

CDC: Revised Recommendations for HIV Testing of Adults, Adolescents, and Pregnant Women in Health-Care Settings; Policy Background and Recommendations

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Background

The Centers for Disease Control and Prevention (CDC) last updated their human immunodeficiency virus (HIV) screening guidelines for all adults, adolescents, and pregnant women in 2006. These clinical guidelines state that all people between the ages of 13 and 64 years should be screened for HIV at least once in their lives. This same guidance notes that individuals at higher risk for HIV infection (e.g., gay, bisexual, and men who have sex with men [MSM]) should be rescreened at least annually while sexually active).

In 2017, the CDC released brief guidance advising clinicians to screen patients more frequently based on individual risk factors (e.g., sexual activity), local HIV rates, and local policies.

This policy brief reviews current definitions of HIV **screening**, outlines the **problems** with current practice around HIV screening, and offers specific **policy recommendations** for addressing these problems.

HIV Screening, Defined

The CDC defines HIV screening as HIV diagnostic testing for patients, specifically “performing an HIV test for all persons in a defined population”.¹ The CDC notes that all adolescents and adults should receive HIV screening at least once unless they decline the test (i.e., opt-out of testing). CDC guidance notes that HIV testing should be an element of all prenatal testing and occur during the third-trimester of pregnancy in regions with high HIV transmission rates, unless they opt-out of testing. The guidance further notes that clinicians do not need to request separate written consent from patients to provide this screening.¹

Table 1 presents existing problems with the CDC’s HIV Screening Guidelines as well as policy recommendations vetted by a stakeholder group including PCPs, policy experts, public health practitioners, and academics.

Table 1:
HIV Screening Policy Problems & Recommendations

Policy Problems	Policy Recommendations
HIV screening is narrowly defined as diagnostic testing, which does not include the vital priming conversations and counseling that should preface and follow all clinical testing. This is especially salient since the HIV screening guidelines rely on more	We must expand what counts as ‘screening’ beyond HIV diagnostic testing alone to include HIV screening conversations . Such screening conversations must normalize discussing sexual health, use sex-positive language, and rely on a set of

<p>than one HIV testing approach. The conversations that occur in a clinical setting between patient and practitioner are a critical part of screening and are not clearly addressed in any of the guidance documents available through the CDC.</p>	<p>standardized questions asked of all patients. The Give-Offer-Ask-Listen-Suggest (GOALS) framework² recommends that clinicians introduce sexual history taking as part of primary care that is not focused on risks but on health. In this way, patients may feel more comfortable talking about sex as a natural part of their lives and healthcare. Clinicians can use the sex and STI counseling ICD-10 code (Z70) to bill for time spent posing and fielding questions during limited clinical time. Policy makers can also investigate creating a CPT code and other billing codes for HIV screening discussions.</p>
<p>HIV testing approaches are not implemented in a standardized and comprehensive way. CDC HIV screening guidance calls for a minimum of risk-based HIV testing. With this approach, clinicians use risk-based screening to determine which of their patients are suited for testing. The problem with this approach is that when HIV testing is left to the discretion of clinicians, patients are inherently profiled for their perceived risks. As implemented, risk-based screening increases the stigma associated with having HIV and getting tested for HIV. This approach relies on bias- and not just racial, ethnic, sexual, and gender-related bias- but also age and marital status bias.</p> <p>Still, the CDC clinical guidance recommends that the ideal approach to HIV testing is the opt-out method, wherein HIV testing becomes a routine clinical laboratory test patients receive as part of their primary care unless they decline. This approach remains problematic in its implementation because patients are not introduced to HIV testing as an opt-out test nor are these tests prefaced with HIV counseling. In most settings and regions where HIV testing is</p>	<p>To eliminate stigma, clinicians must invite all patients to get tested for HIV. Federally qualified health centers and states with opt-out HIV testing demonstrate the high yields of universal (or routine) HIV screening, despite doubts that the costs outweigh the benefit.³</p> <p>When implementing HIV as the standard of care as a universal screening, opt-out discussions and informed refusal needs to occur consistently, and as part of sexual history taking and counseling.</p>

<p>routine, it is not combined with a sexual history taking. Instead, the HIV test is automatically included in the battery of lab tests run. This is a violation of patient rights to informed refusal. Experiences like these only reinforce patient mistrust and fear.</p>	
<p>Recommending HIV testing at least once for patients between the ages of 13 and 64 is not enough. For clinicians who work in settings where HIV testing is not the standard of care, patients' ongoing needs are not accounted for with a once in a lifetime screening recommendation.</p>	<p>Screening conversations need to occur regularly (at least annually) during PCP visits. To help clinicians remember to engage in sexual history taking and overall sexual health conversations, a reminder can be added to the electronic medical record that automatically comes up on the screen. In this way, when clinicians are introducing a range of other preventative screenings and/or managing the health of a medically complex patient, they do not run the risk of forgetting or omitting this necessary part of the primary care visit.</p>
<p>As current CDC guidelines do not provide language regarding priming conversations and counseling, there is also a gap in guidance as to how PCPs should support minoritized patient populations.</p>	<p>While clinicians should rely on compassionate and nonjudgmental communication for all of their patients when discussing sexual health and HIV screening, they need to especially rely on culturally responsive communication when caring for racial, ethnic, sexual, and gender minoritized patients. This form of communication invites clinicians to not only consider their patients' culture but to also do so alongside the culture of medicine, the culture of racism, as well as their own culture. This reflexivity will allow clinicians to practice antiracist and unbiased care. The Two in One Model offers free CME-bearing training on practicing culturally responsive communication.</p>
<p>There is currently no focus on the patient experience related to screening and counseling present in CDC guidelines. This gap presents ongoing concerns that</p>	<p>Accountable Care Organizations must partner with clinicians and public health practitioners to identify indicators of quality care for patient engagement. One</p>

emerging policy guidance may continue to perpetuate structural inequities that contribute to health disparities.	such example may include patient satisfaction.
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Call to Act

Join our [Mailing List](#) and commit to engaging with our stakeholder network in the coming months to discuss policy design, practice, and health improvement efforts, engage in a [collaborative discussion](#) with researchers, advocacy organizations, educational societies, and PCPs in clinical practice to inform policy development, and plan to attend the GW Two in One Program Policy Summit (details to come in early 2024)!

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References

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