially infected with HIV. There are two main avenues of partner notification: patient or provider. With patient notification, patients directly inform partners of their exposure to HIV. With provider referral, the primary care provider or trained health department DIS worker locates partners using the names, descriptions, and addresses provided by the patient. During the notification process, the confidentiality of the patient is maintained and the patient's name is not revealed to partners who are notified. Partner notification helps ensure early testing of possible contacts and early referral to prevention, treatment, and case management services if results indicate HIV infection. Partner notification is a key HIV

prevention strategy and should always be voluntary, confidential, and culturally appropriate.

PS should not be a one-time service. It should be offered as soon as an individual learns that he or she is infected with HIV and should be made available throughout that person's care and treatment if there is an indication of risky sexual or drug-use behavior with a person of unknown or HIV-negative status or if there is a diagnosis of an STD. This is especially true for patients in health centers that provide HIV primary care services on-site or that co-manage patients with another medical provider. If new partners are exposed in the future, PS should be made available again. HIV-infected individuals should have the ability to access PS whenever needed; it must always be voluntary.

## Reporting HIV/AIDS cases and other applicable laws and regulations

Health centers must follow state laws and health department regulations for reporting confirmed cases of HIV infection. For more information on reporting requirements and other laws and regulations pertaining to partner services, confidentiality, or other issues, health centers should contact their state or local health department. The Compendium of State HIV Testing Laws describes key state HIV testing laws and policies and can also be a valuable resource. Each state's HIV testing laws are unique and many have undergone revision or supplementation since the release of CDC's 2006 HIV testing recommendations. The Compendium is designed to help clinicians understand HIV testing laws and to implement sound HIV testing policies. It should not, however, be used as the only source of official legal guidance.



## Duty to warn

Health centers should become familiar with the state laws regarding duty to warn, which offer guidance on protecting a patient's confidentiality and informing a partner about the patient's HIV status. Persons providing services to those who are infected with HIV have the responsibility to encourage them to disclose their HIV status to sexual partners and to anyone with whom they may have shared needles or drug equipment. This can create a quandary for someone who is working with a patient who chooses not to share this information with a spouse, partner, or others and thereby continues to put those people at risk. Health care providers may feel torn between informing an unsuspecting partner about the ongoing behavior and a concern about breaching

the patient's confidentiality. However, legal responsibilities concerning a duty to warn are often a matter of state law and such questions should be shared with a supervisor, administrator, and legal counsel. Physicians may have a unique responsibility in this area that differs from other health care personnel.

Health centers should address the specifics of the laws of the state in which they operate in their procedures, protocols, and staff training related to duty or privilege to warn. It may be advisable to contact local legal organizations or the health department for guidance.

## Technical assistance and other resources

For more information on implementing routine HIV screening in health centers or to find out about health centers in your state that may already be conducting routine HIV screening, please contact:

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E-mail: [kmcnamara@nachc.com](mailto:kmcnamara@nachc.com)  
Phone: (301) 347-0400.

## Other resources

1. National Association of Community Health Centers, Inc. <http://www.NACHC.org>.
2. *Integrating HIV Screening into Routine Primary Care: A Health Center Model*. Available at <http://www.nachc.com/clinicalhiv.cfm>.
3. Teague R. *Resources and References for HIV Routine Testing in Health Care Settings*; 2009. Available at <http://aidsetc.org/aidsetc?page=etres-display&resource=etres-427>.
4. Agency for Healthcare Research and Quality. Community Health Centers Integrate *Rapid HIV Screening into Routine Primary Care, Leading to Significant Increases in Testing Rates*. Available at: <http://www.innovations.ahrq.gov/content.aspx?id=2445>.
5. Society of General Internal Medicine. *Routine HIV/AIDS Testing*. Available at <http://www.sgim.org/index.cfm?pagelid=391>.
6. National HIV/AIDS Clinicians' Consultation Center. *Compendium of State HIV Testing Laws*. Available at [http://www.nccc.ucsf.edu/consultation\\_library/state\\_hiv\\_testing\\_laws/](http://www.nccc.ucsf.edu/consultation_library/state_hiv_testing_laws/).

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